Report of the Primary Care Payment Work Group to the ACO Payment Sub-Committee December 29, 2015

I. Provider Payment Model: Primary Care Capitation (From the "Framework")

Primary care providers (PCPs) are the foundation of Vermont's health care system and are critical to the success of the State's health care reform initiatives. Primary care provider payment should more accurately reflect the value of primary care, and steps should be taken to increase payments to PCPs either through enhanced fee-for-service payments, or preferably, through capitation payments based on the enhanced fee-for-service payments.

Based on the above premise, primary care practices participating in the ACO should be offered the option of primary care capitation or enhanced fee-for-service payment. Preference should be given for adoption of capitation payments by those practices for which it would be suitable. The Primary Care Payment Work Group ("Work Group") recognizes that capitation may never be a viable option for some practices (e.g., very small practices that may never have enough attributed patients). However, all primary care practices participating in the ACO should be entitled to enhanced FFS payments and be eligible for performance incentive payments. The GMCB should require that primary care providers are paid based on approved payment methods by either the insurer or ACO.

II. Special Considerations for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

FQHCs and RHCs participating in the ACO network should continue to be reimbursed in accordance with federal rules related to FQHC and RHC payments. The State should not ask CMS to waive its FQHC and RHC payment regulations, FQHC and RHC service requirements, and/or FQHC and RHC HRSA grants, as part of the waiver negotiations. An exception to the above would provide that the State may ask CMS for flexibility to pay FQHCs and RHCs for Medicare services through an alternative reimbursement method if the payment model is mutually agreed upon by the ACO, FQHCs and RHCs. FQHCs and RHCs may also accept Medicaid alternative payment models that are mutually agreed upon by the ACO, FQHCs and RHCs. Commercial payments to FQHCs and RHCs participating in the ACO should be based on capitation payments or enhanced fee-for-service payments approved by the GMCB and the ACO for primary care practices. FQHCs and RHCs participating in the ACO will be eligible for enhanced performance-based payments as approved by the ACO and the GMCB.

III. Primary Care Capitation Rate Characteristics

- Primary care capitation rates should be structured with a goal of similar payment for panels with similar patient characteristics. While the ACO may receive different capitation payments from different types of payers (Medicare, Medicaid, commercial),

the ACO should be allowed to blend those payments into a common risk-adjusted capitation payment for primary care practices based upon the health status of the patients that are included in the practice panel, and not related to the payer mix of the panel. These capitation payments should be sufficient to produce income for primary care providers in the practice to be consistent with the goal to increase payments to primary care providers. Measures of the adequacy of these payments may be related to market payments to hospitalists and/or emergency department providers and should result in a re-balancing of primary care payments as a percentage of total health care expenditures.

- Measures of the adequacy of these payments may be related to market payments to hospitalists and/or emergency department providers and should result in a re-balancing of primary care payments as a percentage of total health care expenditures. It is assumed that these increased payments to primary care providers would be funded within the context of an overall cap in annual growth of health care expenditures, and would likely result in lower percentage increases from year to year in the expenditure growth rates for hospitals and specialists in Vermont relative to primary care clinicians.

Capitation rates should:

1. Be clinically risk-adjusted using a method(s) other than HCCs for commercial and Medicaid, with possible additional future adjustment for socioeconomic risk following investigation of potential methods;
2. Be based on enhanced primary care fee-for-service rates using a common service set, and with any rate increases financed by reductions in hospital and possibly specialists growth rates as part of a population health management approach;
3. Be developed based on aggregate utilization experience across all practices by line of business (i.e., commercial, Medicaid, Medicare), rather than based on the utilization experience of each individual practice;
4. Account for the delivery of capitated primary care services by provider(s) other than the patient's designated primary care provider;
5. Be complemented by performance incentives that, in a to-be-defined fashion, blends practice-specific, regional and statewide performance;
7. Be potentially complemented by performance incentives *or* disincentives specifically related to ED visits and specialty referral rates;
8. Replace Blueprint practice support payments for qualifying practices;
9. Be potentially supplemented for newly attributed patients to cover the costs of outreach and an expanded assessment, and
10. Not obviate the obligation of the practice to submit claims for information tracking purposes.

In order to develop an approach to the design of capitation payments based on the principles noted above, the ACO Payment Subcommittee created the Primary Care Payment Work Group ("Work Group") and charged it with the following tasks:

> ***The Primary Care Payment Work Group shall develop detailed operational specifications for the methods by which primary care practices participating with a unified ACO shall be paid for their services. The work group will use the methodology description contained within the "Vermont ACO All-Payer Framework" as a starting point for its deliberations. The work group shall focus upon how best to design and implement a primary care capitation model. The work group shall draw upon the expertise of its members and the experience of payers and providers with operational primary care capitation models outside of Vermont. The work group shall also consider the role and design of possible complementary performance incentive bonuses. The final product shall be presented to the ACO Payment Subcommittee for review, discussion and adoption. It should provide sufficient detail such that primary care practices considering ACO participation would feel adequately informed regarding how they would be paid – although not how much – if they should chose to join the ACO.***

