

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION

BISHCA



LEGISLATIVE REPORT

DIVISION OF HEALTH CARE ADMINISTRATION

Provider Reimbursement Report

Submitted to the
Vermont General Assembly

March 12, 2008

Acknowledgements

BISHCA would like to acknowledge the effort made by the participating insurers to define, collect, prepare and submit the data required for this report.

This report was produced by Policy Integrity, LLC.

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Executive Summary

Act 71 of the Vermont legislature's 2007 session, "Ensuring Success in Health Care Reform,"¹ included a requirement that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct several surveys of major private health insurers doing business in Vermont to provide information comparing reimbursement paid to primary care providers, mental health and substance abuse (MHSA) providers, and other non-physician health care providers. This information is intended to "improve our understanding of access to care, the cost shift, and workforce issues in Vermont".

This report presents information on reimbursement to primary care providers and mental health and substance abuse providers. **A subsequent report will include information on other non-physician health care providers.**

Vermont has a highly concentrated health insurance market. Four insurers – Vermont BlueCross Blue Shield, CIGNA, MVP, and TVHP account for about 99 percent of the market, measured by earned premium. Although TVHP is a separate product, it is administered by BCBS and uses the same contracts. In this report, BCBS and TVHP are consolidated.

For both primary care and MHSA, the most frequent services show minimal variation, while for other services in the 10 most common codes, there is substantial variation. For both the top ten primary care and MHSA procedure codes, BCBS/TVHP and MVP have the highest reimbursement for five. CIGNA is frequently, although not always, lowest.

For the least variable services, the highest is five percent above the lowest. For the most variable, in MHSA, the difference can exceed 50 percent.

The summary tables below show procedure codes, the average reimbursement across BCBS/TVHP, CIGNA, and MVP, the ratio of highest to lowest, and the rank of each insurer within procedure code.

¹ See Appendix 1 for statutory language

Summary Table – Primary Care

Procedure Code	Average	Hi / Low Ratio	Ranks		
			BCBS	CIGNA	MVP
99213 Office visit, established patient, moderate	\$68.18	1.052	2	3	1
99214 Office visit, established patient, more complex	\$106.07	1.096	2	3	1
36415 Routine venipuncture	\$7.54	1.568	1	3	2
90471 Administration of immunization	\$22.21	1.329	1	2	3
99212 Office visit, established patient, less complex	\$45.15	1.203	2	3	1
99396 Preventive med. visit, estab patient, age 40-64	\$136.77	1.243	1	3	2
99211 Office visit, established patient, least complex	\$25.88	1.259	2	3	1
99391 Preventive med. visit, estab patient, infant	\$99.92	1.202	1	3	2
99392 Preventive med. visit, estab patient, age 1-4	\$112.07	1.191	1	3	2
93000 Complete electrocardiogram	\$45.07	1.344	2	3	1

Summary Table – Mental Health and Substance Abuse

Procedure Code	Average	Hi / Low Ratio	Ranks		
			BCBS	CIGNA	MVP
90806 Individual office visit, 45-50 minutes	\$63.65	1.095	2	3	1
90847 Family therapy, with patient	\$65.74	1.339	1	3	2
90807 Individual office visit, 45-50 minutes, with evaluation	\$109.12	1.351	2	3	1
90801 Diagnostic interview	\$77.45	1.521	1	3	2
90862 Medication management	\$58.54	1.362	2	3	1
90853 Group psychotherapy	\$36.19	1.447	3	2	1
90805 Individual office visit, 20-30 minutes, with evaluation	\$64.15	1.671	3	2	1
90808 Individual office visit, 75-80 minutes	\$85.18	1.045	1	3	2
90846 Family therapy, without patient	\$71.96	1.173	1	3	2
90804 Individual office visit, 20-30 minutes	\$37.45	1.175	1	3	2

Introduction

Act 71 of the Vermont legislature's 2007 session, "Ensuring Success in Health Care Reform,"² included a requirement that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct several surveys of major private health insurers doing business in Vermont to provide information comparing reimbursement paid to primary care providers, mental health and substance abuse providers, and other non-physician health care providers. This information is intended to "improve our understanding of access to care, the cost shift, and workforce issues in Vermont". A separate report addressing reimbursement of non-physician health care providers will be released at a later date.

BISHCA chose to work with Policy Integrity LLC, a health policy consulting firm based in Montpelier. In preparation for the surveys, several meetings were held to consider alternative approaches to the survey, definitional issues, and procedural questions. Specific issues and their resolutions are discussed in the methodology section.

Representatives from the major insurance companies participated in discussions to help BISHCA and the contractor to understand their data and to clarify instructions.

One of the challenges in preparing this report was to develop the required information while respecting provider confidentiality and competitive issues. Several specifications in the legislation addressed these concerns, including:

- A requirement that information be sufficiently aggregated so that the amount paid to a specific provider or facility could not be determined
- An exemption of any provider or facility-specific information from disclosure under a public records request
- A requirement that data be at least 90 days old at time of release of the report

In addition, the contractor is required to return all information to BISHCA and expunge it from the contractor's files when the project is complete.

² See Appendix 1 for statutory language

Methodology

In implementing the requirements of the relevant sections of Act 71, several decisions had to be made. These decisions, along with their rationales, are listed below.

Which insurers to include in the survey? The Vermont health insurance market is highly concentrated. Measured in terms of earned premiums in 2006 for comprehensive major medical products, the top four companies represent over 99% of the market. Because of this concentration, the survey focused on Vermont BlueCross BlueShield (64.3%), MVP (14.5%), TVHP (10.9%) and CIGNA (9.4%). Note that these figures do not include any third-party administrator (TPA) business. (As will be explained later in this report, CIGNA chose to include TPA business in the reporting of average reimbursement rates).

How to define primary care? Several different sources for a definition were considered, including Vermont's Health Resource Allocation Plan (HRAP), the definition used by the Vermont Department of Health, and definitions used by the major payers. All definitions included the following physician specialties that were used to define primary care for the purpose of this report addressing reimbursement for primary care services: Family Practice, General Practice, Internal Medicine, Obstetrics & Gynecology, and Pediatrics. For the purpose of this survey, OBGYN providers were included only if they had been identified as a primary care provider by a beneficiary (extremely rare).

How to identify the top 10 procedure codes? Claims submitted by health care professionals most frequently identify the services provided using a coding system called Current Procedural Terminology (CPT)³. Each section of this report is based on CPT codes or on an extended coding scheme based on CPT called the Healthcare Common Procedure Coding System (HCPCS). The full description of CPT codes used in this report can be found in Table 1 (primary care) and Table 3 (mental health and substance abuse).

Two different approaches to identify the top 10 were considered. The first was to create a preliminary survey to identify the most common primary care procedure codes at each insurer and to merge the results for the second survey. The alternative was to create a list of 15 common procedure codes based on other sources and to request payment and claim count information for all 15 codes. Determination of the top 10 would be based on this information. This approach was taken to reduce the burden on respondents and to make the survey results more timely.

