Comparing Physician and Dentist Fees Among Medicaid Programs

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Prepared for the Medi-Cal Policy Institute by

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Acknowledgments

This project was dependent on the willingness of state Medicaid staff throughout the country to participate in the fee survey effort. The fact that a 100 percent response rate was achieved speaks for itself regarding the amount of appreciation that is owed state Medicaid agencies. State agency staffs' politeness, helpful demeanor, and enthusiasm for "making Medicaid better" came across resoundingly in this project. In return, we certainly hope that the comparative information in this report, which we have sent to each Medicaid agency, will be of strong interest and policy-making value.

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Executive Summary

Background

This study compares fee-for-service (FFS) payment rates in the Medi-Cal program to the rates paid by every other state's Medicaid program, and contrasts the states' fees as a percentage of Medicare's average allowed charge.

FFS rates are important in shaping the broader Medi-Cal program. Despite its generous benefits package, Medi-Cal, like other state Medicaid programs across the country, is often considered to be a second-class system of coverage. Many attribute this, at least partially, to low reimbursement levels that limit the involvement of "mainstream" providers. Fee levels for front-line health professionals play a critical role in the way health care is accessed by and delivered to California's Medi-Cal beneficiaries. The lower the fees, the more difficult it is to assure beneficiaries access to a comprehensive provider network similar to what is available to Medicare beneficiaries and privately insured persons.

Low fees also make it more difficult to access providers who already participate in Medi-Cal. These providers often find it necessary to close their practices to new Medi-Cal patients. They also are more likely to carry a high patient load, resulting in longer waiting times and restrictions on the amount of time practitioners can spend with each patient.

The specific goals of this study are to:

- **Provide a national context.** While it is commonly held that Medi-Cal's physician fees are less than robust, policymakers need objective information about the relative adequacy of the Medi-Cal payment schedule as compared to other states.

- **Measure the impact of Medi-Cal's recent fee increases.** Given that Medi-Cal fees for most physician services were increased as of August 1, 2000, this was a particularly opportune time to conduct a national comparison. This study quantifies the degree to which the recent increases have changed Medi-Cal's ranking relative to other states' Medicaid programs.

- **Examine payment variations across clinical categories.** This study measures the relative adequacy of Medi-Cal fees in different clinical areas (e.g., surgery, maternity,

evaluation and management), and identifies where Medi-Cal fees are lowest relative to Medicare's rates.

Overview of Survey Approach

The Lewin Group, a health care consulting firm based in Falls Church, Virginia, was selected to conduct the study. The study was conducted through a survey of each state's Medicaid fees. Roughly 50 procedures were selected for the national comparison.

For most of the targeted procedures, fees were compiled and compared across 51 Medicaid programs (the 50 states plus the District of Columbia). The fees collected represent the amount most typically applied when the service is rendered to a fee-for-service Medicaid patient by a private practitioner. To the extent different amounts are paid to hospital or clinic-based providers, by capitated health plans contracting with Medicaid, or on behalf of special Medicaid population subgroups, these alternative fees were not factored into the comparisons.

In order to put each state's Medicaid FFS payments in context with another large payer, average Medicare-allowed charges for each surveyed fee were calculated for each state. Lewin Group staff also developed geographic cost factors depicting average physician practice costs in each state. Rankings for each state were calculated both before and after applying these geographic cost adjustment factors.

Once all the data were collected, analyzed, and edited, each state's Medicaid fees were ranked according to three scales:

1. The dollar value of each fee;
2. The fee as a percentage of the average Medicare-allowed charge in the state; and
3. The dollar value of each fee after adjusting for geographic physician practice cost differences.

California was ranked across all states, then separately across the ten states with the largest Medicaid programs. The impact of the recent Medi-Cal fee increases (which became effective August 1, 2000) were also evaluated, and this study illustrates how these increases "moved California up" in terms of the state-by-state rankings.

Summary of Findings

The major findings of this study are summarized below.

- Medi-Cal FFS payments to physicians are below average when contrasted with all states' fee schedules. Medi-Cal's ranking among 51 Medicaid programs for an aggregation of physician services was 37th in terms of the unadjusted fees, 42nd when all states' fees were adjusted by geographic cost factors, and 40th as a percentage of the average Medicare-allowed charge. On average, Medi-Cal's physician fees represented 65.2 percent of statewide average Medicare-allowed charges.

- Medi-Cal's payment levels as compared to Medicare and other states' Medicaid fees vary considerably from one clinical area to the next. Medi-Cal appears to be a relatively strong payer of surgical services, laboratory services, and dental services and relatively weak as

a payer of evaluation and management services, maternity/delivery, psychiatry, and vision services.

- When California's fees are compared to the ten states with the largest Medicaid expenditures as opposed to all states, California's fees rank more favorably – right at the median. None of the nation's ten largest states ranked among the top 25 states on any of the aggregated fee schedule statistics. Larger states have found it particularly challenging to bring their Medicaid fees in line with those of other major payers (e.g., Medicare).

- The Medi-Cal fee increases that went into effect August 1, 2000, were substantial and were targeted at those areas (e.g., evaluation and management services) where Medi-Cal physician payments had been relatively low. It is estimated that these increases brought Medi-Cal from 57.7 percent to 65.2 percent of California's average Medicare payment rates across all physician services.

- While many states' Medicaid fee schedules have remained unchanged over time, the trend has clearly been in the direction of bringing Medicaid payments more closely in line with mainstream payers' payments. Fourteen states' physician payments now average at least 90 percent of Medicare, and twenty-six states' payments average at least 80 percent of Medicare. Only six states' payments average below 60 percent of Medicare.

Rates Roundtable

On March 5, 2001, the findings from this study were presented at a Medi-Cal Rates Roundtable in Sacramento, California, hosted by the Medi-Cal Policy Institute. Participants included state legislative staff, Department of Health Services staff, physician association leaders, and Medi-Cal health plan staff. While the purpose of the gathering was not necessarily to form a consensus about which policy options were most appropriate to pursue, there was agreement on the following issues:

- The August 1, 2000, increases were probably not sufficient to bring physicians into the Medi-Cal program who are not currently participating (or who participate on a limited basis). It was urged that a study to accurately quantify the degree to which California's physicians accept Medi-Cal patients should be undertaken in order to understand the access opportunities and barriers that come with carrying a Medi-Cal insurance card.

- The August 2000 increases were nonetheless significant in size and may have been of substantial short-term value in encouraging physicians to continue accepting Medi-Cal patients.

- While it is unfortunate that Medi-Cal physician payments are weakest in many areas where access is most critical (e.g., office visits and maternity services), the recent fee increases were pointedly targeted toward bolstering up these parts of the fee schedule. This serves as a useful model for allocating future fee increases.

- The wide gap between Medi-Cal fees and "mainstream" payer payments still remains. The sheer size of the Medi-Cal program makes it unlikely that sufficient funds will become available to implement a one-time adjustment that allows Medi-Cal to move up to, or very near, Medicare fee levels. Thus, if a mainstream Medi-Cal provider delivery system is the long-term objective, it will be critical that policymakers continue to increase Medi-Cal fees incrementally over time.

- Annual increases of a few percentage points will probably be necessary just to keep Medi-Cal where it is now, relative to other payers.

- It was urged that increases in the fee-for-service Medi-Cal program continue to be factored into the capitation rates paid to Medi-Cal health plans. These plans face the same constraints in attracting and maintaining a quality delivery system as any other payer.

- California's broader ability to attract and retain physicians is of great concern. While Medi-Cal reimbursement rates may be a relatively small factor in determining where a physician chooses to practice, the state's large HMO penetration among Medicare and privately-insured individuals makes it particularly difficult for physicians to "make up losses" incurred through their participation in Medi-Cal.

Conclusions

The fiscal trade-offs involving various Medi-Cal policy options, as well as trade-offs between Medi-Cal and other public programs, are extremely complex. The advisability of further Medi-Cal fee increases needs to be evaluated against competing demands for State funds. The Medi-Cal Policy Institute and the authors of this study are not taking any policy position regarding the degree to which Medi-Cal fees should be increased or decreased. We hope, however, that the findings from this study lend valuable support to the policy-making process.

I. Introduction

Medi-Cal's fee-for-service payment rates play a critical role in the way health care is accessed by and delivered to California's Medi-Cal beneficiaries. Despite its generous benefits package – including pharmacy coverage, long-term care, and minimal patient cost sharing – Medi-Cal, like other Medicaid programs across the country, is often considered to be a second class system of coverage. Many attribute this at least partially to low reimbursement levels that discourage the involvement of "mainstream" physicians and dentists in the program. The lower the fees, the more difficult it is to assure beneficiaries access to a comprehensive provider network similar to what is available to Medicare beneficiaries and privately-insured individuals.

The impact of Medi-Cal fee levels reaches beyond the nearly 50 percent of Medi-Cal beneficiaries who still receive services through the fee-for-service delivery system. Because Medi-Cal managed care capitation rates are bounded by the Medi-Cal fee schedule through the federal "Upper Payment Limit" requirement, California's 2.6 million Medi-Cal managed care beneficiaries are also impacted by fee-for-service payment rates.[1]

As documented in an earlier report by the Medi-Cal Policy Institute, Medi-Cal fee-for-service rates experienced little growth in the 1990s in spite of spiraling health care costs.[2] This trend was cited by a number of reports as a barrier to physician participation in the program, and raised concerns about access to health care services for Medi-Cal beneficiaries. However, in the 1998-99 and 1999-2000 California state budgets, Medi-Cal rates were increased for the first time in 12 years for a number of specific services. And, in the 2000-01 budget, the California legislature approved an across-the-board increase for physicians totaling $133 million.

