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Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare

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I. Executive Summary

For years, Medi-Cal's fee-for-service program has reimbursed physicians far less for many services than other states, and the disparity is getting worse.

This report highlights the current and growing gap between Medi-Cal's physician service fees and those provided by Medicare and other states' Medicaid programs. It also compares select dental fees to national averages.

Findings

From 2003 to 2008, Medi-Cal fees for the 30 medical procedures included in this study grew, on average, by 2 percent. In contrast, Medicaid fees grew by 15 percent nationally, while general inflation reached 20 percent during this same period.

Medi-Cal fees fell from 91 percent of Medicaid's national average in 2003 to 83 percent in 2008, while also losing ground relative to Medicare fees in most service categories. In contrast, average Medicaid fee increases nationwide actually surpassed those realized by Medicare.

Medi-Cal fees ranked in the bottom half of the distribution for all states in all but one service category—surgery. Overall, California's fees ranked 47th among all states when adjusted for geographic differences in the cost of providing medical care. Among the ten largest state Medicaid programs, California ranked 9th; only New York had lower average Medicaid fees relative to Medicare for services provided in office settings.

Low average Medi-Cal reimbursement levels extend to dental care, with fees for most procedures falling short of those for other Medicaid programs. Even the more generous Medicaid dental fees lag behind commercial rates, which may account for limited Medicaid participation among California dentists.

Implications

Small increases or decreases in Medicaid fees have not dramatically altered access to care; however, persistently low fee-for-service reimbursement rates are likely to deter physicians and dentists from providing broad-based care for Medi-Cal patients, effectively limiting their access to care. In fact, studies have shown that only about 50 percent of physicians[1] and 40 percent of private dental practices[2] in the state accept Medi-Cal patients, limiting access and potentially shifting the burden of care to more expensive settings, such as emergency departments and hospitals.

II. Introduction

For years, Medi-Cal's fee-for-service program has reimbursed physicians far less for many services than other states.[3–5] Despite the growth in Medi-Cal managed care, these fees remain relevant, reflecting services provided to a large share of the state's beneficiaries and influencing rates paid to managed care plans.

Medi-Cal fees remained static between 1993 and 1998. Subsequently, state policymakers raised Medi-Cal physician fees between 1998 and 2001, during California's robust economic years. These fee increases did improve Medi-Cal's position to some degree, from 77 percent of the national average for Medicaid in 1998 to 91 percent of the national average in 2003, but California still remained one of the ten states paying the lowest physician fees-for-service within Medicaid.

This report presents an updated picture on the state of Medi-Cal's fee-for-service program through an analysis of 2008 survey data for select physician and dentist fees.

The analysis, presented in meaningful and clinically related services groups, compares: 1) Medi-Cal fees for select medical and dental services with Medicaid fees in other states and with national Medicaid averages, and 2) Medi-Cal fees for select medical services with Medicare fees in California.

The analysis also compares Medi-Cal fee changes, using comparable survey data from 2003 and 2008, and how those changes have altered the relationships between Medi-Cal, Medicaid, and Medicare fees.

III. Data and Methodology

Data Collection

The 2008 Medicaid physician and dentist fee data used in this study were collected from fee schedules posted on state Web sites and from state surveys fielded by the Urban Institute. In 2008, Medi-Cal tried to implement fee cuts that were subsequently blocked by a court injunction. This analysis disregards this short-lived rate reduction.[6]

To maintain continuity with a 2003 Urban Institute survey, data for the same set of medical services were collected in 2008.[7] This latest survey also gathered data on seven dental procedures to provide information on this important area of health care where access problems have been observed.

The authors chose procedures to cover a broad range of service types and to include many of the most common services provided to Medicaid beneficiaries. The survey included fees for 32 medical procedures covering eight types of services:

- Evaluation and management,
- Medicine and testing,
- Vision care,
- Obstetrical care,
- Hospital care,
- Surgery,
- Radiology and laboratory tests, and
- Psychotherapy.[8]

Medi-Cal does not use two of the 32 procedure codes included in the survey: vaginal delivery with postpartum care (59410) and cesarean delivery with postpartum care (59515). These services were included when calculating indices for other states to maintain compatibility with concurrent research but were excluded from calculations for California.

The authors collected fee data from 49 states and the District of Columbia that have a fee-for-service component in their Medicaid programs (Tennessee has no fee-for-service component) by locating the state's fee schedule online, when available, or surveying the state directly. States with online fee data were contacted to confirm that the correct set of information was being accessed, and that it reflected fees being paid as of July 1, 2008. A paper copy of the survey was mailed to the Medicaid director of each state if there was no current (July 1, 2008) fee schedule available online, or if the authors could not confirm that the posted fee schedule was current. An electronic version of the survey was supplied to states, when requested. Between these various data collection methods, full participation was achieved among fee-for-service states.

The online information and the survey results were examined to identify any fees that had increased by 50 percent or more between 2003 and 2008 or decreased at all during the study period. For these services, Web sites were revisited to confirm the accuracy of the fee information. In addition, state Medicaid agencies were called if the available information did not seem plausible, e.g., where Medicaid fees looked like they had been cut or raised significantly across the board or were much higher than comparable Medicare fees. States were also contacted to validate data in cases where it appeared that fees for the services studied had not changed at all. This process gave the authors the chance to

correct a few erroneous fees that had produced some of the observed large fee increases or decreases, but generally confirmed that the fee data were correct.

As a part of this data collection effort, the authors determined if physician fees were adjusted for specific types of providers or services to meet policy objectives. Seventeen states — Alabama, California, Connecticut, Florida, Illinois, Kansas, Louisiana, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Texas, Utah, Virginia, Washington, and Wisconsin — reported that they adjusted rates for certain populations, for specific preventive or obstetric services, or for particular provider types (e.g., pediatricians or specialists). Three of the 17 — Alabama, Utah, and Wisconsin — reported using different fees to reimburse providers in rural areas at a higher rate. For each of the 17 states, a statewide fee as a simple average of the observed fees was created. In the case of California, the physician fees for office and hospital visits used in this analysis are a simple average of fees for visits provided to adults and for those provided to children.[9]

While some states reimburse at different rates for services provided in a facility (i.e., those provided by hospital-based physicians), and all are required to pay higher rates for services performed in a Federally Qualified Health Center (FQHC), the authors focused solely on physician fees for services provided in office settings. However, in states with low Medicaid fees for office-based services, beneficiaries may frequently gain access to certain physician services through institutional settings. For example, evidence suggests that many physician services are provided to Medicaid beneficiaries in low-fee states through hospital outpatient departments, emergency rooms, and FQHCs,[10] and that, in general, physicians in institutional settings are more likely than others to accept Medicaid patients.[11]

Key Analytic Variables

To combine data on individual fees from different states into key analytic variables, weights were constructed to reflect the relative importance of each service and each state. The weight for each physician service was defined as its share of Medicaid physician expenditures among the procedures surveyed, computed from service-specific Medicaid expenditures obtained from the Center for Medicare and Medicaid Services (CMS).[12] Table 1 shows spending for each Medi-Cal procedure as a percentage of total expenditures of the procedures surveyed[13] and the national mean fee for each service studied, grouped into eight service categories. Comparable expenditure data for dental services was not available, so another approach was used.