Other sources included information provided to BISHCA as part of the transparency requirements of Act 191, national information, and historical Medicaid information. The 15 codes were also chosen to ensure that at least some codes unique to specific primary care specialties, such as age-specific codes used by pediatricians, would be included.

³ CPT codes, descriptions, and other data are copyright 1966, 1970, 1973, 1977, 1981, 1983-2007 by the American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

How to identify mental health and substance abuse providers? The list of categories for mental health and substance abuse (MHSA) providers was initially based on licensure categories from the Secretary of State's office. Discussions with each insurer ensured that these categories would map to categories that the insurers use for contracting purposes. For comparative purposes, psychiatrists were also included in the list. Payments to other providers who may provide some mental health and substance abuse services, such as primary care physicians, are excluded.

How to identify mental health and substance abuse services? After consulting with insurers and examining recommendations from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the definition was based on a specific range of CPT codes – 90801 to 90899.

How to identify the top 10 procedure codes? After discussion, the same approach was taken as was used for primary care – requesting the counts and average reimbursement for each insurer's top 15 MHSA codes across professions and education levels. Using this list, information will be provided for each provider type / education. Note that when providers reimburse different licensure types at the same level, insurers will indicate which provider types are included and report consolidated averages.

In cases where fewer than 15 distinct CPT codes were found in the data, the insurers were instructed to indicate this, and to provide information for all CPT codes used.

Data universe – the information provided by the insurers was based on the claims incurred by Vermont residents. Although the vast majority of these claims were paid to Vermont providers, claims paid to non-Vermont providers were also included in counts and averages.

Self-insured / Administrative Services Only business – one concern in developing this survey was that in some cases, insurers may provide administrative services (pay claims), but not have a contractual relationship with providers (for example, paying charges). Information included in this survey is limited to transactions based on a contract between the insurer and the provider. BCBS and CIGNA included any self-insured business where reimbursement was based on the same contracts as fully-insured business.

Data Collection Process

In order to obtain information necessary to design the reimbursement survey, an initial questionnaire was sent to the four identified health insurers⁴. Note that for purposes of this report, Vermont BlueCross BlueShield submitted information that combined BCBS and TVHP business. This questionnaire asked for information about which specific professions the insurer

⁴ All administrative services for TVHP are provided by Vermont BlueCross BlueShield

contracts with, factors that influence reimbursement, use of capitation, and definition of primary care. This questionnaire is included in the appendix to this report.

Following this survey, a conference call that included the insurers, the consultant, and BISHCA staff was held. A number of questions arose that insurers were not comfortable discussing with other insurers, so individual conversations were held to resolve issues which might have caused concerns about competition and collusion had they been discussed on the conference call.

To ensure comparability among insurers and to comply with the requirement that data be at least 90 days old at time of publication, averages were to be based on claims incurred (date of service) between January 1, 2007 and September 30, 2007.

The figure used in calculation of reimbursement was “allowed charges.” This is the amount set in a provider contract, prior to any reductions for cost sharing (deductibles, coinsurance, or copayments). Any pay-for-performance or other quality-based reimbursement was excluded. This was done to ensure comparability, because some carriers include this type of payment reimbursement for individual services, while others make a periodic aggregate payment.

In cases where more than one rate applied to a specific service and provider type or specialty, the average rate was provided. This figure was a weighted average, using claim frequency as a weight. See the instructions in the appendix for an example of how weighted averages are computed.

Services that were covered under a direct capitation agreement were excluded, but services that were reimbursed under any form of aggregate agreement such as a per-member-per-month target and settlement contract were included.

The data collection form and instructions were distributed to insurers in late January, 2008. Responses were received by the end of February.

A series of edits were developed for this project. These included:

- Distribution of services among CPT codes (e.g. what percentage of the top 10 volume is represented by CPT code X for each insurer?)
- Market share within CPT codes compared to total market share (e.g. if an insurer represents 25 percent of earned premium, does that insurer account for about 25% of services within a CPT code?)
- For primary care, ratio of reimbursement of selected CPT codes to a baseline code (99213 – office visit for evaluation and management of an established patient). This edit looked for inconsistencies in relationships among procedure codes.

After data were edited and any issues resolved, the top 10 primary care and MHSA CPT codes were identified.

Other than the edits discussed above, both BISHCA and the consultant relied on the accuracy of the information provided by the insurers. No external validation of the data was attempted.

Weighted Averages – this report makes use of weighted averages in both the data collection process and analyses. Weighted average is a way of computing averages that recognizes the different counts of services at different reimbursement levels. For example, if an insurer paid 10 claims at \$20 and 5 claims at \$30, the weighted average would recognize that twice as many claims were paid at \$20 than at \$30. The calculation is $((10 * \$20) + (5 * \$30)) / (10 + 5)$, or \$23.33, rather than $(\$20 + \$30) / 2$.

Findings – Primary Care

Using the service count information provided by the insurers, the aggregate top 10 primary care codes were identified. Table 1 shows the codes and their descriptions. Figure 1 shows the proportion of the top 10 that each code represents.

Table 1

Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
36415	Collection of venous blood by venipuncture
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years old.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

Figure 1 shows the distribution of specific codes among the top 10. The most common code, 99213, accounts for over 45 percent of services among the top 10 codes.