This study, commissioned by the Medi-Cal Policy Institute and conducted by The Lewin Group, compares fee-for-service payment rates in the Medi-Cal program to those paid by every other state's Medicaid program. The goals were to:

- **Provide a national context**. Nearly all state Medicaid programs have faced the same fundamental tensions that confront California's Medi-Cal system – historically low Medicaid payment levels to physicians and dentists that may be both very valuable – and very costly – to increase. It is not news to providers that Medi-Cal payments are low relative to other California payers. However, it is helpful to place Medi-Cal's payments in a national context, comparing Medi-Cal's rates to the Medicaid payments made for the same services in other states.

- **Measure the impact of Medi-Cal's recent fee increases**. This is an opportune time to assess Medi-Cal payments, given that payment rates for many Medi-Cal fees increased substantially in August 2000. This study quantifies the degree to which these recent increases have changed Medi-Cal's ranking, relative to other states' Medicaid programs.

- **Examine payment variations across clinical categories**. This study identifies the relative adequacy of Medi-Cal fees in different clinical areas (e.g., surgery, maternity, evaluation and management). Many states have moved to Medicare's resource-based relative value schedule (RBRVS) methodology that seeks to maintain relative fee parity across the realm of physician services. This study identifies those clinical areas where Medi-Cal fees are lowest, relative to Medicare's rates.

This study is part of an ongoing effort by the Medi-Cal Policy Institute to provide objective analysis of the Medi-Cal program's payment policies. On March 5, 2001, the findings from this research were presented at a Medi-Cal Rates Roundtable in Sacramento, California. Participants included state legislative staff, Department of Health Services staff, physician association members, and Medi-Cal health plan representatives. The Medi-Cal Policy Institute is committed to fostering informed discussion and sound decision-making in the area of Medi-Cal payment.

II. Methodology

A. Survey Design

The predominant source of the collected data was a survey submitted to each Medicaid agency. A copy of the survey instrument is presented in the Appendix.[3] The survey was administered through a combination of facsimiles, regular and electronic mail, and telephone follow-up calls.

A full national comparison of all the Medicaid physician and dental fees would be an overwhelmingly lengthy and expensive undertaking. Thousands of physician procedure codes are used, for example. Therefore, the project focused on a selected subset of 52 procedures chosen to encompass a wide range of service categories. The selected procedures and medical service categories, as shown in Exhibit A, tended to be among the highest dollar volume procedures in each category. The volume of Medi-Cal procedures in the fee-for-service setting during the second half of calendar year 1998 is also shown in Exhibit A.

The codes selected comprised at least 25 percent of total Medi-Cal claims payments in nine of the twelve medical service categories, as shown in Exhibit B. Although the selected codes constitute only a fraction of all procedures that can be billed to Medicaid, they represent approximately one-third of the dollars paid to physicians and dentists in the Medi-Cal program. Given that Medi-Cal recipients are extensively enrolled in managed care, the selected codes probably represent an even greater proportion of the physician payments in most other states (where, for example, fee-for-service payments for newborn deliveries are likely to constitute a much higher proportion of overall physician payments in other states than in California).

Of the 52 procedures selected, 41 reflect the current procedural terminology (CPT) codes used by physicians. These CPT codes included ten categories of physician services: evaluation and management, anesthesia, surgery, maternity/delivery, radiology, laboratory/pathology, psychiatry, medicine and testing, vision/ophthalmology, and audiology/hearing. Three dental procedures were also included. The remaining non-CPT codes involved selected vision and hearing services, and durable medical equipment.

Exhibit A: Procedures Selected for Fee Survey

Procedure Code	Description	Frequency Count, Medi-Cal FFS Claims, June-Dec. 1998
Evaluation and Management Services		
99203	Office visit, new patient, low complexity	242,271
99204	Office visit, new patient, moderate complexity	248,282
99213	Office visit, established patient, low complexity	1,454,559
99222	Initial hospital visit, moderate complexity	31,930
99232	Subsequent hospital visit, moderate complexity	268,788
99283	Emergency department visit, moderate complexity	210,238
99431	History and examination of the normal newborn	54,305
Anesthesia Services		
00840	Anesthesia, surgery of abdomen	11,064
00850	Anesthesia, C section	12,432
00955	Analgesia, vaginal delivery One 15-minute time unit	5,995
Surgical Services (excluding maternity/delivery)		
11721	Debride nail	22,053
29881	Knee arthroscopy w/ meniscectomy	594
33533	CABG, arterial, single	757
43239	Upper gastrointestinal endoscopy	11,471
66984	Cataract removal with insertion of lens	6,136
Maternity/Delivery		
59025	Fetal non-stress test	61,852
59400	Obstetric care package, with vaginal delivery	24,623
59409	Vaginal delivery only	33,562
59510	Obstetric care package, with cesarean delivery	11,199
59514	Caesarean delivery only	18,701
Radiology		
70450	Computerized axial tomography, head or brain	36,669
71020	Chest x-ray, two views	214,129
76092	Mammography screening, bilateral	28,384
76805	Echography, pregnant uterus	125,141
Lab/Pathology		
80074	Hepatitis panel	98,187
85025	Hemogram and platelet count (CBC)	518,802
87490	Infectious agent, DNA/RNA	93,401
87590	Infectious agent, DNA/RNA	86,941
Psychiatry		
90804	Individual psychotherapy, 20-30 minutes	388
90805	Individual psychotherapy, 20-30 minutes	1,469
90806	Individual psychotherapy, 45-50 minutes	1,466
90807	Individual psychotherapy, 45-50 minutes	1,615

Exhibit A: Procedures Selected for Fee Survey (continued)

Procedure Code	Description	Frequency Count, Medi-Cal FFS Claims, June-Dec. 1998
Medicine and Testing		
97140	Manual therapy techniques	105,121
93000	Electrocardiogram, routine	117,813
93307	Echocardiography, transthoracic	74,110
94010	Spirometry, including graphic record	46,578
94060	Bronchospasm evaluation	43,911
95904	Nerve conduction study	182,668
Vision/Ophthalmology		
V2020	Frames, purchases	237,857
92004	Comprehensive eye exam, new patient	103,268
92014	Comprehensive eye exam, established patient	70,102
Audiology/Hearing		
V5010	Assessment for hearing aid	8,610
V5050	Hearing aid, monaural, in the ear	5,839
92525	Evaluation of swallowing and oral function	20,459
Dental Services		
D0110	Oral evaluation	509,255
D1110	Prophylaxis, adult	259,444
D2150	Amalgam, two surfaces, permanent	492,367
D7110	Extraction, single tooth	169,120
Durable Medical Equipment		
E0245	Tub stool or bench	18,163
E0450	Volume ventilator, stationary or portable	4,037
L3020	Foot insert, removable, molded	47,325
L8160	Gradient compression stocking, full length	123,786

Exhibit B. Percentage of Total Medi-Cal Payments Associated with Survey Codes

Based on Medi-Cal claims payments from July-December, 1998

Service Categories Included in Survey	Number of Survey Procedures	Percent of Total Category Cost Represented in Survey
Evaluation and Management Services	7	48%
Anesthesia Services	4	32%
Surgical Services (excluding maternity/delivery)	5	11%
Maternity/Delivery Services	5	90%
Radiology Services	4	27%
Laboratory/Pathology Services	4	11%
Psychiatry Services	4	22%
Medicine and Testing Services	6	37%
Vision/Ophthalmology Services	3	81%
Audiology/Hearing Services	3	54%
Dental Services	3	28%
Durable Medical Equipment, Supplies, Orthotics, and Prosthetics	4	26%
All Service Categories	**52**	**34%**

B. Handling of Multiple Payment Rates for the Same Service

In several states, including California, Medicaid fees for a given service vary depending on criteria such as patient age, gender, provider specialty, setting in which the provider practices, and participation in a primary care case management program. Detailed, state-by-state descriptions of which fees were entered in our comparative spreadsheets, and what fee variations exist in a given state's Medicaid program, are available on the Medi-Cal Policy Institute's Web site (www.medi-cal.org). This study focused on the payments most commonly made to a physician in private practice, and did not consider the following types of arrangements:

- Cost-based payments that states make to Federally Qualified Health Centers;
- Other clinic rates that were not matched to the exact mix of services rendered;
- Payments made to facility-based practitioners (e.g., hospital-based physicians) as distinguished from those made to private practitioners; and
- Medicaid payments that were reduced due to other coverage held by the beneficiary (we focused on Medicaid's maximum allowed payment for a given procedure, as opposed to the average amount actually paid by Medicaid for a given procedure).

In the scope of this study it was not possible to take the myriad payment distinctions made by Medicaid programs into account. It is our opinion that California's rankings as compared to other states would not change substantially if the many fee adjustments made in the Medi-Cal program were fully taken into account. Medi-Cal makes both upward adjustments (e.g., many fees for pediatric patients are approximately 10 percent above those for adults), and downward adjustments (e.g., payments in the outpatient hospital setting are typically 20 percent lower than in the office setting). Medi-Cal's adult rates were used in this study; most children are enrolled in managed care programs and the Medi-Cal fee schedule is most frequently used for services rendered to adults.

C. Medicare-allowed Charges

Medicare tends to be the single largest payer of health care services in the country. An important aspect of the study was to compare each state's Medicaid fees to the charges allowed by Medicare. Data on these Medicare-allowed fees – for each state and CPT code – are derived from the November 2, 1999 *Federal Register* for calendar year 2000. For states with multiple Medicare rate localities, statewide average Medicare-allowed charges were calculated using the Geographical Practice Cost Indices (GPCI) in effect across the state. The average was derived by weighting each locality's GPCI by the total population in that locality.

State level fees for clinical laboratory services were obtained from the Medicare clinical lab fee schedule for 2000.

D. Geographic Adjustment Factors

The adequacy of physician payment levels is determined not simply by the absolute values of the amounts paid, but also by how these amounts compare to local costs of practicing medicine. Medicaid fees were therefore compared across states before and after applying Geographic

Adjustment Factors (GAFs). GAFs reflect the relative costs of physician's practice expense, malpractice insurance, and work in a given state compared to the national average. The GAFs used in this analysis were derived from Geographic Practice Cost Indices developed by HCFA for the Medicare program.