IV. Identifying Primary Care Providers

Prior to Work Group formation, the Payment Subcommittee drew upon the experience of its clinician members to develop the criteria by which primary care should be defined. These recommendations included both the types of services to be provided and examples of the types of diagnoses to be covered, and were used to define the specialties to be included in the definition of primary care. The services recommended for inclusion were the following:

<u>Preventive care</u>

- comprehensive "wellness" visits
- immunizations: counseling and administration
- injections and medications administered in the office
- lipid, diabetes, depression, substance abuse, obesity, and blood pressure screening, and management and initial treatment of abnormal screenings
- ordering and managing the results of recommended screening tests for ages /risk groups appropriate to specialty. For example:
    - Pediatrics/ Family Medicine: newborn screening, developmental screening, lead
    - Internal Medicine/Family Medicine: colon, breast, cervical cancer screenings

<u>Acute care</u> of appropriate common problems for age groups of specialty (e.g., sore throat, headache, febrile illness, abdominal pain, chest pain, urinary symptoms, rashes, GI disorders, bleeding)

- telephone triage and same-day visit capability
- 24/7 telephone availability for triage and care coordination

- ordering and managing appropriate testing, prescribing medications, and coordinating referrals and consultations for specialty care

Chronic care of common medical problems, including at least: allergies, asthma, COPD, diabetes (type 2), hypertension, lipid disorders, GERD, depression and anxiety

- arranging and managing regular testing, screenings, consultations appropriate to the conditions

Coordination of care

- providing a "Medical Home" for a panel of patients
- maintaining a comprehensive, current medical record, including receipt, sign-off and storage of external records, consults, hospitalizations and testing
- assisting in transition of care into facilities, and in return to outpatient care

Other

- selected outpatient laboratory tests (lipids, HbA1c and PT/INR[1])
- health education and counseling services performed in the office
- routine vision and hearing screening
- prescribing common primary care acute and chronic medications using an unrestricted DEA license

Based on this definition of primary care services, the Work Group agreed that the provider would be considered to be a primary care provider if meeting each of the following three criteria:

1. The provider specialty must be one of:

- Family Practice;
- Internal Medicine with no subspecialty;
- Internal Medicine with subspecialty of geriatrics;
- Pediatrics with no subspecialty;
- General Practice,
- Nurse Practitioner[2], or
- Physician Assistant.

2. The provider must be designated as a PCP by BCBSVT, DVHA or MVP, initially.

For providers designated by one or two, but not all three, GMCB and the plans will consider them on an individual basis to understand the cause of variation.

[1] Prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are used to determine the clotting tendency of blood.
[2] Currently coded in VHCURES as "RN."

3. The provider must not be a hospitalist as defined using the method of Welch et al.
See www.cms.gov/mmrr/Downloads/MMRR2014_004_02_b01.pdf.

It should be noted that in the Vermont Universal Primary Care Analysis, Act 54 of 2015, Universal Primary Care is defined as "health services provided by health care professionals who are specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and includes pediatrics, internal and family medicine, gynecology, primary mental health services, and other health services commonly provided at federally qualified health centers. Primary care does not include dental services". This is different than the work group's definition of primary care as described above since the work group's list excludes gynecology and primary mental health services.

V. Identifying Primary Care Providers: Working Definition Used for Analytic Work

The group's initial analysis found that many of these provider types, particularly internists and physician assistants, were providing very few services typically considered to be primary care. For example, there were providers primarily billing for inpatient hospital care codes. Because identifying providers listed as primary care providers by the payers in VHCURES was found to be infeasible, the Work Group analysis instead used a criterion that providers received at least 60% of their revenue from the services in the proposed list of capitation codes. This cutoff was used because it aligned with the criteria set by the Medicaid enhanced primary care payment program. The Work Group also analyzed the distribution of providers by the amount of revenue that they received from primary care services and determined that this cut-off point was not problematic.

Capitation Code Selection

Once the list of eligible providers was agreed upon, the Work Group identified the CPT codes that ought to be included in the capitation payments. This was done by examining previous work done by other groups studying primary care spending. The Work Group considered code sets developed by the Blueprint for Health and the RAND Corporation, and capitation code lists used by the Capital District Physicians' Health Plan and Massachusetts Medicaid. The selection process included the identification of services that had significant practice revenue impact. The final list was decided upon by the Work Group based on:

- CPT codes that accounted for a significant portion of primary care practice revenue;
- consensus that the service was a primary care services and/or the service was an important part of primary care in Vermont, and
- the service having been provided by a significant number of Vermont PCPs.

The Work Group examined the total spending for those codes where the service provider met the primary care definition for analysis. The results fell into four broad categories:

1. codes for which there was overwhelming consensus that the service should be included;
2. codes for which there was significant spending on for Vermont primary care providers, but which few of the sources examined had included;
3. codes for which there was limited consensus and limited spending, and
4. codes which appeared on few lists and which had little spending in Vermont.