The analysis of Medi-Cal physician fees presented in this report is based on four nationwide indices of Medicaid fees.

Medicaid Fee Index

Medicaid fees from each state were compared to national average fees. This index is the weighted sum of the ratios of each state's fee for a given service to the respective national average fee, using the available physician expenditure weights. The national average fee is a weighted average of fees across states, where the weight for each state is the state's share of national Medicaid enrollment (excluding beneficiaries in Tennessee), derived from the 2003 Medicaid Statistical Information System.

Medicaid-to-Medicare Fee Index

Medicaid fees were compared to Medicare fees in the same state, where the index is the weighted sum of the service-specific Medicaid-to-Medicare fee ratios in each state. The same expenditure weights were used in this index as in the Medicaid fee index that compares fees across states. Medicare fees were

calculated by obtaining the Relative Value Units conversion factor and Geographical Practice Cost Indices (GPCIs) from the December 31, 2007 Federal Register, and using the 2008 Clinical Diagnostic Fee Schedule.[14]

The ratio of each service's Medicaid fee to Medicare fee was computed by state. For states with multiple Medicare localities, Medicare fees for the surveyed services were calculated for each locality. A state average for each service was then created by weighting each locality's fees by the proportion of the state's Medicare enrollees in that locality, using county level enrollment from CMS as of July 1, 2007.[15] Again, the ratios of each state's Medicaid fees to its average Medicare fees were combined into a single index (and sub-indices by type of service) as the weighted sum of the ratios, using the same expenditure weights as in the other indices.

Geographically Adjusted Medicaid Fee Index

The first Medicaid fee index was recomputed to adjust for regional differences in the cost of providing medical care, using geographically adjusted fees calculated by applying a Geographic Adjustment Factor (GAF) to each state's Medicaid fees. GAFs are designed to reflect the variation in cost of work, malpractice insurance, and practice expenses across states compared to a national average. The GAFs used in this analysis (shown in the Appendix) were calculated using Medicare GPCIs for each locality. These GPCIs were weighted to create a GAF, with physician work accounting for 54.5 percent of the total, practice expenses accounting for 42.3 percent, and malpractice insurance expenses accounting for 3.2 percent. For states with multiple localities, each locality's GAF was weighted by the proportion of the total state population in that locality to calculate a state average GAF.

To calculate geographically adjusted Medicaid fees, each state's fees were divided by the state's GAF, resulting in lower fees in high-cost states and higher fees in low-cost states. The District of Columbia had the largest GAF at 1.124, resulting in the largest downward adjustment, while Arkansas had the lowest at 0.914, resulting in the largest upward adjustment. The GAF for California was 1.078, resulting in a downward adjustment in fees of 7.3 percent. As in the indices discussed above, a Geographically Adjusted Medicaid Fee Index was calculated by combining the ratios of each state's geographically adjusted fees to national average fees into a single index using the Medicaid expenditure weights for each procedure.

Medicaid Fee Change Index

Finally, the authors computed a Medicaid Fee Change Index to capture fee changes between 2003 and 2008. This index is the weighted sum of the ratios of each service's fee in 2008 to that same service's fee in 2003, using the same expenditure weights as in the Medicaid Fee Index. For simplicity, the values of the Medicaid Fee Change Index are expressed as the cumulative percent change in Medicaid fees between 2003 and 2008.

Dental Fees

A simpler approach was used for analyzing dental fees for several reasons. First, these services are not covered by Medicare, eliminating the need for that comparison. Second, the authors did not have access to data on dental expenditures at the service level that would allow creation of a Medicaid Dental Fee Index. Finally, changes in fees could not be analyzed because dental services were not part of the 2003 Urban Institute fee survey.[16] Instead, data on the fee for each dental service is presented by state and compared to the national average fee for that service.

Table 1. Procedures Selected for Fee Survey, by Category, 2008

CODE	PROCEDURE	DISTRIBUTION OF SPENDING (among surveyed procedures)	NATIONAL MEAN FEE (weighted by state enrollment)	MEDI-CAL FEE (as of July 1, 2008)
Primary Care				
	Evaluation and Management			
99203	Office Visit, New Patient, 30 Minutes	2.7%	$62.59	$59.81
99204	Office Visit, New Patient, 45 Minutes	2.2%	$88.46	$72.04
99213	Office Visit, Established Patient, 15 Minutes	24.9%	$38.05	$25.09
99214	Office Visit, Established Patient, 25 Minutes	9.3%	$56.12	$39.21
99244	Office Consultation, New Patient, 60 Minutes	1.3%	$108.77	$85.11
99283	Emergency Department Visit	7.9%	$43.63	$44.60
	Medicine and Testing			
93000	Electrocardiogram	0.5%	$20.66	$24.60
93307	Echocardiography, Transthoracic	1.4%	$142.70	$150.10
95904	Nerve Conduction, Amplitude and Latency/ Velocity Study	0.3%	$30.85	$26.24
	Vision			
92004	Ophthalmological Services, New Patient	1.1%	$68.85	$49.78
92014	Ophthalmological Services, Established Patient	0.8%	$54.67	$38.43
Obstetric Care*				
59400	Total Obstetric Care, Vaginal Delivery	8.4%	$1,331.03	$1,088.56
59409	Vaginal Delivery Only, No Postpartum Care	4.6%	$713.12	$544.28
59410	Vaginal Delivery, Postpartum Care	6.6%	$859.16	n/a*
59510	Total Obstetric Care, Cesarean Delivery	2.0%	$1,434.00	$1,088.62
59514	Cesarean Delivery, No Postpartum Care	2.8%	$812.17	$544.72
59515	Cesarean Delivery, Postpartum Care	1.6%	$987.91	n/a*
Other Services				
	Hospital Care			
99222	Initial Hospital Care, New or Established Patient, 50 Minutes	1.3%	$75.75	$76.53
99232	Hospital Visit, New Patient, 45 Minutes	4.3%	$39.18	$39.52
99254	Initial Inpatient Consultation, 80 Minutes	1.1%	$93.67	$65.01
	Surgery			
43235	Upper Gastrointestinal Endoscopy	0.4%	$202.12	$224.12
43239	Upper Gastrointestinal Endoscopy with Biopsy	1.3%	$230.12	$234.18
58120	Dilation and Curettage	0.2%	$190.59	$222.95
58150	Total Hysterectomy	0.3%	$703.59	$810.72
66984	Cataract Removal with Lens Implant	1.5%	$709.43	$1,005.21
69436	Tympanostomy	1.5%	$127.71	$120.63

Table 1. Procedures Selected for Fee Survey, by Category, 2008, *continued*

CODE	PROCEDURE	DISTRIBUTION OF SPENDING (among surveyed procedures)	NATIONAL MEAN FEE (weighted by state enrollment)	MEDI-CAL FEE (as of July 1, 2008)
Other Services, *continued*				
	Radiology and Laboratory Tests			
70450	Computerized Axial Tomography Scan, Head or Brain	1.9%	$178.48	$196.84
71020	X-Ray, Chest, Two Views	3.0%	$25.35	$25.98
76805	Echography, Pregnant Uterus	3.6%	$97.80	$94.32
88305	Surgical Pathology	1.4%	$59.12	$60.25
	Psychotherapy			
90811	Individual Psychotherapy, 20 to 30 Minutes	0.0%	$50.22	$35.12
90813	Individual Psychotherapy, 45 to 50 Minutes	0.0%	$72.43	$49.94

*Medi-Cal does not use two of the 32 procedure codes included in the survey: vaginal (59410) or cesarean (59515) delivery with postpartum care. However, for compatibility with previous and concurrent research, these codes were included in this report when calculating indices for other states. These two procedures are not listed on subsequent tables in this report that contain data on only Medi-Cal physician fees.