The Geographic Practice Cost Indices take into account three components:

- Physician work, as measured by the median earnings for professional specialties;

- Practice expense, which includes wages for clerical and nursing staff, rent for commercial office space, costs of medical equipment and supplies, and other miscellaneous supplies; and

- Costs of medical malpractice insurance.

Geographic Practice Cost Indices are developed by HCFA for each Carrier/Locality area within the Medicare Program. In cases where multiple Carrier/Locality areas exist within a single state (e.g., California has nine Medicare payment regions), we developed weighted average Geographic Practice Cost Indices for those states based on the proportion of their total population in specific localities.

A Geographic Adjustment Factor was computed for each state as the weighted average of the three components of the Geographic Practice Cost Indices. The weights for each Geographic Practice Cost Index component are as follows:

Physician Work	54.5%
Practice Expense	42.3%
Malpractice Expense	3.2%

The Geographic Adjustment Factors used to adjust each state's fees are shown in Exhibit C. In high-cost areas, fees were lowered, and in low-cost areas, fees were raised. Alaska, which had the nation's highest GAF (1.125), had the largest downward adjustments. The largest upward adjustment to fees occurred in South Dakota, where the GAF was 0.893. The weighted average GAF used for California is 1.067, which resulted in a downward adjustment of 6.3 percent to the Medi-Cal fees when the GAF was applied.[4]

Exhibit C: Geographic Adjustment Factors

State	Geographic Adjustment Factor
Alabama	0.930
Alaska	1.125
Arizona	0.991
Arkansas	0.894
California	**1.067**
Colorado	0.974
Connecticut	1.101
Delaware	1.018
District of Columbia	1.096
Florida	1.005
Georgia	0.974
Hawaii	1.075
Idaho	0.919
Illinois	1.018
Indiana	0.936
Iowa	0.916
Kansas	0.933
Kentucky	0.924
Louisiana	0.945
Maine	0.956
Maryland	1.005
Massachusetts	1.062
Michigan	1.043
Minnesota	0.964
Mississippi	0.902
Missouri	0.940
Montana	0.913
Nebraska	0.901
Nevada	1.016
New Hampshire	1.008
New Jersey	1.083
New Mexico	0.938
New York	1.101
North Carolina	0.935
North Dakota	0.910
Ohio	0.971
Oklahoma	0.916
Oregon	0.962
Pennsylvania	0.985
Rhode Island	1.045
South Carolina	0.923
South Dakota	0.893
Tennessee	0.929
Texas	0.961
Utah	0.936
Vermont	0.964
Virginia	0.953
Washington	0.988
West Virginia	0.921
Wisconsin	0.956
Wyoming	0.928

III. Presentation of Findings

A. Medi-Cal Fees

Medi-Cal fees for each of the selected survey procedures are presented in Exhibit D, which summarizes the following information by selected procedure:

- Medi-Cal fee prior to August 1, 2000;
- Medi-Cal fee as of August 1, 2000 (current fee);
- Current Medi-Cal fee as a percentage of the average Medicare-allowed charge in California; and
- Current Medi-Cal fee after applying the Geographic Adjustment Factor (GAF).

At least two observations can be made upon review of the percentage of Medicare-allowed charge figures in Exhibit D. First, there is substantial variation at the individual CPT code level, with payments ranging from 40 to over 100 percent of Medicare. Second, despite this variation, the Medi-Cal fees vis-à-vis Medicare tend to be fairly similar *within* each clinical category. For example, Evaluation and Management payments tend to hover around 60 percent of Medicare, Surgical Services payments tend to be near 85 percent of Medicare[5], Medicine and Testing payments are clustered around 75 percent of Medicare, and Laboratory Services payments are consistently nearly 100 percent of Medicare.

These Medicare figures are a moving target across California: while Medi-Cal fees are constant statewide, Medicare-allowed charges vary across nine California regions. Medicare's payments vary by about 15 percentage points between the highest-cost region (San Francisco) and the various, mostly rural, areas that comprise a "Rest-of-State" region. Thus, in high Medicare fee areas such as San Francisco and Santa Clara, Medi-Cal payments as a percentage of Medicare are lower than those shown in Exhibit D. In rural areas, Medi-Cal constitutes a higher percentage of Medicare's fees than the statewide average figures in Exhibit D indicate.

The bar chart in Exhibit E summarizes Medi-Cal's fees in each area as a percentage of the statewide average Medicare-allowed charge. These figures indicate the Medi-Cal fee levels both before and after a broad set of Medi-Cal fee increases went into effect on August 1, 2000.

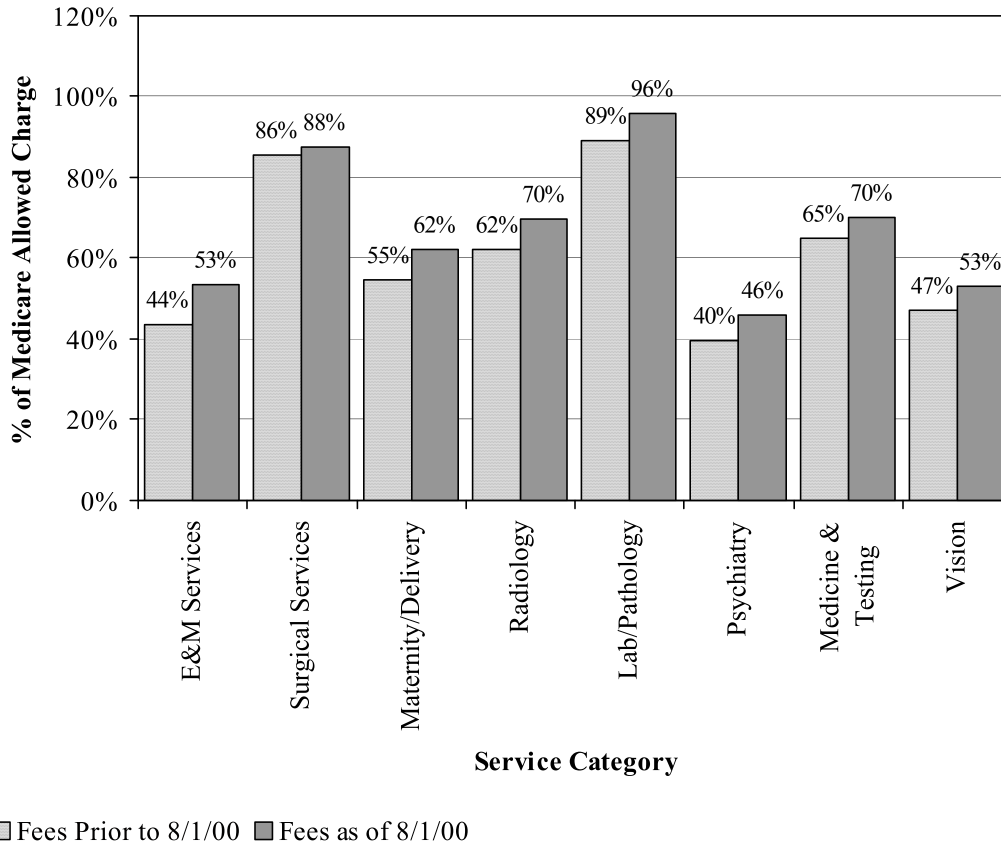
Exhibit D: Summary of Medi-Cal Fees, Selected Procedures

Procedure Code	Description	Medi-Cal Prior to 8/1/00	Current Medi-Cal Fee (as of Aug 2000)	Current Medi-Cal Fee, % of Medicare-allowed Charge	Current Medi-Cal Fee, Geographically Adjusted
Evaluation and Management Services					
99203	Office visit, new patient, low complexity	$50.50	$57.20	60%	$53.62
99204	Office visit, new patient, moderate complexity	$60.80	$68.90	50%	$64.59
99213	Office visit, established patient, low complexity	$18.18	$24.00	47%	$22.50
99222	Initial hospital visit, moderate complexity	$64.64	$73.20	60%	$68.62
99232	Subsequent hospital visit, moderate complexity	$33.33	$37.80	64%	$35.43
99283	Emergency department visit, moderate complexity	$31.85	$44.60	67%	$41.81
99431	History and examination of the normal newborn	$45.45	$49.30	61%	$46.22
Anesthesia Services					
00840	Anesthesia, surgery of abdomen	$68.23	$75.93		$71.18
00850	Anesthesia, C section	$96.90	$107.82		$101.07
00955	Analgesia, vaginal delivery	$69.26	$77.11		$72.29
Time unit	One 15-minute time unit		$14.01	79%	$13.13
Surgical Services (excluding maternity/delivery)					
11721	Debride nail	$29.41	$33.13	75%	$31.06
29881	Knee arthroscopy w/ meniscectomy	$551.08	$551.00	83%	$516.52
33533	CABG, arterial, single	$1,871.92	$1,871.92	88%	$1,754.79
43239	Upper gastrointestinal endoscopy	$234.10	$234.18	88%	$219.53
66984	Cataract removal with insertion of lens	$1,005.21	$1,005.21	125%	$942.31
Maternity/Delivery					
59025	Fetal non-stress test	$20.27	$22.80	50%	$21.37
59400	Obstetric care package, with vaginal delivery	$961.20	$1,088.56	69%	$1,020.45
59409	Vaginal delivery only	$480.60	$544.28	62%	$510.22
59510	Obstetric care package, with cesarean delivery	$961.27	$1,088.62	61%	$1,020.50
59514	Caesarean delivery only	$480.64	$544.72	52%	$510.64
Radiology					
70450	Computerized axial tomography, head or brain	$187.18	$196.84	78%	$184.52
71020	Chest x-ray, two views	$22.92	$25.98	66%	$24.35
76092	Mammography screening, bilateral	$50.42	$67.50	97%	$63.28
76805	Echography, pregnant uterus	$83.28	$94.32	64%	$88.42
Lab/Pathology					
80074	Hepatitis panel	$51.66	$62.94	96%	$59.00
85025	Hemogram and platelet count (CBC)	$10.11	$10.11	94%	$9.48
87490	Infectious agent, DNA/RNA	$27.07	$27.07	98%	$25.38
87590	Infectious agent, DNA/RNA	$27.07	$27.07	98%	$25.38
Psychiatry					
90804	Individual psychotherapy, 20-30 minutes	$24.60	$29.18	45%	$27.35
90805	Individual psychotherapy, 20-30 minutes	$26.08	$32.98	45%	$30.92
90806	Individual psychotherapy, 45-50 minutes	$41.00	$46.44	46%	$43.53
90807	Individual psychotherapy, 45-50 minutes	$43.46	$49.22	46%	$46.14