All codes from the first group were included. These included categories such as office visits (e.g., CPT codes 99213 and 99214) which had significant spending, and also services with little financial impact, but which were widely considered to be an important part of primary care, such as alcohol and substance abuse screening.

Codes from the second group were included based on the group's assessment of their importance to primary care, particularly as it is practiced and paid for in Vermont. This group most notably includes the FQHC encounter visit code (T1015), and also some of the vaccine administration codes.

Codes with limited consensus and spending were discussed, but mostly excluded. These included many services which are still primary care, but which are performed and billed by a limited number of providers. This includes categories such as primary care visits to nursing homes or home visits by a primary care provider. The group decided that these types of services should still be paid for on a fee-for-service basis.

Finally, codes appearing on few lists and with little spending tended to be for services provided differently in other states. Vaccinations were the most striking example of this: Massachusetts Medicaid had included payment for the vaccines themselves in addition to the payment for administering the vaccines. Because the Vermont Department of Health pays for most vaccines outside of the insurance system, including them here was deemed inappropriate.

The list of codes and total spending across all payers is provided in Table 1. A complete list by individual CPT codes and payer is provided in Appendix A.

VI. Policy for Capitated Services Delivered by Non-Capitated Providers

The Work Group discussed how best to address payment for capitated services delivered by a providers other than the capitated provider. The Work Group endorsed the policy and practice of the Capital District Physicians' Health Plan:

- Request for fee-for-service payment to another practice that is part of the same tax ID (i.e., the same corporate provider entity) as the capitated practice for a capitated service to a capitated practice-attributed patient should be *denied*.
- Request for fee-for-service payment to another practice that is not part of the same tax ID (i.e., the same corporate provider entity) as the capitated practice for a capitated service to a capitated practice-attributed patient should be *paid*.

- The ACO should run attributions monthly and if a capitated provider is not providing capitated services to a practice-attributed provider, but another ACO primary care practice is doing so, the ACO should switch patient attribution to the ACO primary care provider who is providing the services.
- Capitated primary care providers who make unexpectedly heavy use of urgent care providers, emergency departments and/or specialists should perform less well than other ACO-capitated primary care providers on their practice-specific performance-based incentive assessment.

Table 1: Spending by CPT Group

Group	Description	Codes	Spending
Office Visit	Office Visit	99201-99205, 99211-99215	$ 94,426,497
	Prolonged Service Office Visit	99354, 99355	$ 45,067
	Hospital Outpatient Clinic Visit	G0463 (Medicare only)	$ 6,519,567
Encounter Payment	Clinic Service (FQHCs)	T1015	$ 22,647,376
Preventive Visit	Comprehensive Preventive Medicine	99381-99387, 99391-99397	$ 21,925,027
	Preventive Counseling	99401-99404, 99411, 99412	$ 73,871
	Smoking Cessation Counseling	99406, 99407	$ 33,450
	Alcohol/Substance Abuse Screening	99408, 99409	$ -
	Health Risk Assessment	99420	$ 11,536
	Unlisted Preventive Service	99429	$ -
	Initial Preventive Physical Exam	G0402	$ 201,220
	Annual Wellness Visit	G0438, G0439	$ 1,797,206
Vaccine Administration	Immunization Administration	90460, 90461, 90471-90474	$ 5,916,827
	Flu Vaccine Administration	G0008	$ 448,981
	Pneumonia Vaccine Administration	G0009	$ 106,482
Care Management	Transitional Care Management	99495, 99496	$ 400,865

The Work Group agreed that T1015 should only be used for building FQHC capitation rates, for non-commercial payers, and that for patients who have seen both FQHCs/RHCs and private practices, the ACO should calculate the capitation rate either by using an average visit rate value for the FQHC/RHC visit, or by calculating a rate with just patients who have used private practices.

VII. Analysis of Primary Care Spending

The group examined how much of primary care providers' activity would be covered by this code set. The primary analysis used required that providers have a primary care taxonomy and received more than 60% of their revenue from the services on this list in 2013 and 2014. The payers participating in the Work Group ran the same analysis using their internal definitions of primary care providers. These are contractually defined relationships for the commercial payers, typically for the providers that a patient can select as their PCP if their plan requires such selection for certain products, or other providers in a primary care practice that the patient can see. The latter includes providers such as physician assistants who may not be able to be selected as a patient's PCP, but who are providing primary care within the practice.