Source: Urban Institute 2008 Medicaid Physician Survey

IV. Findings

Medi-Cal Physician Fees in 2008

Medi-Cal fees as a share of national average Medicaid fees varied considerably across procedures, with fees ranging from less than 70 percent to over 140 percent of the national average, as shown in Table 2. For example, the Medi-Cal fee for the service representing the largest share of spending in this study—a 15-minute office visit with an established patient—was only 66 percent of the national average Medicaid fee. Obstetric care services were also reimbursed at rates ranging from nearly 20 to over 30 percentage points below the national average.

However, not all Medi-Cal visit fees were low. For example, a 30-minute office visit with a new patient was paid more generously: 96 percent of the national average. The highest Medi-Cal fee in this study relative to national average Medicaid fees was for cataract removal (142 percent of the national average).[17]

Variation across service categories exists, although to a lesser extent. Medi-Cal fees for four of the six surgical services studied were at least 10 percent higher than their national average counterparts. Psychotherapy and vision services paid at the lowest overall rates using this measure, with reimbursements hovering around 70 percent of the national average. Evaluation and management services also fell short of national rates, with the exception of one service—

Table 2. Summary of Medi-Cal Fees for Select Procedures, by Category, 2008, *continued*

CODE	PROCEDURE	MEDI-CAL FEE As of July 1, 2008	MEDI-CAL FEE Geographically Adjusted	MEDI-CAL FEE AS A % OF... Weighted National Average Medicaid Fee	MEDI-CAL FEE AS A % OF... Medicare-Allowed Charge
Primary Care					
Evaluation and Management					
99203	Office Visit, New Patient, 30 Minutes	$59.81	$55.45	96%	61%
99204	Office Visit, New Patient, 45 Minutes	$72.04	$66.79	81%	48%
99213	Office Visit, Established Patient, 15 Minutes	$25.09	$23.26	66%	39%
99214	Office Visit, Established Patient, 25 Minutes	$39.21	$36.35	70%	40%
99244	Office Consultation, New Patient, 60 Minutes	$85.11	$78.91	78%	44%
99283	Emergency Department Visit	$44.60	$41.36	102%	73%
Medicine and Testing					
93000	Electrocardiogram	$24.60	$22.81	119%	$22.81
93307	Echocardiography, Transthoracic	$150.10	$139.18	105%	$139.18
95904	Nerve Conduction, Amplitude and Latency/ Velocity Study	$26.24	$24.33	85%	$24.33
Vision					
92004	Ophthalmological Services, New Patient	$49.78	$46.16	72%	36%
92014	Ophthalmological Services, Established Patient	$38.43	$35.63	70%	34%

Table 2. Summary of Medi-Cal Fees for Select Procedures, by Category, 2008, *continued*

CODE	PROCEDURE	MEDI-CAL FEE As of July 1, 2008	MEDI-CAL FEE Geographically Adjusted	MEDI-CAL FEE AS A % OF... Weighted National Average Medicaid Fee	MEDI-CAL FEE AS A % OF... Medicare-Allowed Charge
Obstetric Care*					
59400	Total Obstetric Care, Vaginal Delivery	$1,088.56	$1,009.37	82%	63%
59409	Vaginal Delivery Only, No Postpartum Care	$544.28	$504.69	76%	72%
59510	Total Obstetric Care, Cesarean Delivery	$1,088.62	$1,009.43	76%	56%
59514	Cesarean Delivery, No Postpartum Care	$544.72	$505.09	67%	61%
Other Services					
	Hospital Care				
99222	Initial Hospital Care, New or Established Patient, 50 Minutes	$76.53	$70.96	101%	62%
99232	Hospital Visit, New Patient, 45 Minutes	$39.52	$36.65	101%	59%
99254	Initial Inpatient Consultation, 80 Minutes	$65.01	$60.28	69%	39%
	Surgery				
43235	Upper Gastrointestinal Endoscopy	$224.12	$207.82	111%	70%
43239	Upper Gastrointestinal Endoscopy with Biopsy	$234.18	$217.14	102%	64%
58120	Dilation and Curettage	$222.95	$206.73	117%	91%
58150	Total Hysterectomy	$810.72	$751.74	115%	85%
66984	Cataract Removal with Lens Implant	$1,005.21	$932.08	142%	149%
69436	Tympanostomy	$120.63	$111.85	94%	72%
	Radiology and Laboratory Tests				
70450	Computerized Axial Tomography Scan, Head or Brain	$196.84	$182.52	110%	76%
71020	X-Ray, Chest, Two Views	$25.98	$24.09	102%	70%
76805	Echography, Pregnant Uterus	$94.32	$87.46	96%	59%
88305	Surgical Pathology	$60.25	$55.87	102%	52%
	Psychotherapy				
90811	Individual Psychotherapy, 20 to 30 Minutes	$35.12	$32.57	70%	44%
90813	Individual Psychotherapy, 45 to 50 Minutes	$49.94	$46.31	69%	45%

*Medi-Cal does not use two of the 32 procedure codes included in the survey: vaginal (59410) or cesarean (59515) delivery with postpartum care. Therefore, they are not shown in this table.

Source: Urban Institute 2008 Medicaid Physician Survey

emergency department visit fees ran 102 percent of the national rate.

Like the majority of all states' Medicaid fees, Medi-Cal reimbursements were a fraction of Medicare-allowed charges. With the exception of one surgical procedure (cataract removal with lens implant), all were below 2008 Medicare fees, and ten of the 30 service fees fell below 50 percent of the Medicare-allowed charge.

Changes in Medi-Cal Physician Fees: 2003 to 2008

Before looking at the changes in Medi-Cal fees from the current survey, it is useful to review Medi-Cal's fee change history. Between 1993 and 1998, Medi-Cal fees were virtually flat.[18] Nationally, Medicaid fees also grew slowly during this period and lagged behind inflation. The years from 1998 to 2001 brought strong economic growth and robust state revenues, with Medi-Cal fees rising substantially. For example, fees for evaluation and management services rose, on average, from 44 percent to 53 percent of Medicare rates.[19] A study of Medi-Cal fees from 1998 to 2003 shows a 29 percent increase, on average, for Medi-Cal fees[20]—slightly above the national average increase and well above the roughly 13 percent rise in overall prices.[21]

Data from the current survey show that Medi-Cal fees grew, on average, by only 2 percent between 2003 and 2008 (Table 3). In comparison, Medicaid fees grew by 15 percent nationally, while the overall inflation rate reached about 20 percent.[22] The result: Medicaid fees did not keep pace with general inflation, and the gap widened between average Medi-Cal fees and average Medicaid fees nationally. This was true for all types of services. Fees for the surveyed obstetrical services were unchanged in Medi-Cal, but grew by almost 9 percent nationally. Similarly, evaluation and management fees grew by 20 percent nationally—essentially keeping pace with general inflation, but increased by only 4 percent in California. The two vision services in this study had their fees reduced in California between 2003 and 2008, but were among the faster growing fees nationally.

