State of Vermont
Agency of Administration
Health Care Reform
109 State Street
Montpelier, Vermont 05609

REPORT TO THE VERMONT LEGISLATURE

Cost Estimates for Universal Primary Care

In accordance with Act 54 of 2015, Sections 16-19

Submitted to:

Joint Fiscal Committee
Health Reform Oversight Committee
House Committee on Appropriations
House Committee on Health Care
House Committee on Ways and Means
Senate Committee on Appropriations
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Senate Committee on Finance

Submitted by:

Robin Lunge, Director of Health Care Reform
Agency of Administration

Prepared by:

Marisa Melamed, Health Care Reform Policy and Planning Coordinator
Michael Costa, Deputy Director of Health Care Reform
Devon Green, Special Counsel for Health Care Reform

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1. Executive Summary

To advance the principles of health care reform set forth in Act 48 of 2011, the Vermont legislature passed Act 54 of 2015.[1] The law required the Agency of Administration (AOA) to study the creation of a system of universal primary care for all Vermont residents, regardless of insurance coverage. Specifically, the legislature required the Secretary of Administration, in consultation with the Green Mountain Care Board (GMCB) and the Joint Fiscal Office (JFO), to estimate the cost of providing primary care to all Vermont residents both with and without patient cost-sharing, beginning on January 1, 2017. [2] Additionally, the report must include the estimated cost of primary care services without a system of universal coverage, i.e. the status quo, and the sources of funding for those services.

Act 54, Section 18 required AOA to submit draft estimates to JFO by October 15, 2015. Following submission of the draft estimates, JFO had six weeks to perform an independent review and submitted comments back to AOA by December 2. AOA then had two weeks to respond to the comments by the JFO. This document is the final report prepared by AOA and submitted to JFO and the legislature on December 16, 2015. The report presents the universal primary care estimates called for in Act 54 and describes the methodology and assumptions that form the basis of the estimates. JFO will present their final analysis to the legislature by January 6, 2016.

What is Universal Primary Care?

Act 54 defines universal primary care (UPC) as a publicly financed program that would provide primary care services to all Vermonters, regardless of insurance coverage, ensuring that all Vermonters have access to primary care.[3] Vermonters would need to maintain additional coverage for all other health care services in order to maintain minimum essential coverage as required under the Affordable Care Act. Additional coverage would pay for medical costs incurred but not covered under universal primary care, according to the covered services and

[1] See Appendix A for the complete statutory language of Act 54 (2015), Sections 16-19.

[2] "Cost-sharing" is the money paid out-of-pocket for health services by consumers. The cost of health services is shared in proportion with the insurance plan. Cost-sharing generally includes deductibles, co-insurance, and co-pays. It does not include monthly premium payments required to maintain coverage. It also does not include the cost for health services received that are not covered by the insurance plan. For a glossary of health insurance terms see: http://info.healthconnect.vermont.gov/glossary.

[3] Like Green Mountain Care, the primary requirement for universal primary care coverage is Vermont residency. Resident is defined in 33 V.S.A. 1823(12) as "…an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent. An individual shall not be considered to be a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state."

cost-sharing of the plan. Uninsured Vermonters would be covered under universal primary care, but would potentially remain uninsured for other services.[4]

The Legislature defined primary care services 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.*[5]

Guided by the legislative definition, AOA and its consultant actuaries identified fifteen categories of services to be included in universal primary care. Fourteen specialty types were identified as providers of primary care. The service categories and specialty types are illustrated in Figure 1 below.

Figure 1: Universal Primary Care Service Categories and Specialty Types

Universal Primary Care Service Categories	Universal Primary Care Specialty Types
•New or Established Patient Office or Other Outpatient Visit •Initial New or Established Patient Preventive Medicine Evaluation •Other Preventive Services •Patient Office Consultation •Administration of Vaccine •Prolonged Patient Service or Office or Other Outpatient Service •Prolonged Physician Service •Initial or Subsequent Nursing Facility Visit •Other Nursing Facility •New or Established Patient Home Visit •New or Established Patient Assited Living Visit •Other Home or Assisted Living Facility •Alcohol, Smoking , or Substance Abuse Screening or Counseling •All-Inclusive Clinic Visit (FQHCs/RHCs) •Behavioral Health	•Family Medicine MD •Registered Nurse •Internal Medicine MD •Pediatrician MD •Physician Assistant/Nurse Practitioner •Psychiatrist •OB/GYN MD •Naturopath •Geriatric •Registered Nurse - Psychiatric/Mental Health •Social Worker •Psychologist •Counselor •Counselor - Addiction

The statutory charge includes “health services commonly provided at federally qualified health centers.” FQHC services are captured in the definition of primary care through inclusion of the

[4] Some uninsured Vermonters may be eligible for, but not enrolled in, Medicaid.
[5] Act 54 (2015) § 17

service category “All-Inclusive Clinic Visit.” The All-Inclusive Clinic Visit represents a full-spectrum of services that may be provided during a patient encounter, including “enabling services” not typically provided in other primary care settings. FQHCs do not bill individually for each service and services that may be included in an FQHC encounter are broader than the individual services defined as primary care in this study. As a result, we could not quantify the cost of services in order to extend to all Vermonters. Accordingly, our analysis is conservative on this issue, because it generally includes a narrower set of primary care services than offered at Vermont’s non-FQHC primary care practices and billed under a fee-for-service approach. Further discussion of FQHCs and the methodology used to estimate the cost of their services is included in the body of the report and recommended for additional analysis.

The Administration made the assumption that Blueprint for Health patient centered medical home and community health team payments would continue and be integrated into a system of universal primary care.

How Much Would Universal Primary Care Cost?

Today, primary care is paid for by a combination of payers, both public and private. In general, primary care services are included in a comprehensive health benefit plan along with non-primary care services like specialists, hospital care, and emergency care. Universal primary care would create a system where all residents of Vermont, regardless of employment or other insurance coverage, would have access to primary care services with limited or no cost-sharing through a public system. Therefore, the private insurance market and self-insured employers in Vermont would no longer have to pay for primary care services for most of its members.[6] Universal primary care would be publicly funded. Self-insured employers could choose to continue to cover primary care services as they do today.

The analysis done for this report is based on primary care claim costs for six coverage groups in Vermont:

- Commercial
- Military
- Federal
- Medicaid
- Medicare
- Uninsured

[6] To be compliant with the ACA, the state would have to receive a waiver under Section 1332 of the Affordable Care Act in order to remove primary care services from Qualified Health Plans (QHPs).

Each coverage group is funded by public, private, or a combination of public and private dollars. Public dollars may be state, federal, or a combination of state and federal.

The statute calls for the study to look at three scenarios for the cost of primary care in 2017:

1. ***Status quo*** estimate – without reform
2. Universal primary care reform estimate ***with member cost-sharing***
3. Universal primary care reform estimate ***without member cost-sharing***

Program costs consist of four components. First, the base costs presented here are total estimated primary care claim costs only. Second, we add an estimated 7% to 15% in additional administrative costs required to run the program. Third, we estimate the cost of a potential policy decision to increase primary care provider reimbursement. Fourth, total system costs will likely be higher when other factors are included. A discussion of recommended future analysis that may quantify additional costs is summarized below and discussed in more detail in the body of the report.

The base cost for primary care claims are shown in Table 1a. Total Medicaid claims for primary care are subtracted because they do not represent new costs to the state.[7]

Table 1a. Summary of Claim Cost Estimates for Universal Primary Care in 2017, With and Without Cost-Sharing[8]

Claim Costs	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
Total Claim Costs	$221,747,000	$220,236,000	$281,929,000
Paid by Medicaid[9]	($107,371,000)	($107,371,000)	($107,371,000)
Net Claim Costs	$114,376,000	$112,865,000	$174,558,000
% Covered by the payer, on average	87%	87%	100%

In addition to claim costs, there would be administrative costs to the state required to operate the program. AOA health care reform staff estimate those costs to be between 7% and 15%.

[7] This is the gross Medicaid dollars (state and federal).
[8] This methodology results in a cost estimate range for the legislature from status quo to 100% coverage.
[9] Wakely assumed a payment rate trend of 1.7 for Medicaid estimates and trended forward three years from 2014 to 2017. If Medicaid grows more slowly the total cost estimate will increase.

Table 1b shows estimates of the administrative costs that would need to be added on top of the claim costs of universal primary care.

Table 1b. Administrative Cost Estimates for Universal Primary Care in 2017, 7% - 15%

Administrative Costs	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
7% Admin Cost (low estimate)	$8,006,320	$7,900,550	$12,219,060
15% Admin Cost (high estimate)	$25,746,080	$25,519,430	$34,773,380

Additionally, policymakers may choose to increase provider reimbursement rates for primary care as part of a universal primary care system. The Agency of Administration asked our consulting actuaries to calculate the cost of increasing primary care provider rates by 10%, 25%, and 50%, in order to illustrate a range of choices for policymakers. Cost estimates for increasing primary care provider reimbursement are shown in Table 1c.

Table 1c. Provider Reimbursement Increases at 10%, 25%, and 50% above Status Quo[10]

Provider Reimbursement Increases	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
10 % increase	$25,164,000	$24,838,000	$26,941,000
25% increase	$62,709,000	$62,097,000	$67,353,000
50% increase	$125,285,000	$124,193,000	$134,705,000

Amount to be Publicly Financed[11]

The study estimated that the amount to be publicly financed for a universal primary care system ***with member cost-sharing*** is $113 million in claims. In addition to claim costs, policymakers would need to finance between $8-$26 million in administrative costs. Additionally, policymakers may choose to increase primary care provider reimbursement. The

[10] The actuaries estimated reimbursement increases two ways 1) fixed cost-sharing and 2) proportionate cost-sharing. AOA chose to include only the fixed cost-sharing estimates in the executive summary under the assumption that the fixed cost-sharing scenario is the most likely. Both fixed and proportionate cost-sharing estimates are presented and described in the body of the report.

[11] The amount to be publicly financed reflects the subtraction of Medicaid costs because these are already publicly financed today. Additionally, there are populations receiving primary care services today that are funded by state public employers, such as state government, municipalities, and school districts. The study does not quantify these dollars given that costs and utilization vary among Vermont's several hundred public employers and it is unclear how implementation of this program would change overall health care costs for employers.

actuaries estimated reimbursement increases ranging between 10% and 50% above status quo. Overall, this means that policymakers would need to finance between $121 million and $138 million to cover the cost of claims and administrative expenses. Additional revenue of $25 million to $124 million would be required to fund provider reimbursement rate increases.

The estimated amount to be publicly financed for a universal primary care system ***without member cost-sharing*** is $175 million in claims, plus an additional $12-35 million for administrative costs. Overall, this means that policymakers would need to finance between $187 million and $209 million to cover the cost of claims and administrative expenses. Additional revenue of $27 million to $135 million would be required to fund provider reimbursement rate increases if policymakers choose to increase provider reimbursement 10% to 50% above status quo in this scenario.

The Administration assumed that under a system of universal primary care providers would be paid a per member per month (PMPM) rate to cover the primary care needs of a panel of patients attributed to their practice.[12] In addition to total dollar amounts, estimates for universal primary care claims were calculated as a PMPM. Table 1d illustrates the universal primary care base claim cost estimates expressed as PMPM. Policymakers could choose to add provider reimbursement increases to the PMPM rates. Administrative costs are not factored into the PMPM, because the administrative costs estimated in this study are costs to the state to run the program and not part of provider payments. An analysis of administrative costs to providers in a universal primary care system would need further study and estimation.

Table 1d. Summary of PMPM Rates (claims only) for Universal Primary Care in 2017, With and Without Cost-Sharing

PMPM	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
Paid by Plan	$35.14	$34.94	$44.01
Paid by Member	$5.30	$5.24	$0.00
Total Paid PMPM	$40.44	$40.19	$44.01
% Covered by the Payer, on average	87%	87%	100%

In addition to estimates for base claim costs, administrative costs, and provider reimbursement increases, the report recommends further analysis of other implementation costs that we are unable to quantify in this study. In order to estimate implementation costs and narrow the range, the legislature would need to make or delegate policy decisions on plan design (such as

[12] This assumption was based on the legislative discussion when the study was passed in 2015.

cost-sharing), provider reimbursement rates, and administration. It is premature to estimate implementation costs without an operational plan developed by the state agency that would implement the program. In addition, the time and resources allocated to this study were insufficient to do this work. Any costs identified by future analysis would represent additional revenue to be raised.

Recommended Future Analysis

The analysis presented here is for claims costs only, with an additional estimated range for administrative costs and possible provider reimbursement increases. Additional analysis is required in order to calculate the full cost of implementing and operating a universal primary care program. Recommended future analysis includes:

- Public financing plan
- Economic analysis of the financing plan
- Legal and waiver analysis
- Operational plan
- Plan design

The public financing plan and economic analysis are similar to the studies submitted for Green Mountain Care in January 2015. Further legal analysis is required to ensure compliance with federal law, including a complete analysis of any federal waiver requirements or necessary coordination with existing waivers, and an ERISA analysis.[13] A system of universal primary care would also require development of plan designs; a system to determine provider reimbursement; and a number of additional analyses that may affect the cost estimates or financing plan. Based on stakeholder feedback, the legislature may also choose to do further analysis to adjust the primary care covered services and provider types assumed in this report. Specific recommendations for further analysis are described in Section 4.

2. Universal Primary Care: Definition and Key Assumptions

Definition of Primary Care

In Act 54, Section 17, the legislature defined primary care as follows:

> *As used in Secs. 16 through 19 of this act, "primary care" means health services provided by health care professionals who are specifically trained for and skilled in first-contact*

[13] ERISA is the Employee Retirement Income Security Act of 1974, "a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans," U.S. Department of Labor ERISA page: http://www.dol.gov/dol/topic/health-plans/erisa.htm.

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.

The Agency of Administration's methodology and recommendation for defining primary care is described in this section. The final claim cost estimates for universal primary care were determined using the primary care services and the primary care providers defined here.

The first step was to review the statutory definition and translate the statutory definition into a set of Current Procedural Terminology (CPT) codes and provider types that could be used for the cost analysis.

Through a competitive bidding process, AOA retained Wakely Consulting (Wakely) to perform the analysis needed to define primary care and develop cost estimates. To inform the definition and methodology, AOA health care reform staff and actuaries from Wakely consulted with subject matter experts from the Green Mountain Care Board, Blueprint for Health, Joint Fiscal Office, and Policy Integrity LLC, a health care consultant to the state. AOA consulted with various providers, including Dr. Deborah Richter, as well as Bi-State Primary Care Association on behalf of FQHCs and primary care health clinics. AOA collected additional information and received feedback from additional stakeholders by participating in the Green Mountain Care Board's Primary Care Payment Work Group.[14]

To align this study with past and ongoing work on primary care in Vermont, Richard Slusky, Payment Reform Director at the Green Mountain Care Board, and Dr. Craig Jones, Director of the Blueprint for Health, provided information about other efforts in Vermont to define primary care services. From those interviews AOA collected two separate but similar lists of primary care codes and descriptions.

AOA and Wakely compared these initial code sets to other primary care definitions and refined the codes based on the statutory language. Wakely's analysis included the primary care code set developed by the federal government for the Affordable Care Act (ACA) Enhanced Primary

[14] The scope of the Primary Care Payment Work Group is to focus on how best to design and implement a primary care capitation model. While their objective is different than the charge of the UPC study, the group is also focused on developing an operational definition of primary care services and providers. The group consists of stakeholders including providers, ACOs, the hospital association (VAHHS), Blueprint, Bi-State Primary Care Association, BCBS-VT, MVP, as well as consultants working with the GMCB. AOA will work with GMCB staff to provide a comparison of the definitions once the Primary Care Payment Work Group has completed its work.

Care Payment Program, commonly known as the ACA primary care "bump."[15] In addition, Wakely included primary mental health care and gynecology services, as called for in the statute.[16] A draft code set was developed through these efforts.

Wakely used Vermont's all-payer claims database, called the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), to develop the estimates as described in Appendix C.[17] After the initial analysis, Wakely identified additional services in VHCURES that showed a high dollar amount being paid to primary care providers, but were not included on any of our other code lists, to allow us to evaluate whether or not those services should be considered primary care. A few examples include skilled nursing care in a home health or hospice setting, colonoscopies, newborn services, and labs. Additionally, the actuaries compared Vermont's preliminary primary care services code set to the firm's past primary care services work to determine its appropriateness and to identify potential gaps in services.[18]

Figure 1 below illustrates the definition of primary care used in this study based on the statutory definition, AOA research and consultation, and the advice of our actuaries. The definition encompasses fifteen categories of primary care services developed by Wakely to help summarize the list of detailed CPT codes. Wakely identified fourteen specialty types that provide a significant amount of primary care services as part of their practices or provide care specifically required by the statute.

[15] http://www.vtmedicaid.com/Downloads/forms/Website%20Text_Pysicians_Final%2012-21-12%5B1%5D.pdf
[16] AOA provided Wakely with the code set developed by Vermont's Department of Financial Regulation (DFR) to enforce parity in cost-sharing for primary mental health services. http://www.dfr.vermont.gov/reg-bul-ord/guidelines-distinguishing-between-primary-and-specialty-mental-health-and-substance.
[17] http://gmcboard.vermont.gov/vhcures
[18] See Appendix C for Wakely methodology.

Figure 1: Universal Primary Care Service Categories and Specialty Types

Universal Primary Care Service Categories	Universal Primary Care Specialty Types
•New or Established Patient Office or Other Outpatient Visit •Initial New or Established Patient Preventive Medicine Evaluation •Other Preventive Services •Patient Office Consultation •Administration of Vaccine •Prolonged Patient Service or Office or Other Outpatient Service •Prolonged Physician Service •Initial or Subsequent Nursing Facility Visit •Other Nursing Facility •New or Established Patient Home Visit •New or Established Patient Assited Living Visit •Other Home or Assisted Living Facility •Alcohol, Smoking, or Substance Abuse Screening or Counseling •All-Inclusive Clinic Visit (FQHCs/RHCs) •Behavioral Health	•Family Medicine MD •Registered Nurse •Internal Medicine MD •Pediatrician MD •Physician Assistant/Nurse Practitioner •Psychiatrist •OB/GYN MD •Naturopath •Geriatric •Registered Nurse - Psychiatric/Mental Health •Social Worker •Psychologist •Counselor •Counselor - Addiction

See Appendix C for Wakely's complete list of codes and a detailed explanation of their methodology for determining the primary care services and providers for a universal primary care program.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

FQHCs are federally designated health centers that serve an underserved area or population, offer a sliding fee scale, provide comprehensive care and enabling services, and have an on-going quality assurance program. FQHCs receive encounter-based reimbursement from Medicare and Medicaid that covers all FQHC services, including enabling services, in a single bundled payment.[19] RHCs are federally designated and receive encounter-based reimbursement to ensure access to care in rural areas, but RHCs are not necessarily obligated to provide enabling services of the scope and variety the FQHCs must offer.[20]

The statute calls for the universal primary care system to cover "health services commonly provided at federally qualified health centers." This implies that all FQHC services would be available to all Vermonters under a universal primary care program. FQHCs provide a wide range of primary and preventive services, often including mental health care, vision and social services, public health interventions, intensive case management, interpretation, transportation, and other mechanisms that link patients to preventive medicine and necessary

[19] https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers

[20] http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html

treatment. While AOA and its consultants were able to determine the cost of covering FQHC services at FQHC centers at this time under the current system, we did not have the information or resources to determine the need and distribution of these enabling services for the entire population of Vermont.

AOA and its consultants also did not have enough information to determine the actual cost of these enabling services and other care provided by FQHCs in order to apply these benefits to Vermont's entire population. The majority of FQHC services are billed under Medicare and Medicaid under a bundled encounter code called an "All-Inclusive Clinic Visit." This means that the health center bills most services provided to a patient in one day under one encounter and then the health center is reimbursed a pre-established set rate for the total encounter. [21] The encounter payment is the same, regardless of the scope and intensity of services provided. Bundled encounter-based payments account for the majority of health care revenue for FQHCs in Vermont. The remainder comes from services billed outside of an encounter code, mostly from patients who use FQHCs/RHCs and have commercial insurance. Most commercial payments in Vermont are billed and paid under traditional fee-for-service, not bundled payments. Because traditional fee-for-service CPT codes do not capture enabling services, and most commercial insurers do not cover enabling services, current commercial payments to FQHCs may not fully reflect the actual cost of all of the FQHC benefits offered. As a result, AOA and its consultants had no accurate way within available claims data to obtain the actual cost of all FQHC services and had to limit their analysis to health care services actually provided at an FQHC or RHC facility under the current bundled payment structure.

For these reasons, AOA limited its assessment of FQHC services and assumed that all FQHC and RHC services billed as an "All-Inclusive Clinic Visit" at an FQHC or RHC would be included in the services covered by universal primary care. Our analysis assumes services at an FQHC or RHC billed outside of that category would be included or excluded based on our defined services for all other primary care providers. Please see Appendices C and D for further information regarding Wakely's FQHC/RHC methodology and analysis.

Blueprint for Health Integration

A system of universal primary care would be integrated with primary care reform initiatives currently underway to create a unified and comprehensive primary care system that improves health and quality of care while reducing cost growth, and ensures access to high quality primary care services for all Vermonters. The Blueprint for Health emphasizes a focus on

[21] For example, health centers may bill one physical health care encounter and one mental health care encounter for a patient on one day.

building a strong foundation of primary care and a community oriented model with close linkage of medical and social services.[22]

Our claim cost analysis for universal primary care includes payments made to Blueprint for Health patient centered medical homes (PCMHs), and assumes that the PMPM would be paid to primary care medical homes as part of the capitated payment for UPC. Blueprint for Health payments to community health teams (CHTs) were not included in the PMPM, because these payments are made to fiscal intermediaries in the region and not to primary care offices. This study assumes that the community health teams and payments will continue as a separate payment stream to the community.

Key Coverage Assumptions

Covering All Vermonters with Universal Primary Care

Universal primary care is intended to cover primary health care services for all Vermont residents, with public financing, regardless of insurance coverage, ensuring that all Vermonters have access to primary care. For all Vermonters except those on Medicare or TRICARE (or military at VA hospitals), universal primary care would be the first payer of primary care services. Vermonters would need additional coverage for all other health care services. Additional coverage would pay for medical costs incurred but not covered under universal primary care, according to the covered services and cost-sharing of the plan. Therefore, it is important to understand how universal primary care will interact with other types of coverage.

As primary payer for Medicaid and commercial coverage, the UPC program pays for primary care services first, before any other type of insurance coverage pays. Other services not covered under the UPC program, like hospital services or labs, would then be covered by another type of insurance coverage, like an employer plan or a Qualified Health Plan (QHP) on Vermont Health Connect.

For Medicare, UPC acts as a secondary payer. With UPC as the secondary payer, Medicare pays for primary care services first; the UPC program then pays the cost of primary care services not covered by Medicare. Medicare Supplemental Insurance would pay after Medicare and UPC. Medicare impacts and policy choices are discussed in more detail below.

[22]"Blueprint for Health Report: Medical Homes, Teams and Community Health Systems." Revised July 31, 2015. http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/BlueprintOct2014ReportRevised150731b.pdf

There are coverage requirements under the ACA that go beyond primary care so people will be required to have additional coverage. As long as the patient has universal primary care and another type of health care coverage that also covers primary care, coordination of benefits between the UPC program and the additional coverage will be required.

For the purposes of this study AOA made coverage assumptions based on Vermont's existing law, Act 48 of 2011, and federal law governing health insurance and employee benefits, specifically the Affordable Care Act and ERISA. We kept our assumptions consistent with the Green Mountain Care financing plan as much as possible, and noted where and why we made changes.[23] It is important to understand the impacts of state and federal laws on universal primary care in order to produce cost estimates for this report and, for later analysis, in order to consider public financing, implementation, and operation of a universal primary care program.

Impact of Universal Primary Care on Coverage Populations

This section describes how different population groups would be covered by universal primary care. Coverage impacts of universal primary care are summarized in Table 3 below.

Table 3: Coverage Impacts of Universal Primary Care

Coverage Type	Primary Coverage	Secondary Coverage	Considerations
Medicare	Medicare	Universal Primary Care, then Medicare supplemental insurance	Medicare benefits would remain the same. Medicare Supplemental Insurance would remain available.
Military/ TRICARE	Military/ TRICARE[24]	None while on TRICARE	UPC would be available as soon as the individual drops or is no longer eligible for TRICARE or VA benefits. Individuals who are eligible for enhanced benefits from Medicaid would maintain those benefits.