The selected codes consistently accounted for 86% to 88% of primary care providers' revenue across payers. This broke down as follows:

Table 2: Spending by Payer (2014)

Payer	Total Spending on Potentially Capitated Codes	Share of PCPs' Total Revenue
Commercial	$ 75,660,131	86.8 %
Medicaid	$ 46,077,606	88.0 %
Medicare	$ 32,816,234	86.5 %

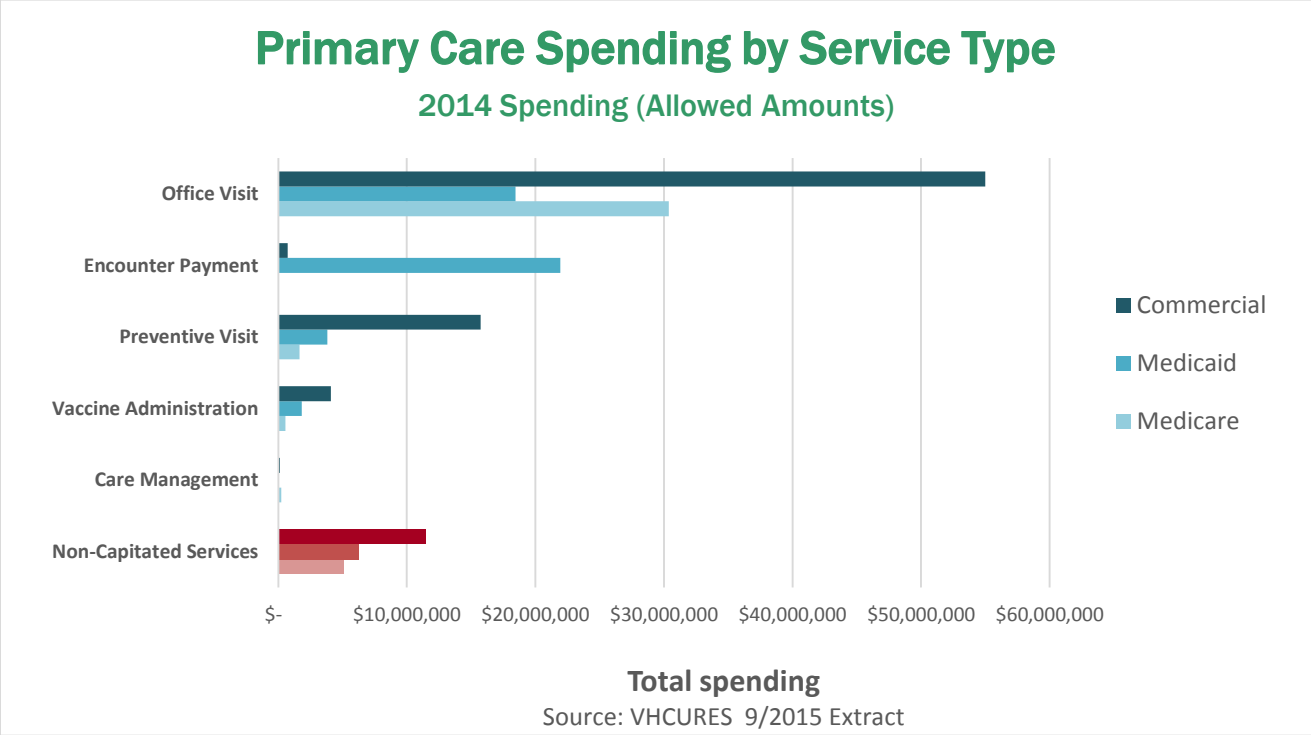
The analyses by the commercial payers yielded very similar results. This suggests that the algorithm used by the Work Group to identify primary care providers worked well, and that the code list selected will work well across payers.

Differences Between Payers

While the total code set yields consistent results across payers, the services billed for are not distributed in the same way. Commercial insurance paid for far more services labeled as preventative than either of the government payers, and Medicaid paid for a significant amount of its services through FQHC encounter payments. Medicare payment rules call for FQHCs to be paid on encounter rate, but the data did not appear to show this. The CPT codes that would have been used (G0466-G0470) did not appear in the Medicare spending analysis for providers