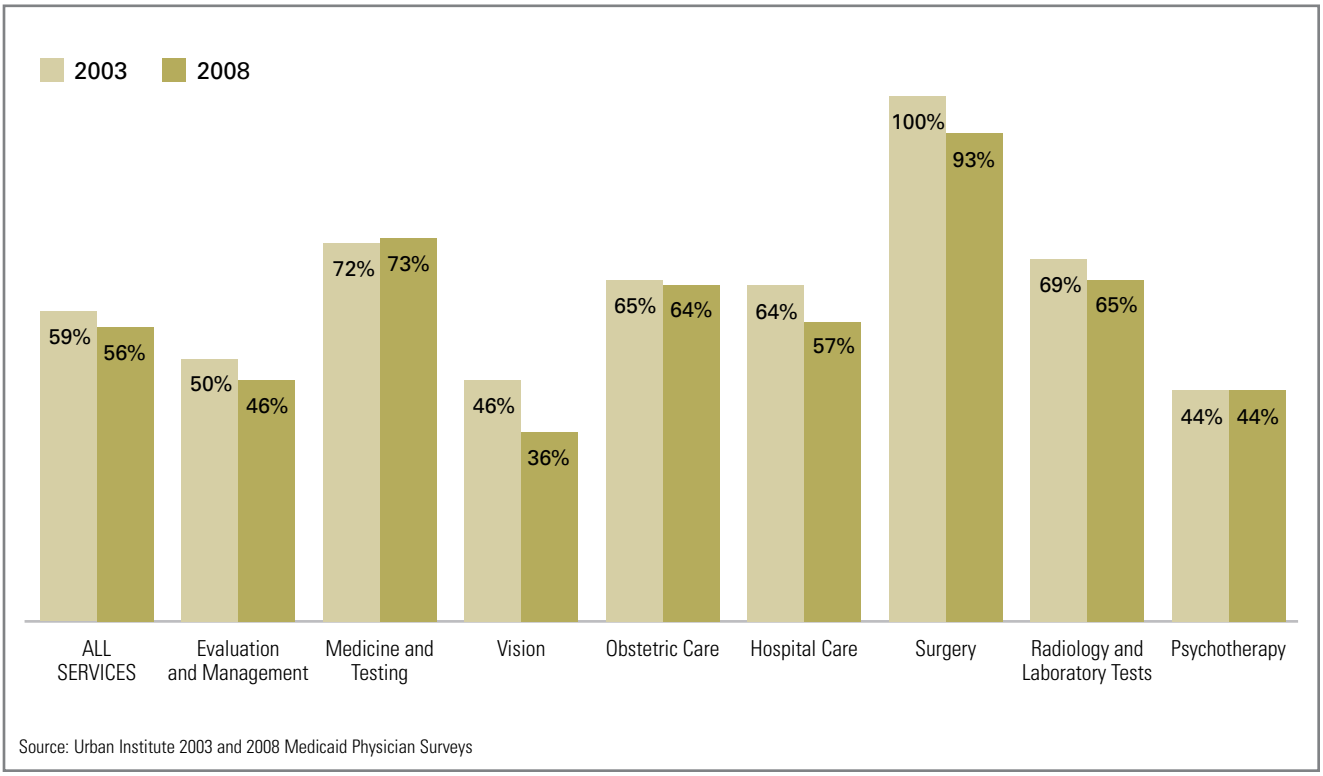
Figure 1 presents the 2003 and 2008 ratios of Medi-Cal to Medicare fees aggregated by service category. For most service categories, Medi-Cal payments declined as a share of Medicare-allowed charges over this time period, making payments for Medi-Cal patients even less attractive to providers compared to payments for Medicare patients. Payments for vision services decreased the most relative to Medicare (10 percentage points) between 2003 and 2008. The two service categories that did not experience a decline relative to Medicare—medicine and testing and psychotherapy—remained virtually the same, paying well below Medicare levels. Surgical procedures continued to be reimbursed at far higher rates compared to other service categories in 2008. Most notably, Medi-Cal fees dropped relative to Medicare during a period in which Medicare fees grew more slowly than the national average growth in Medicaid fees.

Table 3. Change in Medi-Cal and National Average Medicaid Fees, by Service Category, 2003 to 2008

	MEDI-CAL	NATIONAL AVERAGE
All Services	**2%**	**15%**
Evaluation and Management	4%	20%
Medicine and Testing	0%	25%
Vision	–15%	21%
Obstetric Care	0%	9%
Hospital Care	4%	14%
Surgery	0%	2%
Radiology and Laboratory Tests	0%	8%
Psychotherapy	0%	–11%

Source: Urban Institute 2003 and 2008 Medicaid Physician Surveys

Figure 1. Change in Medi-Cal Average Fees as a Percent of Medicare-Allowed Charge, by Service Category, 2003 to 2008



Source: Urban Institute 2003 and 2008 Medicaid Physician Surveys

Medi-Cal Physician Fee Ranking in 2008 and Change from 2003 to 2008

Table 4 shows California's ranking among all states for reimbursement rates for each of the surveyed service procedures and service categories. Except for surgery, California's unadjusted fees rank in the bottom half of the distribution for every service category. Four of the eight service categories studied rank 40th or lower.

When geographic adjustment factors are applied to account for California's higher medical costs, surgery falls from 18th to 26th , while two other categories, medicine and testing and radiology and laboratory tests, drop at least seven places in the rankings. Overall, California ranks near the bottom at 47th. Rankings for individual services remain relatively consistent when comparing Medi-Cal fees as a percentage of Medicare-allowed charges.

Table 5 shows the Medicaid fee indices and rankings for 49 states (no data for Tennessee) and the District of Columbia. These indices reveal how a state's fees compare, on average, to national reimbursement levels. Unadjusted for geographic differences in practice costs, Medi-Cal's physician fees for 2008 were 83 percent of the national average for Medicaid (46th place), compared to 2003 when Medi-Cal's fees were estimated to be 91 percent of the national average (not shown).

When geographically adjusted, the Medicaid fee index for 2008 shows that, overall, Medi-Cal fees dropped to 77 percent of the national average level for Medicaid. In comparison to Medicare, the disparity was even more pronounced: Medi-Cal's fees were about half (56 percent) those of Medicare. These last two comparisons place California 47th among the 50 Medicaid programs in this study.