Figure 1

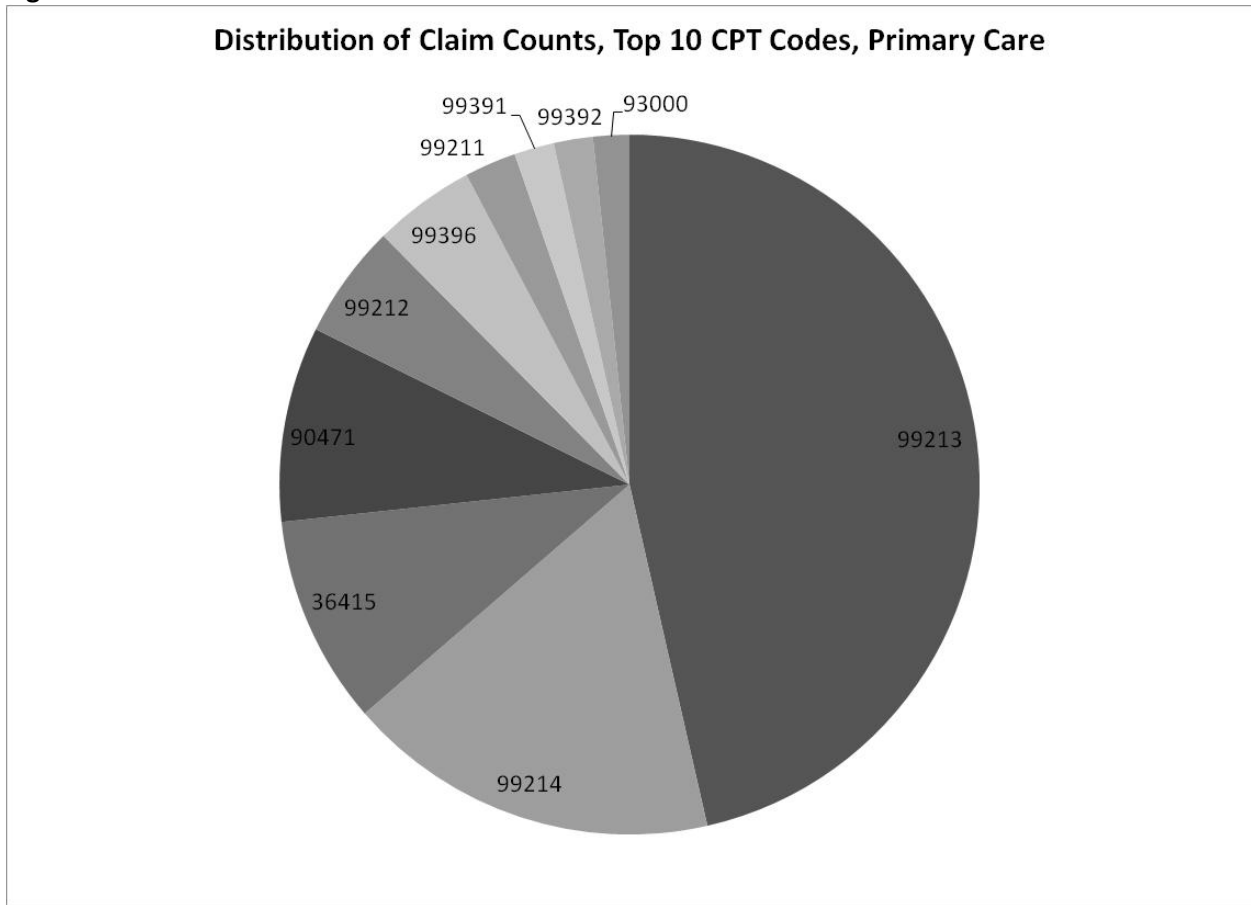


Table 2 shows the reported average allowed charge for each insurer for each of the top 10 primary care CPT codes, the percent that each code represents of the top 10 codes, and the weighted average allowed charge across insurers.

Table 2 – Allowed Charges for Top 10 Primary Care Procedure Codes

CPT Code	BCBS/TVHP	CIGNA	MVP	Percent of top 10 claims	Weighted average
99213	\$68.26	\$67.27	\$70.75	46.4%	\$68.18
99214	\$107.09	\$101.85	\$111.59	17.2%	\$106.07
36415	\$9.09	\$5.80	\$6.10	9.6%	\$7.54
90471	\$24.57	\$18.61	\$18.49	9.0%	\$22.21
99212	\$49.58	\$41.46	\$49.86	5.3%	\$45.15
99396	\$148.71	\$119.60	\$143.08	4.7%	\$136.77
99211	\$27.89	\$22.80	\$28.70	2.4%	\$25.88
99391	\$107.83	\$89.69	\$100.43	1.8%	\$99.92
99392	\$120.55	\$101.24	\$116.25	1.8%	\$112.07
93000	\$48.52	\$37.21	\$50.01	1.7%	\$45.07

Figures 2 and 3 show the distribution of average reimbursement among the insurers for each of the top 10 codes. Two different approaches are taken to show variation. The first, in Figure 2, is to show the actual average for each insurer for each procedure code. The second, in Figure 3, is to show variation relative to the overall average payment for each service. The second approach is helpful in comparing variation when the underlying payment amounts differ. On Figure 2, a 10 percent variation in a procedure code with higher reimbursement will look larger than the same percentage variation in a procedure code with lower variation, while on Figure 3, the same percentage variation will look the same regardless of the underlying dollars.

For example, look at procedure code 36415, venipuncture. In dollar terms, it is a low-variation code (Figure 2), but on a percentage basis, it is the highest-variation code (Figure 3).

The most frequent code, 99213, office visit for evaluation and management of an established patient, is among the least variable, both on a dollar and on a percentage basis.

