

The Seven Joint Principles of Patient-Centered Medical Home

- 1.) That each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- 2.) That the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- 3.) That the personal physician is responsible for providing for all the patient's health care needs and for appropriately arranging care with other qualified professionals.
- 4.) That care is coordinated and/or integrated across all elements of the complex health care system and the patient's community and that care is facilitated by registries, information technology, health information exchange, and other means.
- 5.) That quality and safety are hallmarks of the medical home, including a strong physician-patient-family partnership, the use of evidence-based medicine, and quality improvement activities.
- 6.) Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication among patients, their personal physicians, and practice staff.
- 7.) Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Patient Centered Medical Home

Commission to Study Primary Care
Medical Practice

Jeffrey Aalberg MD
October 26, 2007

Your doctor

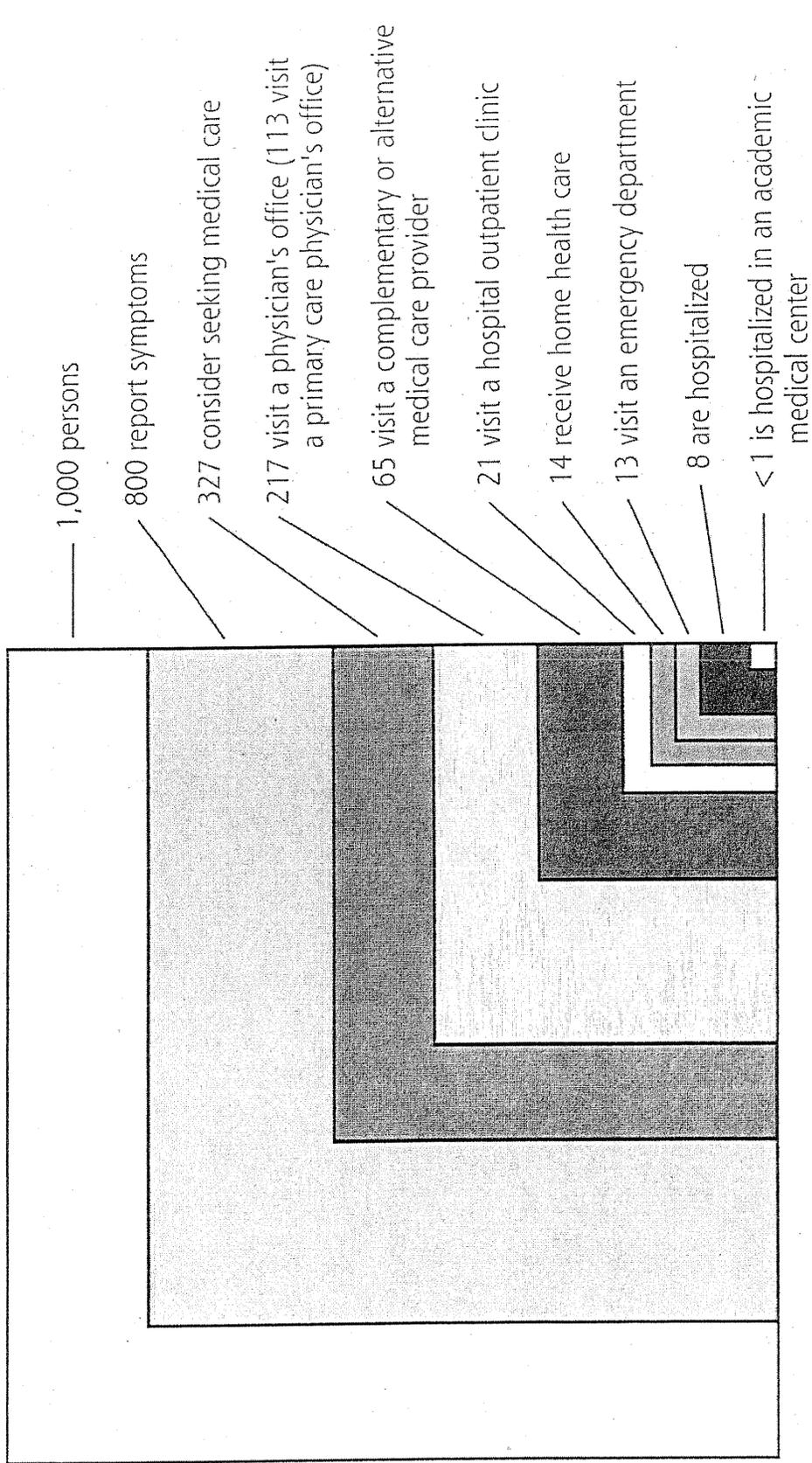
- Personal doctor: trusted, caring
- Available (always?)
- Serves most of your needs and helps you seek other help if needed
- Manages your care
- Highly skilled; experienced
- Has a special relationship with you

What you may not know about your doctor...