Exhibit D: Summary of Medi-Cal Fees, Selected Procedures (continued)

Procedure Code	Description	Medi-Cal Prior to 8/1/00	Current Medi-Cal Fee (as of Aug 2000)	Current Medi-Cal Fee, % of Medicare-allowed Charge	Current Medi-Cal Fee, Geographically Adjusted
Medicine and Testing					
97140	Manual therapy techniques	$19.61	$22.21	78%	$20.82
93000	Electrocardiogram, routine	$24.60	$24.60	77%	$23.06
93307	Echocardiography, transthoracic	$132.53	$150.10	64%	$140.71
94010	Spirometry, including graphic record	$24.60	$24.60	75%	$23.06
94060	Bronchospasm evaluation	$41.00	$45.03	72%	$42.21
95904	Nerve conduction study	$26.24	$26.24	77%	$24.60
Vision/Ophthalmology					
V2020	Frames, purchases	$21.31	$21.31	34%	$19.98
92004	Comprehensive eye exam, new patient	$47.45	$57.79	51%	$54.17
92014	Comprehensive eye exam, established patient	$47.45	$46.44	56%	$43.53
Audiology/Hearing					
V5010	Assessment for hearing aid	$40.54	$52.70		$49.40
V5050	Hearing aid, monaural, in the ear		$883.80		$828.50
92525	Evaluation of swallowing and oral function	$64.87	$73.47	66%	$68.87
Dental Services					
D0110	Oral evaluation		$25.00		$23.44
D1110	Prophylaxis, adult		$40.00		$37.50
D2150	Amalgam, two surfaces, permanent		$48.00		$45.00
D7110	Extraction, single tooth		$45.00		$42.18
Durable Medical Equipment					
E0245	Tub stool or bench	$55.07	$55.07		$51.62
E0450	Volume ventilator, stationary or portable	$6,577.90	$657.79		$616.63
L3020	Foot insert, removable, molded	$72.38	$72.38		$67.85
L8160	Gradient compression stocking, full length	$39.43	$39.43		$36.96

Exhibit E: Medi-Cal Average Percent of Medicare-allowed Charge by Service Category



These averages are derived primarily by using the Medi-Cal procedure volume in Exhibit A to weight each procedure. Some weighting adjustments were made for surgical codes due to the fact that Medi-Cal is often the secondary payer to Medicare; in such instances the maximum Medi-Cal fee is not used.

While the figures in Exhibit E underscore the substantial variation in Medi-Cal fees across clinical areas, it is important to note that the recent (August 2000) Medi-Cal fee increases were targeted at procedures where the Medi-Cal fees lagged furthest behind Medicare. Procedures in areas such as surgery, where payments are relatively high vis-à-vis Medicare, generally received much smaller increases in August 2000. Conversely, fees for many procedures in the "weaker" categories in Exhibit E (such as Evaluation and Management) were raised by more than 10 percent effective August 1, 2000. To the extent that this approach to allocating fee increases is repeated, the variations depicted in Exhibit E between physician service categories will steadily erode.

B. Medicaid Fees from All States

Detailed baseline fee information for all 50 states and the District of Columbia is available on the Medi-Cal Policy Institute's Web site (www.medi-cal.org). This lengthy set of tables includes the following information for each procedure:

- The state's Medicaid fee as of December 2000;
- The geographically adjusted Medicaid fee; and
- The Medicaid fee as a percentage of the average Medicare-allowed charge in that state.

1. Fee-Specific Rankings

Exhibit F summarizes how Medi-Cal's fees compare with those of all the other Medicaid programs. A ranking of "1" indicates that the state's fee is the highest paid by any Medicaid program, whereas a ranking of "51" constitutes the lowest payment. The subtotal in each category indicates California's average ranking when each state's fees in that category are weighted by a standardized frequency table. The frequency weights used are the Medi-Cal volume for each procedure during the second half of calendar year 1998.

Exhibit F also indicates the number of states for which a Medicaid fee was obtained. For most procedures, this number is 51 and thus reflects a full national compilation. For other surveyed procedures where fewer responses were obtained, rankings were typically not calculated.

Detailed ranking information for each of the 50 states and the District of Columbia is available on the Medi-Cal Policy Institute's Web site (www.medi-cal.org).

Exhibit F: California Rankings Summary

Procedure Code	Description	Number of States for Which Fee Was Obtained	Medi-Cal's Rank Among Respondents: Unadjusted Fee	Geographically Adjusted Fee	Percentage of Medicare-allowed Charge
Evaluation and Management Services					
99203	Office visit, new patient, low complexity	51	22	27	27
99204	Office visit, new patient, moderate complexity	51	34	37	37
99213	Office visit, established patient, low complexity	51	44	46	46
99222	Initial hospital visit, moderate complexity	51	30	34	34
99232	Subsequent hospital care, moderate complexity	51	25	32	30
99283	Emergency department visit, moderate complexity	51	23	28	28
99431	History and examination of the normal newborn	51	37	41	41
	E&M Weighted Average Ranking	**51**	**34**	**41**	**41**
Surgical Services (excluding maternity/delivery)					
11721	Debride nail	51	20	29	30
29881	Knee arthroscopy w/ meniscectomy	51	19	28	28
33533	CABG, arterial, single	51	15	24	24
43239	Upper gastrointestinal endoscopy	51	13	20	24
66984	Cataract removal with insertion of lens	51	13	14	15
	Surgical Services Weighted Average Ranking	**51**	**13**	**16**	**24**
Maternity/Delivery					
59025	Fetal non-stress test	51	44	44	43
59400	Obstetric care package with vaginal delivery	40	29	33	33
59409	Vaginal delivery only	51	46	46	46
59510	Obstetric care package with cesarean delivery	41	35	35	35
59514	Caesarean delivery only	51	47	47	46
	Maternity Weighted Average Ranking*	**51**	**46**	**46**	**46**
Radiology					
70450	Computerized axial tomography, head or brain	51	21	25	31
71020	Chest x-ray, two views	51	30	36	37
76092	Mammography screening, bilateral	51	12	18	12
76805	Echography, pregnant uterus	51	30	36	36
	Radiology Weighted Average Ranking	**51**	**24**	**33**	**35**
Lab/Pathology					
80074	Hepatitis panel	51	18	27	26
85025	Hemogram and platelet count (CBC)	51	30	35	33
87490	Infectious agent, DNA/RNA	51	30	31	31
87590	Infectious agent, DNA/RNA	51	30	31	31
	Lab/Pathology Weighted Average Ranking	**51**	**22**	**31**	**26**
Psychiatry					
90804	Individual psychotherapy, 20-30 minutes	45	37	39	39
90805	Individual psychotherapy, 20-30 minutes	44	37	40	40
90806	Individual psychotherapy, 45-50 minutes	44	40	40	40
90807	Individual psychotherapy, 45-50 minutes	43	39	39	39
	Psychiatry Weighted Average Ranking	**43**	**39**	**39**	**39**

Exhibit F: California Rankings Summary (continued)

Procedure Code	Description	Number of States for Which Fee Was Obtained	Medi-Cal's Rank Among Respondents: Unadjusted Fee	Geographically Adjusted Fee	Percentage of Medicare-allowed Charge
Medicine and Testing					
97140	Manual therapy techniques	51	16	24	24
93000	Electrocardiogram, routine	51	17	27	30
93307	Echocardiography, transthoracic	51	27	34	36
94010	Spirometry, including graphic record	51	25	33	35
94060	Bronchospasm evaluation	51	24	31	34
95904	Nerve conduction study	51	21	29	29
	Medicine/Testing Weighted Average Ranking	**51**	**25**	**31**	**33**
Vision/Ophthalmology					
92004	Comprehensive eye exam, new patient	51	25	28	28
92014	Comprehensive eye exam, established patient	51	24	31	32
	Vision Weighted Average Ranking	**51**	**26**	**30**	**30**
Dental Services					
D1110	Prophylaxis, adult	45	6	15	NA
D2150	Amalgam, two surfaces, permanent	48	29	34	NA
D7110	Extraction, single tooth	48	19	28	NA
	Dental Services Weighted Average Ranking	**45**	**21**	**27**	**NA**

* The Maternity Weighted Average only includes codes 59025, 59409, and 49514.

Weighted average rankings are provided where the survey response rate was at or near 100 percent. These include: Evaluation and Management, Surgical Services, Maternity/Delivery, (only codes 59025, 59409, and 59514 were included in the weighted average calculations, however, since the global delivery codes of 59400 and 59514 are not used in many Medicaid programs[6]), Radiology, Lab/Pathology, Psychiatry, Medicine and Testing, and Vision/Ophthalmology (the code for Frames/Purchases, V2020, was not used in several of the states and thus was not included in the weighted average ranking calculations).

Anesthesia codes were excluded from the rankings due to a low response rate (roughly 20 states provided fees for the requested anesthesia codes) and to inconsistencies in the interplay between the base fee and compensation for an anesthesiologist's time. Also due to low response rates, rankings were not produced for audiology services for durable medical equipment (DME) codes. For DME, there were also some inconsistencies in the reported fees regarding whether the rental or purchase price was provided.

Within the 31 procedures that were available for all 51 Medicaid programs, California's highest ranking is 12th, for a radiological mammography screening (CPT 76092). California's worst ranking is 47th, for a caesarian section delivery code (CPT 59514).