[23] "Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System." http://hcr.vermont.gov/GMC_Report_2014

[24] In order for TRICARE to be primary coverage, a state statutory change is needed. This is because, under federal law, TRICARE is always secondary, except to Medicaid. The cost of covering these individuals is not included in the estimates provided in this report.

No coverage – uninsured	Universal Primary Care	None	Some uninsured residents may be eligible for Medicaid.
Medicaid/Dr Dynasaur	Universal Primary Care	Medicaid/Dr Dynasaur covers other health services	Alignment with current Medicaid waiver required.
Vermont Health Connect (individuals)	Universal Primary Care	QHP covers other health services	ACA Section 1332 waiver required to carve out and replace primary care services in these plans with UPC.
Employer Sponsored Insurance (commercial)	Universal Primary Care	ESI plan covers other health services	An ACA Section 1332 waiver is required to replace primary care services in small employer plans. Large employer coverage through UPC requires a state mandate that these benefits be carved out of plans. Additional legal analysis of federal law is required.
Employer Sponsored Insurance (self-insured)	Universal Primary Care	ESI plan covers other health services	Employers could choose to carve out primary care from their plans. Members may have duplicative coverage. Requires coordination of benefits with UPC.
Public employees	Universal Primary Care	Public employee plan covers other health services and depends on bargaining agreement	For the purposes of this study we made the assumption to provide primary coverage to all public employees because it was most consistent with the intent of universal coverage.
Retirees	Universal Primary Care (unless on Medicare)	Retiree plan covers other health services	

Medicare beneficiaries

Coverage for Vermonters who have Medicare would remain the same under universal primary care. For the purposes of this report, we assumed that UPC would serve as secondary primary care coverage for Vermont residents on Medicare in the no cost-sharing scenario only. In this

scenario, Medicare Supplemental Insurance would cover third, meaning that UPC would wrap around Medicare prior to the Medicare Supplemental Insurance providing coverage. This assumption could be modified to allow UPC to pay last, after Medicare and Medicare Supplemental Insurance, which would reduce the cost of the program, but provide limited to no additional coverage for those with Medicare. Medicare recipients are excluded from the cost-sharing scenario because there would be little to no benefit to recipients and the state. AOA and our actuaries determined that the modest benefit (.1% average reduction in cost-sharing) to Medicare recipients would be off-set by the administrative costs required to coordinate benefits.

Our assumptions for Medicare and UPC differ from the GMC financing plan. In GMC, we recommended that wrapping Medicare coverage be deferred until GMC coverage benefits were determined by the GMCB. Then we would determine whether integration was affordable and made sense for Vermont Medicare beneficiaries and the state. For this study, we assumed that Medicare recipients would have UPC as secondary coverage if a plan without cost-sharing was implemented, though this assumption should be reconsidered based on how the public financing is designed. We made this assumption, because it provides a more complete estimate of costs of the program.

Military/TRICARE

TRICARE recipients are excluded from UPC until they drop or are no longer eligible for TRICARE. This is because federal law requires TRICARE to be secondary to any coverage besides Medicaid.[25] Act 48 requires Vermont to maximize federal funding.[26] In order to ensure continued federal contribution to TRICARE, Vermonters who are covered by TRICARE will continue to receive TRICARE. In addition, the state cannot require the federal program to reduce its coverage for primary care and it is unlikely that the federal government would do so. UPC would be available as soon as the Vermonter drops or is no longer eligible for TRICARE coverage. Those Vermonters who are in both Medicaid and TRICARE would continue to receive their enhanced benefits, including primary care coverage. Vermonters who receive veteran's benefits could continue to receive care at VA clinics, but will also be covered under UPC.

Uninsured

Vermont residents who are uninsured would have coverage for primary care services under the universal primary care program. Some uninsured Vermonters may be eligible for Medicaid.

[25] 32 CFR § 199.8.
[26] Act 48 (2011), Sec. 1(b).

Medicaid/Dr. Dynasaur

Vermont residents covered under Medicaid and Dr. Dynasaur would continue to receive the same coverage, including the enhanced coverage available under Medicaid today. Universal primary care would cover primary care services and could be financed with Medicaid dollars for this population.

Vermont Health Connect QHPs & employer sponsored insurance plans

Individuals who purchase QHPs through Vermont Health Connect and employers who sponsor commercial insurance plans for their employees (not self-insured employers), would have primary coverage under universal primary care. The state would need to obtain an ACA Section 1332 waiver from the federal government in order for universal primary care to replace primary care services in QHPs. Under the ACA, individual and small employer plans are required to cover essential health benefits and meet minimum essential coverage, which include primary care services.[27] In order to reduce administrative costs and duplicative coverage, this study assumes that the state receives a waiver to carve out primary care services from QHPs and that those services are covered solely by universal primary care. Carving out primary care from large group insurance would require a state statutory mandate that these benefits be eliminated from insurance plans and further legal analysis of federal law is required. Please see Section 4 for further discussion of the necessary waiver and legal analysis.

Self-insured employer sponsored insurance plan

Any business could continue to provide primary care health benefits to their employees as provided for under the federal Employment Retirement Income Security Act of 1974 (ERISA). This includes the ability to self-insure, which is commonly done today by large, multi-state or national businesses. These types of companies are commonly described as "ERISA companies," although ERISA covers all businesses of any size or type. With universal primary care, businesses could continue to offer primary care coverage. Yet, their employees would now have universal primary care coverage as Vermont residents as well. Given this benefit, employers could choose to carve primary care out of their plans and allow UPC to solely cover these services. Alternatively, these companies could leave primary care services in their plans and UPC would serve as the first payer for primary care coverage, with the employer coverage providing any additional benefits or reduced cost-sharing (if any). ERISA does not allow a state to require employers to carve out primary care services from self-insured plans, so employers who continue to carry primary care coverage and the employees in those plans could end up paying

[27] ACA § 1301 & 1302 requires qualified health plans to have essential health benefits, including primary care. Under § 1301, a qualified health plan, not state government, may provide coverage through a qualified direct primary care medical home plan. Vermont would need a waiver that would allow qualified health plans to carve out primary care.

twice for primary care coverage. Continued primary care coverage in self-insured plans would also require coordination of benefits between the different types of coverage, which is an increased administrative expense. Policymakers could choose to have UPC pay second to other employer coverage. This would reduce the state cost of the program.[28]

State public employees

Public employees include State, education employees, and municipal employees. Public employees would continue to have employer sponsored coverage subject to collective bargaining. Universal primary care would pay first dollar coverage for primary care services.

The State currently uses a self-insured plan for State employees. The study assumes the state would modify their plans to provide only non-primary care coverage for these employees and they would be covered through universal primary care. This assumption is consistent with Act 48 and policy decisions made for the Green Mountain Care financing plan; however, this assumption requires either a statutory change or a modification of the bargaining agreements.

Municipal employees are currently covered in the small or large group insurance market, depending on size, with the exception of the City of Burlington, which is self-insured. With universal primary care, we assumed that these employees were included and had secondary coverage by their employer only for non-primary care services.

Education employees are largely covered by the Vermont Education Health Initiative (VEHI) in a trust. We assumed VEHI would modify their plans to provide only non-primary care coverage for these employees and they would be covered through universal primary care. This would require modifications in the bargaining agreements.

State and education retirees

Retired employees of the State or a school currently receive retiree health care from the state of Vermont. This program is run by the Treasurer's Office.

With implementation of universal primary care, State and education retirees would continue to have the same level of coverage as they do today regardless of residency. If they are Vermont residents without Medicare, they would have coverage through universal primary care.

[28] Any estimate of this impact could be done with microeconomic analysis, but is outside the scope of this actuarial analysis.

Federal employees

We assumed that federal employees would have UPC as primary coverage; however, these employees would be paying for duplicative coverage in their employer plan since the State cannot require federal employees or the federal government to change their coverage. For the purposes of this study, we made the assumption to provide primary coverage to this population because it was most consistent with the intent of universal coverage. This assumption is inconsistent with how Green Mountain Care was designed because with UPC federal employees do not have the option to drop their federal coverage all together. Policymakers could choose to carve these employees out of UPC or provide some measure of transitional relief, in a manner similar to the proposal in the Green Mountain Care financing report.

Key Payment Assumptions

Providing primary care services to all Vermonters and paying providers for those services would be essential functions of the universal primary care system. The Agency of Administration and our consulting actuaries relied on certain payment assumptions to develop and describe cost estimates, including both the use of a per member per month payment model and estimated administrative costs to the state. We also looked at the effect of increasing primary care provider rates as a policy choice.

Cost estimates in this study are based on claims data for the defined set of services. Administrative costs to the state to operate the program were estimated at 7%-15% and added to the estimated claims costs. The study does not recommend a specific percentage for administrative costs because additional analysis is required in order to quantify administrative costs with more certainty, including plan design development and program operational planning.

This study assumes that under a universal primary care system, primary care providers would be paid a per member per month (PMPM) rate to cover the primary care needs of patients attributed to their practices.[29] Paying a PMPM rate for primary care services creates an incentive for practices to provide quality care while controlling costs. The PMPM rates presented in this study are for claim costs only. Full development of a capitated payment model for universal primary would require the state to develop program standards and quality measurements as part of an operational plan.

In Vermont, alternative payment models are already utilized through the Blueprint for Health and Accountable Care Organizations. A primary care capitation model is also currently being

[29] This assumption was made based on the legislative discussion when passing the study in 2015.

studied by the GMCB's Primary Care Payment Work Group, with results from that group expected around the same time as submission of this study. The payment model for universal primary care could align with primary care models already operating in Vermont.

In addition, the base cost estimates assume status quo provider reimbursement levels. There continues to be a discussion about the adequacy of primary care reimbursement rates, especially given the recent decrease in Medicaid reimbursement under the ACA.[30] We have included tables in the next section exhibiting the cost of increasing primary care reimbursements at various levels beyond the status quo.

3. Cost Estimates for Universal Primary Care

Act 54 directs the Secretary of Administration to estimate the cost of providing primary care under three scenarios:

1. ***Status quo*** estimate – without reform
2. Universal primary care reform estimate ***with member cost-sharing***
3. Universal primary care reform estimate ***without member cost-sharing***

The status quo estimate is required to include the sources of funding for care, including employer sponsored and individual private insurance, Medicaid, Medicare, and other government sponsored programs, and patient cost-sharing such as deductibles, coinsurance, and co-payments. The statute requires estimates for the cost of providing universal primary care to all Vermont residents, with and without cost-sharing by the patient, beginning on January 1, 2017.

Claim cost estimates were calculated using claims data from VHCURES as the primary data source. Claims data was restricted to the service codes and provider types included in the primary care definition. Additional data was incorporated into the study to accurately reflect total primary care claim costs. FQHC and RHC settlement costs and Blueprint for Health costs were provided by the Department of Vermont Health Access. [31] The cost analysis memo

[30] The ACA provided a reimbursement increase for primary care up to Medicare levels for two years. The increase sunset on December 31, 2014.

[31] The average Blueprint PMPM paid for primary care medical homes is included in the PMPM claim cost estimate for UPC. The Blueprint for Health payment to community health teams was not included in the PMPM, because these payments are made to fiscal intermediaries in the region and not to primary care offices. This study assumes that the community health teams and payments will continue as a separate payment stream to the community.

prepared by Wakely in Attachment D describes the methodology in more detail. Table 4 shows Wakely's estimate for total claim costs by market for the status quo and both universal primary care cost-sharing scenarios, also whether the population is primary, secondary, or excluded from universal primary care.

Table 4: Estimated Total Claim Costs of the Program

			2017 Estimated Total Claim Cost of Program		
Market	Estimated Members	Universal Primary Care Coverage	Status Quo	Universal Primary Care with Cost Sharing	Universal Primary Care without Cost Sharing
Commercial	296,400	Primary	$103,944,000	$102,464,000	$150,040,000
Military	14,400	Excluded	$0	$0	$0
Federal	14,400	Primary	$4,905,000	$4,905,000	$6,215,000
Medicaid	150,500	Primary	$107,371,000	$107,371,000	$107,371,000
Medicare	140,800	Secondary	$0	$0	$11,382,000
Uninsured	13,100	Primary	$5,527,000	$5,496,000	$6,921,000
Total	**629,600**		**$221,747,000**	**$220,236,000**	**$281,929,000**
Compared to Status Quo				**($1,511,000)**	**$60,182,000**

Base cost estimates in this study are limited in scope to total claims costs for primary care plus an estimate of 7% to 15% for administrative costs to the state to run the program. The Administration also asked Wakely to provide cost estimates for increasing primary care provider reimbursement rates in a universal primary care program. It is outside of the scope of this study to include the costs of modifying information technology systems or other one-time operation costs that must be determined as part of an operations plan. Additional analysis is required in order to calculate the full cost of implementing and operating a universal primary care program and is described in Section 4 of this report.

What is the Cost of Primary Care in 2017 without Reform?

Wakely estimated that the total claim costs for primary care in the 2017 status quo scenario is $222 million, including Medicaid but excluding Medicare and TRICARE. On average, 87% of primary care claims are covered by the health plan and 13% are the responsibility of the member. Table 5 illustrates Wakely's status quo claim costs summary by payer.

Table 5: 2017 Estimated Claim Costs under Status Quo

	Estimated Members	Plan Costs PMPM	Member Costs PMPM	Total Plan and Member Costs PMPM	Percent of Costs Paid by Plan	Total Annual Claim Costs	Total Claim Cost of Program
Commercial							
Fully Insured	148,200	$30.55	$9.76	$40.30	75.8%	$54,323,000	$54,323,000
Self-Funded	148,200	$27.89	$5.93	$33.83	82.5%	$49,621,000	$49,621,000
Sub-Total	296,400	$29.22	$7.85	$37.07	78.8%	$103,944,000	$103,944,000
Military	14,400	$42.83	$3.70	$46.53	92.0%	$7,384,000	$0
Federal	14,400	$28.37	$4.62	$32.99	86.0%	$4,905,000	$4,905,000
Medicaid	150,500	$59.45	$0.00	$59.45	100.0%	$107,371,000	$107,371,000
Medicare	140,800	$21.54	$5.83	$27.37	78.7%	$36,392,000	$0
Uninsured	13,100	$35.14	$5.30	$40.44	86.9%	$5,527,000	$5,527,000
Total	**629,600**	**$35.14**	**$5.30**	**$40.44**	**86.9%**	**$265,523,000**	**$221,747,000**

The status quo estimates in Table 5 do not include administrative costs to payers. Total annual claim costs are divided by total members and then divided by twelve in order to derive estimated PMPM payments to providers.

In the universal primary care scenarios below, AOA health care reform staff used claim costs estimates and administrative cost estimates to determine the total amount to be publicly financed.

What is the Cost of Universal Primary Care in 2017?

Act 54 directed AOA to model the costs of a universal primary system in 2017 both with and without cost-sharing by the patient. Wakely estimated that the total claim costs of a universal primary care program with cost-sharing would be $220 million (excluding Medicare and TRICARE), a -0.7% difference from the status quo.[32] Medicaid funds are already included in the state budget, so the net claim costs of the program with cost sharing are $113 million.[33] The total cost of claims in a universal primary care system covered at 100% with no member cost-sharing would be $282 million, with a $175 million net cost after excluding Medicaid funding. No member cost-sharing for universal primary care results in a 27% claim cost increase from

[32] The status quo and the Universal Primary Care cost-sharing scenarios differ modestly because the creation of an average benefit level, and its imputation to every person, causes some minor changes in actuarial assumptions about how much health care individuals use, i.e. a change in induced demand. In other words, the uniform benefit level means that some people use more health care and some use less, but the overall difference is minor, with a change of less than 1% in member and total costs.

[33] If actual Medicaid funding is different from the amount estimated in this study, these estimates would need to be adjusted to accommodate those funding differences.

the status quo. Administrative costs are in addition to claim costs and are estimated at 7% to 15% above claim costs.

With Cost-Sharing by the Patient

To model cost-sharing in a universal primary care system Wakely based their estimate on the average cost-sharing Vermonters have today and trended it forward to 2017. The average percent of costs paid by payers for primary care based on today's cost-sharing plan designs is 87%. The member pays 13%, on average. The PMPM for paid claims is $34.94. Member cost-sharing PMPM is an additional $5.24 for a total payer and member amount of $40.19.

The 2017 projected costs for universal primary care with patient cost-sharing include fully insured commercial plans, self-funded commercial plans, federal employees, Medicaid, and the cost of the uninsured. Universal primary care will be the primary payer for commercial, self-funded plans, Medicaid, and federal employee plans. Medicare members are not included in the cost-sharing scenario because the amount of cost-sharing is roughly equivalent between the two systems.[34] As noted in the previous section, UPC coverage will be suspended for those who are actively covered by TRICARE. Table 6 below shows the claim cost summary for universal primary care with member cost-sharing.

Table 6: 2017 Estimated Claim Costs under Universal Primary Care with Member Cost Sharing

	Estimated Members	Plan Costs PMPM	Member Costs PMPM	Total Plan and Member Costs PMPM	Percent of Costs Paid by Plan	Total Annual Claim Costs	Total Claim Cost of Program
Commercial							
Fully Insured	148,200	$31.75	$8.53	$40.28	78.8%	$56,469,000	$56,469,000
Self-Funded	148,200	$25.86	$6.94	$32.80	78.8%	$45,995,000	$45,995,000
Sub-Total	296,400	$28.80	$7.73	$36.54	78.8%	$102,464,000	$102,464,000
Military	14,400	$42.83	$3.70	$46.53	92.0%	$7,384,000	$0
Federal	14,400	$28.37	$4.62	$32.99	86.0%	$4,905,000	$4,905,000
Medicaid	150,500	$59.45	$0.00	$59.45	100.0%	$107,371,000	$107,371,000
Medicare	140,800	$21.54	$5.83	$27.37	78.7%	$36,392,000	$0
Uninsured	13,100	$34.94	$5.24	$40.19	86.9%	$5,496,000	$5,496,000
Total	**629,600**	**$34.94**	**$5.24**	**$40.19**	**86.9%**	**$264,012,000**	**$220,236,000**

[34] The primary care AV for Medicare enrollees is .1% below the average for commercial plans. The study does not bring Medicare beneficiaries up to the commercial average % paid by plan in this scenario. Upon advice of our consulting actuaries, it was determined that the cost for coordinating of benefits for the .1% difference would be prohibitive, with administrative costs exceeding the benefit to Vermont residents on Medicare.

Without Cost-Sharing by the Patient

Act 54 also directed AOA to model the cost of universal primary care in 2017 with no member cost-sharing. The total claim costs of universal primary care without cost-sharing, where the program pays 100% of claims, is $282 million. The PMPM for claims is $44.01. The difference from the status quo is an increase of 27% and is accounted for by shifting the value of cost-sharing from members to the state, and by induced demand, as people seek more primary care medical services due to a lack of payment at the point of service.

The 2017 projected costs for universal primary care with no patient cost-sharing include fully insured commercial plans, self-funded commercial plans, federal employees, Medicaid, Medicare, and the cost of the uninsured. Universal primary care will be the primary payer for commercial, self-funded plans, Medicaid, and federal employee plans. UPC will serve as a secondary payer for Medicare, to bring Medicare cost-sharing up to 100% covered. UPC will be suspended for those who are actively covered by TRICARE. Table 7 below shows the claim costs summary for universal primary care with no member cost-sharing.

Table 7: 2017 Estimated Costs under Universal Primary Care with no Member Cost Sharing

	Estimated Members	Plan Costs PMPM	Member Costs PMPM	Total Plan and Member Costs PMPM	Percent of Costs Paid by Plan	Total Annual Claim Costs	Total Claim Cost of Program
Commercial							
Fully Insured	148,200	$46.50	$0.00	$46.50	100.0%	$82,689,000	$82,689,000
Self-Funded	148,200	$37.86	$0.00	$37.86	100.0%	$67,351,000	$67,351,000
Sub-Total	296,400	$42.18	$0.00	$42.18	100.0%	$150,040,000	$150,040,000
Military	14,400	$49.38	$0.00	$49.38	100.0%	$8,514,000	$0
Federal	14,400	$35.95	$0.00	$35.95	100.0%	$6,215,000	$6,215,000
Medicaid	150,500	$59.45	$0.00	$59.45	100.0%	$107,371,000	$107,371,000
Medicare	140,800	$31.62	$0.00	$31.62	100.0%	$53,420,000	$11,382,000
Uninsured	13,100	$44.01	$0.00	$44.01	100.0%	$6,921,000	$6,921,000
Total	**629,600**	**$44.01**	**$0.00**	**$44.01**	**100.0%**	**$332,481,000**	**$281,929,000**

As stated above, no member cost-sharing for universal primary care results in a 27% cost increase from the status quo. Table 8 attributes the increased costs by cost-sharing and induced demand.[35]

[35] "Induced demand" means that increased health care coverage leads to increased demand for services.

Table 8: Difference from Status Quo for UPC covered at 100%

	Cost-Sharing	Induced Demand	Total
Difference from status quo	$39,393,611	$20,788,756	$60,182,367

Administrative Costs to the State

The Agency of Administration estimated administrative costs to the state to operate a universal primary care program to be 7% to 15% on top of the medical claim costs of the program. Wakely concurred that these estimates of administrative expenses are reasonable based on administrative costs of existing programs, like Medicaid and Medicare Supplemental plans, and expected administrative costs from programs which may exhibit similar administrative characteristics of universal primary care. Additional analysis would be required in order to refine these administrative estimates. For example, additional coordination of benefits would be required from most Vermonters having two sources of coverage (i.e. two insurance cards). The state would also need to develop the plan design in order to more accurately estimate the cost of administering the plan.

AOA health care reform staff estimated 7% administrative costs at the low end because 7% is the current rate for Medicaid administrative costs. AOA used 15% as the top of the range for administrative costs based on the administrative expenses of Medicare supplemental plans.

Provider Reimbursement Increases

As noted earlier, the cost estimates above assume no change in provider reimbursement. The tables below provide estimates for increasing provider reimbursement for the services included in universal primary care by 10%, 25%, and 50%. The percent increases are examples only and are included to illustrate a range of options for increasing reimbursements to primary care providers.

Wakely calculated the provider reimbursement increase estimates two ways: 1) using fixed cost-sharing and 2) using proportionate cost-sharing. Fixed cost-sharing assumes that even if the provider payment rate increases, the members will continue to pay the same dollar amount of cost-sharing per service, such as a fixed co-pay. Proportionate cost-sharing assumes that member cost-sharing will increase in proportion to the increase in the provider payment rates, such as a percent for co-insurance. Please see Appendix D and Tables 9a-9e for Wakely's analysis of provider reimbursement increases under the different scenarios.

Table 9a: 2017 Estimated Additional Costs under Status Quo if Provider Payment Rates are increased – Fixed Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$13,185,000	$32,963,000	$65,926,000
Military	$0	$0	$0
Federal	$701,000	$1,556,000	$2,982,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$541,000	$1,347,000	$2,692,000
Compared to Status Quo	**$25,164,000**	**$62,709,000**	**$125,285,000**

Table 9b: 2017 Estimated Additional Costs under Status Quo if Provider Payment Rates are Increased – Proportionate Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$10,394,000	$25,986,000	$51,972,000
Military	$0	$0	$0
Federal	$491,000	$1,226,000	$2,453,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$475,000	$1,188,000	$2,377,000
Compared to Status Quo	**$22,097,000**	**$55,243,000**	**$110,487,000**

Table 9c: Estimated Additional Costs under UPC with Cost Sharing if Provider Rates are Increased – Fixed Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$12,997,000	$32,494,000	$64,987,000
Military	$0	$0	$0
Federal	$570,000	$1,426,000	$2,852,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$534,000	$1,334,000	$2,669,000
Compared to UPC Cost Sharing	**$24,838,000**	**$62,097,000**	**$124,193,000**

Table 9d: Estimated Additional Costs under UPC with Cost Sharing if Provider Rates are Increased – Proportionate Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$10,246,000	$25,616,000	$51,232,000
Military	$0	$0	$0
Federal	$491,000	$1,226,000	$2,453,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$472,000	$1,181,000	$2,361,000
Compared to UPC Cost Sharing	**$21,946,000**	**$54,866,000**	**$109,731,000**

Table 9e: Estimated Additional Costs under UPC with No Member Cost Sharing if Provider Rates are Increased – Fixed and Proportionate Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$15,004,000	$37,510,000	$75,020,000
Military	$0	$0	$0
Federal	$621,000	$1,554,000	$3,107,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$579,000	$1,446,000	$2,893,000
Compared to UPC No Member Cost Sharing	**$26,941,000**	**$67,353,000**	**$134,705,000**

4. Recommended Future Analyses

In order to implement a publicly financed universal primary care program for Vermont, a number of additional analyses need to be performed, similar to the analyses required for public financing of Vermont's Green Mountain Care universal health care plan released in December of 2014.[36] The following are recommendations for future analyses:

- Public Financing Plan
- Economic Analysis of Financing Plan
- Legal and Waiver Analysis
- Operational Plan
- Plan Design and Health Savings Accounts

[36] http://hcr.vermont.gov/GMC_Report_2014

Public Financing Plan

A system of universal primary care for all Vermont residents would require a public financing mechanism to cover its costs. Specifically, legislators would need to enact a set of taxes and/or fees sufficient to cover system costs. Generally, policymakers would need to consider three overall revenue sources: federal funds, existing state revenues that pay for primary care services, and new taxes and/or fees that replace the current spending on primary care services paid by current payers. [37] Additionally, policymakers may want to consider the possibility of financing other costs that may occur due to an expansion of publicly financed health care obligations. These may include, but are not limited to, the acquisition of insurance reserves or reinsurance, budget reserves as the State's financial obligations grow, and a strategy to evaluate and address the long term trend of annual health care growth outpacing annual tax revenue growth.