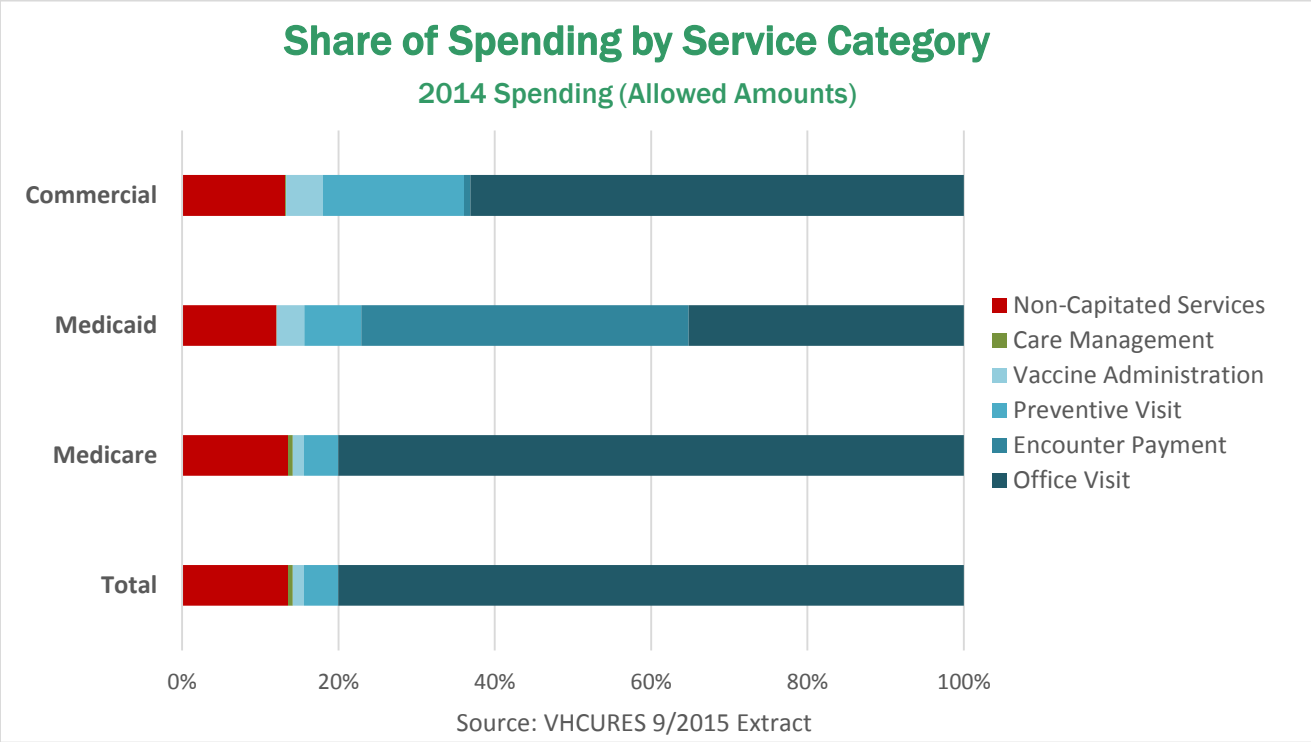
with potential primary care specialties. It is possible that these payments would be included under another specialty, which would require a change to the set of specialties considered to be primary care if FQHCs were to receive a capitated payment for Medicare patients. Encounter payments are a negligible portion of the commercial spending analyzed, as they are only used by one of the major payers, and that payer only recently began using the encounter code. Figure 1 gives the total spending by payer, and Figure 2 gives the distribution of the categories for each payer type.

Figure 1: Total Spending by Payer and Service Type



Note that while non-capitated services are displayed in red, they follow the same payer order as the other service groups.

Figure 2: Distribution of Spending on Service Categories



Spending Per Member

The group also examined the per-member-per-month spending for these services. This analysis was not intended to set a rate that the ACO would pay, but was intended to provide a baseline against which a future payment model might be evaluated. In fact, actual rates are likely to vary based on patient age, gender and clinical characteristics.

The analysis considered two figures: the per-member-per-month (PMPM) spending, which includes all members with coverage in the payer of interest, regardless of whether they used services, and a per-user-per-month (PUPM) amount, which only includes members who used primary care services in 2013, 2014, or the first quarter of 2015. The PUPM figure is likely higher than the PMPM capitation payment would be if the introduction of primary care capitation did not motivate change in PCP behavior. However, the capitation would incentivize providers to bring members who had not previously received services into their practices. Those members who currently use no primary care are likely to use a below-average amount of services even when they establish a relationship with a PCP.

The figures used to calculate PMPM and PUPMs are given in Table 3.

Table 3: Per-Member- and Per-User-Per-Month Spending

	Commercial	Medicaid	Medicare
Spending on Proposed Capitated Codes	$ 75,660,131	$ 46,077,606	$ 32,816,234
Average Membership	306,975	144,743 *	110,916
Members Using Primary Care	235,981	127,920 *	Not Available
Per Member Per Month	$ 20.31	$ 26.37 *	$ 24.66
Per User Per Month	$ 26.43	$ 29.84 *	Not Available

* Full-benefit, non-dual enrollees only

The limitation of the Medicaid analysis to full-benefit, non-dually eligible enrollee results in lower reported membership compared to many reported measures of Medicaid enrollment, but does not significantly impact Medicaid primary care spending. The reason for this is that the limited plans do not typically cover primary care services, and the Medicare-Medicaid dually eligible enrollees' primary care is first covered by Medicare, with Medicaid covering cost sharing and services not covered by Medicare.

Impact of FQHCs and the Enhanced Primary Care Payments on Medicaid PMPMs

The Medicaid per-member figures are inflated by two significant factors: FQHCs are paid at an encounter rate that is higher than other Medicaid payments (and is actually higher than the typical commercial office visit); and these data shows spending for 2014 which included the ACA-based, temporarily enhanced primary care payment rates for Medicaid non-FQHC spending.