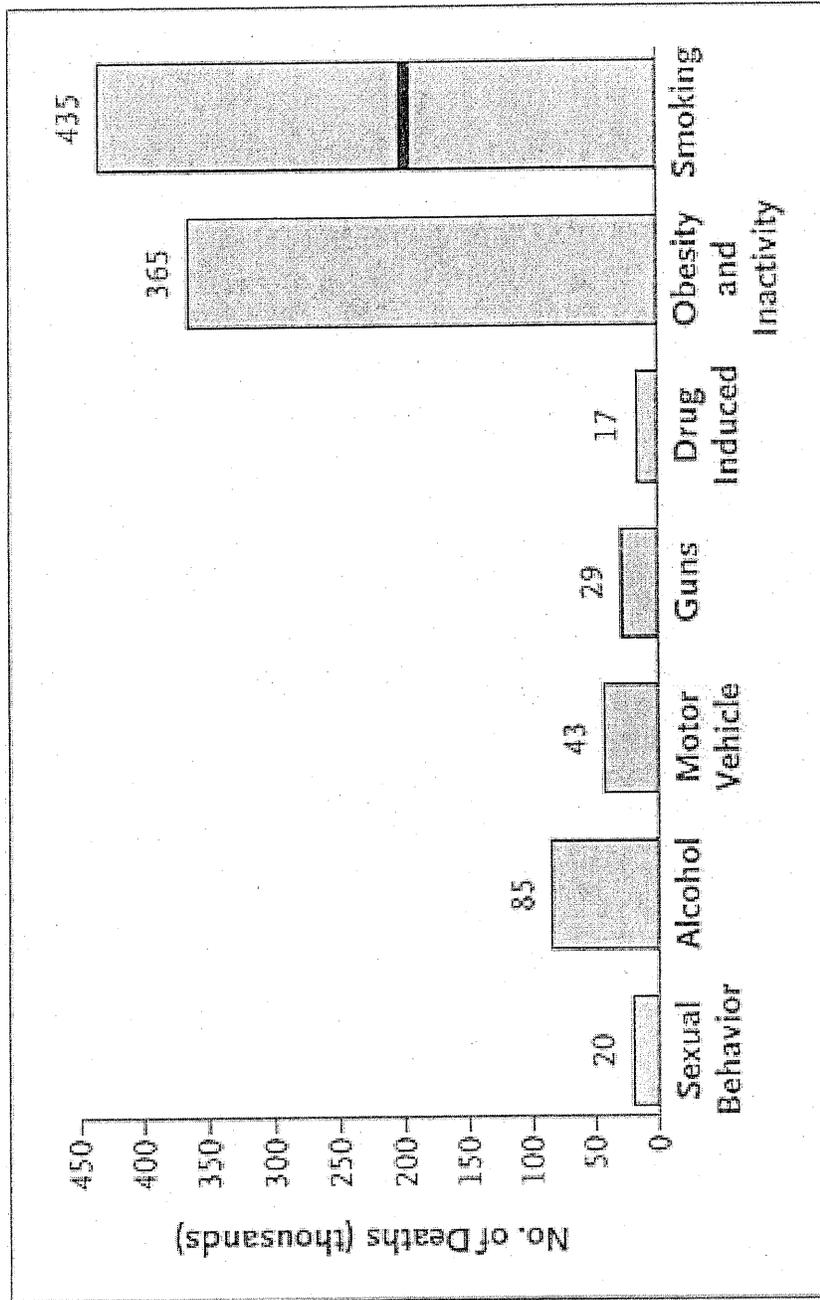
- The paperwork burden
- Reimbursement...adequate?
- Is smart & skilled but may not have data
- His/her own wellness may be at risk
- May need to make personal choices that appear in conflict with your needs

Let's look at data
(from a consumers viewpoint)