Economic Analysis of Financing Plan

A system of universal primary care coverage and accompanying public finance plan would likely change the distribution of health care costs for Vermont employers and families. A micro-simulation model would provide economic analysis that would estimate the distribution of costs for Vermont employers and families. Specifically, economic analysis would likely reveal the change in costs by business size and type for employers compared to the status quo. Concurrently, the analysis would likely estimate the change in out-of-pocket spending, state and federal taxes, and income for families. Additionally, policymakers may choose to pursue macroeconomic modeling, which would show what, if any, impact universal primary care and its accompanying financing plan would have on Vermont's overall economy and various business sectors.

Legal and Waiver Analysis

A legal analysis is required to ensure compliance with federal law and to recommend changes to Vermont state law. The state would need to evaluate the need to obtain new federal waivers and align existing waivers in order to implement a universal primary care plan. For instance, the Affordable Care Act allows qualified health plans to contract with a primary care home plan to provide direct primary care, but it does not envision a state carving out primary care from qualified health plans. [38] This could be accomplished with a Section 1332 ACA Waiver.[39]

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[37] Policymakers will likely want to consider Medicaid spending and money spent on active and retired employee health benefits when evaluating existing state revenues that pay for primary care services.

[38] ACA § 1301.

[39] If the state were to transition to the federal exchange technology, it would be difficult to successfully acquire this waiver as the federal exchange technology is not customizable.

In addition, the Affordable Care Act requires that all health plans, including those in the large group market, offer preventive care at no cost to the patient.[40] Carving out primary care, which includes some preventive care services, of large group insurance plans would require further analysis of federal law. A thorough Employee Retirement Income Security Act (ERISA) analysis should be performed in conjunction with the financing plan.

Operational Plan

A universal primary care system will require an operational plan for implementing the program. The operational plan would include recommendations for the role of state government, the role of commercial insurers, the process for determining provider payment, and the process for determining the overall UPC budget. The operational plan would outline a framework for monitoring quality and providing financial and administrative oversight for the program. An operational plan for UPC would require analyses into four broad operational areas:

1. Program administration, including coordination of benefits
2. Financial administration
3. Capitated rate setting and provider payment
4. Plan design and Health Savings Accounts

Program administration

Administration of a universal primary care program will require Medicaid operational integration, as well as an administrative function for coordinating benefits with other third party payers as either the secondary or primary payer.[41] Program administration will also include the following functions:

- Quality measurement requirements for the state agency administering the program
- Eligibility determination
- Enrollment
- Claims adjudication
- Coordination of benefits and subrogation
- Primary care provider selection and referral management
- Medical necessity determination
- Adjudicating out-of-state coverage for primary care
- Data analysis, reporting, and settlement with at-risk providers
- Hospital, physician, and other provider credentialing and network enrollment, including contracting a national network and covering services out of country

[40] PHS Act § 2713

[41] See "Impact of UPC on Coverage Populations" in Section 3 of this report.

- Program integrity, including some fraud and abuse detection
- Customer service
- Overall evaluation of the performance of UPC in terms of costs, quality of care, and customer experience
- Appeals and grievances

Financial administration

In addition to the public financing plan and economic analysis, universal primary care will require financial administration for budgeting and budget/revenue reconciliation, as well as risk management. Financial administration will also include the following functions:

- One-time start-up operational costs
- The expected rate of increase in UPC expenditures for the coming year, taking into account cost pressures and revenue constraints
- Allowed administrative costs for the state agency administering the program
- Ongoing budget for medical and administrative costs related to the services paid for under UPC
- Financial management functions, including:
    - Reserving
    - Reinsurance
    - Cash flow management
    - Retroactive provider settlements
    - Actuarial analyses, projections, and reporting
    - Budgeting for UPC costs
- Oversight of the total UPC budget and alignment of the budget with available state and federal funding.
- Oversight of the financial health and adequacy of reserves.

Capitated rate setting and provider payment

The state will need to determine a system for paying providers for UPC services, not unlike the state's current Medicaid payment system. Further analysis will need to be done to determine how to execute the following functions in the UPC system:

- Provider reimbursement;
- Setting payment terms for covered services;
- Negotiating provider payments, including population based payments;
- Oversight of provider payment policy.

Further analyses may be required to refine the cost estimates based on plan design and operational decisions for universal primary care. Please see Appendix D for further analyses recommended by Wakely, including:

- Induced demand study;
- Study of administrative costs;
- Analysis of provider or insurer behavior changes, cost-shifting, up-coding, or leakage to and from non-primary care providers as a result of carving out primary care services;
- Impact of other provider payment or health care reforms.

Plan Design and Health Savings Accounts

It should be noted that coverage by UPC will make Vermonters ineligible for Health Savings Accounts (HSAs). In order to be eligible for an HSA, federal law requires that the individual have a high deductible health plan and prohibits coverage under any additional health plan.[42] In August, Senator Bill Cassidy introduced S. 1989, The Primary Care Enhancement Act, which would allow individuals to maintain the tax benefits of an HSA even while they have a separate primary care plan.[43] Without further action from Congress or Treasury, however, Vermont's UPC program would likely make Vermonters ineligible for an HSA. If the legislature moves forward with UPC, this issue will need further analysis.

Appendices

A. Act 54 of 2015, Sections 16-19

B. State of Vermont Memo to Accompany Wakely's Vermont Universal Primary Care Analysis

C. Vermont Universal Primary Care Analysis – Recommended Definition of Primary Care (Wakely Consulting)

D. Vermont Universal Primary Care – Cost Analysis (Wakely Consulting)

E. JFO Independent Review of the Agency of Administration's Draft Estimate of the Costs of Providing Primary Care to All Vermont Residents

F. Memorandum – Summary of Changes to October 15 draft and Stakeholder Feedback

[42] I.R.C. § 223(c)

[43] Primary Care Enhancement Act of 2015, S. 1989, introduced Aug. 5, 2015, https://www.congress.gov/bill/114th-congress/senate-bill/1989/text

Sec. 14. 33 V.S.A. § 1804(c) is amended to read:

(c) On and after January 1, ~~2017~~ 2018, a qualified employer shall be an employer of any size which elects to make all of its full-time employees eligible for one or more qualified health plans offered in the Vermont Health Benefit Exchange, and the term "qualified employer" includes self-employed persons. A full-time employee shall be an employee who works more than 30 hours per week.

Sec. 15. LARGE GROUP MARKET; IMPACT ANALYSIS

The Green Mountain Care Board, in consultation with the Department of Financial Regulation, shall analyze the projected impact on rates in the large group health insurance market if large employers are permitted to purchase qualified health plans through the Vermont Health Benefit Exchange beginning in 2018. The analysis shall estimate the impact on premiums for employees in the large group market if the market were to transition from experience rating to community rating beginning with the 2018 plan year.

* * * Universal Primary Care * * *

Sec. 16. PURPOSE

The purpose of Secs. 16 through 19 of this act is to establish the administrative framework and reduce financial barriers as preliminary steps to the implementation of the principles set forth in 2011 Acts and Resolves No. 48 to enable Vermonters to receive necessary health care and examine the

cost of providing primary care to all Vermonters without deductibles, coinsurance, or co-payments or, if necessary, with limited cost-sharing.

Sec. 17. DEFINITION OF PRIMARY CARE

As used in Secs. 16 through 19 of this act, "primary care" means 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.

Sec. 18. COST ESTIMATES FOR UNIVERSAL PRIMARY CARE

(a) On or before October 15, 2015, the Secretary of Administration or designee, in consultation with the Green Mountain Care Board and the Joint Fiscal Office, shall provide to the Joint Fiscal Office a draft estimate of the costs of providing primary care to all Vermont residents, with and without cost-sharing by the patient, beginning on January 1, 2017. The Joint Fiscal Office shall conduct an independent review of the draft estimate and shall provide its comments and feedback to the Secretary or designee on or before December 2, 2015. On or before December 16, 2015, the Secretary of Administration or designee shall provide to the Joint Fiscal Committee, the

Health Reform Oversight Committee, the House Committees on Appropriations, on Health Care, and on Ways and Means, and the Senate Committees on Appropriations, on Health and Welfare, and on Finance a finalized report of the costs of providing primary care to all Vermont residents, with and without cost-sharing by the patient, beginning on January 1, 2017. The Joint Fiscal Office shall present its independent review to the same committees by January 6, 2016.

(b) The report shall include an estimate of the cost of primary care to those Vermonters who access it if a universal primary care plan is not implemented, and the sources of funding for that care, including employer-sponsored and individual private insurance, Medicaid, Medicare, and other government-sponsored programs, and patient cost-sharing such as deductibles, coinsurance, and co-payments.

(c) The Secretary of Administration or designee, in collaboration with the Joint Fiscal Office, shall arrange for the actuarial services needed to perform the estimates and analysis required by this section. Departments and agencies of State government and the Green Mountain Care Board shall provide such data to the Joint Fiscal Office as needed to permit the Joint Fiscal Office to perform the estimates and analysis. If necessary, the Joint Fiscal Office may enter into confidentiality agreements with departments, agencies, and the

Board to ensure that confidential information provided to the Office is not further disclosed.

Sec. 19. APPROPRIATION

Up to $100,000.00 is appropriated from the General Fund to the Agency of Administration, Secretary's Office in fiscal year 2016 to be used for assistance in the calculation of the cost estimates required in Sec. 18 of this act; provided, however, that the appropriation shall be reduced by the amount of any external funds received to carry out the estimates and analysis required by Sec. 18.

* * * Consumer Information * * *

Sec. 20. 18 V.S.A. § 9413 is added to read:

§ 9413. HEALTH CARE QUALITY AND PRICE COMPARISON

Each health insurer with more than 200 covered lives in this State shall establish an Internet-based tool to enable its members to compare the price of health care in Vermont by service or procedure, including office visits, emergency care, radiologic services, and preventive care such as mammography and colonoscopy. The tool shall include provider quality information as available and to the extent consistent with other applicable laws and regulations. The tool shall allow members to compare price by selecting a specific service or procedure and a geographic region of the State. Based on the criteria specified, the tool shall provide the member with an estimate for each provider of the amount the member would pay for the service or

State of Vermont
Agency of Administration
Health Care Reform
Pavilion Office Building
109 State Street
Montpelier, VT 05609-0201
www.hcr.vermont.gov

[phone] 802-828-2316
[fax] 802-828-3320

Robin Lunge, Director

MEMORANDUM

To: Julie Peper, Director and Senior Consulting Actuary, Wakely and Danielle Hilson, Consulting Actuary, Wakely

From: Michael Costa, Deputy Director of Health Care Reform and Marisa Melamed, Health Care Reform Policy and Planning Coordinator

Date: August 20, 2015

Re: Memo to accompany Wakely's Vermont Universal Primary Care Analysis – Initial Definition of Primary Care

---

In order to advance the principles of health care reform set forth in Act 48 of 2011[1] ("An act relating to a universal and unified health system"), the Vermont legislature passed Act 54 of 2015 directing the Agency of Administration (AOA) to study the creation of a system of universal primary care health services for all Vermonters regardless of insurance coverage. Specifically, the legislature required the Secretary of Administration, in consultation with the Green Mountain Care Board and the Joint Fiscal Office, to estimate the cost of providing primary care health services to all Vermont residents both with and without cost-sharing by the patient, beginning on January 1, 2017. Additionally, the report must include the estimated cost of primary care services without a system of universal coverage, i.e. the status quo, and the sources of funding for those services.

AOA retained Wakely Consulting (Wakely) for this project based on a competitive bidding process. To begin the project, AOA needed to provide an initial definition of primary care health services that would allow Wakely to sort the data available through Vermont's All Payer Claims Database, called the Vermont Health Care Unified Reporting and Evaluation System (VHCURES). AOA consulted several sources to develop a draft set of billing codes that potentially represented the services and providers that define primary care and allow for analysis of available VHCURES data.

First, AOA staff reviewed the statutory definition of primary care services set forth in Act 54. Section 17 defined primary care as follows:

> *"primary care" means 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*

[1] http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT048/ACT048%20As%20Enacted.pdf

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.

With this statutory definition as a framework, staff reviewed primary care code sets utilized by Vermont through the Blueprint for Health and the Green Mountain Care Board payment models work group. Next, AOA staff consulted with staff from the Green Mountain Care Board, the Department of Vermont Health Access, and Policy Integrity, a health care consultant to the state, to refine the existing code sets according to the statutory definition. Based on these consultations, staff included codes for primary mental heath services[2], gynecology, and other health services commonly provided at federally qualified health centers. The AOA staff then directed Wakely to include in the list of primary care codes the Enhanced Primary Care Payment Program (EPCP) code set defined by the federal government in the Affordable Care Act of 2010.[3] The EPCP code set includes evaluation, management, and vaccination codes, many of which were already included in the list.

After this effort, AOA provided Wakely with a specific set of billing codes that represented the services and providers that would define primary care health services. The attached memorandum from Wakely provides the draft code set to be used for the analysis after further review by Wakely based on their experience and actuarial standards. The code set may be modified as the analysis is refined throughout the project.

The objective of Wakely's initial analysis was to determine if the code set AOA generated based on the statutory definition represents the bulk of what primary care providers do in their practices for Vermonters. The analysis was also meant to help us determine which clinicians provide these services as the bulk of their practice to be sure we include the right set of health care professionals providing primary care services to Vermonters. Wakely's initial analysis of both codes and provider type will help the state determine which services and providers are covered under universal primary care.

***

[2] Primary mental health care services are defined in Regulation 1-2013-01 of the Department of Financial Regulation, "Guidelines for Distinguishing Between Primary and Specialty Mental Health and Substance Abuse Services." http://www.dfr.vermont.gov/reg-bul-ord/guidelines-distinguishing-between-primary-and-specialty-mental-health-and-substance

[3] The EPCP is commonly referred to as the primary care "bump."

October 9, 2015

Mr. Michael Costa, Deputy Director of Health Care Reform
Ms. Marisa Melamed, Health Care Reform Policy and Planning Coordinator
Agency of Administration
State of Vermont

RE: Vermont Universal Primary Care Analysis – Recommended Definition of Primary Care

Dear Michael and Marisa,

Act 54 of 2015 requires the Secretary of Administration to provide a draft cost estimate of universal primary care services with and without cost sharing starting January 2017 to the Joint Fiscal Office by October 15, 2015. Pursuant to this legislation, Vermont's Agency of Administration (AoA) retained Wakely Consulting Group (Wakely) to perform the aforementioned cost analysis. As a first step, Wakely was asked to provide recommendations for the services and provider types that should encompass coverage under a universal primary care program.

Section 17 of Act 54 defines primary care 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 memorandum provides a recommendation for detailed procedural codes and provider types, consistent with the definition above, to include in the analysis of the cost of a universal primary care program in Vermont. Additional analysis and feedback may result in future adjustments to these recommendations.

The purpose of this memorandum is to provide a recommendation to AoA on the definition of primary care for use in analyses related to a universal primary care system in Vermont. Other uses of this memorandum may be inappropriate. Wakely does not intend to create a reliance by third parties and assumes no duty or liability to such third parties. Any third parties obtaining this report should rely on their own experts in interpreting the information and any recommendations.

Recommendation

Wakely's recommendation is comprised of two components. The first is a list of procedure types, indicated by Current Procedural Terminology (CPT) categories and codes and the second is a list of provider types to be included under the proposed universal primary care system.

Our understanding in developing the recommendation was that universal primary care coverage should be defined so that it encompasses the majority of services that Vermont's primary care physicians currently perform in their offices. Wakely recommends that the following CPT categories be included in the definition of primary care. The CPT categories were developed by Wakely to help summarize the list of detailed CPT codes. The detailed list of CPT codes to include is provided in Appendix C (these are designated with a "1" in the column labeled "Inclusion Flag").

- New or Established Patient Office or Other Outpatient Visit
- Initial New or Established Patient Preventive Medicine Evaluation
- Other Preventive Services
- Patient Office Consultation
- Administration of Vaccine
- Prolonged Patient Service or Office or Other Outpatient Service
- Prolonged Physician Service
- Initial or Subsequent Nursing Facility Visit
- Other Nursing Facility
- New or Established Patient Home Visit
- New or Established Patient Assisted Living Visit
- Other Home or Assisted Living Facility
- Alcohol, Smoking, or Substance Abuse Screening or Counseling
- All-Inclusive Clinic Visit
- Behavioral Health

Based on an analysis of the provider types that provide a significant amount of primary care services as part of their practices, Wakely recommends that the following specialty types be included in the definition of primary care:

- Family Medicine
- Registered Nurse
- Internal Medicine
- Pediatrician
- Physician Assistant/Nurse Practitioner
- Psychiatrist
- Obstetrics and Gynecology (OB/GYN)

- Naturopath
- Geriatric
- Registered Nurse – Psychiatric/Mental Health
- Social Worker
- Psychologist
- Counselor
- Counselor – Addiction

The statutory definition of primary care includes "other health services commonly provided at federally qualified health centers." Because of the unique role and reimbursement structures of federally qualified health centers (FQHCs) and Rural Health Centers (RHC), Wakely performed a separate cost analysis of services that would be considered primary care as part of the final recommendation on the primary code definition. The majority of FQHC and RHC claims in Medicaid are billed to encounter code T1015, which is included in our recommended primary care definition. Commercial and Medicare do not utilize the T1015 code. Wakely reviewed the CPT codes that providers use with the T1015 code for Medicaid and assumed this list of CPT codes would represent the encounter code services for Medicare and commercial. Therefore, in addition to the recommended codes in Appendix C, Wakely also recommends including any additional codes associated with the claims billed to T1015 in Medicaid only for FQHCs and RHCs.

Methodology

To develop the list of services for consideration as primary care services, Wakely began with a preliminary list of CPT codes and specialty types provided by AoA. These services are identified in the Appendix C as "Initial Vermont Recommendation" in the 'Source' column of the table.

Wakely compared this initial definition to various primary care definitions that Wakely has a knowledge of based on our other work. Codes that were added based on Wakely's work in other states are identified as "Additional Wakely Codes" in the 'Source' column of the table in the Appendix C.

Vermont also provided a set of CPT codes to Wakely that encompasses the enhanced primary care payment program (also known as the primary care "bump"). This program, which expired December 31, 2014, requires that Medicaid reimburses eligible primary care providers at parity with Medicare rates for certain evaluation, management, and vaccination codes. These codes are indicated with a "1" in the "PCP Bump" column of the table in in Appendix C. Many of these codes were already included in the list, but some were added to the list for consideration.

The final set of CPT codes that were added to the list for consideration are those for outpatient mental health and substance abuse summarized by the Department of Financial Regulation (DFR) in Vermont.

This document was provided to Wakely by Vermont. These codes are identified in the Appendix C as "Behavioral Health Codes from DFR Source" in the 'Source' column of the table.

In the recommended procedural code set Wakely determined the following when compared to the initial list provided:

- Exclusion of CPT codes associated with newborns since our understanding is that these are services provided in a hospital setting and no other inpatient services are included in the definition of primary care. This is based on our understanding that the focus of the program is to only include those services provided in an office setting.
- Inclusion of CPT codes associated with administering vaccines, including the cost of the vaccine. These types of codes are included in other Wakely client sources as well as in the primary care bump definition.
- Inclusion of CPT codes for services provided in nursing facilities, patient homes, and assisted living facilities for patients who cannot access provider offices. These types of codes are included in other Wakely client sources as well as in the primary care bump definition.
- For FQHCs/RHCs only, inclusion of CPT codes related to T1015 encounters for commercial and Medicare.

Additionally, the following is criteria used to determine the recommended primary care services and provider types:

- CPT codes that had the majority of their allowed dollars in primary care specialty types or that took place in a primary care office setting (or another appropriate setting if the patient is not able to access a physician's office).
- Specialty types with above 60% of allowed dollars in included CPT codes or a reasonable explanation if the percentage was below 60%.
- Specialty type and CPT code descriptions that appeared consistent with Vermont's definition of primary care and that were consistent with the statute.

See the Limitations section for more information about the data limitations that could impact Wakely's recommendations.

Results

Wakely reviewed the data provided from Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) information for commercial, Medicaid, and Medicare. The results tables within this report include the most recent calendar year of data available in VHCURES, which is 2014 for commercial and Medicaid and 2012 for Medicare.

The table below shows a summary of 2014 commercial and Medicaid, and 2012 Medicare allowed claims from VHCURES for each CPT category considered in the analysis and includes the percent of services in that category covered by the specialty types recommended for inclusion in the primary care definition. While combining different years of data is not ideal, it was felt that any limitations in doing so were outweighed by the value of showing the combined results using the most recent data available for each market.

A full list of the detailed CPT codes that are included and excluded under each category is located in Appendix C. A breakout of the analysis for commercial, Medicaid, and Medicare is located in Appendix A.

Table 1: Percent of Allowed Dollars Included by CPT Category and Specialty Type Based on 2014 Commercial and Medicaid and 2012 Medicare Data Available from VHCURES

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
New or Established Patient Office or Other Outpatient Visit	99201-99205, 99211-99215	Yes	$166,029,044	67.2%	32.8%
Initial New or Established Patient Preventive Medicine Evaluation	99381-99387, 99391-99397	Yes	$26,375,954	98.3%	1.7%
Patient Office Consultation	99241-99245	Yes	$12,232,708	32.1%	67.9%
Emergency Department Visit	99281-99285	No	$20,457,689	32.0%	68.0%
Initial or Subsequent Inpatient Hospital Care	99221-99223, 99231-99233, 99251-99255	No	$22,310,077	63.6%	36.4%
Administration of Vaccine	90460-90461, 90470-90474, 90632-90748	Yes	$8,137,592	96.3%	3.7%
Initial or Subsequent Hospital Observation or Discharge	99217-99220, 99224-99226, 99234-99236, 99238-99239	No	$5,105,186	82.1%	17.9%
Critical or Intensive Care	99291-99292, 99466-99469, 99471-99472, 99475-99479	No	$6,318,300	60.8%	39.2%
Services Associated with Newborns	99460-99465	No	$696,019	97.4%	2.6%
Other Preventive Services	99401-99404, 99411-99412,	Yes	$4,786,903	93.8%	6.2%

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
	99420, 99429, 99450, G0402, G0438-G0439, G9003-G9007, G9009-G9012, H0001, H0004-H0006, H2000, S0610, S0612-S0613				
Prolonged Patient Service or Office or Other Outpatient Service	99354-99355, 99358, 99359	Yes	$365,484	80.0%	20.0%
Initial or Subsequent Nursing Facility Visit	99304-99310	Yes	$3,021,614	91.1%	8.9%
New or Established Patient Home Visit	99341-99345, 99347-99350	Yes	$280,637	91.4%	8.6%
Prolonged Inpatient or Observation Hospital Service	99345-99357	No	$86,197	81.5%	18.5%
Alcohol, Smoking, or Substance Abuse Screening or Counseling	99406-99409, G9001	Yes	$317,913	97.5%	2.5%
Other Nursing Facility	99315-99316, 99318, 99379, 99380	Yes	$127,088	95.6%	4.4%
New or Established Patient Assisted Living Visit	99324-99328, 99334-99337	Yes	$201,207	92.9%	7.1%
All-Inclusive Clinic Visit	T1015	Yes	$27,745,650	99.0%	1.0%
Prolonged Physician Service	99360	Yes	$2,009	100.0%	0.0%
Other Home or Assisted Living Facility	99339, 99340	Yes	$299	63.5%	36.5%
Behavioral Health	90785, 90791-90792, 90832-90834, 90836-90838, 90846, 90847, 90853, 90863, 90875, G9002	Yes	$57,393,585	98.8%	1.2%

The next portion of the analysis was to examine the proposed specialty types and the portion of each specialty type's allowed dollars that were attributable to the recommended CPT codes. The below table shows the results of this analysis. A breakout of the analysis for commercial, Medicaid, and Medicare is located in Appendix B.