Table 4. California Rankings Summary, 2008

CODE	PROCEDURE	NUMBER OF STATES FOR WHICH FEE WAS OBTAINED	MEDI-CAL RANK AMONG ALL STATES		
			Fee Index	Geographically Adjusted Fee Index	Medi-Cal Fees as a % of Medicare-Allowed Charge
Primary Care					
	Evaluation and Management				
99203	Office Visit, New Patient, 30 Minutes	50	36	37	37
99204	Office Visit, New Patient, 45 Minutes	50	43	45	45
99213	Office Visit, Established Patient, 15 Minutes	50	49	49	49
99214	Office Visit, Established Patient, 25 Minutes	50	47	47	47
99244	Office Consultation, New Patient, 60 Minutes	50	45	46	46
99283	Emergency Department Visit	50	32	37	37
	Weighted Average Ranking	50	47	47	47
	Medicine and Testing				
93000	Electrocardiogram	50	12	17	25
93307	Echocardiography, Transthoracic	50	30	36	38
95904	Nerve Conduction, Amplitude and Latency/ Velocity Study	49	40	41	42
	Weighted Average Ranking	50	26	33	38
	Vision				
92004	Ophthalmological Services, New Patient	49	41	42	44
92014	Ophthalmological Services, Established Patient	49	43	44	44
	Weighted Average Ranking	49	42	44	45
Obstetric Care*					
59400	Total Obstetric Care, Vaginal Delivery	37	33	33	34
59409	Vaginal Delivery Only, No Postpartum Care	49	47	47	47
59510	Total Obstetric Care, Cesarean Delivery	38	35	35	35
59514	Cesarean Delivery, No Postpartum Care	47	43	45	45
	Weighted Average Ranking	50	48	48	48
Other Services					
	Hospital Care				
99222	Initial Hospital Care, New or Established Patient, 50 Minutes	50	36	39	38
99232	Hospital Visit, New Patient, 45 Minutes	50	39	39	39
99254	Initial Inpatient Consultation, 80 Minutes	50	47	47	47
	Weighted Average Ranking	50	39	40	40

Table 4. California Rankings Summary, 2008, *continued*

CODE	PROCEDURE	NUMBER OF STATES FOR WHICH FEE WAS OBTAINED	MEDI-CAL RANK AMONG ALL STATES		
			Fee Index	Geographically Adjusted Fee Index	Medi-Cal Fees as a % of Medicare-Allowed Charge
Other Services, *continued*					
Surgery					
43235	Upper Gastrointestinal Endoscopy	50	23	31	32
43239	Upper Gastrointestinal Endoscopy with Biopsy	50	28	32	32
58120	Dilation and Curettage	50	16	23	23
58150	Total Hysterectomy	50	22	28	27
66984	Cataract Removal with Lens Implant	50	7	8	8
69436	Tympanostomy	50	33	38	39
	Weighted Average Ranking	50	18	26	24
Radiology and Laboratory Tests					
70450	Computerized Axial Tomography Scan, Head or Brain	50	20	28	35
71020	X-Ray, Chest, Two Views	49	30	37	38
76805	Echography, Pregnant Uterus	49	36	38	39
88305	Surgical Pathology	50	31	34	39
	Weighted Average Ranking	50	30	38	39
Psychotherapy					
90811	Individual Psychotherapy, 20 to 30 Minutes	44	41	42	42
90813	Individual Psychotherapy, 45 to 50 Minutes	44	43	43	43
	Weighted Average Ranking	44	42	43	43
	OVERALL RANKING	**50**	**46**	**47**	**47**

*Medi-Cal does not use two of the 32 procedure codes included in the survey: vaginal (59410) or cesarean (59515) delivery with postpartum care. Therefore, they are not shown in this table.

Source: Urban Institute 2008 Medicaid Physician Survey

Table 5: Medicaid Fee Indices and Fee Rankings, 2008

STATE	INDEX	RANKING	GEOGRAPHICALLY ADJUSTED		AVERAGE MEDICAID FEE AS A % OF MEDICARE-ALLOWED CHARGE	
			Index	Ranking	Percentage	Ranking
Alabama	1.10	30	1.19	29	89%	25
Alaska	2.05	1	1.97	1	140%	2
Arizona	1.45	4	1.47	4	106%	4
Arkansas	1.10	31	1.20	26	89%	24
California	0.83	46	0.77	47	56%	47
Colorado	1.19	24	1.20	28	86%	29
Connecticut	1.44	5	1.32	14	99%	12
Delaware	1.44	6	1.42	8	100%	11
District of Columbia	0.87	45	0.78	46	58%	46
Florida	0.89	44	0.88	42	63%	45
Georgia	1.21	22	1.23	22	90%	23
Hawaii	1.04	34	0.99	37	73%	38
Idaho	1.33	8	1.43	7	103%	7
Illinois	0.90	41	0.87	44	63%	43
Indiana	0.90	42	0.95	41	69%	40
Iowa	1.22	21	1.31	15	96%	13
Kansas	1.20	23	1.28	19	93%	17
Kentucky	1.10	29	1.19	31	86%	30
Louisiana	1.24	19	1.30	16	92%	20
Maine	0.81	47	0.85	45	63%	42
Maryland	1.27	15	1.21	25	87%	28
Massachusetts	1.30	10	1.20	27	88%	26
Michigan	0.90	43	0.88	43	63%	44
Minnesota	0.98	38	1.00	35	76%	34
Mississippi	1.14	27	1.23	23	87%	27
Missouri	0.94	39	0.99	36	72%	39
Montana	1.33	9	1.43	6	103%	6
Nebraska	1.24	18	1.34	11	101%	9
Nevada	1.46	3	1.43	5	104%	5
New Hampshire	0.98	36	0.98	39	73%	37
New Jersey	0.58	50	0.52	50	37%	50
New Mexico	1.42	7	1.49	3	107%	3
New York	0.62	48	0.57	49	43%	48

Table 5: Medicaid Fee Indices and Fee Rankings, 2008, *continued*

STATE	INDEX	RANKING	GEOGRAPHICALLY ADJUSTED Index	GEOGRAPHICALLY ADJUSTED Ranking	AVERAGE MEDICAID FEE AS A % OF MEDICARE-ALLOWED CHARGE Percentage	AVERAGE MEDICAID FEE AS A % OF MEDICARE-ALLOWED CHARGE Ranking
North Carolina	1.27	14	1.33	12	95%	15
North Dakota	1.30	11	1.41	9	102%	8
Ohio	0.94	40	0.96	40	69%	41
Oklahoma	1.28	12	1.39	10	100%	10
Oregon	1.18	26	1.21	24	90%	21
Pennsylvania	0.98	37	0.98	38	73%	36
Rhode Island	0.59	49	0.57	48	42%	49
South Carolina	1.24	17	1.32	13	93%	19
South Dakota	1.19	25	1.28	18	95%	14
Texas	1.01	35	1.03	34	74%	35
Utah	1.08	32	1.12	33	82%	33
Vermont	1.25	16	1.29	17	95%	16
Virginia	1.23	20	1.24	21	90%	22
Washington	1.28	13	1.28	20	93%	18
West Virginia	1.12	28	1.19	30	85%	32
Wisconsin	1.07	33	1.13	32	85%	31
Wyoming	1.81	2	1.94	2	143%	1