The Ecology of Medical Care

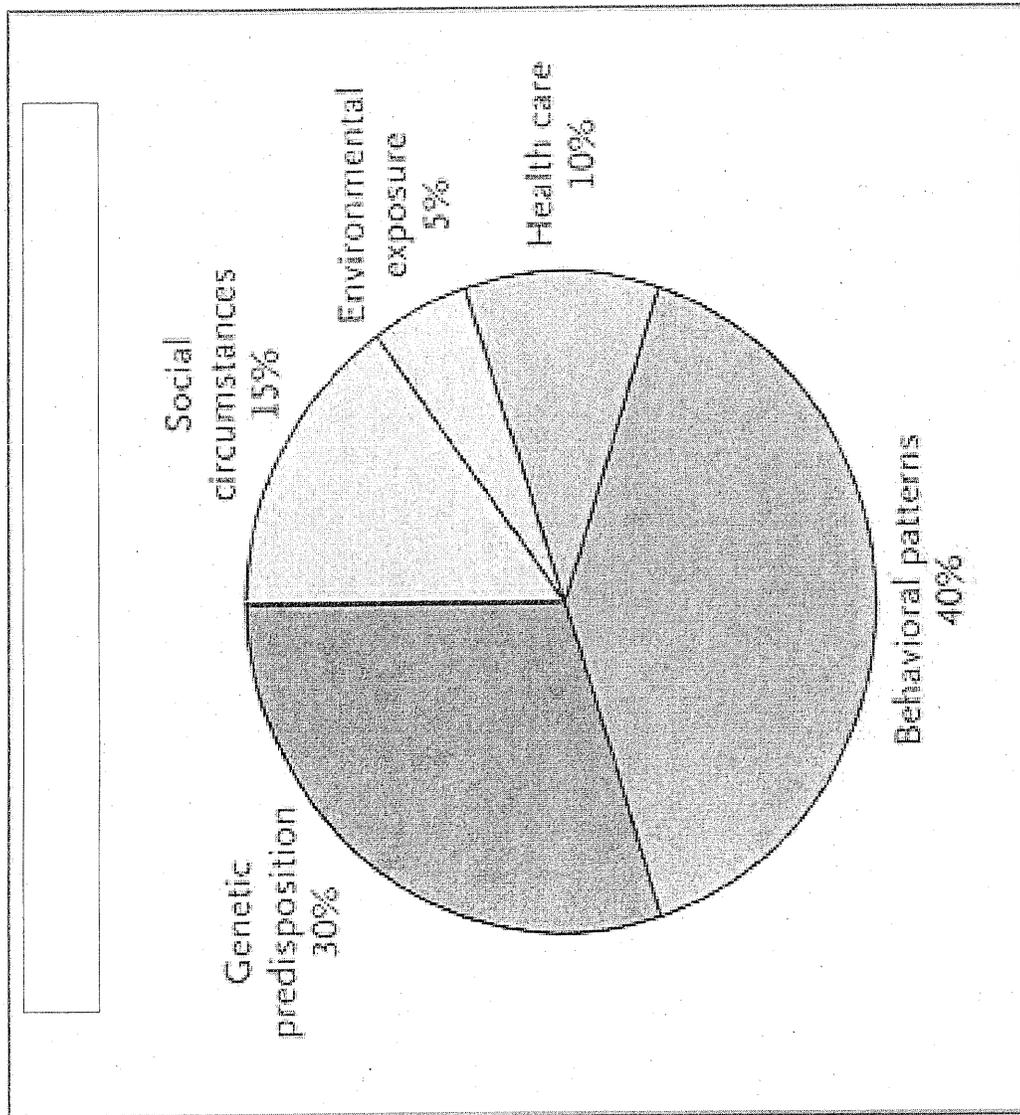


Number of Deaths by Cause



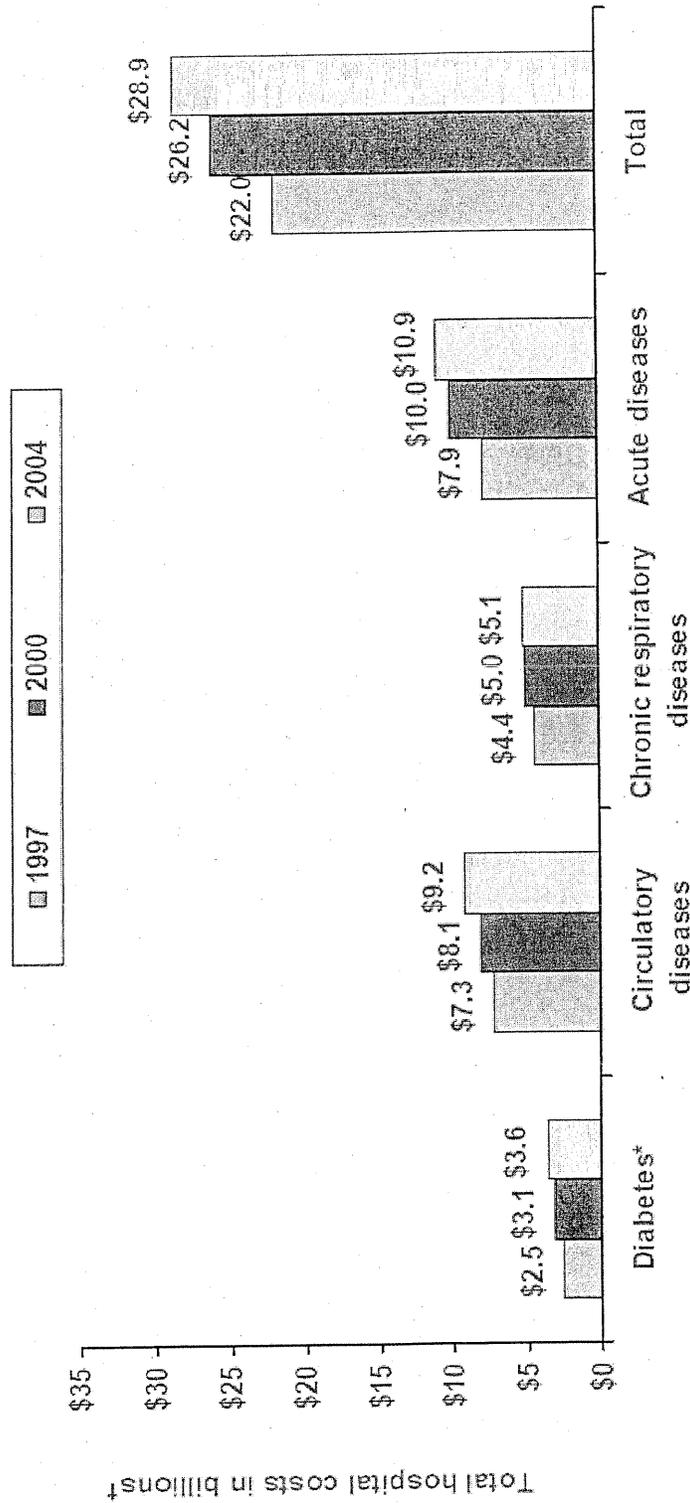
Schroeder S. N Engl J Med 2007;357:1221-1228