Figure 2

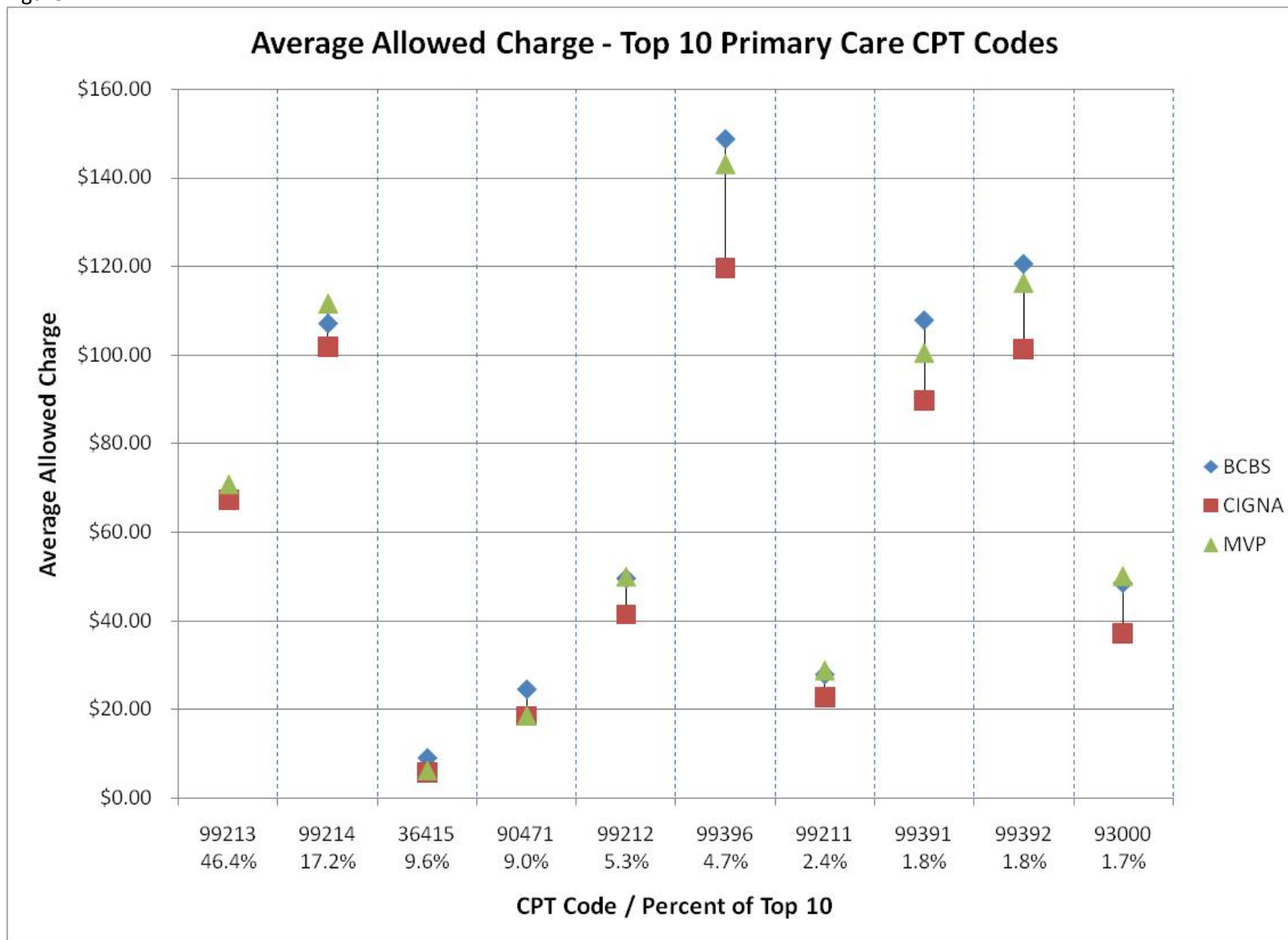
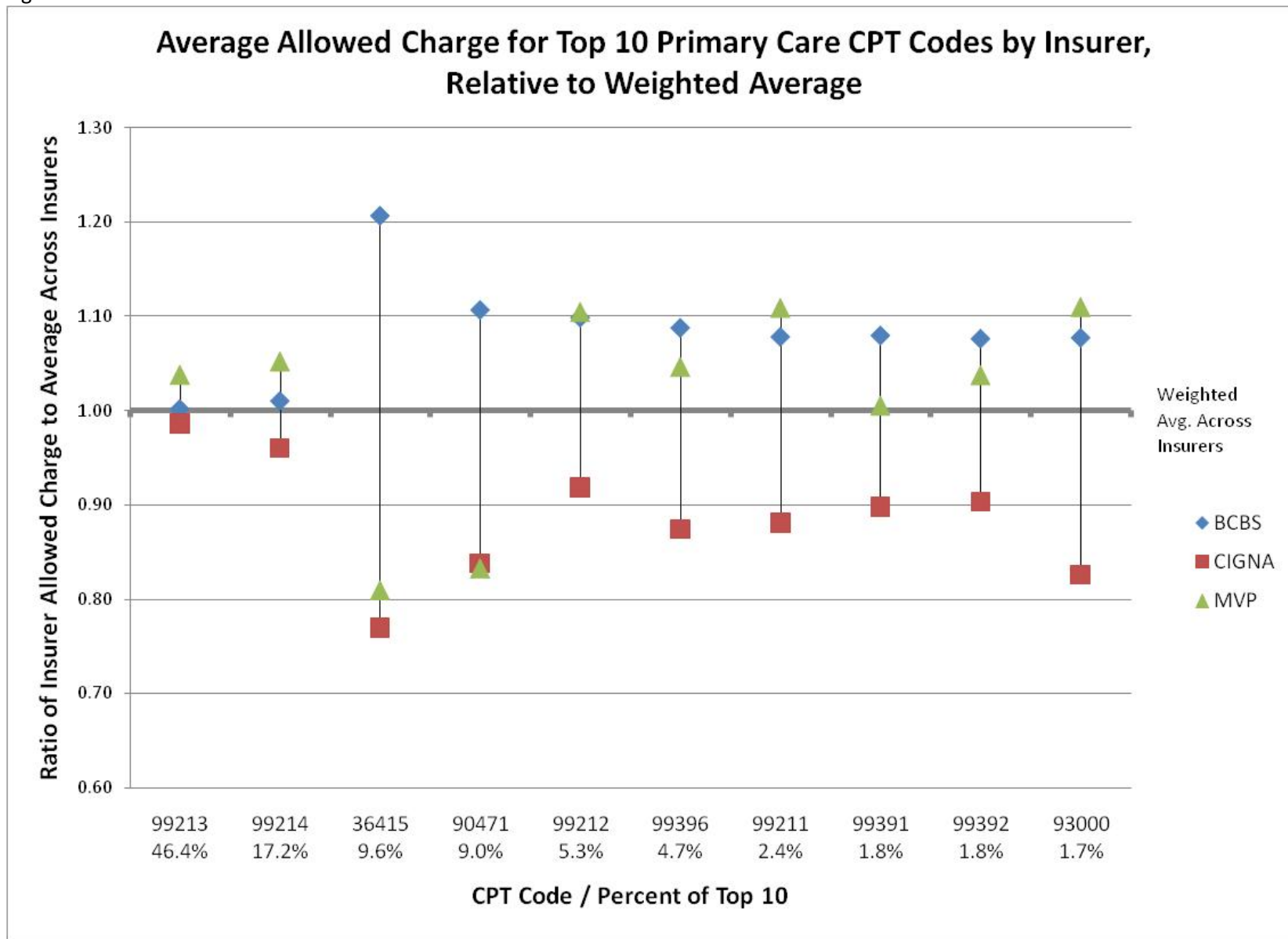


Figure 3



Findings - Mental Health and Substance Abuse

A similar approach has been taken for examination of allowed charges for Mental Health and Substance Abuse (MHSA), but with an additional factor. The language in Act 71 requires this analysis to include an examination of how reimbursement varies by educational level and provider type in addition to variation by CPT code.

This section begins with an examination of overall variability among insurers and then focus on how provider education or type influences reimbursement. Table 3 presents the top 10 procedure codes in this category of care.

Table 3

Code	Description
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90801	Psychiatric diagnostic interview examination
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90846	Family psychotherapy (without the patient present)
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

Figure 4 shows the distribution of procedure codes in the top 10. A single code, 90806, accounts for nearly three-quarters of services.