As might be expected given the Medi-Cal fee variations described earlier, California's rankings within the 51 Medicaid programs are fairly consistent *within* clinical areas, but vary substantially *between* clinical areas. California's surgical fees often rank among the top 20 nationally, whereas Medi-Cal's payments for maternity/delivery procedures collectively rank 46th.

Given the fact that the Geographical Adjustment Factors (GAFs) lower each Medi-Cal fee, California's fees compare more favorably to other states prior to applying the GAFs. Typically, California's ranking after applying the GAFs worsened by about four places. When states' Medicaid payments were ranked based on the percentage of Medicare-allowed charges, California's rankings were closely similar to its GAF rankings.

2. Aggregated Rankings

Creating an aggregate ranking of physician and dental fee adequacy is a complex task. Lewin developed an overall physician services ranking that reflects a weighted average of payments across the medical service categories where full survey responses were available.[7]

The results of the physician aggregated rankings are shown in Exhibit G. A similar table for dental services is shown in Exhibit H. Note that only three procedures were obtained for dental services, and that the weighted average rankings apply to 45 states. On these aggregate comparisons, California's rankings were as follows:

Physician fees (unadjusted):	37th out of 51 Medicaid programs
Physician fees (geographically adjusted):	42nd out of 51 Medicaid programs
Physician fees (% of Medicare-allowed charge):	40th out of 51 Medicaid programs
Dental fees (unadjusted):	21st out of 45 Medicaid programs
Dental fees (geographically adjusted):	27th out of 45 Medicaid programs

Relative to other Medicaid programs, it appears on the whole that Medi-Cal compensates dentists more adequately than it does physicians. However, because there is no Medicare fee schedule against which dental payments can be contrasted, the dental figures do not indicate how well dentists are paid by Medi-Cal vis-à-vis other payers within the state.

C. Large State Analysis

In terms of dollar volume, California has the second largest Medicaid program in the country. It may be useful therefore to contrast California's fees with those of other large Medicaid programs. Exhibit I presents the rankings of physician and dentist fees (using the previously described aggregated approach) among the ten states with the largest dollar volume Medicaid programs. These ten states account for 59 percent of nationwide Medicaid spending.

It is interesting to note that the large states tend to be consistently low payers of physician services. Only one large state, Massachusetts, ranks in the top half nationally on any of the aggregate physician rankings (20th prior to applying the GAFs). In terms of the average percentage of Medicare-allowed charges, Texas (at 77.6 percent of Medicare) ranks highest among the ten largest states but is only 28th nationally.

Among a peer group of large Medicaid programs, California's fees are at, or near, the median rank on every indicator, as summarized below.

Physician fees (unadjusted):	5th out of 10 large states
Physician fees (geographically adjusted):	6th out of 10 large states
Physician fees (% of Medicare-allowed charge):	5th out of 10 large states
Dental fees (unadjusted):	4th out of 10 large states
Dental fees (geographically adjusted):	5th out of 10 large states

Exhibit G: Aggregation of Fee Rankings, Various Physician Services

State	Average Medicaid Fee as % of Medicare-allowed Charge	Volume-Weighted Ranking, Straight Fees	Volume-Weighted Ranking, Geographically Adjusted Fees	Ranking by % of Medicare-allowed Charge
Alabama	88.5%	15	18	18
Alaska	126.8%	1	1	1
Arizona	102.8%	4	4	4
Arkansas	88.9%	21	16	17
California	**65.2%**	**37**	**42**	**40**
Colorado	74.1%	30	31	31
Connecticut	82.1%	11	25	23
Delaware	89.2%	9	17	15
District of Columbia	55.5%	46	48	48
Florida	65.1%	40	40	41
Georgia	82.6%	20	21	21
Hawaii	66.4%	33	38	38
Idaho	97.2%	10	9	10
Illinois	67.0%	36	36	36
Indiana	77.8%	29	28	27
Iowa	100.1%	8	8	7
Kansas	73.7%	38	34	32
Kentucky	84.5%	24	20	20
Louisiana	80.8%	27	24	25
Maine	64.2%	44	41	42
Maryland	66.9%	39	37	37
Massachusetts	77.2%	19	30	29
Michigan	59.7%	42	46	46
Minnesota	82.5%	22	22	22
Mississippi	91.4%	16	12	12
Missouri	56.2%	48	47	47
Montana	90.6%	14	13	13
Nebraska	97.4%	12	10	9
Nevada	103.2%	2	3	3
New Hampshire	63.4%	41	44	44
New Jersey	40.8%	50	50	50
New Mexico	110.7%	3	2	2
New York	35.9%	51	51	51
North Carolina	100.1%	7	7	8
North Dakota	89.1%	17	15	16
Ohio	73.2%	32	33	34
Oklahoma	76.2%	35	29	30
Oregon	73.3%	34	32	33
Pennsylvania	63.5%	43	43	43
Rhode Island	43.7%	49	49	49
South Carolina	66.2%	45	39	39
South Dakota	90.4%	18	14	14
Tennessee	85.0%	23	19	19
Texas	77.6%	28	27	28
Utah	62.1%	47	45	45
Vermont	100.6%	5	6	6
Virginia	81.7%	25	23	24
Washington	72.7%	31	35	35
West Virginia	92.5%	13	11	11
Wisconsin	80.8%	26	26	26
Wyoming	101.6%	6	5	5

* Figures derived through volume-weighted average of each state's Medicaid fees across 31 CPT codes in following areas: Evaluation/Management, Surgery, Delivery, Radiology, Laboratory, Medicine/Testing, and Vision.

Exhibit H: Aggregation of Fee Rankings, Various Dental Services

State	Volume-Weighted Ranking, Straight Fees*	Volume-Weighted Ranking, Geographically Adjusted Fees*
Alabama	8	7
Alaska	1	1
Arizona	4	5
Arkansas	24	18
California	**21**	**27**
Colorado	9	12
Connecticut	44	44
Delaware	NA	NA
District of Columbia	45	45
Florida	37	38
Georgia	NA	NA
Hawaii	43	43
Idaho	16	14
Illinois	29	30
Indiana	42	41
Iowa	14	10
Kansas	20	17
Kentucky	25	21
Louisiana	30	31
Maine	NA	NA
Maryland	28	28
Massachusetts	10	20
Michigan	41	42
Minnesota	35	34
Mississippi	NA	NA
Missouri	40	39
Montana	31	29
Nebraska	19	15
Nevada	2	4
New Hampshire	22	24
New Jersey	38	40
New Mexico	6	6
New York	18	25
North Carolina	11	11
North Dakota	15	9
Ohio	17	19
Oklahoma	5	3
Oregon	26	23
Pennsylvania	23	22
Rhode Island	33	36
South Carolina	3	2
South Dakota	34	32
Tennessee	NA	NA
Texas	36	35
Utah	39	37
Vermont	7	8
Virginia	12	16
Washington	27	26
West Virginia	NA	NA
Wisconsin	32	33
Wyoming	13	13

*Note: Rankings apply only to those states where fees were available. 45 states were included in the weighted average.

Exhibit I: Fee Rankings within 10 Largest States, Various Physician and Dental Services*

State	Average Medicaid Fee as % of Medicare-allowed Charge	Physician Volume-Weighted Ranking, Straight Fees	Physician Volume-Weighted Ranking, COLA Fees	Ranking by % of Medicare-allowed Charge	Dental, Volume-Weighted Ranking, Straight Fees	Dental, Volume-Weighted Ranking, Geographically Adjusted Fees
California	**65.2%**	**5**	**6**	**5**	**4**	**5**
Florida	65.1%	6	5	6	8	8
Illinois	67.0%	4	4	4	6	6
Massachusetts	77.2%	1	2	2	1	2
Michigan	59.7%	7	8	8	10	10
New Jersey	40.8%	9	9	9	9	9
New York	35.9%	10	10	10	3	4
Ohio	73.2%	3	3	3	2	1
Pennsylvania	63.5%	8	7	7	5	3
Texas	77.6%	2	1	1	7	7

* Figures derived through volume-weighted average of each state's Medicaid fees across 31 physician CPT codes in following areas: Evaluation/Management, Surgery, Delivery, Radiology, Laboratory, Medicine/Testing, and Vision. Dental figures based on volume-weighted average of each state's Medicaid fees across dental codes D1110, D2150, and D7110.

Exhibit J portrays the average percentage of Medicare-allowed charges in each large state. While California (65.2 percent) is 12 percentage points lower than Texas, the highest-paying large state on this indicator, Medi-Cal's payments are fairly close to most of the large states and are nearly 30 percentage points above the lowest-paying state (New York).

On this statistic, the national median figure across all 51 Medicaid programs (80.8 percent) and the mean developed by weighting each state's fees as a percentage of Medicare by the dollar size of its overall Medicaid program (61.3 percent) are quite far apart. This is largely because New York, with the nation's largest Medicaid program in terms of dollar volume, pays on average only 36 percent of Medicare to private practitioners.[8]

D. Recent Medi-Cal Fee Increases

1. August 2000 Medi-Cal Fee Increases

Medi-Cal implemented substantial fee schedule increases that took effect August 1, 2000. As indicated in Exhibit E, these increases were targeted most prominently at the fees that lagged relatively furthest behind California's Medicare fee levels. For example, evaluation and management fees increased from 44 to 53 percent of Medicare, whereas surgical fees were increased, on average, from 86 to 88 percent of Medicare. On a weighted average basis, Medi-Cal's physician fees rose from 57.7 to 65.2 percent of the Medicare-allowed charge as a result of the August 1 fee increases.

The August fee increases also improved Medi-Cal's payment levels relative to Medicaid programs in other states. California's rankings were separately calculated in this study, using the Medi-Cal fees prior to the August 2000 fee increases. Had these physician fee increases *not* been implemented, the differences in California's rankings are summarized in Exhibit K.