Source: Urban Institute 2008 Medicaid Physician Survey

Table 6: Fee Rankings for Ten Largest State Programs, 2008

STATE	INDEX	RANKING	GEOGRAPHICALLY ADJUSTED Index	GEOGRAPHICALLY ADJUSTED Ranking	AVERAGE MEDICAID FEE AS A % OF MEDICARE-ALLOWED CHARGE Percentage	AVERAGE MEDICAID FEE AS A % OF MEDICARE-ALLOWED CHARGE Ranking
California	0.83	9	0.77	9	56%	9
Florida	0.89	8	0.88	6	63%	8
Illinois	0.90	6	0.87	8	63%	6
Massachusetts	1.30	1	1.20	2	88%	2
Michigan	0.90	7	0.88	7	63%	7
New York	0.62	10	0.57	10	43%	10
North Carolina	1.27	2	1.33	1	95%	1
Ohio	0.94	5	0.96	5	69%	5
Pennsylvania	0.98	4	0.98	4	73%	4
Texas	1.01	3	1.03	3	74%	3

Source: Urban Institute 2008 Medicaid Physician Survey

It is useful to also examine Medi-Cal in the context of other large programs, because several have fees that are also below the national average ratio of Medicaid-to-Medicare fees. These low fees could be driven by the need to serve large numbers of beneficiaries while limiting program outlays. However, even when compared to states with the ten largest programs (Table 6), Medi-Cal payments again rank near the bottom. California ranks 9th out of the ten largest state programs for Medicaid fees, both unadjusted and adjusted to reflect geographic differences in practice costs. When comparing the average fee ratio of Medicaid to Medicare in this group of ten, only New York reimburses its physicians at lower rates relative to Medicare (Figure 2).[23]

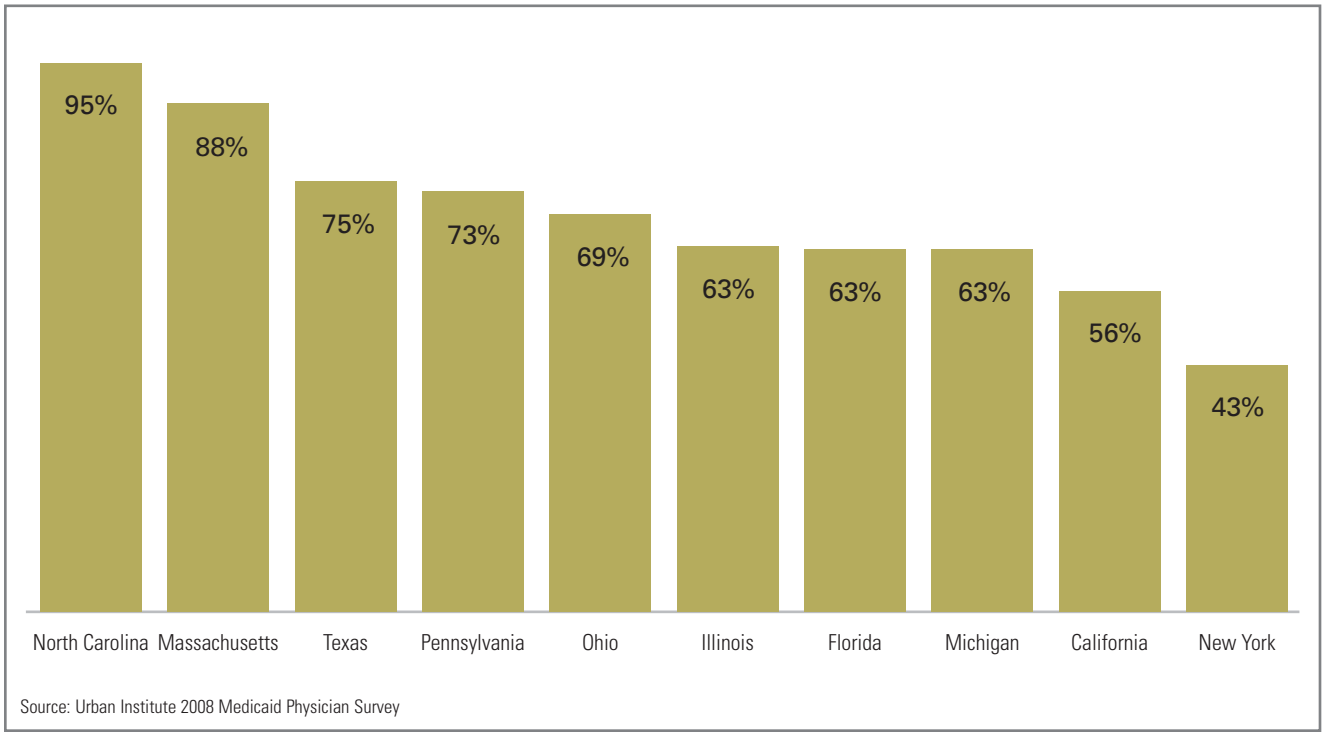
Table 7 summarizes California's drop in rankings nationally and among the ten largest programs from 2003 to 2008. The fall stems from the extremely small increases in Medi-Cal fees noted above. For geographically adjusted Medi-Cal fees and Medi-Cal fees as a percentage of Medicare-allowed charges, California fell from 44th to 47th among all states and from 8th to 9th among the states with the ten largest programs.

Table 7. California Fee Rankings, 2003 and 2008

RANKING...	2003	2008
Among All States (50 fee-for-service Medicaid programs)		
Physician Fees (unadjusted)	41	46
Geographically Adjusted Physician Fees	44	47
Medicaid Fees as a Percentage of Medicare-Allowed Charges	44	47
Within Large State Program Subgroup (10 Medicaid programs)		
Physician Fees (unadjusted)	7	9
Geographically Adjusted Physician Fees	8	9
Medicaid Fees as a Percentage of Medicare-Allowed Charges	8	9

Source: Urban Institute 2003 and 2008 Medicaid Physician Surveys

Figure 2. Average Medicaid Fee as Percent of Medicare-Allowed Charge, by State Program, 2008



Source: Urban Institute 2008 Medicaid Physician Survey

Medi-Cal Dental Fees in 2008

Similar to the patterns observed among physician services, Medi-Cal dental fees (Table 8) were sometimes quite close to the national average across all states and in other cases lagged well behind (Figure 3 on page 22). Dental fees for adult and child prophylaxis (cleaning), set at $40.00 and $30.00, respectively, were above 95 percent of the national average. However, Medi-Cal fees for crowns and extractions were lower, 81 and 76 percent of the national average, respectively. Fees for bitewing x-rays and periodic oral evaluation ran the lowest at about two-thirds the national average. In contrast, New York, another large state program with a history of low fees for physician services, set six of the seven dental fees surveyed well above the national average.