Proportional Contribution to Premature Death



Schroeder S. N Engl J Med 2007;357:1221-1228

Trends in total hospital costs for potentially treatable conditions 1997-2004

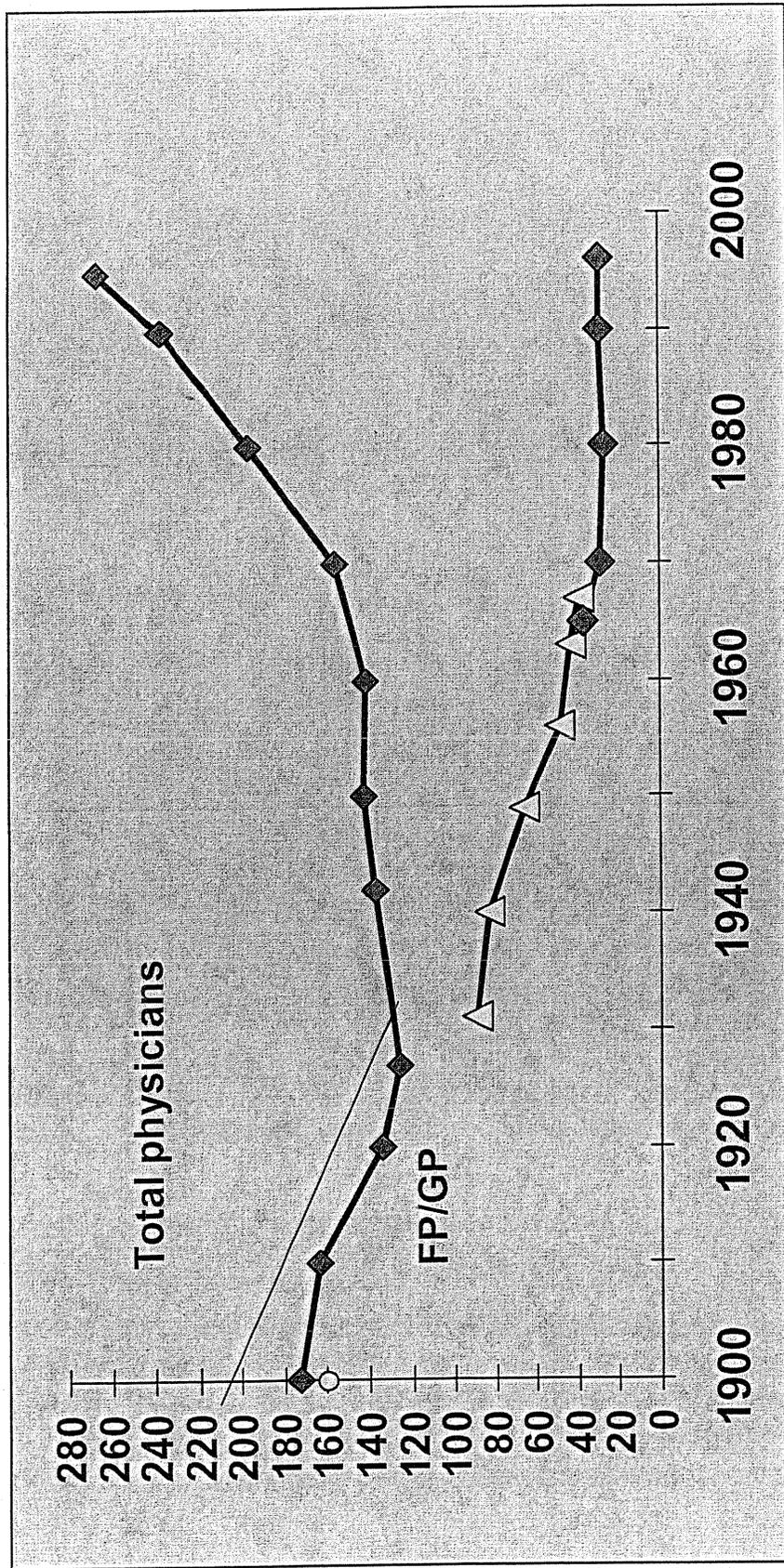


*The diabetes category includes hospital stays for uncontrolled diabetes without complications, short-term diabetes complications, and long-term diabetes complications.

†All costs are adjusted to 2004 dollars using the overall Consumer Price Index.

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 1997, 2000, and 2004.