The August fee increases improved California's unadjusted ranking by eight places, relative to all Medicaid programs. Within the 10 largest Medicaid programs, the recent Medi-Cal increases

brought California from 8th to 5th. Among this peer group of large states, Medi-Cal's fees now essentially represent the median.

Exhibit J: Average Percent of Medicare-Allowed Charge, Ten Largest States

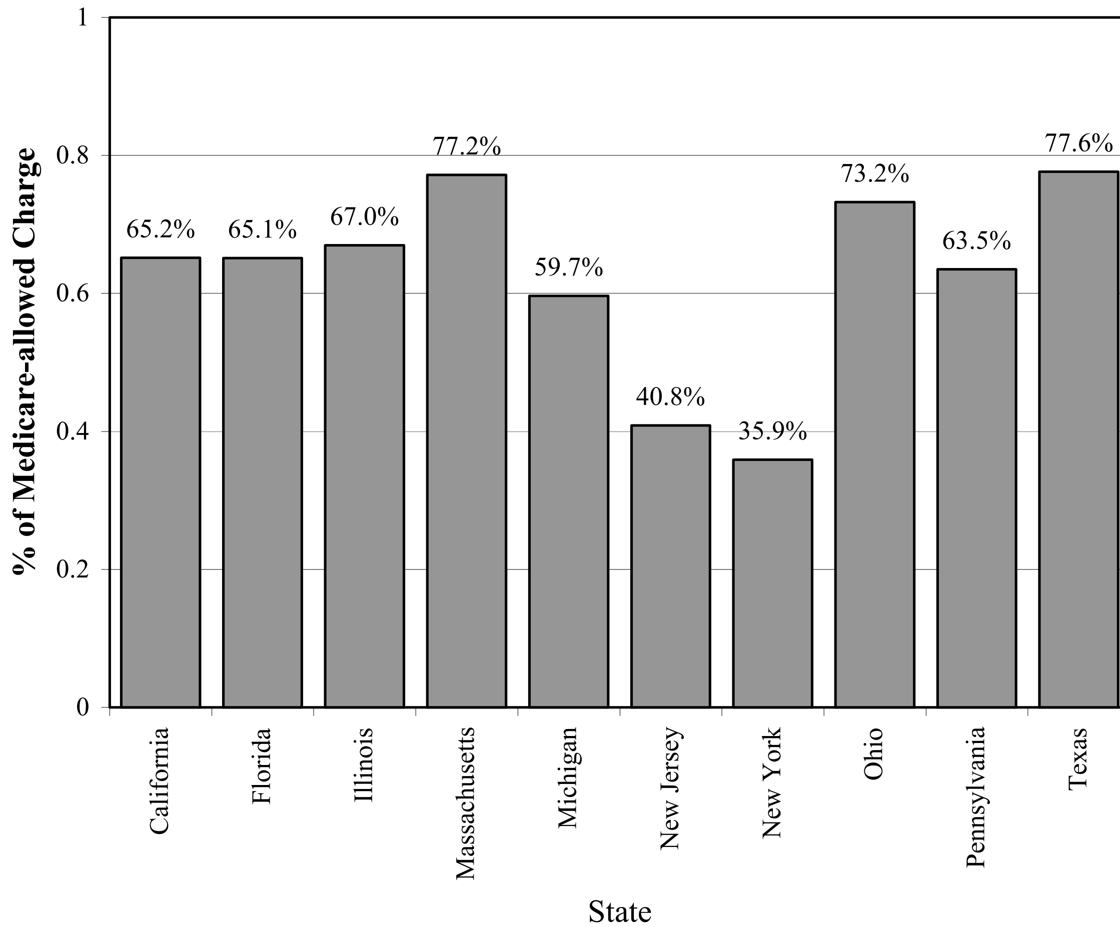


Exhibit K. California's Ranking Changes as a Result of August 2000 Medi-Cal Fee Increases

Aggregated rankings, based on weightings of states' fees across 31 CPT codes

	Ranking Using Fees Prior to August 1, 2000 Increase	Ranking Using Fees After August 1, 2000 Increase
Rankings Among All States (51 Medicaid Programs)		
Physician Fees (Unadjusted)	45	37
Geographically Adjusted Physician Fees	46	42
Medicaid Fees as Percentage of Medicare-allowed charges	46	40
Rankings Within Large State Subgroup (10 Medicaid Programs)		
Physician Fees (Unadjusted)	8	5
Geographically Adjusted Physician Fees	8	6
Medicaid Fees as Percentage of Medicare-allowed charges	8	5

2. Fee Increases in Other States

It is not uncommon for a state Medicaid agency to hold its physician fees constant for a considerable period of time. California and several other states have traditionally raised Medicaid fees sporadically and have not used any form of automatic annual adjustment. The survey instrument captured the inception date of each reported fee. In addition, the average inception date of the fees for the procedure codes in the survey was calculated for each state. The distribution of these dates is shown in Exhibit L.

Current Medicaid physician fees went into effect between 1998 and 2000 in most states. In 18 states, current fees went into effect (on average) prior to 1998.

For most of the surveyed states, it was possible to compare fee increases from 1998-2000 by drawing upon a September 1999 study conducted by The Urban Institute.[9] Average rates of fee increases for two common office visit codes (CPT 99203 and 99213) from 1998-2000 are shown in Exhibit M. These figures demonstrate the tremendous variation in updating physician fees that exists from state to state. While roughly a dozen of the 42 states in the Urban Institute study did not change their fees from 1998-2000 for two codes assessed, several states implemented fee increases of 50 percent or more across this timeframe (for these two codes). Medi-Cal's payments increased by 24 percent for CPT 99203 and by 45 percent for CPT 99213 across this two-year period.