Table 2: Percent of Allowed Dollars for the Included by CPTs by Specialty Type Based on 2014 Commercial and Medicaid and 2012 Medicare Data Available from VHCURES

Specialty Type	Total Allowed in Specialty	Percent in Included CPTs
Family Medicine	$97,078,241	60.2%
Registered Nurse	$48,945,507	62.0%
Internal Medicine	$65,117,524	45.1%
Pediatrician	$45,612,537	62.4%
Physician Assistant	$31,136,138	57.6%
Psychiatrist	$205,990,895	6.5%
OB/GYN	$32,365,168	26.4%
Naturopath	$3,931,162	86.8%
Geriatric	$728,209	60.3%
Social Worker	$18,478,610	82.7%
Registered Nurse - Psychiatric/Mental Health	$1,194,376	81.4%
Psychologist	$21,378,469	84.7%
Counselor	$19,030,012	86.2%
Counselor - Addiction (Substance Use Disorder)	$1,113,736	84.4%

Wakely recommends including all of the above specialty types in the initial definition of primary care. However, we would like to point out a few of our considerations.

- Although the specialty type physician assistant is below the 60% threshold of percent allowed dollars included recommended CPT codes, we recommend including it since it is only slightly below the threshold and the provider type aligns with others in the primary care definition.
- We are recommending including internal medicine physicians, OB/GYNs, and psychiatrists even though the percentages included in the recommended CPT code list is low. Wakely is still recommending that these specialty types be included because these provider types are included in the statutory definition and can be the primary provider for certain members. Note that the psychiatrist percentage is particularly low, which is driven by Medicaid. It is possible that upon further review, some additional Medicaid CPT codes could be included in the definition which would significantly increase the percentage.

LIMITATIONS

Wakely received Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) data for Medicare as well as Medicaid and commercial. VHCURES does not include all commercial business, for example, federal and military plans and insurers with low enrollment in Vermont are excluded. The tables included in this report contain data from 2014 for commercial and Medicaid and from 2012 for Medicare, which are the most recent calendar years of data available. The summaries are based on raw data and have not been adjusted to reflect future costs or policy changes. The Medicare data has not been adjusted or trended to be reflective of 2014 costs.

The tables contained in this report reflect the claims assumed under the primary care definition and do not include the additional claims for FQHCs and RHCs that would be covered under the related T1015 codes for Medicare and commercial. We do not believe these claims would significantly impact this analysis as the majority of claims in FQHCs and RHCs are captured in the primary definition. These additional claims are included in the cost analysis. As a result of the noted limitations, the dollars shown as part of the cost analysis may not tie to the dollars shown in this memo.

Only professional services were considered for this analysis.

RELIANCE

Wakely relied on information provided by the State of Vermont including the initial definition of primary care, the definition of the primary care bump, and the behavioral health codes. We also relied on input and feedback on which codes to include from the State of Vermont and their stakeholders. Wakely reviewed the above information for reasonability, but did not audit the information.

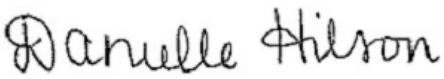
DISCLOSURES

Wakely does not warrant or guarantee that this definition of primary care will accurately reflect the majority of costs for all primary care providers under universal primary care in Vermont. Actual costs will vary by provider.

This report is provided to the AoA for documentation and for inclusion in a broader report on universal primary care coverage. Distribution of this document should be made in its entirety.

Should you have any questions, please feel free to call to discuss.

Sincerely,



Julie Peper
Director and Senior Consulting Actuary
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Danielle W. Hilson
Consulting Actuary
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Cc: Robin Lunge, Agency of Administration
Devon Green, Agency of Administration
Joyce Manchester, Joint Fiscal Office
Nolan Langwell, Joint Fiscal Office
Steve Kappel, Policy Integrity
Julia Lerche, Wakely
Brittney Phillips, Wakely

Appendix A – Allowed Dollars by Line of Business and CPT Category

2014 Commercial

Percent of Allowed Dollars Included by CPT Category and Specialty Type

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
New or Established Patient Office or Other Outpatient Visit	99201-99205, 99211-99215	Yes	$93,447,770	68.7%	31.3%
Initial New or Established Patient Preventive Medicine Evaluation	99381-99387, 99391-99397	Yes	$20,532,973	98.3%	1.7%
Patient Office Consultation	99241-99245	Yes	$10,086,504	31.7%	68.3%
Emergency Department Visit	99281-99285	No	$9,033,787	33.0%	67.0%
Initial or Subsequent Inpatient Hospital Care	99221-99223, 99231-99233, 99251-99255	No	$6,347,106	55.2%	44.8%
Administration of Vaccine	90460-90461, 90470-90474, 90632-90748	Yes	$5,933,475	95.6%	4.4%
Initial or Subsequent Hospital Observation or Discharge	99217-99220, 99224-99226, 99234-99236, 99238-99239	No	$1,585,749	74.9%	25.1%
Critical or Intensive Care	99291-99292, 99466-99469, 99471-99472, 99475-99479	No	$2,957,811	68.4%	31.6%
Services Associated with Newborns	99460-99465	No	$392,561	97.1%	2.9%
Other Preventive Services	99401-99404, 99411-99412, 99420, 99429, 99450, G0402, G0438-G0439, G9003-G9007, G9009-G9012, H0001, H0004-H0006, H2000, S0610, S0612-S0613	Yes	$330,028	86.4%	13.6%

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
Prolonged Patient Service or Office or Other Outpatient Service	99354-99355, 99358, 99359	Yes	$186,081	89.8%	10.2%
Initial or Subsequent Nursing Facility Visit	99304-99310	Yes	$106,161	88.1%	11.9%
New or Established Patient Home Visit	99341-99345, 99347-99350	Yes	$43,820	82.4%	17.6%
Prolonged Inpatient or Observation Hospital Service	99345-99357	No	$26,875	66.4%	33.6%
Alcohol, Smoking, or Substance Abuse Screening or Counseling	99406-99409, G9001	Yes	$19,048	87.4%	12.6%
Other Nursing Facility	99315-99316, 99318, 99379, 99380	Yes	$11,225	91.0%	9.0%
New or Established Patient Assisted Living Visit	99324-99328, 99334-99337	Yes	$15,730	98.1%	1.9%
All-Inclusive Clinic Visit	T1015	Yes	$777,462	97.7%	2.3%
Prolonged Physician Service	99360	Yes	$2,009	100.0%	0.0%
Other Home or Assisted Living Facility	99339, 99340	Yes	$189	100.0%	0.0%
Behavioral Health	90785, 90791-90792, 90832-90834, 90836-90838, 90846, 90847, 90853, 90863, 90875, G9002	Yes	$26,634,275	98.6%	1.4%

2014 Medicaid

Percent of Allowed Dollars Included by CPT Category and Specialty Type

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
New or Established Patient Office or Other Outpatient Visit	99201-99205, 99211-99215	Yes	$29,110,646	80.8%	19.2%
Initial New or Established Patient Preventive Medicine Evaluation	99381-99387, 99391-99397	Yes	$5,671,917	99.4%	0.6%
Patient Office Consultation	99241-99245	Yes	$2,146,204	33.9%	66.1%
Emergency Department Visit	99281-99285	No	$6,419,052	40.6%	59.4%
Initial or Subsequent Inpatient Hospital Care	99221-99223, 99231-99233, 99251-99255	No	$4,159,235	74.3%	25.7%
Administration of Vaccine	90460-90461, 90470-90474, 90632-90748	Yes	$2,112,046	98.9%	1.1%
Initial or Subsequent Hospital Observation or Discharge	99217-99220, 99224-99226, 99234-99236, 99238-99239	No	$1,000,131	87.0%	13.0%
Critical or Intensive Care	99291-99292, 99466-99469, 99471-99472, 99475-99479	No	$1,740,276	74.4%	25.6%
Services Associated with Newborns	99460-99465	No	$303,457	97.9%	2.1%
Other Preventive Services	99401-99404, 99411-99412, 99420, 99429, 99450, G0402, G0438-G0439, G9003-G9007, G9009-G9012, H0001, H0004-H0006, H2000, S0610, S0612-S0613	Yes	$2,844,449	92.5%	7.5%

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
Prolonged Patient Service or Office or Other Outpatient Service	99354-99355, 99358, 99359	Yes	$102,586	85.9%	14.1%
Initial or Subsequent Nursing Facility Visit	99304-99310	Yes	$65,614	88.6%	11.4%
New or Established Patient Home Visit	99341-99345, 99347-99350	Yes	$20,769	99.7%	0.3%
Prolonged Inpatient or Observation Hospital Service	99345-99357	No	$13,532	84.7%	15.3%
Alcohol, Smoking, or Substance Abuse Screening or Counseling	99406-99409, G9001	Yes	$291,025	98.9%	1.1%
Other Nursing Facility	99315-99316, 99318, 99379, 99380	Yes	$4,945	90.4%	9.6%
New or Established Patient Assisted Living Visit	99324-99328, 99334-99337	Yes	$1,321	100.0%	0.0%
All-Inclusive Clinic Visit	T1015	Yes	$26,968,188	99.0%	1.0%
Prolonged Physician Service	99360	Yes	$0	N/A	N/A
Other Home or Assisted Living Facility	99339, 99340	Yes	$109	0.0%	100.0%
Behavioral Health	90785, 90791-90792, 90832-90834, 90836-90838, 90846, 90847, 90853, 90863, 90875, G9002	Yes	$25,135,446	99.5%	0.5%

2012 Medicare

Percent of Allowed Dollars Included by CPT Category and Specialty Type

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
New or Established Patient Office or Other Outpatient Visit	99201-99205, 99211-99215	Yes	$43,470,628	55.1%	44.9%
Initial New or Established Patient Preventive Medicine Evaluation	99381-99387, 99391-99397	Yes	$171,064	57.7%	42.3%
Patient Office Consultation	99241-99245	Yes	$0	N/A	N/A
Emergency Department Visit	99281-99285	No	$5,004,850	19.2%	80.8%
Initial or Subsequent Inpatient Hospital Care	99221-99223, 99231-99233, 99251-99255	No	$11,803,736	64.3%	35.7%
Administration of Vaccine	90460-90461, 90470-90474, 90632-90748	Yes	$92,071	86.1%	13.9%
Initial or Subsequent Hospital Observation or Discharge	99217-99220, 99224-99226, 99234-99236, 99238-99239	No	$2,519,306	84.6%	15.4%
Critical or Intensive Care	99291-99292, 99466-99469, 99471-99472, 99475-99479	No	$1,620,213	32.4%	67.6%
Services Associated with Newborns	99460-99465	No	$0	N/A	N/A
Other Preventive Services	99401-99404, 99411-99412, 99420, 99429, 99450, G0402, G0438-G0439, G9003-G9007, G9009-G9012, H0001, H0004-H0006, H2000, S0610, S0612-S0613	Yes	$1,612,426	97.6%	2.4%

CPT Categories	CPT Code Range	Included CPT Category?	Total Allowed in CPT Category	Included Specialty Types	Excluded Specialty Types
Prolonged Patient Service or Office or Other Outpatient Service	99354-99355, 99358, 99359	Yes	$76,817	48.1%	51.9%
Initial or Subsequent Nursing Facility Visit	99304-99310	Yes	$2,849,838	91.3%	8.7%
New or Established Patient Home Visit	99341-99345, 99347-99350	Yes	$216,048	92.5%	7.5%
Prolonged Inpatient or Observation Hospital Service	99345-99357	No	$45,790	89.4%	10.6%
Alcohol, Smoking, or Substance Abuse Screening or Counseling	99406-99409, G9001	Yes	$7,841	69.6%	30.4%
Other Nursing Facility	99315-99316, 99318, 99379, 99380	Yes	$110,918	96.2%	3.8%
New or Established Patient Assisted Living Visit	99324-99328, 99334-99337	Yes	$184,155	92.5%	7.5%
All-Inclusive Clinic Visit	T1015	Yes	$0	N/A	N/A
Prolonged Physician Service	99360	Yes	$0	N/A	N/A
Other Home or Assisted Living Facility	99339, 99340	Yes	$0	N/A	N/A
Behavioral Health	90785, 90791-90792, 90832-90834, 90836-90838, 90846, 90847, 90853, 90863, 90875, G9002	Yes	$5,623,864	97.0%	3.0%

Appendix B – Allowed Dollars by Line of Business and Specialty

2014 Commercial

Percent of Allowed Dollars for the Included CPTs by Specialty Type

Specialty Type	Total Allowed in Specialty	Percent in Included CPTs
Family Medicine	$37,471,244	80.3%
Registered Nurse	$24,518,266	61.8%
Internal Medicine	$25,269,373	59.0%
Pediatrician	$19,995,681	69.4%
Physician Assistant	$17,186,852	56.9%
Psychiatrist	$5,898,729	72.7%
OB/GYN	$22,794,002	26.8%
Naturopath	$2,841,366	84.9%
Geriatric	$240,636	82.3%
Social Worker	$5,990,501	99.5%
Registered Nurse - Psychiatric/Mental Health	$397,896	96.1%
Psychologist	$10,946,620	93.9%
Counselor	$7,269,087	94.6%
Counselor - Addiction (Substance Use Disorder)	$677,820	79.1%

2014 Medicaid

Percent of Allowed Dollars for the Included CPTs by Specialty Type

Specialty Type	Total Allowed in Specialty	Percent in Included CPTs
Family Medicine	$27,546,129	52.9%
Registered Nurse	$15,503,927	77.1%
Internal Medicine	$9,064,056	54.4%
Pediatrician	$25,228,865	57.6%
Physician Assistant	$8,802,112	74.9%
Psychiatrist	$195,832,218	3.8%
OB/GYN	$6,978,630	25.0%
Naturopath	$1,089,251	91.5%
Geriatric	$55,387	92.0%
Social Worker	$9,422,988	82.7%
Registered Nurse - Psychiatric/Mental Health	$425,753	98.8%
Psychologist	$6,454,567	92.3%
Counselor	$11,732,298	81.1%
Counselor - Addiction (Substance Use Disorder)	$389,208	97.9%

2012 Medicare

Percent of Allowed Dollars for the Included CPTs by Specialty Type

Specialty Type	Total Allowed in Specialty	Percent in Included CPTs
Family Medicine	$32,060,868	43.0%
Registered Nurse	$8,923,314	35.9%
Internal Medicine	$30,784,095	30.9%
Pediatrician	$387,992	16.0%
Physician Assistant	$5,147,174	30.3%
Psychiatrist	$4,259,949	39.8%
OB/GYN	$2,592,536	27.2%
Naturopath	$545	35.8%
Geriatric	$432,186	44.0%
Social Worker	$3,065,121	50.0%
Registered Nurse - Psychiatric/Mental Health	$370,727	45.6%
Psychologist	$3,977,282	46.9%
Counselor	$28,627	49.8%
Counselor - Addiction (Substance Use Disorder)	$46,708	50.0%

Appendix C – Detailed Primary Care Definition Recommendation by CPT Code

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
90460	Administration of first vaccine or toxoid component through 18 years of age with counseling	Administration of Vaccine	Additional Wakely Codes	1	1
90461	Administration of vaccine or toxoid component through 18 years of age with counseling	Administration of Vaccine	Additional Wakely Codes	1	1
90471	Administration of 1 vaccine	Administration of Vaccine	Additional Wakely Codes	1	1
90472	Administration of vaccine	Administration of Vaccine	Additional Wakely Codes	1	1
90473	Administration of 1 nasal or oral vaccine	Administration of Vaccine	Additional Wakely Codes	1	1
90474	Administration of nasal or oral vaccine	Administration of Vaccine	Additional Wakely Codes	1	1
90632-90748	Various Vaccines	Administration of Vaccine	Additional Cost Analysis	1	0
99406	Smoking and tobacco use intermediate counseling, greater than 3 minutes up to 10 minutes	Alcohol, Smoking, or Substance Abuse Screening or Counseling	Initial Vermont Recommendation	1	1
99407	Smoking and tobacco use intensive counseling, greater than 10 minutes	Alcohol, Smoking, or Substance Abuse Screening or Counseling	Initial Vermont Recommendation	1	1
99408	Alcohol and/or substance abuse screening and intervention, 15-30 minutes	Alcohol, Smoking, or Substance Abuse Screening or Counseling	Initial Vermont Recommendation	1	1
99409	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes	Alcohol, Smoking, or Substance Abuse Screening or Counseling	Initial Vermont Recommendation	1	1
T1015	All-inclusive clinic visit	All-Inclusive Clinic Visit	Initial Vermont Recommendation	1	0
90785	Interactive complexity (List separately in addition to the code for primary procedure)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90791	Psychiatric diagnostic evaluation	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
90792	Psychiatric diagnostic evaluation with medical services	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90832	Psychotherapy, 30 minutes with patient and/or family member	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90834	Psychotherapy, 45 minutes with patient and/or family member	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90837	Psychotherapy, 60 minutes with patient and/or family member	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90846	Family psychotherapy (without the patient present)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90853	Group psychotherapy (other than of a multiple-family group)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	Behavioral Health Codes	Behavioral Health Codes from DFR Source	1	0
99291	Critical care delivery critically ill or injured patient, first 30-74 minutes	Critical or Intensive Care	Additional Wakely Codes	0	1
99292	Critical care delivery critically ill or injured patient	Critical or Intensive Care	Additional Wakely Codes	0	1
99466	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99467	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; each additional 30 minutes (List separately in addition to code for primary service)	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)	Critical or Intensive Care	Additional Codes Included in Primary Care Bump Definition	0	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99281	Emergency department visit, self limited or minor problem	Emergency Department Visit	Additional Wakely Codes	0	1
99282	Emergency department visit, low to moderately severe problem	Emergency Department Visit	Additional Wakely Codes	0	1
99283	Emergency department visit, moderately severe problem	Emergency Department Visit	Additional Wakely Codes	0	1
99284	Emergency department visit, problem of high severity	Emergency Department Visit	Additional Wakely Codes	0	1
99285	Emergency department visit, problem with significant threat to life or function	Emergency Department Visit	Additional Wakely Codes	0	1
99381	Initial new patient preventive medicine evaluation infant younger than 1 year	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99382	Initial new patient preventive medicine evaluation, age 1 through 4 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99383	Initial new patient preventive medicine evaluation, age 5 through 11 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99384	Initial new patient preventive medicine evaluation, age 12 through 17 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99385	Initial new patient preventive medicine evaluation age 18-39 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99386	Initial new patient preventive medicine evaluation age 40-64 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99387	Initial new patient preventive medicine evaluation, age 65 years and older	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99391	Established patient periodic preventive medicine examination infant younger than 1 year	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99392	Established patient periodic preventive medicine examination, age 1 through 4 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99393	Established patient periodic preventive medicine examination, age 5 through 11 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99394	Established patient periodic preventive medicine examination, age 12 through 17 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99395	Established patient periodic preventive medicine examination age 18-39 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99396	Established patient periodic preventive medicine examination age 40-64 years	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99397	Established patient periodic preventive medicine examination, age 65 years and older	Initial New or Established Patient Preventive Medicine Evaluation	Initial Vermont Recommendation	1	1
99217	Hospital observation care discharge	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99218	Hospital observation care typically 30 minutes	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99219	Hospital observation care typically 50 minutes	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99220	Hospital observation care typically 70 minutes per day	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99224	Subsequent observation care, typically 15 minutes per day	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	0
99225	Subsequent observation care, typically 25 minutes per day	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	0

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99226	Subsequent observation care, typically 35 minutes per day	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	0
99234	Hospital observation or inpatient care low severity, 40 minutes per day	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99235	Hospital observation or inpatient care moderate severity, 50 minutes per day'	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99236	Hospital observation or inpatient care high severity, 55 minutes per day	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99238	Hospital discharge day management, 30 minutes or less	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99239	Hospital discharge day management, more than 30 minutes	Initial or Subsequent Hospital Observation or Discharge	Additional Wakely Codes	0	1
99221	Initial hospital inpatient care, typically 30 minutes per day	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99222	Initial hospital inpatient care, typically 50 minutes per day	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99223	Initial hospital inpatient care, typically 70 minutes per day	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99231	Subsequent hospital inpatient care, typically 15 minutes per day	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99232	Subsequent hospital inpatient care, typically 25 minutes per day	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99233	Subsequent hospital inpatient care, typically 35 minutes per day	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99251	Inpatient hospital consultation, typically 20 minutes	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99252	Inpatient hospital consultation, typically 40 minutes	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99253	Inpatient hospital consultation, typically 55 minutes	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99254	Inpatient hospital consultation, typically 80 minutes	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99255	Inpatient hospital consultation, typically 110 minutes	Initial or Subsequent Inpatient Hospital Care	Additional Wakely Codes	0	1
99304	Initial nursing facility visit, typically 25 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99305	Initial nursing facility visit, typically 35 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99306	Initial nursing facility visit, typically 45 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99307	Subsequent nursing facility visit, typically 10 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99308	Subsequent nursing facility visit, typically 15 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99309	Subsequent nursing facility visit, typically 25 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99310	Subsequent nursing facility visit, typically 35 minutes per day	Initial or Subsequent Nursing Facility Visit	Initial Vermont Recommendation	1	1
99324	New patient assisted living visit, typically 20 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99325	New patient assisted living visit, typically 30 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99326	New patient assisted living visit, typically 45 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99327	New patient assisted living visit, typically 60 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99328	New patient assisted living visit, typically 75 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99334	Established patient assisted living visit, typically 15 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99335	Established patient assisted living visit, typically 25 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99336	Established patient assisted living visit, typically 40 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99337	Established patient assisted living visit, typically 60 minutes	New or Established Patient Assisted Living Visit	Initial Vermont Recommendation	1	1
99341	New patient home visit, typically 20 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99342	New patient home visit, typically 30 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99343	New patient home visit, typically 45 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99344	New patient home visit, typically 60 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99345	New patient home visit, typically 75 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99347	Established patient home visit, typically 15 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99348	Established patient home visit, typically 25 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99349	Established patient home visit, typically 40 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99350	Established patient home visit, typically 60 minutes	New or Established Patient Home Visit	Initial Vermont Recommendation	1	1
99201	New patient office or other outpatient visit, typically 10 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99202	New patient office or other outpatient visit, typically 20 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99203	New patient office or other outpatient visit, typically 30 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99204	New patient office or other outpatient visit, typically 45 minutes	New or Established Patient Office or Other Outpatient	Initial Vermont Recommendation	1	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
		Visit			
99205	New patient office or other outpatient visit, typically 60 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99211	Established patient office or other outpatient visit, typically 5 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99212	Established patient office or other outpatient visit, typically 10 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99213	Established patient office or other outpatient visit, typically 15 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99214	Established patient office or other outpatient, visit typically 25 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99215	Established patient office or other outpatient, visit typically 40 minutes	New or Established Patient Office or Other Outpatient Visit	Initial Vermont Recommendation	1	1
99339	Physician supervision of patient care at home or assisted living facility, 15-29 minutes in one month	Other Home or Assisted Living Facility	Additional Wakely Codes	1	1
99340	Physician supervision of patient care at home or assisted living facility, 30 minutes or more in one month	Other Home or Assisted Living Facility	Additional Wakely Codes	1	1
99315	Nursing facility discharge day management, 30 minutes or less	Other Nursing Facility	Additional Wakely Codes	1	1
99316	Nursing facility discharge management, more than 30 minutes	Other Nursing Facility	Additional Wakely Codes	1	1
99318	Nursing facility annual assessment, typically 30 minutes	Other Nursing Facility	Additional Wakely Codes	1	1
99379	Supervision of nursing facility patient services, 15-29 minutes per month	Other Nursing Facility	Additional Wakely Codes	1	0