Total Physicians and FP/GP per 100,000 Population



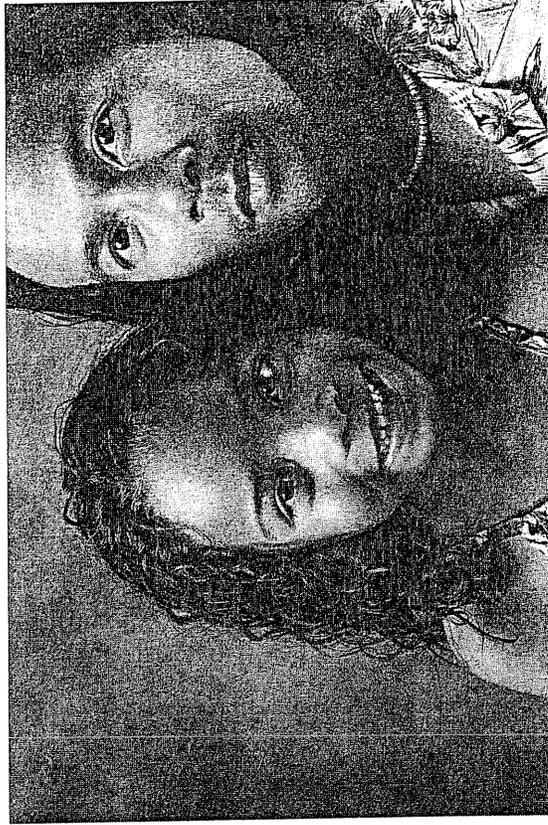
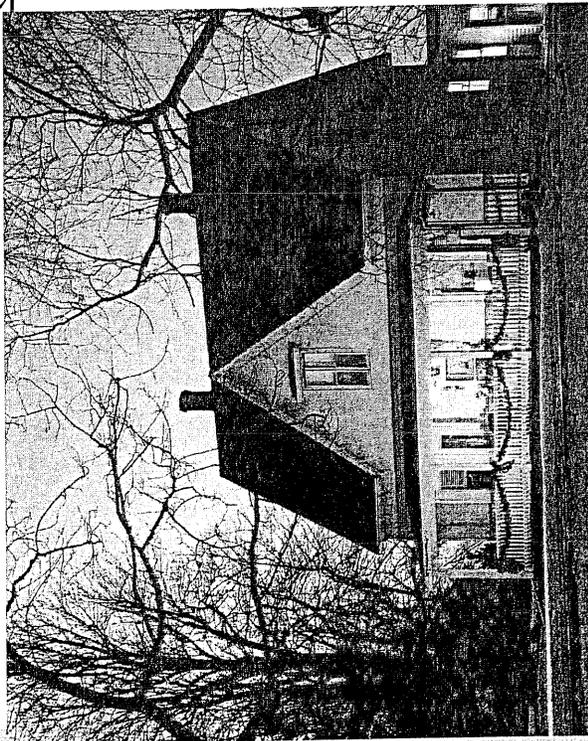
Colwill JW, Cultice J. www.cogme.gov/00_8726.pdf

It seems clear...

We need primary care and a new sustainable
model:

Patient Centered Medical Home

What is a Patient Centered Medical Home? (PCMH)



*It's not a place
It's a system*

Patient Centered Medical Home: Concept

An attempt to reconfigure primary care to meet growing expectations and increased costs using

- Chronic care model
- Increased focus on outcomes
- Resources to support

Care Model

Community

Resources and
Policies

Self-
Management
Support

Health System

Health Care Organization

Delivery
System
Design

Decision
Support

Clinical
Information
Systems

Informed,
Activated
Patient

Productive
Interactions

Prepared,
Proactive
Practice Team

Improved Outcomes

Care Now

Medical Home

-
- Personal doctor; trusted, caring
 - Cares for most of your needs, yet helps you seek other help if needed
 - Physician management
 - Available (sometimes)
 - Highly skilled, experienced
 - Paid for face-to-face encounter
 - Has a special relationship with you
- Personal doctor, but proactive patient care by a team, led by doctor
 - Broad services and coordinates other care using high tech resources
 - Physician-patient-family relationship
 - Access & communication
 - Quality, safety: data to prove
 - Reimbursement aligned with efforts
 - Has a special relationship with you

Medical Home - Defined

- Personal physician
 - Provides longitudinal, comprehensive care
- Physician-directed team
 - Team collectively takes responsibility for care
- Whole-person orientation
 - Cross all stages of life
- Coordinated & integrated care
 - Across all elements of health system & community
- Quality and Safety
 - Evidence Based Medicine
 - Quality Initiatives
- Enhanced access
 - Open Access, enhanced hours
 - Communication
- Payment
 - For added value of PCMH (non face-time work)

See your handout

In real words...

A doctor and team that works with you in all aspects of wellness and sickness with patient centeredness, modern quality means, suitable access and coordinates your transitions in the health care system.

Medical Home - Background

- Introduced AAP in 1964
- Evolving concept: AAP, AOA, ACP, AAFP
- Medicare interest
- Private payers:
 - CIGNA, HUMANA, WELLPOINT, AETNA, the Blues
- Large self insured employers
 - IBM
 - Boeing
- Maine Legislature Senate Resolution 723:
Joint Resolution Commending Concept of Medical Home
for All Patients

Primary Care Workforce: ACP

2006: Called for policy to reverse the “impending collapse” of primary care

2007: Recommend Patient Centered Health Care *system*.

... “proven to result in better quality, more efficient use of resources, reduced utilization and higher patient satisfaction.”

- Medical homes
- Payment system prospective to medical home
- Incentives for quality improvements and cost savings

Evidence for the Importance of PCMH

(Based on Primary Care evidence...)

- Mortality
- Quality
- Costs

Mortality Outcomes

- Primary care:
 - 20% increase in primary care physicians results in 5% decrease in mortality or 40 fewer deaths per 100,000
- Specialists:
 - 8% increase in specialist physicians results in 2% increase in mortality or 16 more deaths per 100,000

Shi. J Am Board Fam Pract 2003;16:412-22.