Exhibit L: Number of States by Average Inception Date

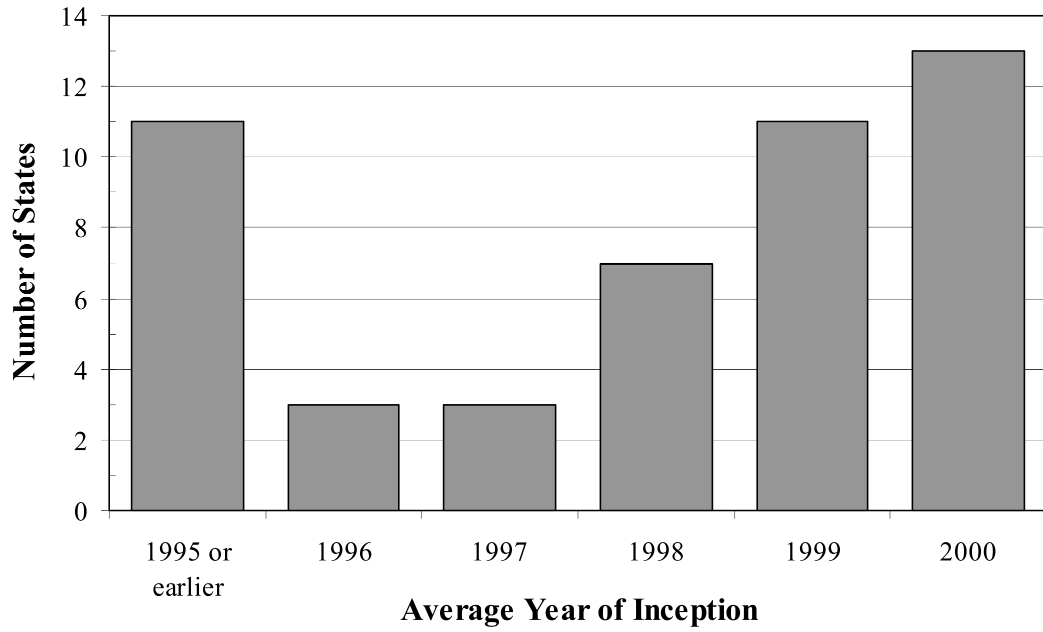


Exhibit M: Fee Increases between 1998 and 2000 for Two Selected CPT Codes

State	Office Visit, New Patient, 30 Minutes (99203)-1998	Office Visit, New Patient, 30 Minutes (99203)-2000	Percent Difference, 99203	Office Visit, Est. Patient, 15 Minutes (99213)-1998	Office Visit, Est. Patient, 15 Minutes (99213)-2000	Percent Difference, 99213
Alabama	$50.50	$75.00	48.5%	$30.50	$39.00	27.9%
Alaska	$95.34	$136.14	42.8%	$53.52	$72.19	34.9%
Arizona		$80.46			$45.35	
Arkansas		$59.00			$66.00	
California	**$46.00**	**$57.20**	**24.3%**	**$16.56**	**$24.00**	**44.9%**
Colorado	$49.11	$53.70	9.3%	$31.50	$32.45	3.0%
Connecticut		$37.61			$21.61	
Delaware		$82.89			$44.11	
District of Columbia	$30.00	$30.00	0.0%	$18.00	$18.00	0.0%
Florida	$43.92	$47.61	8.4%	$25.00	$26.29	5.2%
Georgia	$53.14	$69.32	30.4%	$30.29	$38.15	25.9%
Hawaii	$60.70	$60.70	0.0%	$25.66	$26.60	3.7%
Idaho	$49.43	$54.14	9.5%	$33.26	$36.42	9.5%
Illinois	$25.80	$44.00	70.5%	$18.55	$30.00	61.7%
Indiana	$46.85	$46.85	0.0%	$25.98	$25.98	0.0%
Iowa	$33.47	$81.60	143.8%	$21.05	$43.25	105.5%
Kansas	$28.75	$42.33	47.2%	$19.50	$24.04	23.3%
Kentucky	$48.86	$48.86	0.0%	$27.06	$27.06	0.0%
Louisiana	$32.40	$32.40	0.0%	$24.30	$36.13	48.7%
Maine	$38.66	$38.66	0.0%	$28.94	$28.94	0.0%
Maryland	$37.00	$37.00	0.0%	$31.00	$31.00	0.0%
Massachusetts	$49.51	$68.42	38.2%	$33.54	$43.99	31.2%
Michigan	$35.89	$62.80	75.0%	$21.00	$31.63	50.6%
Minnesota	$40.07	$36.25	-9.5%	$27.32	$24.72	-9.5%
Mississippi		$72.36			$38.38	
Missouri	$25.00	$32.50	30.0%	$18.75	$24.00	28.0%
Montana		$61.41			$33.79	
Nebraska		$50.96			$32.76	
Nevada	$55.02	$56.38	2.5%	$34.06	$34.90	2.5%
New Hampshire	$38.00	$38.00	0.0%	$27.00	$38.14	41.3%
New Jersey	$20.75	$22.00	6.0%	$15.50	$16.00	3.2%
New Mexico	$54.79	$79.38	44.9%	$31.16	$42.16	35.3%
New York	$11.00	$11.00	0.0%	$11.00	$11.00	0.0%
North Carolina	$57.57	$83.37	44.8%	$32.30	$44.46	37.6%
North Dakota	$58.73	$72.18	22.9%	$32.70	$38.54	17.9%
Ohio	$37.83	$48.01	26.9%	$27.48	$34.35	25.0%
Oklahoma	$34.97	$57.96	65.7%	$20.91	$30.87	47.6%
Oregon	$42.75	$72.66	70.0%	$23.75	$36.59	54.1%
Pennsylvania		$25.00			$25.00	
Rhode Island	$29.00	$29.00	0.0%	$20.64	$20.64	0.0%
South Carolina	$30.00	$30.00	0.0%	$21.50	$21.50	0.0%
South Dakota	$49.00	$49.00	0.0%	$28.70	$28.70	0.0%
Tennessee		$70.40			$37.46	
Texas		$48.28			$27.28	
Utah	$42.77	$47.43	10.9%	$23.87	$25.99	8.9%
Vermont	$33.20	$39.51	19.0%	$25.80	$30.70	19.0%
Virginia	$53.78	$62.31	15.9%	$30.54	$34.41	12.7%
Washington		$51.02			$27.10	
West Virginia	$51.99	$77.43	48.9%	$29.34	$39.24	33.7%
Wisconsin		$26.13			$28.21	
Wyoming		$70.27			$37.32	

Source: 1998 fees were obtained from a 1999 Urban Institute paper, *Recent Trends in Medicaid Physician Fees, 1993-1998.*
Notes: Many states did not report fees in the 1999 Urban study. Because many states pay a varying rate to physicians for the same service (e.g., children's services have higher fees), we did not include 1998 fees for a few states that were inconsistent with the Lewin data due to uncertainty on how the fees were reported in the Urban study.

IV. Summary and Discussion

The major findings of this study are summarized below.

- Medi-Cal payments to physicians are below average when contrasted with all states' fee schedules. Medi-Cal's ranking among 51 Medicaid programs for an aggregation of physician services was 37th in terms of the unadjusted fees, 42nd when all states' fees were adjusted by geographic cost factors, and 40th as a percentage of the average Medicare-allowed charge. On average, Medi-Cal's physician fees represented 65.2 percent of statewide average Medicare-allowed charges.

- Medi-Cal's payment levels versus Medicare, and versus other state's Medicaid fees, vary considerably from one clinical area to the next. Medi-Cal appears to be a relatively strong payer of surgical services, laboratory services, and dental services, and a relatively weak payer for evaluation and management services, maternity/delivery, psychiatry, and vision services.

- When California's fees are compared only with large states as opposed to all states, California's fees rank more favorably – right at the median.

- The Medi-Cal fee increases, that went into effect August 1, 2000, were substantial and were targeted at those areas where Medi-Cal physician payments were relatively lowest. Across all physician services, it is estimated that these increases brought Medi-Cal from 58 percent to 65 percent of California's average Medicare payment rates.

- While many states' Medicaid fee schedules have remained unchanged over time, the trend has clearly been in the direction of bringing Medicaid payments more closely in line with mainstream payers. Fourteen states' physician payments now average at least 90 percent of Medicare; and 26 states' payments average at least 80 percent of Medicare. Only six states' payments average below 60 percent of Medicare. However, several of these six states are among the nation's largest – they collectively account for 26 percent of national Medicaid expenditures.

As state policymakers consider future changes in Medi-Cal payments to physicians and dentists, the following observations are offered. First, the recent approach of targeting available fee increase dollars to codes that are particularly "underpaid" makes tremendous sense. Given that

Medi-Cal's fees are lowest in some areas where facilitating access is particularly important (e.g., primary care and maternity-related services), continuation of this approach is warranted. Moving towards a uniform percentage of Medicare is one option to accomplish this. A case can perhaps be made that if Medi-Cal's payments are best kept uneven in proportion to Medicare, they should probably be relatively high in the areas where they are now relatively low.

Second, the spillover impact that any proposed physician fee increases will have on managed care capitation rates needs to be carefully considered. Increases in the fee-for-service setting are likely to translate to capitation rate increases – and all these added costs need to be accurately forecasted. On the positive side, the capitation increases can enhance the Medi-Cal health plans' ability to attract and retain a quality provider network.

Third, the policy objective regarding future increases in fees needs to remain geared towards retaining and attracting quality providers. If this study motivates some policymakers to implement a Medi-Cal fee increase simply to move California up in the national rankings, that would be unfortunate unless such fee increases were designed to bolster the program's physician and dental participation levels. Within Medi-Cal, access to mainstream physicians and dentists has always been a challenge: many physicians and dentists do not serve Medi-Cal altogether, have closed their practices to new Medi-Cal patients, and/or have seriously considered dropping out of serving Medi-Cal at whatever level they are now participating. At a broader level, California is competing with the rest of the nation to attract and retain adequate numbers of quality physicians and dentists. Given California's high managed care penetration among all payer categories, many new practitioners may already be somewhat averse to basing their practices in California.

The fiscal trade-offs involving various Medi-Cal policy options are extremely complex, not to mention other trade-offs that exist between Medi-Cal and other public programs. While this study has quantified the already widely accepted fact that Medi-Cal is not a robust payer of physician and dental services, the advisability of further Medi-Cal fee increases needs to be evaluated against a myriad of competing ways to spend state funds.

V. Survey Participants

Lewin's survey attained a response rate of 100 percent for most of the targeted fees. This response rate can be attributed to several factors. First, all levels of state Medicaid agency staff were tremendously helpful. State agency staff were of course under no obligation to respond to the survey. The survey arrived at a particularly hectic time of year, and its completion required several hours of staff time. Nonetheless, there was a politeness and genuine willingness to help that led most states to respond promptly.

Second, it was often possible to obtain Medicaid fee information from a state's Web site, or to obtain an electronic copy of the full Medicaid fee schedule from which the targeted fees could be compiled.

Third, states did have some incentive to respond. The findings of this study – although oriented towards the Medi-Cal program – convey comparative data about Medicaid fee information that is likely to be of policy interest to most states. A designated staff person in each state Medicaid agency was sent a copy of the comparative rankings.

Medicaid agency staff who assisted in providing information used in this report are acknowledged in Exhibit N. No doubt many additional individuals at several of the states contributed to the survey response beyond those listed – we have listed those with whom we had direct contact.

Exhibit N. State Medicaid Agency Staff Assisting in Fee Survey Effort

Alabama	Beverly Churchwell, Kathy Hall
Alaska	Jeff Kemp, Bob Labbe
Arkansas	Brenda Timmons, Betty Bushy
California	William Brennan, Emily Fishman, Jim Klein, Stan Rosenstein, Mervin Tamai, Tom Winter
Colorado	Barbara Bloem, Dann Milne, Karen Snell
Connecticut	Jim Gaito, Jim Linnane
Delaware	Bruce Ashbaugh
District of Columbia	Calvin Kearney, La Rah Payne
Florida	Lynne Metz, Bob Sharpe
Georgia	Carolyn Ferrell, June Krise, Richard Minter
Hawaii	Lynette Honbo, M.D.,
Idaho	Joe Brunson, Robbie Charlton
Illinois	Jeanette Hickman, Matt Powers
Indiana	Pat Nolting
Iowa	Cathy Coppes, Dennis Heablee, Dennis Janssen, Marty Swartz
Kansas	Joel Stottlemire, Frank Webb
Kentucky	Jay Douds, Janet Johnson
Louisiana	Bruce Gomez
Maine	Data obtained from Internet
Maryland	Linda Lee, Kathlyn Wee, Robert Zielaskiewicz
Massachusetts	Jeremiah Cole, Lisa McDonough
Michigan	Sharon Costello,
Minnesota	Liz Backe, Kristin Dybdal, Paul Olson
Mississippi	Denny Lea
Missouri	Gregory Vadner, Pam Victor
Montana	Data obtained from Internet
Nebraska	Sandy Kahlandt, Deborah Scherer
Nevada	Rita Mackie
New Hampshire	John Fransway
New Jersey	Margaret Murray, Kathryn Plant, Edward Vaccaro
New Mexico	Rosemary Medrano
New York	Data purchased from fiscal agent
North Carolina	Allen Gambill, Pam Munson, Paul Perruzzi,
North Dakota	Dennis Wetzel
Ohio	Becky Jackson, Lorin Ranbom
Oklahoma	Nelda Paden
Oregon	Bev Castor, Hersh Crawford
Pennsylvania	Data obtained from Internet
Rhode Island	Lynne Harrington, Susan Taylor
South Carolina	Gerald Steward, Jonathan Tapley, Darlynn Thomas
South Dakota	Randy Hanson, Larry Iverson
Tennessee	Keith Gaither
Texas	Joe Branton, Linda Wertz
Utah	Blaine Goff
Vermont	Gloria Jacobs, Sue Ellen Squires
Virginia	Bernadette Clark, Sally Rice
Washington	Gaylan Gaither, Mary Wendt
West Virginia	Phil Lynch, Stacey Shamblin
Wisconsin	Larry Hochman, Cheryl McIlquham
Wyoming	Trena Primavera

Appendix: Survey Instrument

Date
Name
Address
Address
Address

Dear ___:

California's Medi-Cal Policy Institute has commissioned a study by The Lewin Group to assess how the Medi-Cal (California's Medicaid program) fees compare with those used by other states' Medicaid programs. A brief overview of the Medi-Cal Policy Institute's mission is enclosed.