Figure 4

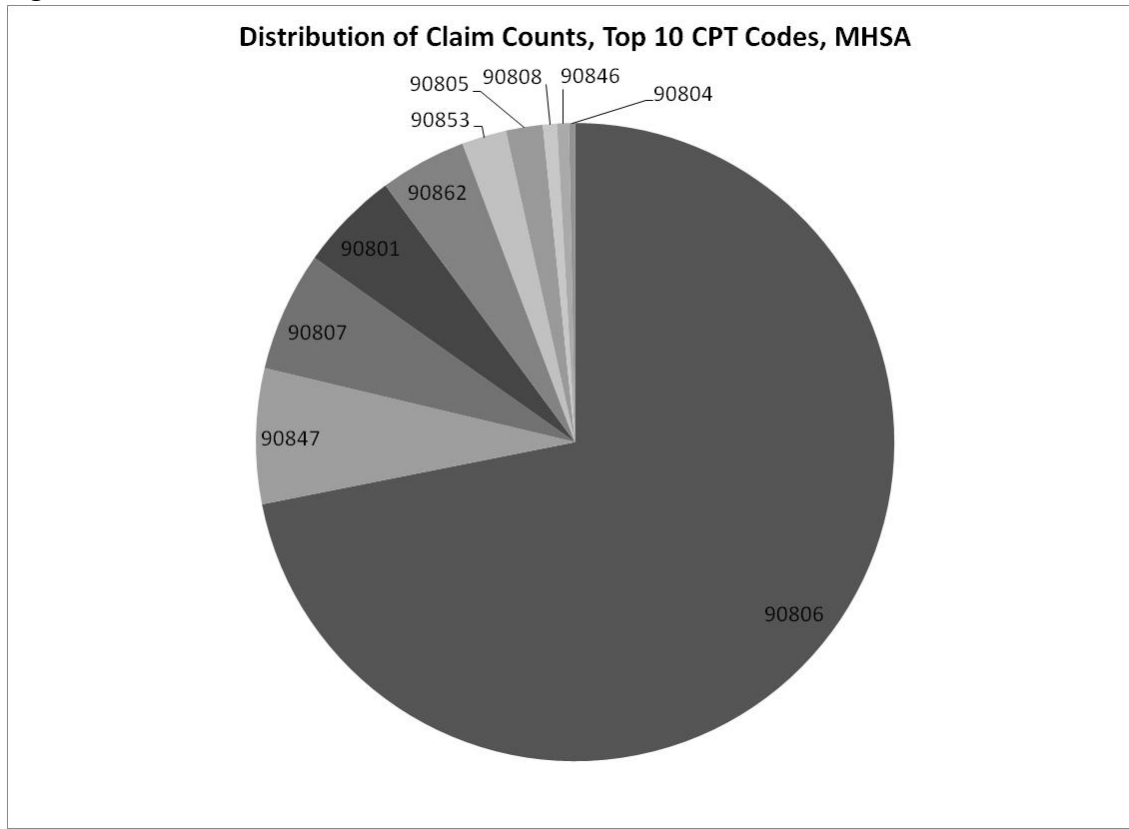


Table 4 shows the average allowed charge for each insurer for each CPT code, across all levels of education, the percent of top 10 represented by each CPT code, and the weighted average allowed charge across insurers.

CPT Code	BCBS/TVHP	CIGNA	MVP	Percent of top 10 claims	Weighted average
90806	\$64.89	\$59.80	\$65.47	71.9%	\$63.65
90847	\$71.00	\$53.01	\$66.00	6.8%	\$65.74
90807	\$109.61	\$98.60	\$133.20	6.1%	\$109.12
90801	\$85.39	\$56.14	\$84.51	5.1%	\$77.45
90862	\$61.81	\$49.36	\$67.25	4.4%	\$58.54
90853	\$33.36	\$38.24	\$48.29	2.3%	\$36.19
90805	\$54.52	\$68.28	\$91.08	1.9%	\$64.15
90808	\$85.71	\$82.00	\$84.27	0.7%	\$85.18
90846	\$76.31	\$65.05	\$76.01	0.6%	\$71.96
90804	\$39.40	\$33.53	\$37.47	0.3%	\$37.45

Figures 5 and 6 show the absolute and relative variability for these 10 services.

Figure 5

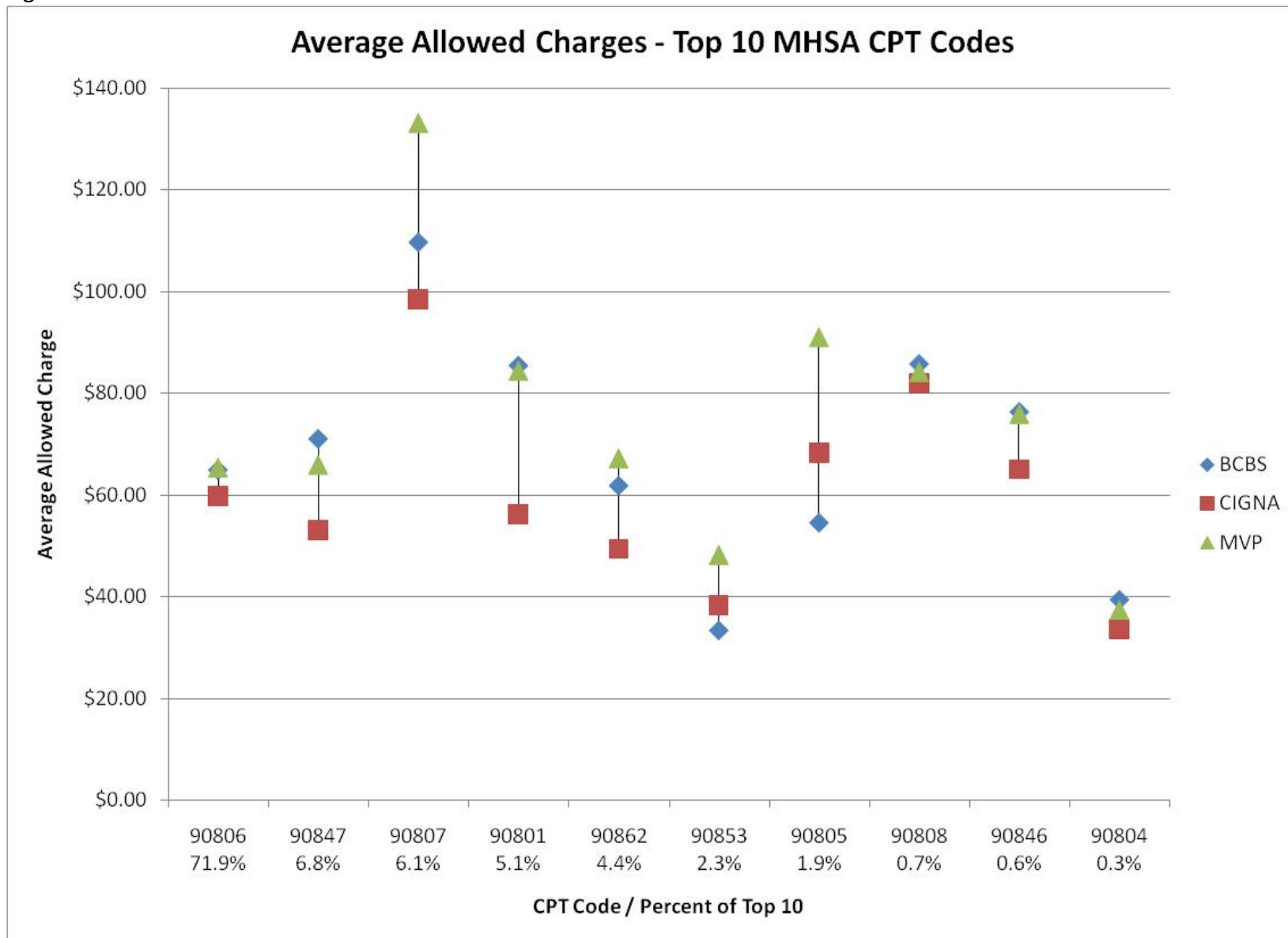
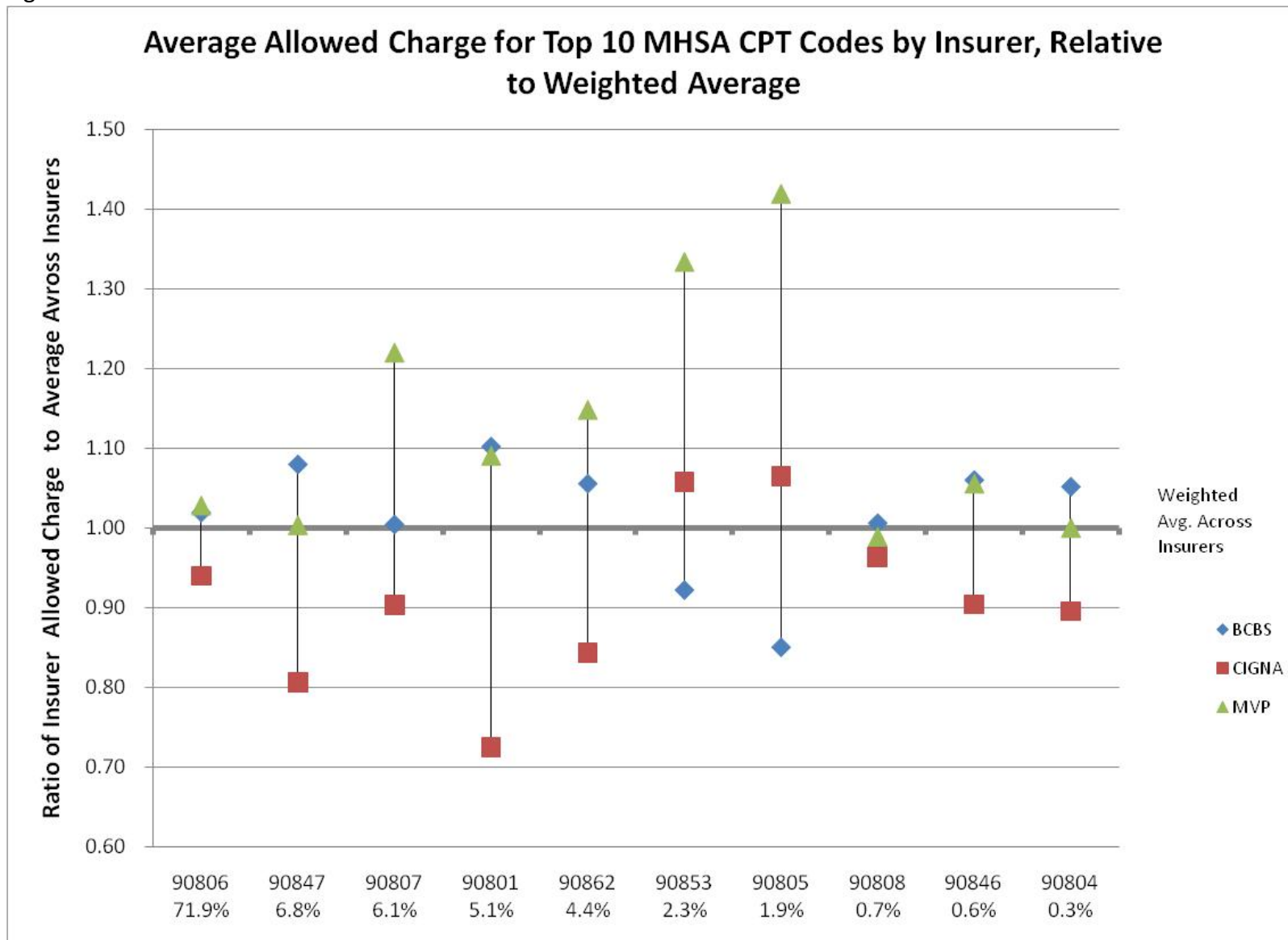