The disaggregated PMPM is presented in Table 4:

Table 4: FQHC vs. Non-FQHC, 2014 Spending

	Per Member Per Month	Per User Per Month	Share of Visits	Share of Spending
FQHC	$ 34.71	$ 39.28	36%	48%
Non-FQHC	$ 21.67	$ 24.52	64%	52%

Impact of Enhanced Primary Care Payment Program

The Affordable Care Act's temporary increase in Medicaid primary care payments was discontinued at the beginning of 2015, leading to a significant decrease in payments to non-FQHC providers. This is shown in Table 5.

Table 5: Impact of Enhanced Primary Care Payment Change

	Per Member Per Month	Per User Per Month	Share of Visits	Share of Spending
Non-FQHC 2014	$ 21.67	$ 24.52	64%	52%
Non-FQHC 2015	$ 16.54	$ 19.34	63 %	45 %
Change	23.7 %	21.1 %		

This payment change did not impact the FQHC payments, and in fact the payment for the FQHC encounter code and the FQHC per member spending increased slightly from 2014 to 2015.

Cost to the System of Increasing Primary Care Payments

The actual cost of the ACO increasing primary care payments will depend on the amount of the increase and the types of providers impacted, but the Work Group began to estimate this impact based on historical spending levels. Table 6 shows the impact of both a 10% and 25% increase in primary care spending over 2014 levels.

Table 6: Impact of Potential Spending Changes

	Actual 2014 Spending	With 10% Increase	Cost of Change	With 25% Increase	Cost of Change
Commercial	$ 75,660,131	$ 83,226,144	$ 7,566,013	$ 94,575,164	$ 18,915,033
Medicaid	$ 46,077,606	$ 50,685,367	$ 4,607,761	$ 57,597,008	$ 11,519,402
Medicare	$ 34,570,034	$ 38,027,037	$ 3,457,003	$ 43,212,543	$ 8,642,509
Total	$156,307,771	$171,938,548	$15,630,777	$195,384,715	$39,076,944

Note that the baseline Medicaid spending here includes the 2014 enhanced primary care payment rates. Simply restoring Medicaid rates to the 2014 levels would require more than a 25% increase in spending for non-FQHC providers. If the total increase is targeted at the non-FQHC providers, however, this would be close to the total cost of a system-wide 10% increase in Medicaid primary care spending off of the 2014 baseline. This assumes that FQHCs would

continue to receive fee-for-service encounter payments from Medicaid at existing payment rates rather than participate in primary care capitation at the rate paid to non-FQHC primary care practices.

VIII. Summary of the Work Group's Work

As noted above, the mission of the Work Group was to identify how a capitation payment model for primary care providers might be implemented in Vermont. In that regard, the Work Group completed the following tasks:

- identify how primary care providers might be defined, and which providers should be eligible for capitation payments;
- identify, through an iterative process, the CPT codes (services) that appear to be appropriate for inclusion in capitation payments to primary care providers;
- analyze the comprehensiveness of these codes relative to historical spending on services provided by primary care providers, and calculate the percentage of services provided by PCPs that were covered by these codes. In all cases (Medicare, Medicaid, and Commercial), the percentage of services covered by these codes approaches ninety percent (90%). The Work Group felt that was a reasonable amount and was sufficient validation of the code selection;
- convert the amounts paid to the PCPs through these CPT codes into a per-member-per-month amount by payer in order to establish the credibility of a potential capitation amount for the ACO to consider, and
- calculate the cost of increasing the capitation payments to the PCPs by a range of percentages in order to meet the goal of increasing the share of total health care expenditures that flow to primary care providers.

IX. Outstanding Questions and Issues Regarding this Initiative:

A number of outstanding issues regarding a move to capitation payments were not specifically addressed by the Work Group because the group believed that many of these issues would best be addressed by the ACO MOU Steering Committee as part of the evolution toward one ACO, or by the ACO itself through its reconstituted governing body. These issues include:

<u>Payment Questions:</u>

- Should a supplemental payment be made to primary care providers to offset the cost of enrolling new patients into their practice?
- Should there be tiered capitation payments to practices that routinely offer mental health and substance abuse services, care management, and other non-traditional services as part of their service offerings?
- How will an adequate capitation rate be determined on a practice-by-practice basis?
    - Should the payer mix of a practice matter?
- Should performance incentives be used to increase or decrease the capitation payments and, if so, what should those performance incentives be and who will develop them?

- How much of an increase in primary care payments will be necessary to meet the goals of increasing access to primary care services, creating an environment that is more likely to attract more primary care providers to Vermont, and encouraging those who are in Vermont practices to remain in Vermont?

Quality and Performance Standards:

- Who will develop the quality and performance standards for primary care providers?
- What are the patient access standards, and how will they be measured?
- How will non-traditional services be tracked (e.g., telephone calls, e-mails, tele-health services, etc.?

Eligibility

- What eligibility criteria, if any, should be required for primary care providers to be eligible for capitation payments and quality and financial performance incentives?
- Should non-ACO practices be eligible to receive capitation payments?