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99380	Supervision of nursing facility patient services, 30 minutes or more per month	Other Nursing Facility	Additional Wakely Codes	1	0
99401	Preventive medicine counseling, approximately 15 minutes	Other Preventive Services	Initial Vermont Recommendation	1	1
99402	Preventive medicine counseling, approximately 30 minutes	Other Preventive Services	Initial Vermont Recommendation	1	1
99403	Preventive medicine counseling, approximately 45 minutes	Other Preventive Services	Initial Vermont Recommendation	1	1
99404	Preventive medicine counseling, approximately 60 minutes	Other Preventive Services	Initial Vermont Recommendation	1	1
99411	Group preventive medicine counseling, approximately 30 minutes	Other Preventive Services	Initial Vermont Recommendation	1	0
99412	Group preventive medicine counseling, approximately 60 minutes	Other Preventive Services	Initial Vermont Recommendation	1	0
99420	Administration and interpretation of health risk assessment instrument	Other Preventive Services	Initial Vermont Recommendation	1	1
99429	Preventive medicine service	Other Preventive Services	Initial Vermont Recommendation - Excluded in Other Sources	1	0
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates.	Other Preventive Services	Additional Codes Included in Primary Care Bump Definition	1	1
G0402	Initial preventive physical exam (Medicare only)	Other Preventive Services	Initial Vermont Recommendation	1	0
G0438	Annual wellness exam (Medicare only)	Other Preventive Services	Initial Vermont Recommendation	1	0
G0439	Annual wellness exam, including prevention plan (Medicare only)	Other Preventive Services	Initial Vermont Recommendation	1	0
99241	Patient office consultation, typically 15 minutes	Patient Office Consultation	Initial Vermont Recommendation	1	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99242	Patient office consultation, typically 30 minutes	Patient Office Consultation	Initial Vermont Recommendation	1	1
99243	Patient office consultation, typically 40 minutes	Patient Office Consultation	Initial Vermont Recommendation	1	1
99244	Patient office consultation, typically 60 minutes	Patient Office Consultation	Initial Vermont Recommendation	1	1
99245	Patient office consultation, typically 80 minutes	Patient Office Consultation	Initial Vermont Recommendation	1	1
99356	Prolonged inpatient or observation hospital service first hour	Prolonged Inpatient or Observation Hospital Service	Additional Wakely Codes	0	1
99357	Prolonged inpatient or observation hospital service each 30 minutes beyond first hour	Prolonged Inpatient or Observation Hospital Service	Additional Wakely Codes	0	1
99354	Prolonged office or other outpatient service first hour	Prolonged Patient Service or Office or Other Outpatient Service	Initial Vermont Recommendation	1	1
99355	Prolonged office or other outpatient service each 30 minutes beyond first hour	Prolonged Patient Service or Office or Other Outpatient Service	Initial Vermont Recommendation	1	1
99358	Prolonged patient service without direct patient contact first hour	Prolonged Patient Service or Office or Other Outpatient Service	Initial Vermont Recommendation - Excluded in Other Sources	1	0
99359	Prolonged patient service without direct patient contact each 30 minutes beyond first hour	Prolonged Patient Service or Office or Other Outpatient Service	Initial Vermont Recommendation - Excluded in Other Sources	1	0
99360	Prolonged physician standby service, each 30 minutes	Prolonged Physician Service	Additional Wakely Codes	1	0
99460	Initial hospital or birthing center newborn infant evaluation and management per day	Services Associated with Newborns	Initial Vermont Recommendation - Excluded in Other Sources	0	1
99461	Initial newborn infant evaluation and management per day	Services Associated with Newborns	Initial Vermont Recommendation - Excluded in Other Sources	0	1
99462	Subsequent inpatient hospital care of newborn per day	Services Associated with Newborns	Initial Vermont Recommendation - Excluded in Other Sources	0	1
99463	Initial inpatient hospital or birthing center same date care and discharge of newborn	Services Associated with Newborns	Initial Vermont Recommendation - Excluded in Other Sources	0	1

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
99464	Physician attendance at delivery and stabilization of newborn	Services Associated with Newborns	Initial Vermont Recommendation - Excluded in Other Sources	0	1
99465	Reviving newborn at delivery	Services Associated with Newborns	Initial Vermont Recommendation - Excluded in Other Sources	0	1
G9001	Alcohol and/or Drug Assessment	Alcohol, Smoking, or Substance Abuse Screening or Counseling	Additional Cost Analysis	1	0
G9002	Behavioral Health and Counseling, per 15 minutes	Behavioral Health Codes	Additional Cost Analysis	1	0
G9003	Coordinated care fee, risk adjusted high, initial	Other Preventive Services	Additional Cost Analysis	1	0
G9004	Coordinated care fee, risk adjusted low, initial	Other Preventive Services	Additional Cost Analysis	1	0
G9005	Comprehensive multidisciplinary evaluation	Other Preventive Services	Additional Cost Analysis	1	0
G9006	Coordinated care fee, home monitoring	Other Preventive Services	Additional Cost Analysis	1	0
G9007	Coordinated care fee, scheduled team conference	Other Preventive Services	Additional Cost Analysis	1	0
G9009	Coordinated care fee, risk adjusted maintenance, level 3	Other Preventive Services	Additional Cost Analysis	1	0
G9010	Coordinated care fee, risk adjusted maintenance, level 4	Other Preventive Services	Additional Cost Analysis	1	0
G9011	Coordinated care fee, risk adjusted maintenance, level 5	Other Preventive Services	Additional Cost Analysis	1	0
G9012	Other specified case management service not elsewhere classified	Other Preventive Services	Additional Cost Analysis	1	0
H0001	Coordinated Care Fee, Initial Rate	Other Preventive Services	Additional Cost Analysis	1	0
H0004	Coordinated care fee, maintenance rate	Other Preventive Services	Additional Cost Analysis	1	0
H0005	Alcohol and/or drug services; group counseling by a clinician	Other Preventive Services	Additional Cost Analysis	1	0

CPT	Description	CPT Category	Source	Inclusion Flag	PCP Bump
H0006	Alcohol and/or drug services; case management	Other Preventive Services	Additional Cost Analysis	1	0
H2000	Coordinated care fee, risk adjusted maintenance	Other Preventive Services	Additional Cost Analysis	1	0
S0610	Annual gynecological examination, new patient	Other Preventive Services	Additional Cost Analysis	1	0
S0612	Annual gynecological examination, established patient	Other Preventive Services	Additional Cost Analysis	1	0
S0613	Annual gynecological examination; clinical breast examination without pelvic evaluation	Other Preventive Services	Additional Cost Analysis	1	0

December 9, 2015

Mr. Michael Costa, Deputy Director of Health Care Reform
Ms. Marisa Melamed, Health Care Reform Policy and Planning Coordinator
Agency of Administration
State of Vermont

RE: Vermont Universal Primary Care – Cost Analysis

Dear Michael and Marisa,

Act 54 of 2015 requires the Secretary of Administration to provide a draft cost estimate of universal primary care services with and without cost sharing starting January 2017 to the Joint Fiscal Office (JFO) by October 15, 2015 and a final report to the JFO and legislative committees by December 16, 2015. Pursuant to this legislation, Vermont's Agency of Administration (AoA) retained Wakely Consulting Group (Wakely) to perform the aforementioned cost analysis. As a first step, Wakely was asked to provide preliminary recommendations for the services and provider types that might make up coverage under a universal primary care program. This recommendation is outlined in a separate memo.

The purpose of this memorandum is to outline the methodology and assumptions used to develop the cost estimates for a universal primary care system in Vermont. Other uses of this memorandum may be inappropriate. Wakely does not intend to create a reliance by third parties and assumes no duty or liability to such third parties. Any third parties obtaining this report should rely on their own experts in interpreting the information and any recommendations.

SUMMARY OF RESULTS

Wakely developed cost estimates under several different scenarios. Under Act 54, cost estimates are required for three scenarios: current (i.e. status quo) environment, universal primary care with member cost sharing and universal primary care with no member cost sharing. For the scenario of universal primary care with cost sharing, Wakely assumed that the cost sharing would be the same as the average cost sharing under the status quo for each market (e.g. commercial).

Based on discussions with the State of Vermont, the universal primary care program was assumed to be the primary payer for each of commercial, federal employees, Medicaid and the uninsured. For Medicare eligible members, Medicare was assumed to pay primary and the universal primary care program would be secondary, if appropriate. The military/Tricare employees are excluded from universal primary care coverage.

The following table summarizes the estimated 2017 claim costs for universal primary care by scenario. The costs of administering the program were calculated by Vermont health care reform staff and are included in the body of the report. Since the universal primary care with cost sharing has essentially the same average cost sharing as status quo, the cost of the program is similar for these two scenarios. The

universal primary care scenario with member cost sharing is slightly lower than the status quo scenario. Even though the average cost sharing is the same in the two scenarios, members whose cost sharing will decrease are expected to use more services and members whose cost sharing is expected to increase may use less services. The overall combination of these changes leads to a slight decrease in overall services and costs in the universal primary care scenario with cost sharing.

The universal primary care with no cost sharing scenario is significantly more costly due to both the high level of coverage and the expectation that members would utilize more services if there is no cost sharing for these services.

Table 1: 2017 Estimated Total Claim Costs of the Program

			2017 Estimated Total Claim Cost of Program		
Market	**Estimated Members**	**Universal Primary Care Coverage**	**Status Quo**	**Universal Primary Care with Cost Sharing**	**Universal Primary Care without Cost Sharing**
Commercial	296,400	Primary	$103,944,000	$102,464,000	$150,040,000
Military	14,400	Excluded	$0	$0	$0
Federal	14,400	Primary	$4,905,000	$4,905,000	$6,215,000
Medicaid	150,500	Primary	$107,371,000	$107,371,000	$107,371,000
Medicare	140,800	Secondary	$0	$0	$11,382,000
Uninsured	13,100	Primary	$5,527,000	$5,496,000	$6,921,000
Total	**629,600**		**$221,747,000**	**$220,236,000**	**$281,929,000**
Compared to Status Quo				**($1,511,000)**	**$60,182,000**

The scenarios were further analyzed to estimate the cost impact if primary care payment rates were increased by 10%, 25% and 50% for all but Medicare services. Tables 2a – 2e illustrate the potential cost impact if the State of Vermont changes primary care payment rates as part of healthcare reform initiatives. Tables 2a and 2b illustrate the impact of the payment changes on the status quo scenarios. Tables 2c and 2d illustrate the impact of the payment change on the universal primary care cost sharing scenario. Table 2e illustrates the impact of the payment change on the universal primary care no member cost sharing scenario.

Wakely estimated the cost of the program under two different cost sharing structures. The first, shown in tables 2a and 2c, assumes that even if the provider payment rates increase, the members will continue to pay the same dollar amount of cost sharing per service, such as a copay (fixed cost sharing). The second structure, shown in table 2b and 2d, assumes that member cost sharing will increase in proportion to the increase in the provider payment rates, such as coinsurance (proportionate cost sharing). Please note that there is only one table for the universal primary care no member cost sharing scenario, since there is no

member cost sharing, there is no variation between the two methods. The impact to the base scenario is equivalent to the increase in the primary care payment rates.

Table 2a: 2017 Estimated Additional Costs under Status Quo if Provider Payment Rates are Increased – Fixed Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$13,185,000	$32,963,000	$65,926,000
Military	$0	$0	$0
Federal	$701,000	$1,556,000	$2,982,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$541,000	$1,347,000	$2,692,000
Compared to Status Quo	**$25,164,000**	**$62,709,000**	**$125,285,000**

Table 2b: 2017 Estimated Additional Costs under Status Quo if Provider Payment Rates are Increased – Proportionate Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$10,394,000	$25,986,000	$51,972,000
Military	$0	$0	$0
Federal	$491,000	$1,226,000	$2,453,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$475,000	$1,188,000	$2,377,000
Compared to Status Quo	**$22,097,000**	**$55,243,000**	**$110,487,000**

Table 2c: 2017 Estimated Additional Costs under UPC Cost Sharing if Provider Payment Rates are Increased – Fixed Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$12,997,000	$32,494,000	$64,987,000
Military	$0	$0	$0
Federal	$570,000	$1,426,000	$2,852,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$534,000	$1,334,000	$2,669,000
Compared to UPC Cost Sharing	**$24,838,000**	**$62,097,000**	**$124,193,000**

Table 2d: 2017 Estimated Additional Costs under UPC Cost Sharing if Provider Payment Rates are Increased – Proportionate Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$10,246,000	$25,616,000	$51,232,000
Military	$0	$0	$0
Federal	$491,000	$1,226,000	$2,453,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$472,000	$1,181,000	$2,361,000
Compared to UPC Cost Sharing	**$21,946,000**	**$54,866,000**	**$109,731,000**

Table 2e: 2017 Estimated Additional Costs under UPC No Member Cost Sharing if Provider Payment Rates are Increased – Fixed and Proportionate Cost Sharing

Market	10% Increase	25% Increase	50% Increase
Commercial	$15,004,000	$37,510,000	$75,020,000
Military	$0	$0	$0
Federal	$621,000	$1,554,000	$3,107,000
Medicaid	$10,737,000	$26,843,000	$53,685,000
Medicare	$0	$0	$0
Uninsured	$579,000	$1,446,000	$2,893,000
Compared to UPC No Member Cost Sharing	**$26,941,000**	**$67,353,000**	**$134,705,000**

Tables 2a – 2d show that the costs increase substantially more at the higher provider payment increases if the member cost sharing is fixed compared to increasing the member cost sharing in proportion to the provider payment increases. Under the proportionate cost sharing, the increase in costs is similar to the increase in provider payment rates. Under the fixed cost sharing, the increase in program costs is higher than the increase in payment rates since the program will absorb the entire increase in provider payments.

METHODOLOGY AND ASSUMPTIONS

Wakely developed the three scenarios using the following methodology and assumptions.

Base Data

The first step was to compile the base data used in the analysis. The data came from multiple sources. The primary data used was Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) data for commercial, Medicaid and Medicare. Wakely reviewed commercial and Medicaid data from 2012 to 2014 and Medicare data for 2012, which is the most recent year available. For commercial and Medicaid the base data used was 2014 while 2012 was used for Medicare.

Wakely used only professional claims and restricted the claims used to the service codes and providers identified in the primary care definition.[1] Wakely pulled number of encounters, defined as the number of unique claims by provider and date of service, plan cost and member cost sharing for each encounter. For Medicaid and Medicare the data was summarized at the market level. For commercial, the data was grouped by self-funded and fully insured members. The commercial data was further segmented by average percent of costs paid by the plan in 10 percent increments. The percent of costs paid by the plan was determined at the group level for members in a group plan and at the individual level for members enrolled in an individual plan. The individual data may not accurately represent the average percent of costs paid by the plan, but since individual plans are a small percent of the overall commercial market the impact to the analysis is expected to be small.

VHCURES data for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) was pulled differently for each market. The majority of FQHC and RHC claims in Medicaid are billed to an encounter code, which is included in the primary care definition. Medicare does not utilize encounter codes, while some commercial carriers utilize encounter codes. The encounter codes are also included in the primary care definition for commercial carriers. For FQHC and RHC claims not billed under an encounter code, Wakely reviewed the Current Procedural Terminology (CPT) categories and codes that providers use with the encounter code for Medicaid and assumed this list of CPT codes would represent the encounter code services for Medicare and commercial. In addition, FQHCs/RHCs bill under multiple provider IDs. In order to pull all claims for FQHCs/RHCs, Wakely used provider IDs provided by Policy Integrity which included all provider IDs with names the same as those of the FQHCs/RHCs that bill under the Medicaid encounter code. These provider IDs were used for Medicaid and commercial. Provider names are not available in the Medicare data so the "bill type" was used to identify FQHC/RHC providers for Medicare. While the resulting claim amounts appear reasonable, it is possible that this methodology is underestimating the FQHC/RHC claim costs.

In addition to the VHCURES data, to accurately reflect total primary care costs, other costs were added to the VHCURES data. FQHC/RHC settlement costs for 2014 were provided to Wakely. Based on conversations with the State of Vermont, some of these settlement costs were for non-primary care services such as dental and pharmacy. As a result the settlement costs were adjusted to account for Wakely's estimate of non-primary care costs in 2014. Based on historical settlement amounts, Wakely estimated $450,000 in costs related to dental and pharmacy services and reduced the 2014 settlement amount by this estimate. The settlement was then reduced an additional 5% to account for the portion of FQHC and RHC professional medical claims not covered by the Universal Primary Care definition, based on an analysis of the FQHC and RHC claims in VHCURES.

[1] See "Vermont AoA_Universal Primary Care Definition_10 09 2015.docx" for the development and definition of primary care services.

Costs were also added for Vermont's Blueprint for Health program[2]. Historical payments and attributed members for Blueprint costs were provided to Wakely. We excluded Blueprint costs that are in VHCURES for Medicare services to ensure no duplication of costs. Based on discussions with the State of Vermont, we only included patient centered medical home (PCMH) Blueprint payments. Based on this information, we calculated a per member per month (PMPM) cost of around $2. This amount was reduced to reflect the portion of members who did not use a primary care service during the year based on VHCURES data and using the universal primary care definition. We assumed this PMPM would be applicable to all members in our base data even though historically there are a number of groups who do not participate in the Blueprint program, such as non-participating self-insured plans. Since most groups are expected to participate in Blueprint in the future, this assumption is not expected to have a significant impact on the overall analysis. We did not include Blueprint costs in the military costs since they are not expected to participate in the Blueprint program.

2017 Claim Cost Estimates – Status Quo

The base data was summarized according to market, and for commercial, additional segmentations of the data were made to more accurately estimate future costs. The following metrics were summarized for each segmentation of the data:

- Average members in the base data (2014 for commercial and Medicaid; 2012 for Medicare)
- Number of encounters per 1,000 members per year
- Average cost per encounter (includes both plan and member costs)
- Plan costs, Total Annual and PMPM
- Member cost sharing, Total Annual and PMPM
- Plan and member costs, Total Annual and PMPM
- Average percent of costs paid by the plan (defined as the plan costs divided by the sum of plan and member costs)

The following adjustments and assumptions were made to the base data to estimate the 2017 costs under the status quo scenario. The base data and the adjustments are detailed in Appendix A.

Trend

We assumed an annual utilization trend of 1.0% for commercial, and 0.9% for Medicaid and Medicare. We assumed a payment rate trend (also called unit cost or cost per service trend) of 3.0% for commercial, 1.7% for Medicaid, and 0.2% for Medicare. Commercial and Medicaid claims were trended for three years (2014 to 2017) while the Medicare data was trended five years (2012 to 2017).

[2] http://blueprintforhealth.vermont.gov/ The Vermont Blueprint for Health is described in statute (18 VSA Chapter 13) as "a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care cost by promoting health maintenance, prevention, and care coordination and management."

Wakely reviewed several sources for the commercial trend assumptions, including publicly available Vermont rate filings, the Segal trend study, and the Health Cost Institute study. The estimates ranged from -1.5% to 2.0% for utilization and 1.4% to 4.4% for payment rate trends in recent years (from 2013 to 2016). Wakely has incorporated a utilization trend of 1.0% and payment rate trend of 3.0% based on actuarial judgment and industry expectations.

Vermont Medicaid trends were not available at the service category level so total Medicaid trends were used based on estimates made as part of the Green Mountain Care analysis. It is likely that Medicaid professional payment rates will not be increased. If this is the case, the 1.7% trend is likely conservative.

Medicare trends are based on the average CMS Medicare FFS trends from 2012 through 2017.

Sensitivity testing on the trend assumptions can be found in Appendix B.

Preventive Services

For commercial there were preventive services in the base data that were not covered 100% by the plan, presumably due to the presence of grandfathered plans or plans that had not yet renewed onto an Affordable Care Act (ACA) plan in 2014. We made an adjustment for 2017 to reflect the assumption that universal primary care will be aligned with the ACA and hence the preventive services under the ACA will all be offered without member cost sharing. It should be noted that the primary care definition does not include all preventive services under the ACA so this adjustment only impacts the preventive services which are covered under the program.

Percent of Costs Paid by the Plan

The percent of costs paid by the plan is calculated as the claims paid by the plan divided by the sum of the claims paid by the plan and the members. We assumed that the percent of costs paid by the plans remained the same between the base and projection periods.

Enrollment

Wakely utilized enrollment estimates by market that were developed for a prior study for Vermont Health Connect to estimate the 2017 enrollment by market, including the number of uninsured. The Joint Fiscal Office (JFO) provided input regarding the 2017 membership estimates, which Wakely used to adjust the 2017 enrollment projections.

The enrollment estimates do not include any increases due to people moving to Vermont in order to be included in the universal primary care program. Given that the coverage includes only a portion of medical and drug coverage, it is assumed that migration to Vermont would be insignificant as a result of this program.

This enrollment is different than the base VHCURES data for each of commercial, Medicaid and Medicare. Table 3 shows the enrollment from the base VHCURES data by market and the enrollment used in the 2017 estimates.

Table 3: Average Members in Base Data and 2017 Estimates

	Base Data			Estimate
Market	**2012**	**2013**	**2014**	**2017**
Commercial	328,300	333,500	279,500	296,400
Military	N/A	N/A	N/A	14,400
Federal	N/A	N/A	N/A	14,400
Medicaid	115,900	120,100	138,800	150,500
Medicare	119,500	N/A	N/A	140,800
Uninsured	N/A	N/A	N/A	13,100
Total	**563,700**	**453,600**	**418,300**	**629,600**

An alternate 2017 membership scenario and the resulting cost estimates can be found in Appendix B.

Data Limitations

VHCURES data was not available for federal employees, Tricare/military employees and the uninsured. As noted, the base data enrollment from VHCURUES is also different than the estimated 2017 enrollment. The following assumptions were made to account for these data limitations:

- For commercial, Medicaid and Medicare, it is assumed that the base data metrics (i.e. PMPMs, encounters per 1,000 members per year, and average costs per encounter) fairly represents the 2017 population and no significant differences in morbidity or cost sharing (commercial) are assumed between the base enrollment and the 2017 enrollment.
- For federal employees, it was assumed that the 2017 utilization and average cost per encounter would be similar to those of the self-funded plans where the plan pays 80% to 90% of costs. We assumed the plan would pay 86% of costs based on the plan designs and an estimated membership distribution of the federal plans.
- For military, it was assumed that the 2017 estimated utilization, average cost per encounter, and percent of costs paid by the plan would be similar to those of the average self-funded plan where the plan pays 90% to 100% of the costs. We do not have an estimate of a membership distribution for the military plans.
- For uninsured, we assumed that the 2017 estimated costs and utilization were assumed to be the same as the estimated average costs and utilization for all other populations combined (commercial, Medicare, Medicaid, military, and federal employees). Wakely considered how the morbidity of the uninsured population compares to the currently insured population and reviewed multiple sources. The sources vary in what they compared the uninsured against (e.g. commercial, Medicaid). They also tended to compare costs for all medical and drug services instead of just primary care services. These sources indicate that the uninsured claim costs could range from 30% to 100% of overall claim costs on a PMPM basis. Wakely is incorporating a conservative estimate by assuming they are the same as the average population. We believe it to be appropriate given that there may be some pent-up demand within the population, which has not otherwise been incorporated into the analysis. In addition, Wakely expects that primary

care services are more likely to be utilized by healthy individuals so the 30% estimate for overall claims is likely understated for primary care services.

Provider Payment Adjustments

The State of Vermont requested that Wakely estimate the cost of provider payment rates increasing should this occur as part of provider payment reform. To model the provider payment reform scenarios, the average provider payment per encounter was increased by 10%, 25% and 50% and total program costs were compared under the status quo scenario. No change in provider payments was made for Medicare since the provider payments in Medicare are determined by CMS. No adjustments were made for utilization or service mix as a results of the payment rate increases.

Wakely estimated the cost of the program under two different cost sharing structures. The first assumes that even if the provider payment rates increase, the members will continue to pay the same dollar amount of cost sharing per service. This would be the situation if a member has a fixed copay for services (e.g. $20 for an office visit). The second assumes that member cost sharing will increase in proportion to the increase in the provider payment rates. This would be the situation if a member's cost sharing is coinsurance (e.g. 20% for an office visit).