Figure 6

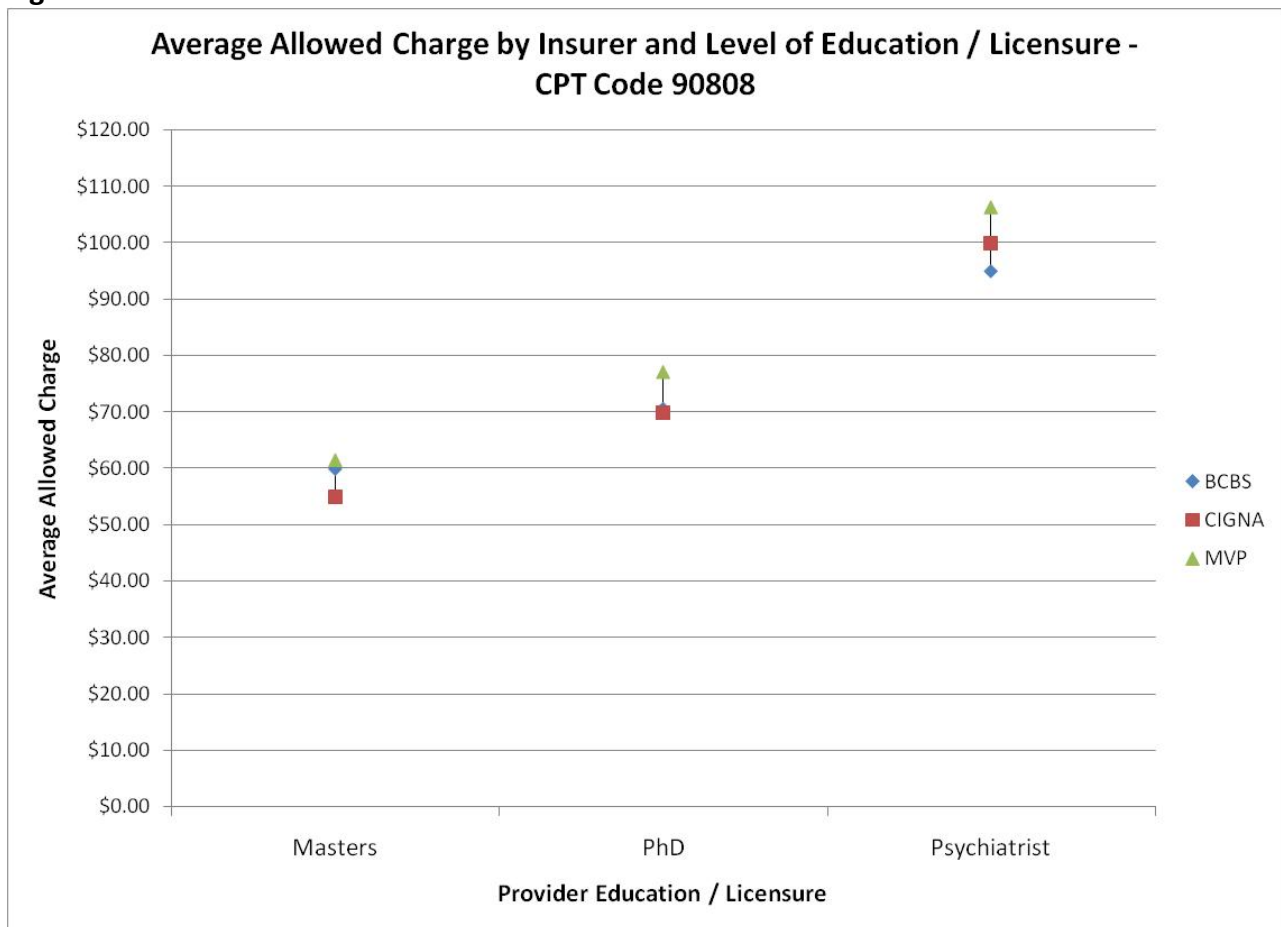


Mental Health and Substance Abuse – Analysis by Provider Type

When establishing a structure for allowed charges for mental health and substance abuse care, each of the responding insurers distinguishes among levels of education, but within a level (masters, Ph.D., MD), all providers are reimbursed at the same level. For example, a clinical social worker with a masters degree would receive the same reimbursement as a masters-prepared psychologist, all other factors being the same.