Quality Outcomes (State rankings):

Add 1 physician to population of 10,000:

- Add a specialist
- Decrease 9 states in quality
- Increase costs \$526/beneficiary
- Add a primary care provider
- Increase 10 states in quality
- Decrease costs \$684/beneficiary

Cost outcomes

Based on studies showing value of care coordinated by a personal physician using systems-based approaches:

- States that rely more on primary care have better quality, lower utilization & lower overall Medicare costs
- Effective care coordination in ambulatory setting can reduce hospital admissions and re-admissions for chronic illnesses (such as diabetes, heart failure)

Starfield, presentation to Commonwealth Fund Roundtable on Primary Care, October 2006
Commonwealth Fund, Chartbook on Medicare, 2006; Dartmouth Atlas, Fall, 2006

Some Solutions

(not all alike)

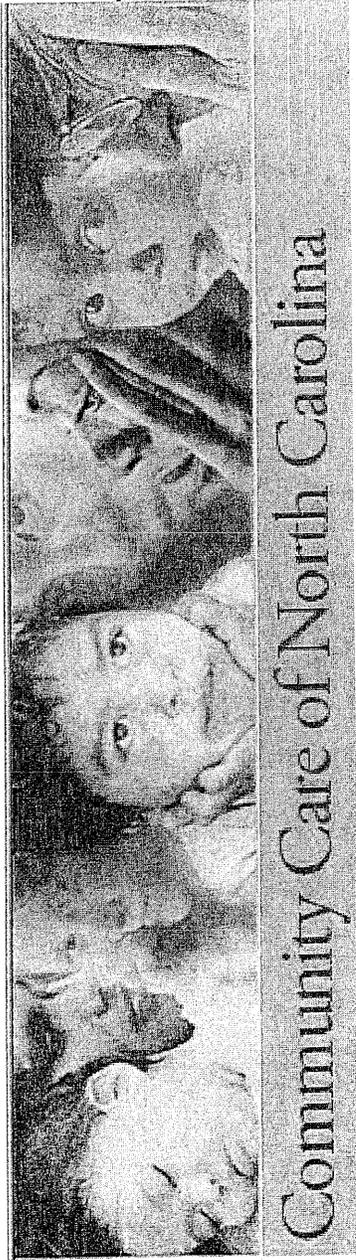
Upcoming Medical Home Pilots

- ACP/AAFP/ AAP/AOA
 - Multiple payers, employers involved
- Payer-specific pilots
 - BCBS: 8 states; Wellpoint: 1 state – Maine!
 - United - Florida
- CMS pilot
 - Via Tax Relief & Health Care Act 2006 - includes Medicare Medical Home Demonstration Project, likely to be launched in 2009
- Others - state pilots
 - NC, VT, RI, others?

Wellpoint-Anthem Pilot: Maine

- Payment System
 - Will establish new prospective payment system, aligned with existing Anthem "Quality Insights" program
 - Ongoing FFS payments
 - Practices will be asked to submit "t codes" to track Medical Home services
 - Bonus for meeting quality targets

North Carolina's Answer



- 750,000 Medicaid patients enrolled:
 - Medical homes
 - Population health management
 - Case management
- July 2003 - 2004
 - Spent \$10.2M, saved \$124 million
 - “staggering results... savings and decreased hospitalizations”

The Rhode Island Chronic Care Sustainability Initiative: *Building a Patient-Centered Medical Home Pilot in Rhode Island*



- A core set of interventions and processes that facilitate the Chronic Care Model
- “The care practices should be based on the concept of the (advanced) medical home...”
- Other elements including shared ROI

A Medical School's Answer: University of Kansas Medical School

- 21.7% entered FM residencies 2007
- Why?
 - Admissions
 - recruit underserved urban and rural students
 - Mentors
 - faculty exemplify virtues of providing quality personal care
 - Finances
 - State loan repayment: 30 students annually
 - Extra stipend for rural settings

Becoming a PCMH is not easy:

NCQA requirements

- Written standards on access and communication
- Uses data to
 - Demonstrate successful access/communication
 - Identify important conditions in practice
- Uses paper or electronic tools to organize information
- Uses evidence based guidelines to track 3 conditions
- Supports patient self management
- Tracks
 - Tests and identifies abnormalities
 - Referrals
 - Service, practice and physician performance

Plus more form a longer list

Being a PCMH has benefits...

- Financial models, for example:
 - Per member per month management fee, and
 - Fee-for-service
- Outcomes?
 - Improved patient care: quality and safety
 - Workforce retention
 - Cost saving

Enhancing primary care will be a process (who will help?)

- Medical schools
- Residencies
- Doctors and other providers
- Medical Societies & Health Care advocates
- Payers
- Employers
- Government
- Public, *the Patients*

**“There are some
doctors who are
more interested in
the disease than the
patient.**

**It seems a funny sort
of attitude to me”**



For more info...

- AAFP/ACP/AAP/AOA Joint Principles of Patient-Centered Medical Home, Feb 2007
http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/0222107medicalhome.pdf
- American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care Policy Monograph, January 2006
http://www.acponline.org/hpp/statehc06_5.pdf
- Patient-Centered Primary Care Collaborative
<http://www.patientcenteredprimarycare.org/>

Report on Financing the New Model of Family Medicine

Stephen J. Spann, MD, MBA for the members of Task Force 6 and The Executive Editorial Team*

Chair, Task Force 6, Houston, Tex.