X. Conclusion

The Primary Care Payment Work Group hopes that this report will provide guidance to the ACO, the Green Mountain Care Board, and others in the State as we move from fee-for-service payments to value-based payments such as capitation for primary care services. As noted above, this report was not intended to recommend specific capitation rates on a practice-by-practice basis, but rather to provide the framework for how those rates might be established, and which providers might be eligible to receive capitation payments. The report also presents a number of questions that will need to be answered regarding the structure of payments, the quality and financial performance requirements that might influence the payments, and the eligibility requirements that must be met in order to receive capitation payments. The Work Group leaves those questions for others to resolve.

The Work Group also wants to reference and acknowledge the work of the Vermont Universal Primary Care Analysis, which was presented to the Legislature in mid-December 2015. Although this report was undertaken by request of the Legislature for a different purpose, much of the underlying data necessary to complete both reports were very similar. For that reason, the staff of the Universal Primary Care Analysis and the staff of the Primary Care Payment Work Group went to great lengths to share information, assumptions, and conclusions during the development of both reports. It might be a useful exercise for the ACO to examine the similarities and differences and the reasons for the differences of the reports.

Respectfully Submitted:

Primary Care Payment Work Group
December 29, 2015

Members of the Primary Care Payment Work Group

The following individuals participating to varying degrees in the Primary Care Payment Work Group process between August and December 2015. While this report represents the general consensus of the participants, this acknowledgement of their participation does not indicate their individual or organizational endorsement of the findings or recommendations contained within this document.

Ena Backus, GMCB
Michael Bailit, Bailit Health
Abraham Berman, OneCare VT
Heather Bolduc, BCBSVT
Patrick Flood, CHAC
Joyce Gallimore, CHAC
Joe Haddock, Vermont Collaborative Physicians, Health*first*
Craig Jones, Blueprint for Health
Pat Jones, GMCB
Kelly Lange, BCBSVT
Karl Finison, OnPoint
Jennifer Le, Blueprint for Health
Kathryn McGraves Lloyd, OnPoint
Marisa Melamed, AOA
Lou McLaren, MVP Healthcare
MaryKate Mohlman, Blueprint for Health
Bryan O'Connor, OneCare VT
Melanie Pinette, OnPoint
Mark Podrazik, Burns and Associates
Allan Ramsay, GMCB
Richard Slusky, GMCB
Zachary Sullivan, GMCB
Tim Tremblay, DVHA
Norman Ward, OneCare VT
Sharon Winn, Bi-State Primary Care Association

Appendix A: Total Spending by CPT

CPT	Description	Total		Commercial		Medicaid		Medicare	
		Allowed Amount	Share of Spending	Allowed Amount	Share of Spending	Allowed Amount	Share of Spending	Allowed Amount	Share of Spending
	Total on Primary Care Capitation List	**$154,553,972**	**87.1%**	**$75,660,131**	**86.8%**	**$46,077,606**	**88.0%**	**$32,816,234**	**86.5%**
	Total All Codes	**$177,459,527**	**100%**	**$87,120,872**	**100%**	**$52,384,524**	**100.0%**	**$37,954,131**	**100%**
99214	Office/Outpatient Visit Est	$43,748,384	24.7%	$23,836,925	27.4%	$7,345,291	14.0%	$12,566,168	33.1%
99213	Office/Outpatient Visit Est	$38,817,902	21.9%	$22,631,503	26.0%	$7,829,139	14.9%	$8,357,261	22.0%
T1015	Clinic Service	$22,647,376	12.8%	$716,305	0.8%	$21,931,071	41.9%		
99396	Prev Visit Est Age 40-64	$7,497,560	4.2%	$7,051,731	8.1%	$445,829	0.9%		
G0463	Hospital Outpatient Clinic Visit Assessment and Management	$6,519,567	3.7%	$37,200	0.0%			$6,482,367	17.1%
99215	Office/Outpatient Visit Est	$3,700,928	2.1%	$1,732,522	2.0%	$663,516	1.3%	$1,304,890	3.4%
99203	Office/Outpatient Visit New	$3,112,662	1.8%	$2,324,600	2.7%	$567,421	1.1%	$220,642	0.6%
90471	Immunization Admin	$2,797,598	1.6%	$2,109,839	2.4%	$650,098	1.2%	$37,661	0.1%
99392	Prev Visit Est Age 1-4	$2,740,614	1.5%	$1,543,792	1.8%	$1,196,822	2.3%		
99395	Prev Visit Est Age 18-39	$2,724,706	1.5%	$2,350,053	2.7%	$374,653	0.7%		
99393	Prev Visit Est Age 5-11	$2,542,554	1.4%	$1,571,112	1.8%	$971,443	1.9%		
99391	Per Pm Re-eval Est Pat Inf	$2,395,985	1.4%	$1,350,070	1.5%	$1,045,915	2.0%		
99394	Prev Visit Est Age 12-17	$2,280,027	1.3%	$1,615,285	1.9%	$664,742	1.3%		
90460	Immunization Administration through 18 years of age	$1,761,441	1.0%	$1,093,578	1.3%	$667,838	1.3%	$25	0.0%
99212	Office/Outpatient Visit Est	$1,756,464	1.0%	$812,549	0.9%	$240,113	0.5%	$703,802	1.9%
99204	Office/Outpatient Visit New	$1,720,102	1.0%	$1,097,422	1.3%	$356,554	0.7%	$266,126	0.7%
G0439	Annual wellness visit	$1,231,452	0.7%	$93,058	0.1%			$1,138,394	3.0%