Administrative Expenses

Wakely understands that the AoA is including an estimate of administrative expenses needed to support the universal primary care program. The range of administrative expenses is estimated to be an additional 7% to 15% of costs based on the administrative costs in existing programs and expected administrative costs from programs which may exhibit the same administrative characteristics of a universal primary care system. Wakely believes these estimates of administrative expenses to be reasonable. These estimates can be refined once there is a better understanding of how the program will be operationalized.

2017 Claim Cost Estimates – Universal Primary Care

The status quo scenario was adjusted to account for two different universal primary care scenarios, one with member cost sharing and one with no member cost sharing. The following outlines the additional adjustments and assumptions made for these scenarios.

Percent of Costs Paid by the Plan

For the universal primary care scenario with member cost sharing the average percent of costs paid by the plan are applied to all members within a market. This primarily impacts the commercial market where in the status quo scenario there is a wide range of plan paid percentages. Since Medicare is assumed to be the same for all members and this program will not impact the federal and military plans, this scenario did not impact these markets. Medicaid already pays at 100% for all members so this market is also the same as the status quo scenario. The uninsured costs are slightly different given the costs are based on the average of all other markets, which includes the change to the commercial market.

For the universal primary care scenario with no member cost sharing, it is assumed that all plans will cover 100% of services. This impacts all markets although military is excluded from the program. For Medicare the program will cover the difference between Medicare and the cost of the service. For all other markets, the program will cover the full cost of the service.

Induced Demand Factors

Generally, when there is a significant change in the cost sharing on elective services, there is a corresponding change in demand for those services, called induced demand. This change in demand is due to the price elasticity of demand and is not driven by the underlying morbidity of the population. As part of the ACA, Health and Human Services (HHS) published federal induced demand factors when the plan pays 60%, 70%, 80%, and 90% of the costs. Wakely linearly interpolated the induced demand factors for other percentages of plan paid costs. Wakely segmented the data in 10-percentage-point ranges for the commercial population. We applied the appropriate induced demand factors to the members in each range to reflect the change in their propensity to use primary care services. For other market segments such as Medicare, all members are assumed to have the same percent of costs paid by the plan. We applied the induced demand factor based on percent of primary care costs paid by the plan for the entire population.

The following table shows the HHS published federal induced demand factors used in the analysis. The factors for the 60% to 90% Percent Paid by Plan are from HHS. The remaining factors were interpolated by Wakely. These factors were used to determine the induced demand adjustment for any changes in percent paid by plan for the two universal primary care scenarios. For example, if in a data segmentation the percent of costs paid by the plan for primary care services was 85%, under universal primary care with no member cost sharing, the induced demand adjustment for this segment of data would be approximately 1.240 / [(1.150 + 1.080) / 2]. If the percent of costs paid by the plan for primary care services was 60%, under universal primary care with no member cost sharing, the induced demand adjustment for this segment of data would be 1.240.

Table 4: Induced Demand Factors

Percent Paid by Plan	Induced Demand Factor
100%	1.240
90%	1.150
80%	1.080
70%	1.030
60%	1.000
50%	0.975
40%	0.955
30%	0.938
20%	0.925

A limitation of using the federal factors is that they were developed for use across a typical basket of services covered under an insurance plan as opposed to just the primary care services. They are also

national, commercial factors and may not be applicable for other populations. There is significant uncertainty around induced demand for primary care services in Vermont. Actual induced demand could vary significantly. The historical data does not show the level of induced demand by percent plan paid segmentation that Wakely would expect. As a result, the factors used assume that the induced demand for professional services is more elastic than the historical Vermont data implies. Wakely recommends that Vermont perform a detailed induced demand study based on VHCURES data prior to the implementation of the universal primary care program to fully understand the potential impact of changes in cost-sharing. This is especially critical if the universal primary care program coverage has no member cost sharing.

Sensitivity testing on the induced demand factors can be found in Appendix B.

Claim Cost of the Program

Once the data was adjusted and trended to 2017, the data for each scenario was summarized by the medical costs paid by the plan and costs paid by the member. Where universal primary care is the primary payer (commercial, Medicaid, federal employees and the uninsured), the cost of the program is equal to the plan costs. Where universal primary care pays secondary to other coverage (Medicare) the cost of the program is equal to the plan costs in excess of the status quo plan costs. Where universal primary care will not apply (military/Tricare), there is no cost to the program.

See the Caveats and Limitations section for more information about data limitations and suggested additional analysis should the State of Vermont pursue universal primary care coverage.

RESULTS

The following tables show the detailed results of the 2017 claim cost estimates for each of the three scenarios. The tables include enrollment by market, plan and member costs PMPM, and percent of plan paid. The total annual claim costs are also shown as are the total claim cost of the program. As noted above, for markets where universal primary care is the primary coverage the total cost of the program is the same as the plan costs. For Medicare, where universal primary care is secondary coverage, the cost of the program is only the costs for any cost sharing that is above their primary coverage, if any. Since military is excluded from the universal primary care program, there are no program costs under any scenario.

Table 5 shows the detailed 2017 estimates for the status quo scenario. Tables 6 and 7 show the detailed 2017 estimates for the universal primary care scenario with and without member cost sharing, respectively.

Table 5: 2017 Estimated Costs under Status Quo

	Estimated Members	Plan Costs PMPM	Member Costs PMPM	Total Plan and Member Costs PMPM	Percent of Costs Paid by Plan	Total Annual Claim Costs	Total Claim Cost of Program
Commercial							
Fully Insured	148,200	$30.55	$9.76	$40.30	75.8%	$54,323,000	$54,323,000
Self-Funded	148,200	$27.89	$5.93	$33.83	82.5%	$49,621,000	$49,621,000
Sub-Total	296,400	$29.22	$7.85	$37.07	78.8%	$103,944,000	$103,944,000
Military	14,400	$42.83	$3.70	$46.53	92.0%	$7,384,000	$0
Federal	14,400	$28.37	$4.62	$32.99	86.0%	$4,905,000	$4,905,000
Medicaid	150,500	$59.45	$0.00	$59.45	100.0%	$107,371,000	$107,371,000
Medicare	140,800	$21.54	$5.83	$27.37	78.7%	$36,392,000	$0
Uninsured	13,100	$35.14	$5.30	$40.44	86.9%	$5,527,000	$5,527,000
Total	**629,600**	**$35.14**	**$5.30**	**$40.44**	**86.9%**	**$265,523,000**	**$221,747,000**

Table 6: 2017 Estimated Costs under Universal Primary Care with Member Cost Sharing

	Estimated Members	Plan Costs PMPM	Member Costs PMPM	Total Plan and Member Costs PMPM	Percent of Costs Paid by Plan	Total Annual Claim Costs	Total Claim Cost of Program
Commercial							
Fully Insured	148,200	$31.75	$8.53	$40.28	78.8%	$56,469,000	$56,469,000
Self-Funded	148,200	$25.86	$6.94	$32.80	78.8%	$45,995,000	$45,995,000
Sub-Total	296,400	$28.80	$7.73	$36.54	78.8%	$102,464,000	$102,464,000
Military	14,400	$42.83	$3.70	$46.53	92.0%	$7,384,000	$0
Federal	14,400	$28.37	$4.62	$32.99	86.0%	$4,905,000	$4,905,000
Medicaid	150,500	$59.45	$0.00	$59.45	100.0%	$107,371,000	$107,371,000
Medicare	140,800	$21.54	$5.83	$27.37	78.7%	$36,392,000	$0
Uninsured	13,100	$34.94	$5.24	$40.19	86.9%	$5,496,000	$5,496,000
Total	**629,600**	**$34.94**	**$5.24**	**$40.19**	**86.9%**	**$264,012,000**	**$220,236,000**

The only difference between the status quo scenario and the universal primary care with member cost sharing scenario is commercial. For commercial the overall percent of costs paid by the plan is the same for both scenarios, on average. In the status quo scenario the percent paid by the plan varies significantly across the commercial market. In bringing these individual and groups all to the same percent of costs

paid by the plan, induced demand was applied to the costs for each segment. For segments where the percent of plan paid is less than the average, the induced demand adjustment increases the number of encounters and the resulting costs. For segments where the percent of plan paid is more than the average, the induced demand decreases the number of encounters and the resulting costs. The net result of these changes is a small decrease in the overall utilization and costs in the universal primary care scenario with member cost sharing. The decrease in costs to the program are all due to the induced demand adjustment. The costs of the uninsured are also impacted since their costs are the average of all markets combined. These adjustments by segment can be seen in the development of the cost estimates in Appendix A.

Table 7: 2017 Estimated Costs under Universal Primary Care with no Member Cost Sharing

	Estimated Members	Plan Costs PMPM	Member Costs PMPM	Total Plan and Member Costs PMPM	Percent of Costs Paid by Plan	Total Annual Claim Costs	Total Claim Cost of Program
Commercial							
Fully Insured	148,200	$46.50	$0.00	$46.50	100.0%	$82,689,000	$82,689,000
Self-Funded	148,200	$37.86	$0.00	$37.86	100.0%	$67,351,000	$67,351,000
Sub-Total	296,400	$42.18	$0.00	$42.18	100.0%	$150,040,000	$150,040,000
Military	14,400	$49.38	$0.00	$49.38	100.0%	$8,514,000	$0
Federal	14,400	$35.95	$0.00	$35.95	100.0%	$6,215,000	$6,215,000
Medicaid	150,500	$59.45	$0.00	$59.45	100.0%	$107,371,000	$107,371,000
Medicare	140,800	$31.62	$0.00	$31.62	100.0%	$53,420,000	$11,382,000
Uninsured	13,100	$44.01	$0.00	$44.01	100.0%	$6,921,000	$6,921,000
Total	**629,600**	**$44.01**	**$0.00**	**$44.01**	**100.0%**	**$332,481,000**	**$281,929,000**

The program costs are significantly higher under universal primary care with no member cost sharing. Of the $60 million increase in program costs compared to status quo, approximately $39 is to cover the cost sharing of the members. The remaining $21 million is for additional costs due to induced demand, or the expected increase in primary care services should the services be free to members.

The development of the costs for each of the three scenarios in Tables 5, 6 and 7 can be found in Exhibit A.

CAVEATS AND LIMITATIONS

The following are caveats and limitations to the analysis.

- The VHCURES data is not always consistent when looking at the different calendar years of data. Wakely relied on the most recent year of data available, given that VHCURES data continues to

improve and the 2014 data for commercial and Medicaid would be a better view of the post-ACA enrollment and utilization of services. While we believe the most recent year of data is the most appropriate to use, the volatility of historical data should be considered when relying on the results of the analysis.

- There is an "Unknown/Other Commercial" set of data in the base VHCURES data which is primarily claims without a corresponding member/insurance group in the membership data. It also includes groups labeled as "Other" and "Short-term Coverage". This group was not included in the 2017 cost estimates.

- This analysis was done at a high level and without knowledge of how the ultimate universal primary care coverage program would be operationalized. Once more program details are known, Wakely suggests the following should be further analyzed to refine the cost estimates:

    - This analysis does not take into account provider or insurer behavior changes, cost shifting, up-coding, or leakage to and from non-primary care providers as a result of carving out primary care services. It is imperative that any program that the State of Vermont implement have controls to limit unwanted shifting of services. Once the program has been further defined, provider utilization changes or other downstream impacts should be incorporated into the cost estimates.

    - The results in this analysis do not include any administrative costs for universal primary care as these are variable depending on the details of the program implemented. A discussion on the costs of administering the program is included in the body of the report.

    - Provider payment reforms or other healthcare reforms in Vermont could have an impact on overall costs. When the implementation date of universal primary care is closer, estimates should be updated to capture the latest Vermont reform efforts that could impact the cost of the program.

    - Estimates were made to account for potential behavior changes for members should their primary care benefits become more or less rich. These induced demand assumptions should be revisited and an induced demand study should be performed on Vermont-specific data.

- The analysis does not take into account the impact the program would have on the ability of the people of Vermont to remain on HSA-qualified plans.

- The commercial percent of costs paid by the plan was calculated at the group level based on actual total costs and plan paid costs in the base data. For individuals, it is based on each individual's actual claims, not plan design. This may cause some minor variability within the results.

- Encounters were determined by combining lines with the same date of service and provider. Therefore, one encounter may encompass several CPT codes and a member could have multiple encounters in one day.

- Only primary coverage was included in the base data. If a member had secondary coverage only the cost sharing for the primary coverage was captured. Therefore, member cost sharing for those with secondary coverages may be overstated. It is not expected that the impact of secondary coverage is significant.

- Appendix B contains a sensitivity analysis to analyze the impact of various assumptions that contribute to the cost of implementing universal primary care. It discusses the total cost of the program under each scenario. However, Wakely would like to clarify that the impact to the State of Vermont could vary based on the portion of costs they are responsible for in each scenario.

RELIANCE

Wakely relied on information provided by the State of Vermont including VHCURES data, 2013-2014 Medicaid FQHC and RHC settlement amounts and Blueprint costs. We relied on the FQHC/RHC provider IDs for the Medicaid and commercial lines of business provided by Steve Kappel at Policy Integrity. We also relied on JFO for input on the total 2017 enrollment projections and the enrollment distribution used in the alternate membership projection scenario in Appendix B. Wakely reviewed the above information for reasonability, but did not audit the information.

DISCLOSURES

It is impossible to estimate costs several years into the future with accuracy, and it is particularly difficult to estimate the effects of untested reforms. We made assumptions in order to develop these estimates. To the extent that actual results differ from these assumptions, overall costs could be materially affected. As a result, Wakely does not warrant or guarantee that the cost estimates will be accurate should the State of Vermont implement universal primary care coverage.

This report is provided to the AoA for documentation and for inclusion in a broader report on universal primary care coverage. Distribution of this document should be made in its entirety.

We are both members of the American Academy of Actuaries and Fellows of the Society of Actuaries, and are qualified to provide the cost estimates included in this memo.

Should you have any questions, please feel free to call to discuss.

Sincerely,

Julie Peper
Director and Senior Consulting Actuary
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Danielle W. Hilson
Consulting Actuary
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Cc: Robin Lunge, Agency of Administration
Devon Green, Agency of Administration
Joyce Manchester, Joint Fiscal Office
Nolan Langwell, Joint Fiscal Office
Steve Kappel, Policy Integrity
Brittney Phillips, Wakely

2017 Development of Cost Estimates – Status Quo

	BASE DATA		AVERAGE ANNUAL TREND					2017 ESTIMATES			PMPM	
	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Utilization	Cost/Encounter	Years of Trend*	Induced Demand	Adj. for Preventive CS (Only applied to Paid Claims)	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Total Plan and Member Cost	Member Cost	Plan Cost
Commercial												
Fully Insured Commercial												
< 40% AV	3,156.73	$115.80	1.0%	3.0%	3	1.000	1.003	3,252.38	$126.54	$34.30	$23.27	$11.03
40% - 50% AV	3,426.25	$120.75	1.0%	3.0%	3	1.000	1.004	3,530.07	$131.94	$38.81	$19.93	$18.89
50% - 60% AV	3,482.69	$121.85	1.0%	3.0%	3	1.000	1.007	3,588.22	$133.15	$39.82	$16.93	$22.88
60% - 70% AV	3,136.62	$122.71	1.0%	3.0%	3	1.000	1.006	3,231.66	$134.09	$36.11	$11.55	$24.56
70% - 80% AV	4,207.80	$104.24	1.0%	3.0%	3	1.000	1.009	4,335.31	$113.90	$41.15	$8.45	$32.70
80% - 90% AV	4,062.35	$107.70	1.0%	3.0%	3	1.000	1.003	4,185.45	$117.69	$41.05	$6.08	$34.97
90% + AV	4,142.04	$113.25	1.0%	3.0%	3	1.000	1.001	4,267.55	$123.75	$44.01	$2.55	$41.46
Fully Insured Sub-Total								*3,999.09*	*$120.94*	*$40.30*	*$9.76*	*$30.55*
Self-Funded Commercial												
<= 40% AV	979.06	$137.07	1.0%	3.0%	3	1.000	1.015	1,008.73	$149.78	$12.59	$6.93	$5.66
40% - 50% AV	2,841.27	$123.01	1.0%	3.0%	3	1.000	1.006	2,927.37	$134.42	$32.79	$17.08	$15.71
50% - 60% AV	2,601.13	$123.59	1.0%	3.0%	3	1.000	1.002	2,679.94	$135.05	$30.16	$12.40	$17.76
60% - 70% AV	2,179.06	$138.43	1.0%	3.0%	3	1.000	1.006	2,245.08	$151.26	$28.30	$9.01	$19.29
70% - 80% AV	2,459.53	$120.19	1.0%	3.0%	3	1.000	1.017	2,534.06	$131.33	$27.73	$5.81	$21.92
80% - 90% AV	2,846.68	$123.53	1.0%	3.0%	3	1.000	1.012	2,932.93	$134.99	$32.99	$3.87	$29.13
90% + AV	4,396.76	$118.13	1.0%	3.0%	3	1.000	1.001	4,529.99	$129.09	$48.73	$3.88	$44.85
Self-Funded Sub-Total								*3,013.07*	*$134.73*	*$33.83*	*$5.93*	*$27.89*
Commercial Sub-Total								**3,506.01**	**$126.86**	**$37.07**	**$7.85**	**$29.22**
Military								4,529.99	$123.26	$46.53	$3.70	$42.83
Federal								2,932.93	$134.99	$32.99	$4.62	$28.37
Medicaid	6,862.46	$96.18	0.9%	1.7%	3	1.000	1.000	7,042.72	$101.30	$59.45	$ -	$59.45

APPENDIX A - 2017 Development of Cost Estimates

	BASE DATA		AVERAGE ANNUAL TREND					2017 ESTIMATES			PMPM	
	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Utilization	Cost/Encounter	Years of Trend*	Induced Demand	Adj. for Preventive CS (Only applied to Paid Claims)	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Total Plan and Member Cost	Member Cost	Plan Cost
Medicare	3,685.38	$84.35	0.9%	0.2%	5	1.000	1.000	3,858.11	$85.14	$27.37	$5.83	$21.54
Uninsured								4,460.28	$108.81	$40.44	$5.30	$35.14
Total								**4,460.28**	**$108.81**	**$40.44**	**$5.30**	**$35.14**

2017 Development of Cost Estimates – Universal Primary Care with Member Cost Sharing

	BASE DATA		AVERAGE ANNUAL TREND				2017 ESTIMATES		PMPM		
	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Utilization	Cost/Encounter	Years of Trend*	Induced Demand	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Total Plan and Member Cost	Member Cost	Plan Cost
Commercial											
Fully Insured Commercial											
< 40% AV	3,156.73	$115.80	1.0%	3.0%	3	1.141	3,711.63	$126.54	$39.14	$8.28	$30.85
40% - 50% AV	3,426.25	$120.75	1.0%	3.0%	3	1.105	3,899.84	$131.94	$42.88	$9.08	$33.80
50% - 60% AV	3,482.69	$121.85	1.0%	3.0%	3	1.081	3,878.83	$133.15	$43.04	$9.11	$33.93
60% - 70% AV	3,136.62	$122.71	1.0%	3.0%	3	1.049	3,389.78	$134.09	$37.88	$8.02	$29.86
70% - 80% AV	4,207.80	$104.24	1.0%	3.0%	3	0.997	4,322.42	$113.90	$41.03	$8.68	$32.34
80% - 90% AV	4,062.35	$107.70	1.0%	3.0%	3	0.962	4,027.44	$117.69	$39.50	$8.36	$31.14
90% + AV	4,142.04	$113.25	1.0%	3.0%	3	0.904	3,859.26	$123.75	$39.80	$8.42	$31.38
Fully Insured Sub-Total							*3,989.13*	*$121.16*	*$40.28*	*$8.53*	*$31.75*
Self-Funded Commercial											
<= 40% AV	979.06	$137.07	1.0%	3.0%	3	1.113	1,122.96	$149.78	$14.02	$2.97	$11.05
40% - 50% AV	2,841.27	$123.01	1.0%	3.0%	3	1.106	3,239.01	$134.42	$36.28	$7.68	$28.60
50% - 60% AV	2,601.13	$123.59	1.0%	3.0%	3	1.077	2,886.83	$135.05	$32.49	$6.88	$25.61
60% - 70% AV	2,179.06	$138.43	1.0%	3.0%	3	1.049	2,354.06	$151.26	$29.67	$6.28	$23.39
70% - 80% AV	2,459.53	$120.19	1.0%	3.0%	3	0.999	2,531.52	$131.33	$27.71	$5.86	$21.84
80% - 90% AV	2,846.68	$123.53	1.0%	3.0%	3	0.944	2,768.43	$134.99	$31.14	$6.59	$24.55
90% + AV	4,396.76	$118.13	1.0%	3.0%	3	0.919	4,164.55	$129.09	$44.80	$9.48	$35.32
Self-Funded Sub-Total							*2,916.35*	*$134.96*	*$32.80*	*$6.94*	*$25.86*
Commercial Sub-Total							**3,452.67**	**$126.99**	**$36.54**	**$7.73**	**$28.80**
Military**							4,529.99	$123.26	$46.53	$3.70	$42.83
Federal							2,932.93	$134.99	$32.99	$4.62	$28.37

APPENDIX A - 2017 Development of Cost Estimates

	BASE DATA		AVERAGE ANNUAL TREND				2017 ESTIMATES		PMPM		
	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Utilization	Cost/Encounter	Years of Trend*	Induced Demand	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Total Plan and Member Cost	Member Cost	Plan Cost
Medicaid	6,862.46	$96.18	0.9%	1.7%	3	1.000	7,042.72	$101.30	$59.45	$-	$59.45
Medicare	3,685.38	$84.35	0.9%	0.2%	5	1.000	3,858.11	$85.14	$27.37	$5.83	$21.54
Uninsured							4,434.63	$108.75	$40.19	$5.24	$34.94
Total							**4,434.63**	**$108.75**	**$40.19**	**$5.24**	**$34.94**

2017 Development of Cost Estimates – Universal Primary Care without Member Cost Sharing

	BASE DATA		AVERAGE ANNUAL TREND				2017 ESTIMATES			PMPM	
	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Utilization	Cost/Encounter	Years of Trend*	Induced Demand	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Total Plan and Member Cost	Member Cost	Plan Cost
Commercial											
Fully Insured Commercial											
< 40% AV	3,156.73	$ 115.80	1.0%	3.0%	3	1.317	4,284.64	$126.54	$ 45.18	$-	$ 45.18
40% - 50% AV	3,426.25	$ 120.75	1.0%	3.0%	3	1.275	4,501.90	$131.94	$ 49.50	$-	$ 49.50
50% - 60% AV	3,482.69	$ 121.85	1.0%	3.0%	3	1.248	4,477.65	$133.15	$ 49.68	$-	$ 49.68
60% - 70% AV	3,136.62	$ 122.71	1.0%	3.0%	3	1.211	3,913.10	$134.09	$ 43.73	$-	$ 43.73
70% - 80% AV	4,207.80	$ 104.24	1.0%	3.0%	3	1.151	4,989.73	$113.90	$ 47.36	$-	$ 47.36
80% - 90% AV	4,062.35	$ 107.70	1.0%	3.0%	3	1.111	4,649.20	$117.69	$ 45.60	$-	$ 45.60
90% + AV	4,142.04	$ 113.25	1.0%	3.0%	3	1.044	4,455.05	$123.75	$45.94	$-	$45.94
Fully Insured Sub-Total							*4,604.98*	*$121.16*	*$46.50*	*$-*	*$46.50*
Self-Funded Commercial											
<= 40% AV	979.06	$137.07	1.0%	3.0%	3	1.285	1,296.32	$149.78	$16.18	$-	$16.18
40% - 50% AV	2,841.27	$123.01	1.0%	3.0%	3	1.277	3,739.06	$134.42	$41.88	$-	$41.88
50% - 60% AV	2,601.13	$123.59	1.0%	3.0%	3	1.243	3,332.50	$135.05	$37.50	$-	$37.50
60% - 70% AV	2,179.06	$138.43	1.0%	3.0%	3	1.210	2,717.48	$151.26	$34.25	$-	$34.25
70% - 80% AV	2,459.53	$120.19	1.0%	3.0%	3	1.153	2,922.34	$131.33	$31.98	$-	$31.98
80% - 90% AV	2,846.68	$123.53	1.0%	3.0%	3	1.090	3,195.83	$134.99	$35.95	$-	$35.95
90% + AV	4,396.76	$118.13	1.0%	3.0%	3	1.061	4,807.48	$129.09	$51.71	$-	$51.71
Self-Funded Sub-Total							*3,366.58*	*$134.96*	*$37.86*	*$-*	*$37.86*
Commercial Sub-Total							**3,985.70**	**$126.99**	**$42.18**	**$-**	**$42.18**
Military**							4,807.48	$123.26	$49.38	$-	$49.38
Federal							3,195.83	$134.99	$35.95	$-	$35.95

APPENDIX A - 2017 Development of Cost Estimates

	BASE DATA		AVERAGE ANNUAL TREND				2017 ESTIMATES			PMPM	
	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Utilization	Cost/Encounter	Years of Trend*	Induced Demand	Encounters per 1,000 Members per Year	Total Plan and Member Cost/Encounter	Total Plan and Member Cost	Member Cost	Plan Cost
Medicaid	6,862.46	$96.18	0.9%	1.7%	3	1.000	7,042.72	$101.30	$59.45	$-	$59.45
Medicare	3,685.38	$84.35	0.9%	0.2%	5	1.155	4,456.65	$85.14	$31.62	$-	$31.62
Uninsured							4,840.22	$109.10	$44.01	$-	$44.01
Total							**4,840.22**	**$109.10**	**$44.01**	**$-**	**$44.01**

APPENDIX B: ANALYSIS OF THE SENSITIVITY OF ASSUMPTIONS

Wakely performed a sensitivity analysis to analyze the impact of various assumptions that contribute to the claim cost of implementing universal primary care. The sensitivity analysis focused on the payment rate trend assumption and the induced demand factor assumptions. Wakely also calculated the claim cost of implementing universal primary care under an alternative 2017 projected membership scenario.