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► **ABSTRACT**

PURPOSE To foster redesigning the work and workplaces of family physicians, this Future of Family Medicine task force was created to formulate and recommend a financial model that sustains and promotes a thriving New Model of care by focusing on practice reimbursement and health care finances. The goals of the task force were to develop a financial model that assesses the impact of the New Model on practice finances, and to recommend health care financial policies that, if implemented, would be expected to promote the New Model and the primary medical care function in the United States for the next few decades.

METHODS The members of the task force reflected a wide range of professional backgrounds and expertise. The group met in person on 2 occasions and

communicated by e-mail and conference calls to achieve consensus. A marketing study was carried out using focus groups to test the concept of the New Model with consumers. External consultants with expertise in health economics, health care finance, health policy, and practice management were engaged to assist the task force with developing the microeconomic (practice level) and macroeconomic (societal level) financial models necessary to achieve its goals. Model assumptions were derived from the published medical literature, existing practice management databases, and discussions with experienced physicians and other content experts. The results of the financial modeling exercise are included in this report. The initial draft report of the findings and recommendations was shared with a reactor panel representing a broad spectrum of constituencies. Feedback from these individuals was reviewed and incorporated, as appropriate, into the final report.

RESULTS The practice-level financial model suggests that full implementation of the New Model of care within the current fee-for-service system of reimbursement would result in a 26% increase in compensation (from \$167,457 to \$210,288 total annual compensation) for prototypical family physicians who maintain their current number of work hours. Alternatively, physicians could choose to decrease their work hours by 12% and maintain their current compensation. This result is sensitive to physician practice group size. The societal level financial model shows that modifications in the current reimbursement system could lead to further improvements in compensation for family physicians practicing the New Model of care. Reimbursement for e-visits and chronic disease management could further increase total annual compensation to \$229,849 for prototypical family physicians maintaining their current number of work hours. The widespread introduction of quality-based physician incentive bonus payments similar to some current programs that have been implemented on a limited basis could further increase total annual compensation up to \$254,500. The adoption of a mixed reimbursement model, which would add an annual per-patient fee, a chronic care bonus, and an overall performance bonus to the current reimbursement system,

could increase total annual compensation for the prototypical family physician continuing the current number of hours worked to as much as \$277,800, a 66% increase above current compensation levels. The cost of transition to the New Model is estimated to range from \$23,442 to \$90,650 per physician, depending on the assumed magnitude of productivity loss associated with implementing an electronic health record. The financial impact of enhanced use of primary care on the costs of health care in the United States was estimated. If every American used a primary care physician as their usual source of care, health care costs would likely decrease by 5.6%, resulting in national savings of \$67 billion dollars per year, with an improvement in the quality of the health care provided.

CONCLUSIONS Family physicians could use New Model efficiency to increase compensation or to reduce work time. There are alternative reimbursement methodologies compatible with the New Model that would allow family physicians to share in the health care cost savings achieved as a result of effective and efficient delivery of care. The New Model of care should enhance health care while propelling the US system toward improved performance and results that are satisfying to patients, health care professionals, purchasers, and payers. The New Model needs to be implemented now. Given the recognized need for improvements in the US health care system in the areas of quality, safety, access and costs, there is no reason to delay.

Key Words: Family practice • primary health care • family medicine • medical informatics • patient-centered care • practice management • quality of health care • health care costs • reimbursement • incentive • economics

► **DISCUSSION**

The accuracy of any economic or financial prediction model is dependent on the accuracy of the assumptions contained in the model. The models described in this report contain a number of assumptions. These assumptions were based on information derived from the published medical literature, existing practice management databases, and discussions with experienced physicians and other content experts. There was less literature-based information available for the microeconomic model, and this analysis was more heavily reliant on expert judgment. The projections of the financial impact of the New Model are based on the best information available; the accuracy of the projections must ultimately be tested in a live demonstration project. The macroeconomic model was more heavily based on data from the published literature, and it also used assumptions based on some reimbursement methods that are currently being utilized on a limited basis. The projection of major cost savings to the health care system based on a wider use of primary care physicians is consistent with the findings of studies of other countries with stronger primary health care delivery.^{30,35-38} The analysis assumes that widespread implementation of the New Model of care would encourage most patients to utilize primary care physicians, ultimately decreasing the overall cost of health care. It does not assume financial inducements to patients to increase primary care physician utilization; such incentives would likely further increase the magnitude of health care system savings. The incremental costs of a transition to the New Model of care are considerable, but these costs can be offset by increased revenues attributable to improved efficiencies of care and ultimately by new methods of reimbursement that recognize enhanced quality and value of care. Implementation of the New Model should result in a win-win outcome for patients, payers, and family physicians alike.

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► **CONCLUSIONS**

The task force draws the following conclusions from its deliberations and analyses:

- The United States has the opportunity to enhance the value of the health care system by strengthening primary care expenditures.
- The New Model should enhance health care, while propelling the US system toward improved performance and results that are satisfying to patients, health care professionals, purchasers, and payers.
- In the current payment system, the New Model should result in increased volume of services and quality of care provided by family physicians.
- The net financial impact of the New Model could be at minimum a 5% reduction in health care expenditures.
- Family physicians could use the New Model efficiency to increase compensation or to reduce work time.
- Alternative reimbursement methods that are compatible with the New Model would allow family physicians to share in the health care cost savings achieved as a result of effective and efficient delivery of care.
- Transition costs are a formidable barrier to transforming frontline health care and require immediate attention through additional payments in the current system or moving to more innovative models of payment directed toward value generation.