Figure 7 shows the absolute variation in allowed charges for CPT code 90806, which accounts for nearly three-quarters of all MHSA care. Analyses for other CPT codes were not performed because for many codes, no claims were paid by one or more insurers.

Figure 7



Conclusion

This report provides a unique look at comparative reimbursement among Vermont's major health insurers. It identifies procedure codes where there is minimal variation and other procedure codes where variation is substantial.

Variation between lowest and highest allowed charges ranges from about 5 percent to over 50 percent. Blue Cross / TVHP and MVP have the highest reimbursement for five out of the top 10 procedure codes, both in primary care and in mental health / substance abuse.

BISHCA would like to acknowledge the effort made by the participating insurers to define, collect, prepare and submit the data required for this report.

Appendices

Appendix 1 – Excerpt from Act 71 (2007)

Sec. 9. 18 V.S.A. § 9409a is added to read:

§ 9409a. HEALTH CARE INSURANCE REIMBURSEMENT SURVEY

In order to understand the impact of reimbursement on access to health care, the cost shift, the workforce shortages and recruitment and retention of health care professionals, the commissioner shall annually survey health insurers to determine the reimbursement paid for the ten most common billing codes for primary care health services. Each insurer shall report the average reimbursement paid for a specific service. The survey shall be managed by the department of banking, insurance, securities, and health care administration, and any public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. When published, survey data will be at least 90 days old. Only the department will have access to the underlying survey responses. The department shall provide a copy of the survey results to the house committee on health care and the senate committee on health and welfare.

Sec. 15. MENTAL HEALTH AND OTHER NON-PHYSICIAN PROVIDER

REIMBURSEMENT SURVEYS

(a) In order to understand the impact of reimbursement on access to mental health care providers, the cost shift, the workforce shortages, and recruitment and retention of health care professionals, the commissioner of banking, insurance, securities, and health care administration shall administer a one-time survey of health insurers to determine the reimbursement paid for the ten most common billing codes for mental health services, along with differences in reimbursement based on the provider's level of education or licensure. Each insurer shall report the average reimbursement paid for a specific service for each applicable provider level of education or licensure.

(b) In order to understand the impact of reimbursement on access to other non-physician health care providers, the cost shift, the workforce shortages, and recruitment and retention of health care professionals, the commissioner of banking, insurance, securities, and health care administration shall administer a one-time survey of health insurers to determine the reimbursement paid for the most common billing codes for non-physician health care provider services. Each insurer shall report the average reimbursement paid for a specific service for each provider level of education or licensure, when applicable. The department may limit the survey to a total of 20 billing codes except that it shall ensure that the survey includes reimbursement for at least two common billing codes for each major class of provider.

(c) The surveys shall be managed by the department of banking, insurance, securities, and health care administration. Any public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to

any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. Only the department will have access to the underlying survey responses. Neither survey shall include hospital reimbursements.

(d) No later than December 15, 2008, the department shall provide the results of the surveys to the commission on health care reform, the house committees on health care and human services, and the senate committee on health and welfare. In addition, the department shall also provide the results of the survey conducted pursuant to subsection (a) to the mental health oversight committee.

Appendix 2 – Initial survey

BISHCA Provider Reimbursement Survey – Background Questionnaire

Please return the completed questionnaire by Friday November 16, 2007 to:

Steven Kappel

Policy Integrity LLC

1855 North Street

Montpelier, VT 05602

sikappel@policyintegrity.com

1. Organization _____

2. Respondent _____

Contact Information: Email _____

Phone _____

3. Please indicate the health care professions that you reimburse / contract with

PROFESSION	Reimburse	Contract with
Acupuncturists		
Advanced Practice Nurses		
Chiropractors		
Clinical Mental Health Counselors		
Clinical Social Workers		
Dieticians		
Drug & Alcohol Counselors		
Marriage & Family Therapists		
Mental Health Counselors		
Midwife, Licensed		
Naturopathic Physician		
Occupational Therapists		
Opticians		
Optometrists		
Physical Therapists		
Physicians (MDs)		
Physicians (Osteopath)		
Podiatrists		
Psychoanalysts		
Psychologists (Masters or Ph.D.)		
Psychotherapists		
Speech Language Pathologists & Audiologists		
Other (specify):		
Other (specify):		
Other (specify):		
Other (specify):		
Other (specify):		

4. Please indicate the factors that MAY influence the allowed charge for a service. Not all of these factors will influence calculation of allowed charge for every claim.
- Individual provider or organization contract
 - Provider profession (e.g. physician, nurse, psychologist)
 - Provider specialty (e.g. internal medicine, cardiology)
 - Provider education (e.g. Masters vs. Ph.D)
 - Network status (contracting vs. non-contracting)
 - Patient characteristics (e.g. patient age, special contract)
 - Line of business (e.g. HMO, PPO, individual market, Catamount Health)
 - Other, please indicate _____
5. Do you reimburse for any primary care under a capitation agreement?
- No
 - Yes – Please indicate the percent of covered lives under capitation ___%
6. Does your organization have a specific definition for primary care?
- No
 - Yes – Please provide

See next page for instructions

BISHCA Provider Reimbursement Survey – Instructions

This information is being collected to ensure that information provided about actual reimbursement amounts is interpreted correctly.

- 2) Name of the person to contact with questions
- 3) For each profession, indicate if you ever reimburse members of that profession directly, and whether you ever contract with members of that profession.
- 4) For each category, please indicate whether it is ever used as a factor in determining allowed charge. This does not mean that it is always a factor.
 - a. Individual provider or organization contract – do your allowed charges ever vary based on contracts with individual providers or organizations? For example, does allowed charge for a specific service provided by the same type of provider with the same specialty vary by who that provider works for?
 - b. Provider profession – for example, do you ever calculate a different allowed charge for the same service provided by a psychiatrist or a psychologist?
 - c. Provider specialty – for example, do you ever calculate a different allowed charge for the same service provided by a pediatrician or a family practitioner (both MDs)?
 - d. Provider education – for example, do you have a different allowed charge for Master’s and Ph.D. psychologists providing the same service?
 - e. Network status – is your allowed charge ever different for contracting providers than non-contracting providers?
 - f. Patient characteristics – does your allowed charge ever vary either for specific customers or patients? For example, does the amount ever vary for the same service provided to a child or an adult?
 - g. Line of business – does the allowed charge ever vary by specific product (HMO, POS, PPO, TPA)?
 - h. Are there any other factors that are used in calculation of allowed charge?
- 5) The agreement may be just for primary care or may include other services as well.