Trend

The universal primary care claim cost estimate for 2017 depends on the growth assumed in primary care costs from the base period. Due to the uncertainty surrounding the payment rate trends, Wakely performed an analysis decreasing the trend by 1% and increasing the trend by 1% from the base scenario for the commercial, Medicaid, and Medicare markets. The payment rate trend could be different due to different contracted rates with providers or could also be the result of the mix of services being different in the future than current. The resulting assumed payment rate trends can be seen in Table 1. These trends are annual trends over multiple years, so the trend differences will be more than 1% in aggregate.

Table 1: Payment Rate Trends Used in Sensitivity Testing

	Payment Rate Trend		
Market	**Base**	**Low**	**High**
Commercial	3.0%	2.0%	4.0%
Medicaid	1.7%	0.7%	2.7%
Medicare	0.2%	-0.8%	1.2%

Table 2 shows the resulting total claim cost of the program under the no cost sharing scenario for each the base, low, and high trend assumptions. Decreasing the payment rate trend by 1% reduces the 2017 cost of the program (under the no cost share scenario) by $8.4 million. Increasing the payment rate trend by 1% increases the 2017 cost of the program (under the no cost share scenario) by $8.6 million. This is a change of approximately 3% of claim costs compared to the base scenario in each direction.

Table 2: Cost of Program Under Trend Scenarios

	Universal Primary Care without Cost Sharing - Base Estimate	Universal Primary Care without Cost Sharing - 1 percentage point decrease in payment rate trend		Universal Primary Care without Cost Sharing - 1 percentage point increase in payment rate trend	
Market	**2017 Estimated Total Claim Cost of Program**	**2017 Estimated Total Claim Cost of Program**	**Difference from Base Estimate**	**2017 Estimated Total Claim Cost of Program**	**Difference from Base Estimate**
Commercial	$150,040,000	$145,713,000	($4,327,000)	$154,453,000	$4,413,000
Military	$0	$0	$0	$0	$0
Federal	$6,215,000	$6,036,000	($179,000)	$6,398,000	$183,000
Medicaid	$107,371,000	$104,236,000	($3,135,000)	$110,568,000	$3,197,000
Medicare	$11,382,000	$10,825,000	($557,000)	$11,962,000	$580,000
Uninsured	$6,921,000	$6,698,000	($223,000)	$7,150,000	$229,000
Total	**$281,929,000**	**$273,508,000**	**($8,421,000)**	**$290,531,000**	**$8,602,000**

Induced Demand

The induced demand factors assumption also contains a lot of uncertainty. Wakely performed two alternate scenarios for induced demand. The first assumes that induced demand had less of an impact than the base scenario. Vermont data indicates that there currently does not appear to be significant induced demand in the current market but a more detailed analysis is needed to confirm. As can be seen in Table 3, the induced demand range has shrunk from 0.925 – 1.240 in the base scenario to 0.962 – 1.114 in scenario 1.

The second scenario has consistent induced demand factors for the majority of the categories in the base scenario, but it has a higher induced demand factor for the 100% paid by plan segment. In the 100% paid by plan segment, the base induced demand factor was taken to the power of 1.25 (or increased by approximately 5.5%). This change will only significantly impact the universal primary care without member cost share scenario (since all segments effectively move to the 100% paid by plan segment). For all segments that currently have cost sharing it will increase the induced demand factors by approximately 5.5% compared to the original universal primary care without member cost share scenario.

Table 3: Induced Demand Factors Used in Sensitivity Testing

	Induced Demand Factor		
Percent Paid by Plan	**Base**	**Scenario 1**	**Scenario 2**
100%	1.240	1.114	1.309
90%	1.150	1.072	1.150
80%	1.080	1.039	1.080
70%	1.030	1.015	1.030
60%	1.000	1.000	1.000
50%	0.975	0.987	0.975
40%	0.955	0.977	0.955
30%	0.938	0.968	0.938
20%	0.925	0.962	0.925

Table 4 shows the resulting total claim cost of the program under the no cost sharing scenario for each the base scenario, scenario 1, and scenario 2. Reducing the overall impact of induced demand in scenario 1 decreased the 2017 cost of the program (under the no cost share scenario) by $10.8 million, which is approximately 3.8% compared to the base scenario. Increasing the impact of the induced demand factor in the 100% paid by plan segment (scenario 2) increased the 2017 cost of the program (under the no cost share scenario) by $9.0 million, which is approximately 3.2% compared to the base scenario.

Table 4: Cost of Program Under Induced Demand Scenarios

	Universal Primary Care without Cost Sharing - Base Estimate	Universal Primary Care without Cost Sharing - Decrease in Induced Demand Assumptions		Universal Primary Care without Cost Sharing - Increase in 100% Induced Demand Factors	
Market	**2017 Estimated Total Claim Cost of Program**	**2017 Estimated Total Claim Cost of Program**	**Difference from Base Estimate**	**2017 Estimated Total Claim Cost of Program**	**Difference from Base Estimate**
Commercial	$150,040,000	$140,586,000	($9,454,000)	$157,820,000	$7,780,000
Military	$0	$0	$0	$0	$0
Federal	$6,215,000	$5,954,000	($261,000)	$6,558,000	$343,000
Medicaid	$107,371,000	$107,371,000	$0	$107,371,000	$0
Medicare	$11,382,000	$10,591,000	($791,000)	$12,011,000	$629,000
Uninsured	$6,921,000	$6,630,000	($291,000)	$7,164,000	$243,000
Total	**$281,929,000**	**$271,132,000**	**($10,797,000)**	**$290,924,000**	**$8,995,000**

Alternate Projected Membership Scenario

Wakely ran an additional scenario with an alternate 2017 projected membership distribution. The alternate projected membership distribution was provided to Wakely by the JFO. Table 5 contains the comparison of the base membership distribution and the alternate membership distribution. In the alternate membership scenario, for simplicity, we are assuming each market segment has the same morbidity and demographic composition compared to the base data even if the enrollment changes are significant.

Table 5: Alternate Membership Scenario

	Membership	
Market	**Base**	**Alternate**
Commercial	296,400	276,500
Military	14,400	14,500
Federal	14,400	14,600
Medicaid	150,500	171,400
Medicare	140,800	131,600
Uninsured	13,100	21,000
Total	**629,600**	**629,600**

Table 6 shows the resulting total claim cost of the program under the no cost sharing scenario for the alternate 2017 membership scenario. The impact of changing the distribution as is done in the alternate membership scenario increased the 2017 cost of the program (under the no cost share scenario) by $8.5 million, which is approximately 3.0% compared to the base scenario. However, since this scenario primarily shifts costs from commercial to Medicaid, and the federal match will cover a portion of the Medicaid costs, actual costs to the State should be considered when evaluating this and all other scenarios.

Table 6: Cost of Program Under Alternate Membership Scenario

	Universal Primary Care without Cost Sharing - Base Estimate	Universal Primary Care without Cost Sharing - Alternative Membership Distribution	
Market	**2017 Estimated Total Claim Cost of Program**	**2017 Estimated Total Claim Cost of Program**	**Difference from Base Estimate**
Commercial	$150,040,000	$139,934,000	($10,106,000)
Military	$0	$0	$0
Federal	$6,215,000	$6,298,000	$83,000
Medicaid	$107,371,000	$122,301,000	$14,930,000
Medicare	$11,382,000	$10,640,000	($742,000)
Uninsured	$6,921,000	$11,285,000	$4,364,000
Total	**$281,929,000**	**$290,458,000**	**$8,529,000**

ONE BALDWIN STREET
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483
WEBSITE: www.leg.state.vt.us/jfo/

STATE OF VERMONT
LEGISLATIVE JOINT FISCAL OFFICE

Independent Review of the Agency of Administration's Draft Estimate of the Costs of Providing Primary Care to All Vermont Residents

December 2, 2015

As required by Act 54, Section 18

Prepared by
Joyce Manchester
and Nolan Langweil
Legislative Joint Fiscal Office

JFO Independent Review of the AoA Draft Estimate of the Costs of Providing Primary Care to All Vermont Residents

Section 18 of Act 54 required the Agency of Administration or its designee to provide "a draft estimate of the costs of providing primary care to all Vermont residents, with and without cost sharing by the patient, beginning on January 1, 2017." Section 18 further required the Joint Fiscal Office (JFO) to conduct an independent review of the draft estimate and provide its comments and feedback to the Secretary or designee on or before December 2, 2015.

This report conveys the primary comments and feedback of the Joint Fiscal Office in response to the draft report of October 15, 2015, and explains the basis for those comments and feedback.

General Remarks about the Cost Estimates

JFO is aware that much effort went into defining exactly what the phrase "primary care" means and turning that definition into billing codes used by the various providers. JFO applauds that effort and agrees with the definition of services and providers as presented in the draft report.

JFO appreciates the efforts by Wakely Consulting Group to generate estimates of the cost of medical claims under a system of universal primary care in Vermont starting January 1, 2017. In addition, we thank Wakely for responding to many of our concerns during the October-November comment period. We look forward to updated estimates with additional scenarios in the next version of the report.

Overview

Based on the draft estimate provided to JFO on October 15, 2015, three major concerns arise:

- The report provides cost estimates stemming from medical claims only. "Costs of providing primary care to all Vermont residents" include more than the costs of medical claims alone. JFO would like to see a discussion—and numbers where possible—to cover the costs of transition and start-up, reserves, administration and oversight, information technology, potential impacts on state revenues, and the loss of federal subsidies for health care in Vermont. Other issues related to a move to universal primary care arise as well. JFO would like to see a discussion of the ability of primary care providers to meet the need if demand grows significantly. Some people are already concerned about sufficient access to primary care under the status quo, and additional demand could exacerbate any existing problem areas. A related issue is whether higher reimbursement rates would be necessary to ensure access to providers. The report addresses that issue generally but a more thorough discussion would be useful. Recognizing that the legislation set a benchmark date of January 1, 2017, the infeasibility of implementing

universal primary care in Vermont by 2017 without incurring sizeable additional costs is also a concern.

If "other non-medical costs" are not included in the report's cost estimates, the executive summary should prominently highlight that omission with statements such as the following: "The analysis here is for claims costs only. Total costs will be higher when other factors such as administrative and start-up costs are included. In addition, the report should include a discussion of implementation challenges if universal primary care begins in 2017."

- The cost estimates rely on outdated numbers to allocate Vermonters among different insurance types. In particular, the distribution of types of insurance used by Vermonters in the report may understate Medicaid enrollment. The report's estimate of Medicaid enrollment in 2017 relies on Medicaid enrollments in 2014, but higher-than-anticipated enrollments in 2015 surprised Vermont policy makers. JFO sent updated projections for a couple of the various insurance types to Wakely in November. It also appears that Wakely used state fiscal year enrollments (July 1st to June 30) to obtain spending over calendar years. Because Medicaid enrollments have been growing over time, using calendar year enrollments could lead to somewhat higher estimates of Medicaid enrollments. Costs to the State would be slightly lower, however, because the federal government pays for part of Medicaid expenses.

- The report does not analyze uncertainty surrounding the rate at which primary care costs might grow. Costs in 2017 depend strongly on the trend rate of health care costs between the base year and 2017. JFO would like to see sensitivity analysis or at least a discussion to recognize the effect of faster or slower growth in health care costs between the base year and 2017. The base year for Medicare data is 2012; the base year for data for Medicaid and commercial health insurance is 2014.

  In addition, the report currently says nothing about costs of providing universal primary care beyond 2017. Some discussion of expected cost growth rates beyond 2017 will be important for policy makers as they contemplate future costs.

Other issues appear below, including how much additional demand for primary health care might come from having free or almost free primary care, how universal primary care would interact with other State initiatives such as an all-payer model and accountable care organizations (ACOs), the need to clarify net new costs to the State of Vermont, and possible cost savings derived from more appropriate use of different types of health care facilities and improved population health over time.

JFO Concerns with the Draft Estimates

1. The report provides cost estimates stemming from medical claims only.

JFO recognizes that the majority of on-going costs of providing universal primary care to Vermonters will come from the claims for primary care. However, policy makers need complete information about the total costs of the initiative before they can make an informed decision about its possible implementation. The following items should be included in the cost estimate; if estimating the cost of the items is not possible at this time, the report should include discussion of each item:

- Reserves and/or reinsurance
- Start-up costs and transition costs, both one-time and on-going, such as information technology (IT) for both the payers and the providers
- Administrative complications and/or new responsibilities, including coordination of benefits, multiple billing for single visits, oversight, quality assurance, and the like
- The possibility of higher reimbursement rates for providers as a possible strategy to meet demand
- Implications for existing state revenue sources (e.g., the health care claims tax)
- Growth in primary care costs in future years that could increase state funds needed
- Loss of federal tax expenditure for HSAs and also employer-sponsored insurance
- Changes in who pays for primary care among state, federal, and other providers

For example, it would be prudent for the State of Vermont to hold reserves greater than 10 percent of the expected expenditure incurred for primary care in the first years of implementation to protect the state from extraordinary costs. Alternatively, the report could acknowledge the price at which the state could buy reinsurance or discuss other ways to offload risk.

The report currently glosses over start-up costs such as establishing an IT system to communicate with payers and providers. The introduction of a new, widespread program such as universal primary care would undoubtedly present many complicated issues involving oversight, quality assurance, fraud prevention, and the like. Those issues need sufficient attention and resources prior to implementation. Given the recent experience with Vermont Health Connect, the report needs to address time needed, system issues, and costs in transitioning to the new system. Implications for existing state funding sources such as the health care claims tax require analysis as well.

Legislators also need to know what will happen to the costs of providing universal primary care beyond the first year of implementation. Health care costs historically have increased faster than general inflation or real economic growth, and most analysts expect that trend to continue. The report would be more useful if it contained a discussion of likely costs going forward.

The loss of federal tax subsidies as a consequence of adopting a universal primary health care program in Vermont is also a concern, but the current draft does not address it. Many Vermonters today obtain health insurance through their employer. They are able to pay health insurance premiums as well as contribute to Health Savings Accounts (HSAs) or Health Reimbursement Accounts (HRAs) using pre-tax dollars. Neither income taxes nor payroll taxes are levied on the total premium—both the share paid by the employer and the share paid by the employee. If their employer-provided health insurance no longer covers primary care services, they will lose the tax exclusion for the premium amount that today covers those primary care services. As a result, the people of Vermont could lose a sizeable federal subsidy to the State's economy.

A number of policy issues arise beyond the "costs" of providing primary care for all Vermonters. JFO would like to see a discussion of the ability of primary care providers to increase available services if universal primary care led to greater demand but no increase in the supply of primary care providers. Geographical differences in access to primary care could be an important issue, particularly in regions of Vermont that already may be understaffed for medical care or behavioral health services. A discussion of possibly higher reimbursement rates to boost the supply of primary care services would be helpful.

The infeasibility of implementing universal primary care in Vermont in 2017 is a concern as well, although we recognize that Act 54 established the timeframe. Even if the legislature passed a universal primary care law in the upcoming session, given all of the planning, analysis, infrastructure needs, and coordination that would need to take place, putting the system in place by January 1, 2017, seems next to impossible. Implementation issues that arose in the early days of the ACA illustrate the importance of not rushing the rollout of a major change in the health care system.

2. The report does not analyze uncertainty surrounding the rate at which primary care costs might grow.

The dollar figure estimated for 2017 depends on the trends in primary care cost growth assumed for years between the base year for each type of coverage and the implementation year of 2017. The base year for commercial insurance and Medicaid is 2014, and the base year for Medicare is 2012. As shown in Table 1, the Wakely estimates use one set of trends in utilization, or services used, and payment rates.

Table 1. Trends in Utilization and Payment Rates, Annual Rates of Growth

	Utilization Trend	Payment Rate Trend
Commercial	1.0%	3.0%
Medicaid	0.9%	1.7%
Medicare	0.9%	0.2%

In light of considerable uncertainty about the cost trends, JFO would like to see sensitivity analysis using growth rates in payment rates that are 1 percentage point above and 1 percentage point below the

trends shown above. If such sensitivity analysis is not possible, a discussion of the potential effect of different rates of growth on costs would be helpful.

3. The cost estimates rely on outdated numbers to allocate Vermonters among different insurance types.

The distribution of types of insurance used by Vermonters in the report is outdated and likely understates Medicaid enrollment in particular, which in turn may overstate commercial enrollment. Because the State of Vermont pays a substantial share of Medicaid costs incurred by Vermont residents, undercounting the number of Medicaid patients may lead to inaccurate estimates of the cost of providing universal primary care under the status quo and of net new costs to the State under universal primary care.

The report's current estimate of Medicaid enrollment in 2017 relies on actual Medicaid enrollments in State fiscal year (SFY) 2014, but higher-than-anticipated enrollments in SFY 2015 surprised Vermont policy makers. Actual enrollments in SFY 2015 suggest a higher Medicaid trend than projected in the report.

JFO acknowledges that some uncertainty accompanies the Vermont Medicaid projections for SFY 2016 and 2017. One possible reason is that Medicaid eligibility redeterminations have been on hold for a year as the State was sorting out problems with Vermont Health Connect. When those redeterminations resume in 2016, the numbers of people enrolled in Medicaid for their primary coverage could change. JFO sent updated projections where available to Wakely in November (see Table 2 below). Adjusting those numbers will affect status quo costs as well as projected costs under universal primary care.

In the October 2015 cost estimates, Wakely used state fiscal year enrollments (covering July 1st to June 30) to calculate spending over calendar years. Growing Medicaid enrollments over time imply that using calendar year enrollments would show slightly higher Medicaid enrollment in 2017. Higher Medicaid enrollment means lower primary care costs to the State because the federal government pays about half of Medicaid costs for enrollees.

In addition, the report uses federal match rates, known as FMAP and based on federal fiscal years, to calculate calendar year Medicaid cost estimates. JFO cannot discern whether the federal match rates were blended across federal fiscal years to correspond with the calendar years used in the report. Doing so is important to account for the state and federal shares of Medicaid costs properly. Adjusting both enrollments and the FMAP for calendar years could lead to higher or lower costs of providing universal primary care in the State of Vermont.

Table 2.	Wakely Estimate	Working JFO Estimate	JFO Comments
Market	**2017**	**2017**	
Commercial	300,200	See notes	One piece of the commercial market is the individual market. If the basis for the Wakely number for commercial insurance is last year's data, the individual market estimates may be too high. DVHA budget estimates for SFY'15 were that 42,785 people would receive Vermont Premium Assistance. Revised budget adjustment estimates lowered the number to 18,007. Actual SFY'15 VPA enrollment was 13,177. It is likely that the estimate overstates the individual market in the commercial estimates.
Military	14,500	See notes	This estimate may be too low. According to the 2014 VT Household Insurance Survey (VHHIS), military insurance covers 18,547 lives. Why might it drop by 4,000 by 2017?
Federal	14,600	No JFO estimate	
Medicaid – primary only	150,500	See notes	SFY'15 actual enrollment for Medicaid as a primary source of coverage was 156,228. The current JFO/Admin consensus estimates, although not yet finalized, are 165,642 for SFY'16 BAA and 171,428 for SFY'17. Furthermore, if they were converted to calendar year, they would be slightly higher. Those numbers are not yet finalized, and we are not sure what effect Medicaid redeterminations will have on enrollments. Nonetheless, we firmly believe an estimate of 150,500 is too low.
Medicare	142,500	131,600	Using the same ratio of Medicare enrollees to the 0-64 and 65+ populations as in 2012, we estimate 137,100 primary Medicare enrollees in 2017. However, a greater share of 65+ people in 2017 will continue to work and have ESI as primary coverage. Using 95% of the 65+ number gives us 131,600 in 2017.
Uninsured	13,300	See notes	The Wakely estimate appears to be too low. An uninsured rate of 2.1% seems unlikely and would be unprecedented. The VHHIS uninsured rate for 2014 was 3.7%. In the absence of significant policy intervention, we have no reason to believe that the uninsured rate will drop much more. An uninsured rate of 3.7% yields 23,300; if the rate is 3.3%, the number is 21,000.
Total	**635,600**	**629,600**	Official Consensus Joint Fiscal Office-Administration projection developed by Kavet and Carr in October 2015. The precise number projected for 2017 is 629,574.

Finally, JFO is concerned that Wakely is using a projection of Vermont's population in 2017 that is too large. Based on the Census estimate for 2011 through 2014, the October 2015 Kavet-Carr consensus projection for Vermont in 2017 appears in Table 2. Population growth was very slow between 2010 and 2014, and the Kavet-Carr projections raise that rate of growth somewhat to reflect a stronger economy. Reaching 629,600 in 2017 seems plausible, but the report's estimate of 635,600 seems too high.

4. Additional concerns

a. Additional demand for primary care given the availability of free or almost free care

The draft cost estimates use one set of assumptions regarding induced demand, or how much additional care Vermonters will demand given State provision of primary care to most of the population. Uncertainty surrounds estimates of demand for health care at low or zero cost sharing; sensitivity analysis would show how different assumptions for induced demand affect the cost estimates.

JFO would like to see a more in-depth treatment of induced demand in two areas. First, significant uncertainty surrounds the estimates of demand for primary care when no cost sharing occurs because not much evidence exists on consumer behavior when patients bear none of the costs. For example, differences could arise in induced demand for care among people of different ages, or among people with chronic conditions.

Wakely currently uses induced demand factors from the U.S. Department for Health and Human Services for insurance plans with actuarial values from 60 percent to 90 percent; Wakely interpolated factors at other levels of actuarial value (see Table 3).[1] JFO would like to see sensitivity analysis using larger factors in particular for plans at the 100 percent actuarial value. Little recent evidence exists to indicate how much demand for primary care might change if people face no costs of obtaining health care.[2] The "no cost sharing" cost estimate currently in the draft report might change under different induced demand factors; knowing how sensitive costs might be to that particular factor is important.

Second, the estimates assume that little induced demand would come from people who relocate to Vermont to access state-provided primary care. JFO would like to see additional discussion of the assumption in this area prior to a more in-depth study of the issue that might come following the final report.