The New Model needs to be implemented now. Given the recognized need for improvements in the US health care system in the areas of quality, safety, access, and costs, there is no reason to delay.

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► **RECOMMENDATIONS**

Based on these conclusions, the task force makes the following recommendations:

Recommendation 6.1. A national demonstration project should be launched immediately, involving 10 to 20 family medicine practices of varying sizes, locations, and patient populations, to implement fully all elements of New Model. This 24- to 36-month project should be an "in vivo" exercise focused on demonstrating proof of concept. A careful multimethod evaluation program should be imbedded in the project to determine empirically the business and medical performance characteristics of the New Model.

Recommendation 6.2. One or more business entities should be created to facilitate the implementation of the New Model by providing products and services necessary for a turnkey implementation, as well as consultation on selective components of the model. This assistance organization should be launched in tandem with the demonstration project.

Recommendation 6.3. Federal and private sector leadership is needed at various levels to assure a coherent and sustained movement toward the New Model. This movement should include support for (1) experimental payment strategies, such as blended payment including fees per patient, fees for service, and incentives

for performance; and (2) standardization of data across health care settings in support of the New Model and the rest of the health care system.

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
February 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care

planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians
<http://www.futurefamilymed.org>

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians
<http://www.acponline.org/advocacy/?hp>

American Osteopathic Association
<http://www.osteopathic.org>

Good afternoon. My name is Virginia Ann La Noce. I am a Family Nurse Practitioner practicing in North New Portland. My practice, NP Family Medicine, is privately owned with me as the sole provider. I am living a dream I have had ever since I first heard of Independent Nurse Practitioners back in 1980. This dream was to have my own practice in a rural area providing care to members of the community in which I resided. But this dream has a nightmare aspect!! Too little reimbursement to cover cost and/or excessive labor and extensive knowledge, beyond my medical training, required to get reimbursement. The cost of maintaining the practice is constantly running nose to nose with the revenue. Each month I struggle to keep overhead low and revenue up. My husband works long hours and does a great job getting the best prices and the best deals on office and pharmaceutical supplies to keep my cost low. He also does a large amount of the scanning that's required to be paperless, maintains the eleven computers I need and the lan that connects them, spends hours each week putting together medical records requested by others and lobbies for me at the PAG, TAG and DHHS legislative committee. But his single biggest time requirement is spent trying to get Mainecare reimbursement. We still have not been reimbursed for patient visits as far back as 2004!!!!

No matter how hard I try, I cannot do much to increase my revenue. 70% of my visits are Mainecare. On every straight 99213 visit, I lose at least \$10. As you can see by the table of rates I have provided, Mainecare pays on average only 40% of the Medicare allowable rate but they require much additional effort to get that claim paid. This is wrong.

I realize it is a ludicrous idea, given current circumstances, to raise the level of reimbursement for Mainecare. Until we get some kind of fiscal stability in this state, it's not going to happen. We need to find other ways to help Primary Care Providers increase revenue or decrease overhead because as with any business, survival depends on "The Bottom Line". As much as the concept of providing healthcare is to provide service, it still has a business side. I would love to just provide care and not worry about the money, but I can't.

My thoughts on how we can do this might include:

1. **Allow providers to bill for "No Shows"**. Medicare allows this. If you do not show up for an appointment and you do not call to cancel, you should pay a penalty no matter who you are.
2. **When Mainecare is the secondary insurer, they should pay for copays and deductibles** up to their allowed amount for that code. Currently Mainecare pays nothing saying you've already been reimbursed by the primary. But the primary's reimbursement is based on you getting that copay. (When the primary is Mainecare then and only then will they pay the copays.) This is wrong.
3. **Simplify the procedure and paperwork for Mainecare reimbursement.** Why does the billing process have to be so intricate? Several times a week my billing person will comment about how now on the 1500 form she has to put this number in this box and change this number to this box or this number is not accepted anymore. WHY? How many hoops do we have to jump through to get paid for a service we have already provided? Why do the hoops keep on changing? I believe these obstacles are constantly being put in the way in hopes that we might just give up trying to collect what is owed us.

Commission to Study Primary Care Medical Practice

COMPENSATION COMPARISON

Regular office visits:

	MAINECARE	MEDICARE	ANTHEM
99212	\$19.85	\$28.92	\$51.80
99213	\$28.94	\$47.63	\$70.59
99214	\$42.50	\$72.24	\$110.69

Well child checks and preventative visits:

	MAINECARE	AETNA	ANTHEM
99391	\$43.75	\$77.00	\$95.64
99392	\$44.50	\$82.00	\$106.49
99393	\$45.25	\$82.00	\$105.50
99394	\$46.50	\$90.00	\$115.86
99395	\$47.78	\$91.00	\$116.84
99396	\$47.78	\$100.00	\$129.17
99397	\$47.78	\$110.00	\$142.97