Our analysis requires collecting fee schedule information from every state's Medicaid program. To make sure that each state agency has the opportunity to benefit from its staff efforts, we will share with you a copy of our final report. This report will compare, for each surveyed procedure, each state's fees before and after adjusting for the cost of living in each state. We will also compare each Medicaid fee with average Medicare-allowed amounts in each state.

The survey has two components. The qualitative portion, reflected on the next two pages, asks a set of questions regarding how your state's Medicaid fees are structured, such that we can make valid comparisons across states. The quantitative portion, reflected on the final page, requests the current payment amounts for each selected procedure.

We have tried to minimize your staff efforts in the following ways and are happy to assist you in any way we can to further minimize the staff time required:

- Limiting the number of service types and procedures in the survey.

- Offering you options for getting the information to us, including:

    a) completing the survey, then faxing us the document;

    b) mailing or e-mailing us full fee schedules; so we can extract the targeted codes;

    c) providing the qualitative information to us via phone; and/or

    d) directing us to state Web sites that contain the requested information.

I can be contacted as follows: my direct phone number is (703) 269-5598; my fax number is (703) 269-5705; and my e-mail address is **joel.menges@lewin.com**. We will follow up with you to determine the best contact person(s) at your agency. We need to complete our data collection effort by January 17, and are hoping to obtain responses from the vast majority of states by January 12. We greatly appreciate your agency's assistance with this project, and in turn look forward to providing you with comparative information that proves beneficial to your ongoing policy-making efforts.

Sincerely,

Joel J. Menges
Vice President

QUALITATIVE SURVEY **State: _______________**

1) **How is your Medicaid physician fee schedule derived? Please check all boxes that apply and comment.**

   ______ **Constant relationship to Medicare-allowed charges (e.g., RBRVS is used)**
   ______ **Relationship to another non-Medicare payer's fees (if so, describe source)**
   ______ **"Home grown" Medicaid fee schedule developed over the years**
   ______ **Other**

   Comments: ____

2) **Is the Medicaid physician fee schedule used for outpatient hospital services and/or (non-FQHC) clinics? _____ If not, please describe the mechanisms used to develop payment schedules for outpatient hospital services and non-FQHC clinics. (We understand that FQHCs receive cost-based reimbursement and are not considering these payment rates in our study.)**

3) **On average, are payments to HOSPITALS for a given outpatient medical service (check one):**

   ______ **Substantially (more than 10 percent) below what Medicaid would pay for the same services for a solo practitioner physician?**
   ______ **Within ten percentage points (either way) of what Medicaid would pay for the same services for a solo practitioner physician?**
   ______ **10-50 percent above what Medicaid would pay for the same services for a solo practitioner?**
   ______ **More than 50 percent above what Medicaid would pay for the same services for a solo practitioner?**

4) **Do Medicaid fees to physicians for the same service vary? ______ If so, describe the criteria (e.g., by physician specialty, patient age or eligibility category, PCCM program, geographic location, etc.) and the average magnitude and direction of these variations.**

5) **How are Medicaid physician fees adjusted over time (e.g., annually, using a predetermined index, other approaches)?**

6) Describe the approximate overall average percent increases in the following fee schedules (i.e., roughly how much more would the practitioner receive for rendering the same volume and mix of services each year, due to fee schedule changes) between the following years:

Years	Primary Care Physicians	Specialist Physicians	Outpt. Clinics	Dentists	DME Providers
1998-99					
1999-00					
2000-01*					

* Please estimate average rates of increase for next year.

7) Please comment on how your Medicaid dental fee schedule has been developed and how it is updated.

8) Please comment on how your Medicaid durable medical equipment (DME) fee schedule has been developed and how it is updated.

9) Roughly what percentage of the active practitioners in your state participate in your fee for service (FFS) Medicaid program?

	% Accepting New FFS Medicaid Patients	% Serving Any FFS Medicaid Patients	Comments
Primary Care Physicians			
Specialist Physicians			
Dentists			

10) Please comment on how your Medicaid fee-for-service payments to physicians compare with typical amounts your Medicaid health plans pay physicians.

11) Please share with us who provided this information, and to whom we should send our final project report.

	Person(s) completing survey	Person to receive final report
Name:		
Title:		
Address:		
E-Mail:		

QUANTITATIVE SURVEY

State ____________

Type of Service and Procedure Code	Current (Dec '00) Medicaid Fee For Solo Practitioner	Year That Current Fee Went Into Effect	Comment
Evaluation and Management Services:			
CPT Code 99203	________	________	________
CPT Code 99204	________	________	________
CPT Code 99213	________	________	________
CPT Code 99222	________	________	________
CPT Code 99232	________	________	________
CPT Code 99283	________	________	________
CPT Code 99431	________	________	________
Anesthesia Services:			
CPT Code 00840	________	________	________
CPT Code 00850	________	________	________
CPT Code 00955	________	________	________
One 15 Min. Time Unit	________	________	________
Surgical Services (excluding maternity/delivery):			
CPT Code 11721	________	________	________
CPT Code 29881	________	________	________
CPT Code 33533	________	________	________
CPT Code 43239	________	________	________
CPT Code 66984	________	________	________
Maternity/Delivery Services:			
CPT Code 59025	________	________	________
CPT Code 59400	________	________	________
CPT Code 59409	________	________	________
CPT Code 59510	________	________	________
CPT Code 59514	________	________	________
Radiology Services (Show Global Fee – Professional Plus Technical Components):			
CPT Code 70450	________	________	________
CPT Code 71020	________	________	________
CPT Code 76092	________	________	________
CPT Code 76805	________	________	________
Laboratory/Pathology Services (Show Global Fee):			
CPT Code 80074	________	________	________
CPT Code 85025	________	________	________
CPT Code 87490	________	________	________
CPT Code 87590	________	________	________
Psychiatry Services:			
CPT Code 90804	________	________	________
CPT Code 90805	________	________	________
CPT Code 90806	________	________	________
CPT Code 90807	________	________	________

Type of Service and Procedure Code	Current (Dec '00) Medicaid Fee For Solo Practitioner	Year That Current Fee Went Into Effect	Comment
Medicine and Testing Services:			
CPT Code 97140			
CPT Code 93000			
CPT Code 93307			
CPT Code 94010			
CPT Code 94060			
CPT Code 95904			
Vision/Ophthalmology Services:			
Code V2020			
CPT Code 92004			
CPT Code 92014			
Audiology/Hearing Services:			
Code V5010			
Code V5050			
CPT Code 92525			
Dental Services:			
ADA Code D1110			
ADA Code D2150			
ADA Code D7110			
Durable Medical Equipment, Supplies, Orthotics & Prosthetics:			
Code E0245			
Code E0450			
Code L3020			
Code L8160			

Notes

[1] Capitation rates paid by the Department of Health Services (DHS) to managed care health plans are actuarially derived and take into account the payment levels used in the fee-for-service Medi-Cal setting. While health plans and physicians can agree to any payment rate or approach they deem mutually acceptable, an increase in Medi-Cal fee-for-service rates that causes capitation rates to rise is likely to increase health plan payments to providers.

[2] *A History of Medi-Cal Physician Payment Rates*. Medi-Cal Policy Institute. Oakland, CA: March 2000.

[3] As shown in the Appendix, the survey instrument initially requested both qualitative information and fee information. While state staff were consistently able to complete the fee survey, the responses to the qualitative questions were less consistent – these questions posed a particular burden on state staff. As an example, states were asked to provide a rough estimate of the percentage of active physicians and dentists that (a) treated any Medicaid patient in the prior year; and (b) have their practices open to new Medicaid patients. While this information would be valuable in linking Medicaid fee levels and provider participation rates, fewer than five states provided this information. Midway through the data collection effort, Lewin staff opted to focus on obtaining the fee data and to curtail pursuit of the qualitative information. This reduction in the amount of requested information, however, considerably helped in the successful effort to achieve a 100 percent response rate regarding current fees for most of the requested procedures.

[4] The unadjusted Medi-Cal fee, when divided by the 1.067 GAF, yields a fee that is 93.7 percent of the original amount.

[5] A significant exception to the norm for the targeted surgical fees was CPT 66984, cataract removal, where Medi-Cal's payment is 125 percent of Medicare. Based on input from Department of Health Services staff, this code was given little weighting when deriving the surveyed surgery codes' average percentage of Medicare-allowed charges in California.

[6] These two global delivery procedures were included in the calculation of California's average percentage of Medicare-allowed charges in the maternity/delivery category.

[7] The complications lie in how to best average together the figures across the different medical categories. One consideration is that Medi-Cal is often the secondary payer to Medicare, which restricts the Medi-Cal fee schedule's relevance for many procedures (particularly the coronary bypass and cataract removal codes targeted in the survey). Another issue is whether the Medi-Cal fee-for-service (FFS) volume should be adjusted to represent an estimate of full usage by the beneficiary population – encompassing both FFS and managed care beneficiaries. Maternity usage may be particularly under-weighted when focusing only on the FFS population, for example. The weighting method relied on total Medi-Cal payments in each clinical category as a starting point, but lowered the weights for surgical services due to dual eligibility issues while raising the weights for maternity services to acknowledge managed care usage.

[8] New York's figure is somewhat misleading in developing a weighted national mean because of the high degree to which New York's Medicaid payments for physician services go to institutional-based providers as opposed to private practitioners. New York, in fact, experiences the highest per capita Medicaid expenditures in the nation. If New York is removed from the calculation, the national mean rises to 70.8 percent of Medicare as opposed to 61.3 percent of Medicare.

[9] *Recent Trends in Medicaid Physician Fees, 1993-1998*, Stephen Norton, The Urban Institute, September 1999.