[1] Actuarial value is the average percentage of health care costs a health plan will cover under a particular plan. One minus the AV is the average percentage of health care costs incurred by the patient in a particular plan.
[2] The RAND Health Insurance Experiment, conducted in the United States between 1974 and 1982, remains the only long-term, experimental study of cost sharing and its effect on service use, quality of care, and health. Participants who paid for a share of their health care used fewer health services than a comparison group given free care. In addition, free care led to improvements in hypertension, vision, and selected serious symptoms, especially among the sickest and poorest patients. http://www.rand.org/pubs/research_briefs/RB9174.html

Table 3. Induced Demand Factors for Plans with Different Actuarial Values

Actuarial Value, or Percent Paid by Plan	Induced Demand Factor Now Assumed
100	1.24
90*	1.15
80*	1.08
70*	1.03
60*	1.00
50	0.975
40	0.955
30	0.938
20	0.925

*Note: Factors in blue came from the U.S. Department of Health and Human Services. Other factors were interpolated by Wakely.

b. Implications of universal primary care for payment reform initiatives

Vermont has several large-scale payment reform initiatives underway. The State is negotiating with the Center for Medicare and Medicaid Services (CMS) regarding an all-payer model, and substantial resources have already been invested in accountable care organizations (ACOs). It would be most helpful to see a paragraph or two in the report explaining how universal primary care would interact or impact those initiatives.

c. More detail needed on net new costs to the state

The report does not differentiate clearly between costs already incurred by the State and net new costs. JFO would like to see additional detail regarding the amounts to be publicly financed by the State of Vermont. It would be helpful to add a column showing "Amounts to be Publicly Financed" to Tables 2, 5, and 6 in the draft report. For example, the State already pays a share of Medicaid costs and pays for State employees (both active and retired), retired teachers, and Medicare buy-in enrollees. The draft does not explain clearly whether "net cost" recognizes those costs.

d. Possible cost savings depending on how the system is set up operationally

Having a system of universal primary care could result in cost savings in some areas if it works as many people expect. For example, we might expect reduced use of emergency room care for ailments such as sore throats or sprained ankles, and uncompensated care should drop significantly if all residents have primary care available to them. Over the longer term, we might expect improvement in general health status because everyone will have received basic care over their lifetimes.

On the other hand, incentives might exist that would raise the cost of care overall. For example, primary care providers might be encouraged to send patients to specialists for what could be considered routine care if the reimbursement rates of specialists are higher. Similarly, the practice of assigning an

inaccurate billing code to a medical procedure or treatment to increase reimbursement—known as upcoding—could occur more frequently without proper oversight or regulation.

e. Presentation issues

Various aspects of the report might be difficult for non-technical people to digest. For example, the report analyzes alternative scenarios with Medicaid reimbursement rates increased by 10 percent, 20 percent, and 50 percent. Legislators are familiar with comparing Medicaid reimbursement rates to Medicare reimbursement rates. It might be helpful to relate the various levels of increased Medicaid reimbursement rates to Medicare reimbursement rates to the extent possible. JFO believes such a comparison is doable without "endorsing" particular levels of reimbursement.

State of Vermont
Agency of Administration
Health Care Reform
Pavilion Office Building
109 State Street
Montpelier, VT 05609-0201
www.hcr.vermont.gov

[phone] 802-828-2316
[fax] 802-828-3320

Robin Lunge, Director

MEMORANDUM

To: Joint Fiscal Office
Health Reform Oversight Committee
House Committee on Appropriations
House Committee on Health Care
House Committee on Ways and Means
Senate Committee on Appropriations
Senate Committee on Health and Welfare
Senate Committee on Finance

From: Robin Lunge, Director of Health Care Reform, Agency of Administration

Date: December 16, 2015

Re: Appendix F to the Universal Primary Care Report – Summary of Changes to October 15 Draft Report and Stakeholder Feedback

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On or before December 16, 2015, Act 54 of 2015 requires the Secretary of Administration to provide to the legislature a finalized report on the costs of providing primary care to all Vermont residents.

As required by the statute, draft estimates from AOA were submitted to the JFO on October 15, 2015. Following submission of the draft estimates, JFO had six weeks to perform an independent review and submit comments back to AOA by December 2. AOA then had two weeks to review the comments by the JFO and submit the final report to JFO and the legislature by December 16. JFO will present their final analysis to the legislature by January 6, 2016.

This memorandum outlines changes made to the October 15 draft report after receiving feedback from the JFO's independent review process. In addition, AOA also solicited feedback from various stakeholders during the review period. Changes and comments emerging from the stakeholder review are also outlined in this memo. Stakeholder comments and AOA responses are included at the end of this memo.

Response to the Joint Fiscal Office December 2 Independent Review

Headings in italics are copied directly from the JFO report provided as Appendix E to the Universal Primary Care report.

The report provides cost estimates stemming from medical claims only.
The Administration clarified the total amount to be publicly financed. Specifically, program costs consist of four components. First, the base costs presented in the report are total estimated primary care claim costs. Second, we add an estimated 7% to 15% in additional administrative costs required to run the program. Third, we estimate the cost of a potential policy decision to increase primary care provider reimbursement. Fourth, there could be additional implementation costs and it is premature to estimate these without a program design. A discussion of recommended future analysis that may quantify additional costs is discussed in more detail in the body of the report. Fiscal estimates for additional analysis recommended in the final report were not possible under the scope and resources provided for this report. During the legislative session, I testified to legislative committees that $100,000 would fund only an actuarial estimate of the cost of care.

The cost estimates rely on outdated numbers to allocate Vermonters among different insurance types.
Based on consultation with JFO, Wakely adjusted the total population estimate to be consistent with the State's population forecast. Allocation among insurance types was based on a 2012 Wakely analysis of Vermont's insurance market, as described in Wakely's cost estimate report. Given uncertainty in how to allocate individuals by insurance type, Wakely set forth an alternative membership scenario in Appendix B of their cost estimate report.

The report does not analyze uncertainty surrounding the rate at which primary care costs might grow.
Wakely assumed a payment and utilization trend for January 1, 2017. Additional trend analysis for future years is recommended for future study before implementation.

Additional demand for primary care given the availability of free or almost free care.
Wakely provided induced demand sensitivity testing in Appendix B to their cost estimate report.

Implication of universal primary care for payment reform initiatives.
The legislative discussion of this study included paying for UPC using a capitated payment methodology. This is consistent with the current planning and stakeholder recommendations to the Green Mountain Care Board.

More detail needed on new costs to the state.
In the final report AOA more clearly indicated the total amount to be publically financed and additional costs that may affect the total cost of the program. Operational cost estimates would be premature at this time without further legislative action on program design and an operations plan.

Possible cost savings depending on how the system is set up operationally.
The scope of the report and available resources did not allow for AOA to develop a full operational plan. An operational plan would be required for implementation and evaluation of any potential cost savings.

Presentation Issues
AOA adjusted the tables presenting the final cost estimates in the executive summary. JFO recommended comparing potential primary care provider reimbursement increases to Medicare rates. AOA chose not to make this comparison in the report so as not to appear that AOA is recommending a percent of Medicare rates as the "right" amount for primary care. In addition, stakeholders had objected to a percentage of Medicare rates as a comparison technique in previous reports.

Summary of Additional Stakeholder Feedback

Definition of Primary Care
In their December 2 report, the JFO states agreement with the definition of primary care as presented in the AOA draft report. However, we received feedback from some stakeholders that our list of primary care providers is too broad and includes providers who do not offer comprehensive primary care services, specifically psychiatrists and OB/GYN MDs. AOA included these providers in this study to be sure we were capturing comprehensive primary mental health and gynecology services as called for specifically in the legislation. In further study the legislature may choose to refine the primary care definition used here based on stakeholder feedback.

Also, based on stakeholder feedback for the initial draft, AOA considered refining the fifteen categories of primary care services identified by Wakely to make them more recognizable to general health care consumers. The final report retains the use of Wakely's service categories to align with Wakely's methodological memo. Wakely's categories could be generalized further to make them more user friendly, similar to the CPT categories utilized by the GMCB primary care payment work group. At the time of this report, AOA and GMCB have not yet completed a thorough cross-walk of the defined primary care service types incorporated into each analysis. This analysis will be prepared for the legislative session. However, the universal primary care service types likely fit into similar categories identified by the GMCB work group and may be more accessible. They include:

- Office Visit
- Encounter Payment i.e. All Inclusive Clinic Visit
- Preventive Visit
- Vaccine Administration
- Care Management

Federally Qualified Health Centers and Rural Health Clinics
AOA health care reform staff worked with Sharon Winn at Bi-State Primary Care Association to clarify the description of FQHC/RHC services and provider payments as they were described in the draft report. FQHC clinic encounters also include additional enabling services described in the report that are not traditionally covered at other types of primary care practices. The final report makes clear that our cost analysis includes all encounter based payments provided at FQHCs and fee-for-service payments that are included in our definition of primary care, but it does not estimate the cost of extending all FQHC services to Vermonters.

Blueprint for Health Integration
The final report adds a paragraph describing integration with the Blueprint for Health program. The cost estimate section clarifies that Blueprint patient centered medical home (PCMH) payments are included in the claim cost estimates. Community health team (CHT) payments are not included in the claim cost estimates because they are paid to regional entities and not paid directly to providers, however we wanted to make it clear in the report that CHT payments will continue under universal primary care as an essential part of the Blueprint model and primary care in Vermont.

Cost Estimates
AOA added an administrative cost estimate range to the final report. The final report clarifies that the total amount to be publicly financed includes claim costs and administrative costs; estimates for increasing primary care provider reimbursement are also included and represent potential additional costs to the system.

Compilation of Questions and Comments Received from Stakeholders
Stakeholder comments and questions below are based on the October 15th draft report. Comments that are not included in this summary regarded typographical or other errors that were corrected in the final draft. AOA responses are written in italicized text.

Lou McLaren, MVP
Wakely says that registered nurses should be included in the definition of primary care. I'm not sure how their services can be identified easily. RNs who practice in offices bill under their supervising physician, so they are not captured as individuals in the claims system. Most payers (and possibly all) don't know who the RNs are, don't register or credential them, and don't track them separate and apart from the physicians. I'm not sure how Wakely could identify those claims in VHCURES. However, claims for PAs and NPs can be captured.

> *RNs are included due to a data quality problem with how NPs are coded in VHCURES. Our understanding from Zach Sullivan, Health Policy Analyst at GMCB, is that NPs are not coded as PAs, they are listed as RNs in VHCURES. Zach has reported this issue to Onpoint.*

We do take issue with including psychiatrists under the definition of primary care. Were you to apply Rule 09-03's access standards, along with generally accepted specialty definitions, you would see that psychiatrists are considered specialists and not primary care providers. Yes, they can bill CPT codes that fall under primary care, but then so do all specialists (E&M codes). We would argue against including them.

> *We included psychiatrists based on the statutory requirement to include primary mental health services. Even though Wakely's analysis determined that the codes making up our primary care definition account for only 6.5% of psychiatrist claims, a psychiatrist may be the primary mental health provider for some members.*

Instead of registered nurse – psychiatric/mental health, I assume you mean psych NPs, as providers who render primary care. Again, as with psychiatrists, we would argue against including them. It is more common to consider master's level and doctorate level providers (social workers and PhDs) as primary care mental health providers.

> *They are included for the same reason as psychiatrists above.*

Wakely reports that the T1015 code [All-Inclusive Clinic Visit] is for Medicaid only. However, MVP allows the FQHCs to bill with that code for our exchange members, and we pay the encounter rate. We believe the code needs to be included for those commercial plans/payers where appropriate.

> *Wakely pulled the T1015 code for Commercial and Medicare, so the FQHC/RHC dollars captured include these for MVP.*

We would expect any universal PMPM to be payer-specific, in that very few commercial dollars are spent by primary care providers on nursing home and SNF [skilled nursing facility] visits. Please reference the work done by the ACO primary care cap work group. Including those particular types of services in the UPC model overstates the cost for commercial members.

> *Universal primary care is a public program with a universal PMPM, where private payers would no longer be required to cover primary care services for most members.*

It would be helpful to include how Medicare Advantage plans would be handled. Right now the report says that UPC would be secondary for Medicare, but I assume this means Medicare Part B. MVP sells Medicare Advantage plans in VT. How would those be treated?

This is addressed in the report (p.16). AOA assumed Medicare members would be excluded from a universal primary care system with cost-sharing because there would be little to no benefit to recipients and the state. AOA and our actuaries determined that the modest benefit (.1% average reduction in cost-sharing) to Medicare recipients would be off-set by the administrative costs required to coordinate benefits. Under a system of universal primary care with no member cost-sharing, Medicare Advantage plans are a third level of primary care coverage. Medicare members only benefit if 100% is paid for universal primary care with no member cost-sharing.

The end of the report recommends future analyses that should be performed. To that list I would add private payer analyses to see if there is any alignment in PMPM rates. There needs to be some sort of external validation to this report, because each payer's experience most likely is different from the Wakely analysis.

Universal primary care is a public program where private insurers would no longer be covering these services for most members.

Tom Boyd, Department of Vermont Health Access
The other thing to consider which we discussed as part of the Green Mountain Care effort is the need to address provider payments for those individuals seeking services out-of-state. For example, the snow-birds that are retirees. There are also State Retirees that live out of state.

This is an operational issue that needs further analysis as part of an operational plan.

Peter Sterling, Alliance for a Just Society
My only comment is on tables [9] a, b, and c. The charts that show potential costs associated with increasing the reimbursement rates by 10%, 25% and 50%. Is there a way to get the total for these figures in terms of 100% of Medicare, e.g. "raising rates to 105% of Medicare, 130% of Medicare, etc.? This seems to be the most common way reimbursement rates are publicly discussed.

We chose not to make a comparison to Medicare rates in the report because it could appear that AOA is recommending a percentage of Medicare rates when we do not have a consensus that a percentage of Medicare rates is the "right" amount for primary care. It is outside the scope of the report to recommend primary care rates. In addition, stakeholders had objected to prior reports where this was used to explain provider rates.

Dr. Joe Haddock, Thomas Chittenden Health Center (TCHC), HealthFirst
The VHCURES data has to be significantly modified to approximately reflect true payments and patient attribution for individual practices/providers.

The timeframe required by the legislation for this study only allowed the actuaries to use VHCURES data and limited additional data from DVHA and Blueprint to develop and modify estimates. Additional analysis could examine individual practice data.

93-95% of the provider revenue to our practice is from the usual E/M codes used by primary care - quite a different number from that mentioned in the report.

The numbers in the report are based on aggregated data from VHCURES and may vary from individual practice data.

Many of the Primary Care providers named in the study don't provide comprehensive primary care.

The statute defined primary care and including some services that are not traditionally offered at a primary care practice. AOA received feedback that some of the providers included do not provide comprehensive primary care, specifically psychiatrists and OB/GYN MDs. We included them in this study to be sure we were capturing comprehensive primary mental health and gynecology services as called for specifically in the statute; however, in further study the legislature may choose to refine the primary care definition used here based on stakeholder feedback.

I would recommend that at least a couple of practices, or more, be examined to verify payments actually received rather than what is reported as having been spent. Also, it would be of value to determine actual patients attributed to those practices.

Additional analysis for refining the cost estimates presented in this study could include analysis of individual practice data.

TCHC received nothing near $40 PMPM for primary care; therefore, I assume that a significant amount was spent on primary care elsewhere if the numbers are correct. Where was that spent? Other providers called primary care in the report?

PMPM estimates and claim cost estimates were derived using VHCURES data primarily. Individual primary care practice data may vary due to patient and payer mix variation.

The Blueprint and Community Health Team reimbursements need to be clarified further.

Blueprint and community health team payments were clarified in the final report.

Deborah Richter, MD and Ellen Oxfeld, Ph.D.

Is a macroeconomic impact study really necessary for this? Unlike a single payer system, in which the legislature would be raising over $2.4 billion, the amount listed here (under $200 million) is less than the annual rise in hospital costs now, and there is certainly not an economic impact study each year on the hospital cost increases.

Micro- and macroeconomic analyses are the best practice when considering new taxes, which is why we recommended these to policymakers. The legislature could decide that they do not need the analysis due to the size of the program. We recommended that policymakers consider a microeconomic analysis of the new tax financing in order to better understand business and consumer behavior and cost shifting that might result. We recommended that policymakers consider a macroeconomic analysis to ensure that, when implemented, the program will not have a negative aggregate impact on Vermont's economy. While not legally required, this is consistent with the statutory requirements for setting up a universal health care program as set forth in Act 48 of 2011. See 33 V.S.A. 1822(a)(5)(B). These analyses would provide useful information to ensure implementation of the program and the financing accomplished the intended goals and that there are not unintended behavioral consequences.

We would also point out that while the study estimated administrative costs for a UPC system, it might well make administration easier in the end, as capitation per patient is certainly simpler than billing for every

procedure. Indeed, administrative savings are a likely bonus if payment is consolidated, and there is a new payment mechanism like capitation. Similarly, even if there are increases in utilization, this should not increase costs greatly in a capitated system, especially as any increase in demand is further likely to be compensated for by savings from early intervention and prevention.

> *The administrative costs estimated in the study are administrative costs to the state to run the program. The study does not take into account administrative costs to provider practices.*

The report uses a Vt. population figure of 635,500 which is almost certainly wrong. …The latest census-confirmed figure from 2010 was 625,475 (2010) and latest estimate from 2014 is 626,562. It's been suggested they are including NY patients. Or, could it be that this is a 2017 estimate of population?

> *In consultation with the JFO, population estimates from the October 15 draft were amended. The final report uses a population figure of 629,200 for 2017.*

In that regard another point or points could be made clearer. Maybe a later version is going in this direction? The overriding aim of the report, if anything is to come from it, is to make crystal clear to the Legislature and Administration how much NEW money they might be responsible for raising to finance UPC under each of the scenarios. If I'm a legislator I'd wonder at the jump (I'm looking at the chart on [draft] Page 5) of nearly 50% from UPC/status quo to UPC/no cost sharing. Does that mean that commercial insurances require 50% cost sharing now? That doesn't seem possible. Then where does the $46 million leap come from?

> *The final report includes a section that clearly calls out our estimate for the amount to be publicly financed.*

The report projects an induced demand under UPC, which of course is very probable. But it might want to project a reduced demand in ERs for what amounts to primary care. It might be that the reduction at ERs may simply migrate over to the induced demand category.

> *AOA is not able to quantify this assumption under the resources available for this report. This question could be considered in future analysis.*

Sharon Winn, Bi-State Primary Care Association

The report and its accompanying analyses confine themselves to a set of services narrower than "health services commonly provided at federally qualified health centers" because it's impossible to capture the broad range of FQHC services in claims data. I made that point when we met last summer. Federal law requires FQHCs to provide a wide range of primary and preventive services, often including mental health care, vision and social services, public health interventions, intensive case management, interpretation, transportation, and other mechanisms that link patients to preventive medicine and necessary treatment. The enabling services FQHCs offer are outlined at 42 USC §254(b)(1)(A)(ii-iv).

Here's an example of how these services play out at a Vermont FQHC: Eight percent of Community Health Center of Burlington patients are Nepali, and they have a Nepali patient who is deaf from trauma. CHCB finds translators to translate from Nepalese sign language (not American sign) into – usually – at least one intermediary language. So it can take 2-3 translators to communicate between the clinician and the patient. The translators help not only with straight communication of the message back and forth, but they also help CHCB staff grasp the culture of the patient. This enabling service is not reimbursable under a separate CPT code and its part of what has to be paid for in the encounter rate. The FQHCs exist to provide care to patients who otherwise would be disenfranchised from the system.

In other words, the T1015 encounter code is bigger than the sum of its CPT parts.

AOA worked with Sharon Winn to clarify the description of FQHC and RHC services and how AOA could not quantify specific FQHC services at this time.

Julia Shaw and Kaili Kuiper, Vermont Legal Aid
The full comments from Vermont Legal Aid are attached. Responses from AOA are below in italicized text.

1. *AOA added an administrative cost estimate range to the final report. The final report clarifies that the total amount to be publicly financed includes claim costs and administrative costs; estimates for increasing primary care provider reimbursement are also included and represent additional costs to the system.*

2. *Capitation is the model that was discussed by the legislature and Dr. Deborah Richter during testimony regarding this study. However, the final report clarifies that the PMPM rates presented in this study are for claim costs only. Full development of a capitated payment model for universal primary would require the state to develop program standards and quality measurements as part of an operational plan. In addition, questions regarding attributing patients to PCP panels, reimbursement, and rate-setting require operational planning, which is beyond the scope of this study. An analysis of handling services provided out of state under a system of universal primary care would also be required as part of an operational plan.*

3. *The draft report used population numbers developed in 2012 for estimating enrollment in Vermont Health Connect. After consulting with JFO we amended the population numbers to reflect the most recent state forecast. In addition, an alternative membership scenario was analyzed by Wakely in Appendix B to their report.*

4. *AOA is not able to quantify this assumption under the resources available for this report. This question could be considered in future analysis.*

5. *Yes, the report takes into account the fact that the ACA requires certain preventive services to be offered with no cost-sharing.*

6. *No, labs are not included in the primary care services defined for this report because of the definition provided by the legislature.*

Dr. Paul Reiss, Chief Medical Officer, HealthFirst IPA
The full comments from Dr. Reiss are copied below. AOA responses are provided in italics.

Report prepared by: Paul J Reiss, MD, FAFP
Chief Medical Officer, Healthfirst IPA
Partner, Evergreen Family Health, Williston VT

November 6, 2015

Thank you for the opportunity to provide commentary and feedback on the Agency of Administration's DRAFT Universal Primary Care report.

On behalf of the Healthfirst Independent Practice Association let me state that we are in favor of Vermonters having universal access to primary care services, without significant barriers. To this end we support a robust primary care workforce that is paid more rationally, simply and fairly. We would like to provide the following information for consideration in creating the final report:

1) Removal of copays and deductibles for primary care

Although the report predicts that there will be some increase in primary care use due to removal of financial barriers, there is little historical evidence that this increase results in significant number of unnecessary visits or overall increase in costs. The notion of placing a financial barrier may make sense for specialty, ER and other services, but for primary care a deterrent is not beneficial to the health care system.

a. Primary care practices with the lowest ER rates, specialty referral rates, and best care for chronic conditions have higher rates of primary care visits.
b. Countries around the world with universal health care coverage do not experience their primary care system being overwhelmed with unnecessary visits. Experience in universal primary care exists internationally and could be referenced in this report.
c. The practice overhead cost of collecting many small copays and deductible amounts from patients in primary care offices is a substantial resource and financial burden. Removing this complex administrative process will result in savings to the primary care delivery system, and should be considered as part of the overall financing equation.

2) Effect of universal primary care coverage and access

Missing from the report is a discussion and analysis of perhaps the most important financial effect of providing universal primary care to a population, namely, the reduction in "downstream" costs. Countries with universal health care coverage have substantially lower costs to their health care system only in part because they are "single payer," but more importantly they have a much more robust and supported primary care workforce without financial barriers to access primary care.

a. One must take into account the reduction in ER visits and delayed diagnosis, and the improved preventive screenings and testing, as well as reduction in direct access visits to specialty care due to the presumed continued financial disincentives of copays and deductibles for specialty and ER care.

We would hope that the AOA would emphasize in this report that the funding of a universal primary care system comes from substantially greater savings elsewhere, and one cannot look purely at the increased spend on primary care services to understand the overall positive financial impact of Universal Primary Care.

As was discussed during the legislature, the purpose of this study is to quantify the cost of providing universal primary care through a publically financed system in order to inform legislative decision-making on program design and financing. Because of that, an actuarial analysis was used to predict the initial costs of the program. It is beyond the scope and resources provided to quantify the assumptions in 1) and 2) for this report. The administrative costs estimated in the study are administrative costs to the state to run the program. The study does not take into account administrative costs to provider practices, because the statutory language did not assume that provider payments would be reduced to account for reduced administration at the practice level.

3) Definition of primary care

Although many types of practitioner provide primary care services, one will need to make a distinction between comprehensive primary care generalists, and practitioners who provide some of the components of first-contact primary care services. Certainly we are not looking to pay mental health care professionals, social workers, psychiatrists or RNs for example a global primary care capitation to deliver comprehensive primary care services. Moreover, it is widely known and accepted that OB GYNs overwhelmingly do not wish to be considered comprehensive primary care practitioners, and would not be capitated as such.

When considering increasing the primary care costs related to supporting comprehensive primary care services that would be capitated, we would recommend looking at only current payments to Internal Medicine, family medicine and pediatrics and the APNPs and PAs that practice generalist primary care.

AOA received feedback that some of the providers included do not provide comprehensive primary care, specifically psychiatrists and OB/GYN MDs. We included them in this study to be sure we were capturing comprehensive primary mental health and gynecology services as called for specifically in the statute; however, in further study the legislature may choose to refine the primary care definition used here based on stakeholder feedback.

4) Effect on primary care workforce

a. Universal Primary Care has the potential to reduce the administrative burdens for primary care and presents the opportunity to more fairly compensate primary care practitioners. This will then attract more practitioners into primary care so that every Vermonter can have a primary care practitioner. Having an accessible primary care practitioner is the best predictor of a healthy high value health system.

AOA is not able to quantify this assumption under the resources available for this report. This question could be considered in future analysis.

References:

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