Although some states' fees appear relatively generous when compared to the national average, Medicaid fees likely lag behind commercial rates.[24] Therefore Medicaid beneficiaries may still have difficulty getting the care they need. In California, dentists may be limiting their practice to private payers due to relatively low Medi-Cal fees; only 40 percent of private dental practices in the state accept Medi-Cal patients.[25]

Table 8. Summary of Select Dental Fees, by State, 2008

	D0120 PERIODIC ORAL EVALUATION		D0272 BITEWINGS, TWO FILMS		D1110 ADULT PROPHYLAXIS		D1120 CHILD PROPHYLAXIS	
STATE	Fee	as % of National Average	Fee	as % of National Average	Fee	as % of National Average	Fee	as % of National Average
UNITED STATES	$22.74	100%	$15.64	100%	$40.58	100%	$31.12	100%
Alabama	$18.00	79%	$18.00	115%	$35.00	86%	$28.00	90%
Alaska	$38.50	169%	$32.90	210%	$84.80	209%	$62.40	201%
Arizona	$29.50	130%	$25.30	162%	$52.80	130%	$45.40	146%
Arkansas	$26.60	117%	$24.70	158%	$48.45	119%	$36.10	116%
California	$15.00	66%	$10.00	64%	$40.00	99%	$30.00	96%
Colorado	$20.80	91%	$19.24	123%	$38.20	94%	$28.60	92%
Connecticut	$26.60	117%	$24.32	156%	$48.64	120%	$46.00	148%
Delaware	—	—	—	—	—	—	—	—
D.C.	$35.00	154%	$40.00	256%	$77.50	191%	$47.00	151%
Florida	$15.00	66%	$9.00	58%	$18.00	44%	$14.00	45%
Georgia	$23.34	103%	$22.27	142%	$32.88	81%	$32.88	106%
Hawaii	$33.36	147%	$22.47	144%	$36.40	90%	$26.00	84%
Idaho	$20.25	89%	$16.71	107%	$43.87	108%	$30.70	99%
Illinois	$28.00	123%	$9.40	60%	—	—	$41.00	132%
Indiana	$22.58	99%	$24.81	159%	$47.75	118%	$34.50	111%
Iowa	$16.63	73%	$16.63	106%	$36.38	90%	$24.95	80%
Kansas	$21.00	92%	$20.00	128%	$41.00	101%	$30.00	96%
Kentucky	$101.50	446%	$16.10	103%	$42.55	105%	$48.10	155%
Louisiana	$24.28	107%	$21.91	140%	$44.41	109%	$32.57	105%

Table 8. Summary of Select Dental Fees, by State, 2008, *continued*

STATE	D0120 PERIODIC ORAL EVALUATION		D0272 BITEWINGS, TWO FILMS		D1110 ADULT PROPHYLAXIS		D1120 CHILD PROPHYLAXIS	
	Fee	as % of National Average	Fee	as % of National Average	Fee	as % of National Average	Fee	as % of National Average
Maine	$13.00	57%	$15.00	96%	$40.00	99%	$30.00	96%
Maryland	$29.08	128%	$15.00	96%	$58.15	143%	$42.37	136%
Massachusetts	$23.50	103%	$25.00	160%	$57.00	140%	$41.50	133%
Michigan	$14.89	65%	$10.98	70%	$24.91	61%	$19.53	63%
Minnesota	$15.46	68%	$14.10	90%	$26.52	65%	$18.34	59%
Mississippi	—	—	$16.80	107%	—	—	$24.00	77%
Missouri	$24.00	106%	$13.09	84%	$26.95	66%	$19.25	62%
Montana	$21.89	96%	$18.76	120%	$46.91	116%	$31.27	100%
Nebraska	$16.00	70%	$12.00	77%	$31.00	76%	$21.00	67%
Nevada	$33.24	146%	$21.22	136%	—	—	$57.28	184%
New Hampshire	$29.00	128%	$26.00	166%	$53.00	131%	$38.00	122%
New Jersey	$14.50	64%	$5.00	32%	$16.50	41%	$13.50	43%
New Mexico	$22.97	101%	$20.67	132%	$47.10	116%	$32.15	103%
New York	$29.00	128%	$17.00	109%	$58.00	143%	$43.00	138%
North Carolina	$27.01	119%	$19.38	124%	$35.35	87%	$25.50	82%
North Dakota	$20.94	92%	$20.22	129%	$41.84	103%	$30.92	99%
Ohio	$17.08	75%	$10.00	64%	$34.13	84%	$20.00	64%
Oklahoma	$23.50	103%	$20.14	129%	$50.36	124%	$33.57	108%
Oregon	$24.07	106%	$11.10	71%	$37.81	93%	$29.07	93%
Pennsylvania	$20.00	88%	$16.00	102%	$36.00	89%	$30.00	96%
Rhode Island	$10.00	44%	$14.00	90%	$30.00	74%	$22.00	71%
South Carolina	$22.00	97%	$21.00	134%	$35.00	86%	$31.00	100%
South Dakota	$24.00	106%	$22.00	141%	$45.00	111%	$32.00	103%
Texas	$29.44	129%	$23.86	153%	$56.00	138%	$37.50	120%
Utah	$14.57	64%	$14.57	93%	$30.06	74%	$23.48	75%
Vermont	$20.00	88%	$17.00	109%	$47.00	116%	$32.00	103%
Virginia	$20.15	89%	$20.15	129%	$47.19	116%	$33.52	108%
Washington	$24.63	108%	$8.81	56%	$37.37	92%	$23.69	76%
West Virginia	$20.00	88%	$19.00	121%	—	—	$30.00	96%
Wisconsin	$14.39	63%	$12.88	82%	$27.48	68%	$21.60	69%
Wyoming	$32.00	141%	$24.00	153%	$50.00	123%	$35.00	112%

Notes: Delaware reimburses 85 percent of charge. Fees not available for some states.