Questions? Contact Steve Kappel at sjkappel@policyintegrity.com or 802-522-0986

Appendix 3 - BISHCA Reimbursement Survey - Instructions

General

Data Period – include all services provided (incurred) between January 1, 2007 and September 30, 2007. Paid dates should be as current as possible. There is no need to include IBNR estimates.

Lines of Business – include all business for which you have a direct contractual relationship with providers. Exclude any business for which you do not have a contractual relationship with providers.

Capitation – exclude any services for which no fee-for-service payment is made, such as a capitation agreement.

Calculation of average payment – calculation should use allowed charge / contract amount, prior to any reduction for deductibles, coinsurance, co-payment, or third party liability. The average should be computed across all provider contracts and all lines of business that use fee-for-service reimbursement. Any bonuses or supplemental payment amounts based on quality of care or pay-for-performance agreements should be excluded. An example of different ways to calculate average is appended.

Report 1 – Primary Care

Providers – include physicians whose specialties are general practice, family practice, pediatrics, or internal medicine (CMS specialty codes 01, 08, 37, or 11). Include advanced practice RNs and physician assistants associated with physicians with these specialties. Exclude OBGYNs unless they have agreed to act as primary care providers.

CPT codes – use attached list. Treat modifiers as different codes.

Other instructions – the CPT code list includes 15 codes. Please include the count of services that were used in the calculation of the average. Counts will be used only to determine top 10 CPT codes across payers and will not be included in any reports.

Report 2 – Mental Health and Substance Abuse

Providers – Include psychiatrists, psychologists (doctorate), psychologists (masters), Clinical Mental Health Counselors, Licensed Clinical Social Workers, Drug & Alcohol Counselors, Marriage & Family Therapists, Mental Health Counselors, Psychoanalysts, and Psychotherapists (Secretary of State licensure categories). If reimbursement is the same, categories may be merged. For example, if LCSWs and psychologists (masters) are reimbursed at the same level for each CPT code, averages may be reported for LCSW/psychologist(masters) combined. Please be sure to indicate all provider types that are included in the calculation of the averages.

CPT codes – Please provide information on the 15 most frequent CPT codes in your data in the range of 90801 to 90899. Top 15 should be calculated based on the combination of all MHSA providers, not on

individual provider types. In addition to average payment, please provide count of services. Counts will be used only to identify the top 10 CPT codes and will not be included in any reports.

Report 3 – Other Providers

Providers – The attached list shows licensure categories for non-MD, non-MHSA providers. Please include any of these categories for which you have paid for services during the data period.

CPT codes – Please provide information on the 5 most frequent CPT codes for EACH provider type. If all services are accounted for by fewer than 5 codes, please indicate that. In addition to average payment, please provide count of services. Counts will be used only to identify the top CPT codes and will not be included in any reports.

List of CPT codes for Report 1 - Primary Care

36415 ROUTINE VENIPUNCTURE
81000 URINALYSIS, NONAUTO W/SCOPE
90471 IMMUNIZATION ADMIN
90658 FLU VACCINE, 3 YRS & >, IM
93000 ELECTROCARDIOGRAM, COMPLETE
93010 ELECTROCARDIOGRAM REPORT
99000 SPECIMEN HANDLING
99211 OFFICE/OUTPATIENT VISIT, EST
99212 OFFICE/OUTPATIENT VISIT, EST
99213 OFFICE/OUTPATIENT VISIT, EST
99214 OFFICE/OUTPATIENT VISIT, EST
99391 PER PM REEVAL, EST PAT, INF
99392 PREV VISIT, EST, AGE 1-4
99394 PREV VISIT, EST, AGE 12-17
99396 PREV VISIT, EST, AGE 40-64

List of Other Providers

Acupuncturists
Audiologists
Chiropractors
Dentists
Dietitians
Hearing Aid Dispensers
Midwives, Licensed (not RNs)
Naturopaths
Nurse midwives
Occupational Therapists
Opticians
Optometrists
Physical Therapists
Podiatrists
Radiologic Technologists
Respiratory Care Practitioners
Speech Language Pathologists

Calculation of Averages

For a specific CPT code and provider type(s)

Contract	Claims Paid	Allowed	Total Allowed	% of Claims	% of Dollars
1	500	\$70	\$35,000	17.9%	22.2%
2	800	\$60	\$48,000	28.6%	30.4%
3	1500	\$50	\$75,000	53.6%	47.5%
Total	2800		\$158,000	100.0%	100.0%

Ways to compute average

Acceptable		Result	
1	Summation	$158000/2800$	\$56.43
2	Weight /count	$(70*0.179)+(60*0.286)+(50*0.536)$	\$56.43
Not Acceptable			
3	Weight/\$	$(70*0.222)+(60*0.304)+(50*0.475)$	\$57.47
4	Average	$(70+60+50)/3$	\$60

Allowed is the contractual amount, prior to any cost sharing.

Appendix 4 – Contractor Confidentiality Agreement



Vermont . . .

Department of Banking, Insurance, Securities
and Health Care Administration
Division of Health Care Administration

State Confirmation Regarding Designee and Use of Insurer Data

The Department of Banking, Insurance, Securities and Health Care Administration (hereafter referred to as the State) located at 89 Main Street, Montpelier, VT 05620-3601 confirm on this ___ day of _____, 20___ the following:

Steven Kappel of Policy Integrity LLC having a principal place of business at 1855 North Street, Montpelier, VT 05602 is acting on behalf of the State as a designee of the State in provision of contract services in consulting, data collection and report preparation addressing the Act 71 provider reimbursement surveys; and

Per the provisions of Act 71 addressing public records law and disclosure of information, public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. When published, survey data will be at least 90 days old. Only the department will have access to the underlying survey responses.

Name and Title

Date

Contractor Confirmation Regarding Status As Designee of State of Vermont

I, Steven Kappel, of Policy Integrity LLC having a principal place of business at 1855 North Street, Montpelier, VT 05602 confirm on this ___ day of _____, 20___ as a designee of the State of the following:

I am managing the data submitted by each health insurer in a secure and confidential manner and will not disclose health insurers’ data to any parties other than the State;

I will not publish health insurers’ data or any reports based on these data without the permission of the State; and

Upon termination of this contract, I shall destroy the data files submitted by the health insurers and any other secondary files containing the required data submitted by health insurers and provide a letter of notification to the State regarding the destruction of the data files.

Name and Title

Date