99202	Office/Outpatient Visit New	$809,643	0.5%	$606,199	0.7%	$155,597	0.3%	$47,847	0.1%
90461	Each additional vaccine administered (use with 90460)	$588,131	0.3%	$359,686	0.4%	$228,444	0.4%		
G0438	Annual wellness visit	$565,754	0.3%	$58,077	0.1%			$507,677	1.3%
90472	Immunization Admin, Each Add	$542,086	0.3%	$324,095	0.4%	$216,554	0.4%	$1,438	0.0%
99397	Periodic Comprehensive Preventive Medicine E&M W/Hx/Exam, Est Pt; 65+ Yr	$465,810	0.3%	$461,227	0.5%	$4,583	0.0%		
G0008	Flu Vaccine Administration	$448,981	0.3%	$41,409	0.0%			$407,573	1.1%
99211	Office/Outpatient Visit Est	$430,719	0.2%	$174,943	0.2%	$69,736	0.1%	$186,040	0.5%
99386	Prev Visit New Age 40-64	$425,482	0.2%	$393,769	0.5%	$31,713	0.1%		
99385	Prev Visit New Age 18-39	$422,657	0.2%	$379,822	0.4%	$42,835	0.1%		
99205	Office/Outpatient Visit New	$296,517	0.2%	$172,744	0.2%	$60,629	0.1%	$63,144	0.2%
99495	Transitional Care Management Services	$223,385	0.1%	$71,466	0.1%	$24,079	0.0%	$127,840	0.3%
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	$201,220	0.1%	$20,230	0.0%			$180,990	0.5%
90473	Immunization Admin Oral/Nasal	$199,140	0.1%	$144,898	0.2%	$54,241	0.1%		
99496	Transitional Care Management Services	$177,480	0.1%	$52,999	0.1%	$17,108	0.0%	$107,374	0.3%
99381	Init Pm E/M New Pat Inf	$162,368	0.1%	$97,350	0.1%	$65,018	0.1%		
G0009	Pneumonia vaccine administration	$106,482	0.1%	$9,880	0.0%			$96,603	0.3%
99384	Prev Visit New Age 12-17	$98,331	0.1%	$60,249	0.1%	$38,082	0.1%		
99383	Prev Visit New Age 5-11	$90,425	0.1%	$51,499	0.1%	$38,926	0.1%		
99382	Init Pm E/M New Pat 1-4 Yrs	$65,625	0.0%	$34,818	0.0%	$30,807	0.1%		

99401	Preventive Counseling Indiv	$65,228	0.0%	$63,449	0.1%	$1,779	0.0%		
99354	Prolonged Service Office	$40,295	0.0%	$24,537	0.0%	$12,711	0.0%	$3,047	0.0%
99201	Office/Outpatient Visit New	$33,176	0.0%	$23,816	0.0%	$6,456	0.0%	$2,903	0.0%
99406	Smoking / Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Min up to 10 Min	$29,440	0.0%	$11,901	0.0%	$11,664	0.0%	$5,875	0.0%
90474	Immunization Admin Oral/Nasal Addl	$28,431	0.0%	$16,805	0.0%	$11,626	0.0%		
99387	Init Pm E/M New Pat 65+ Yrs	$12,882	0.0%	$12,611	0.0%	$272	0.0%		
99420	Admin and Interpret, Health Risk Assessment	$11,536	0.0%	$10,715	0.0%	$821	0.0%		
99355	Prolonged Service Office	$4,772	0.0%	$3,507	0.0%	$1,265	0.0%		
99411	Prev Med Counseling	$4,320	0.0%	$4,320	0.0%				
99407	Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes	$4,010	0.0%	$1,802	0.0%	$1,659	0.0%	$549	0.0%
99402	Preventive Counseling Indiv	$3,614	0.0%	$3,056	0.0%	$558	0.0%		
99403	Preventive Counseling, Indiv	$404	0.0%	$404	0.0%	$0	0.0%		
99404	Preventive medicine counseling and/or risk factor reduction intervention provided to an individual, approximately 60 minutes	$276	0.0%	$276	0.0%				
99412	Prev Med Counseling	$28	0.0%	$28	0.0%				
99429	Unlisted Prev Med Service	$0	0.0%	$0	0.0%				
99409	Alcohol/Substance Abuse Screening	$0	0.0%						
99408	Alcohol/Substance Abuse Screening	$0	0.0%						