Source: Urban Institute 2008 Medicaid Physician Survey

Table 8. Summary of Select Dental Fees, by State, 2008, *continued*

STATE	D2150 AMALGAM, TWO SURFACES, PERMANENT		D7140 EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT		D2751 CROWN, PORCELAIN FUSED TO BASE METAL	
	Fee	as % of National Average	Fee	as % of National Average	Fee	as % of National Average
UNITED STATES	$63.34	100%	$53.72	100%	$420.43	100%
Alabama	$60.00	95%	$53.00	99%	$427.00	102%
Alaska	$131.60	208%	$115.50	215%	$680.00	162%
Arizona	$92.80	147%	$88.00	164%	$600.30	143%
Arkansas	$80.75	127%	$72.20	134%		0%
California	$48.00	76%	$41.00	76%	$340.00	81%
Colorado	$71.76	113%	$68.12	127%	$426.40	101%
Connecticut	$86.64	137%	$87.40	163%	$611.80	146%
Delaware	—	—	—	—	—	—
District of Columbia	$115.00	182%	$110.00	205%	—	—
Florida	$41.00	65%	$27.00	50%	$228.00	54%
Georgia	$79.56	126%	$65.77	122%	—	—
Hawaii	$57.51	91%	$62.13	116%	—	—
Idaho	$59.29	94%	$46.35	86%	$332.14	79%
Illinois	$48.15	76%	$39.12	73%	$235.20	56%
Indiana	$71.93	114%	$77.24	144%	—	—
Iowa	$59.25	94%	$51.97	97%	$426.14	101%
Kansas	$64.00	101%	$42.50	79%	$450.00	107%
Kentucky	$57.50	91%	$43.70	81%	—	—
Louisiana	$82.90	131%	$77.57	144%	—	—
Maine	$48.00	76%	$67.00	125%	—	—
Maryland	$88.00	139%	$103.01	192%	$375.00	89%
Massachusetts	$83.50	132%	$81.50	152%	$647.00	154%
Michigan	$39.81	63%	$35.05	65%	$393.23	94%
Minnesota	$41.65	66%	$44.70	83%	—	—
Mississippi	$60.00	95%	$52.80	98%	$422.40	100%
Missouri	$48.51	77%	$46.59	87%	$315.00	75%
Montana	$68.79	109%	$68.79	128%	$500.32	119%
Nebraska	$63.00	99%	$52.00	97%	$350.00	83%
Nevada	$86.04	136%	$45.10	84%	$328.00	78%
New Hampshire	$109.00	172%	$82.00	153%	$200.00	48%
New Jersey	$36.75	58%	$31.00	58%	$266.00	63%

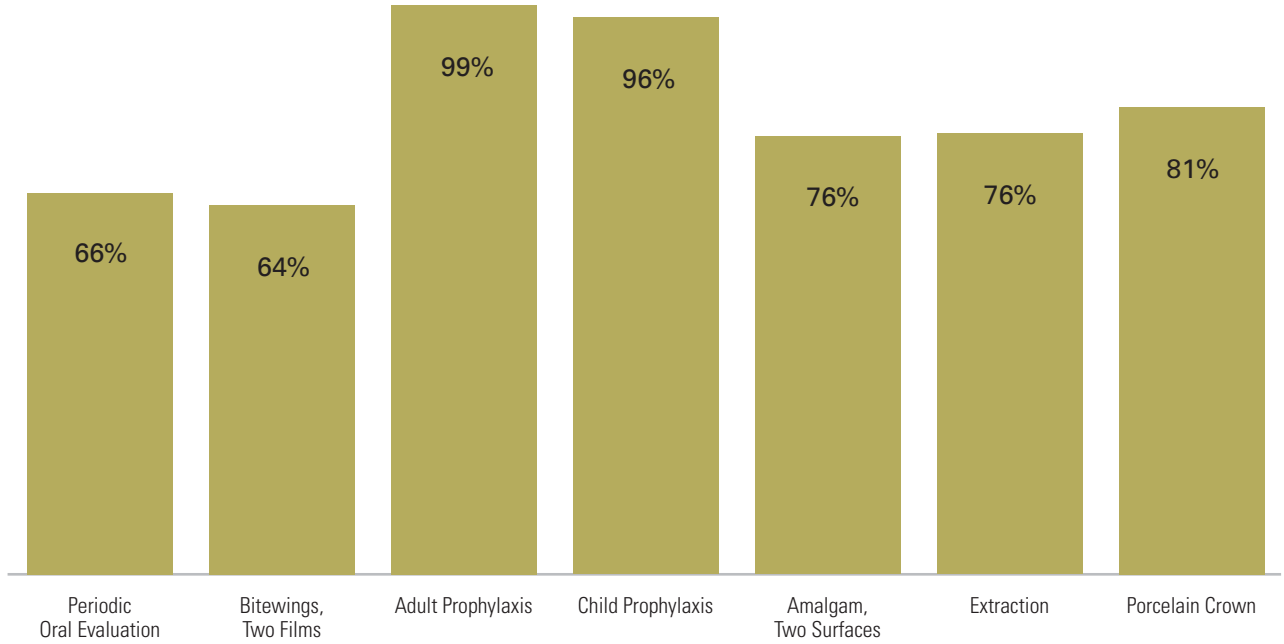
Table 8. Summary of Select Dental Fees, by State, 2008, *continued*

STATE	D2150 AMALGAM, TWO SURFACES, PERMANENT		D7140 EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT		D2751 CROWN, PORCELAIN FUSED TO BASE METAL	
	Fee	as % of National Average	Fee	as % of National Average	Fee	as % of National Average
New Mexico	$74.66	118%	$67.76	126%	$461.71	110%
New York	$84.00	133%	$45.00	84%	$580.00	138%
North Carolina	$79.41	125%	$60.50	113%	—	—
North Dakota	$69.60	110%	$55.09	103%	$392.33	93%
Ohio	$54.00	85%	$52.45	98%	—	—
Oklahoma	$73.85	117%	$73.85	137%	$537.12	128%
Oregon	$47.39	75%	$77.90	145%	$266.35	63%
Pennsylvania	$55.00	87%	$65.00	121%	$500.00	119%
Rhode Island	$37.00	58%	$39.00	73%	$450.00	107%
South Carolina	$75.00	118%	$62.00	115%	—	—
South Dakota	$77.00	122%	$69.00	128%	$440.39	105%
Texas	$87.46	138%	$67.04	125%	$528.00	126%
Utah	$43.21	68%	$42.36	79%	$225.44	54%
Vermont	$73.00	115%	$88.00	164%	$420.00	100%
Virginia	$75.53	119%	$69.00	128%	$500.00	119%
Washington	$60.74	96%	$46.29	86%	$659.96	157%
West Virginia	$72.00	114%	$44.00	82%	$510.00	121%
Wisconsin	$43.26	68%	$40.59	76%	—	—
Wyoming	$82.00	129%	$70.00	130%	$600.00	143%

Notes: Delaware reimburses 85 percent of charge. Fees not available for some states.

Source: Urban Institute 2008 Medicaid Physician Survey

Figure 3. California Dental Fees as Percent of National Average, by Procedure, 2008



	Periodic Oral Evaluation	Bitewings, Two Films	Adult Prophylaxis	Child Prophylaxis	Amalgam, Two Surfaces	Extraction	Porcelain Crown
CALIFORNIA FEE	$15.00	$10.00	$40.00	$30.00	$48.00	$41.00	$340.00
NATIONAL AVERAGE MEDICAID FEE	$22.74	$15.64	$40.58	$31.12	$63.34	$53.72	$420.43

Source: Urban Institute 2008 Medicaid Physician Survey

IV. Summary and Implications

CALIFORNIA PAYS SOME OF THE LOWEST FEES among all Medicaid programs in the United States, although there is considerable variation by procedure. Similar patterns emerge when comparing dental fees.

In 2008, Medi-Cal fees were, on average, only 83 percent of national average Medicaid fees and 56 percent of Medicare fees. As a result, California ranked 46th in the nation and 9th among the ten largest state Medicaid programs. When accounting for geographic variation in practice costs or comparing Medicaid fees to Medicare fees, California ranked 47th.

State policymakers made a concerted effort to increase physician fees for only the short period of time from 1998 to 2001. Since then, Medi-Cal fees have remained virtually unchanged. Consequently, the growth of Medi-Cal fees since 2003 has not kept pace with the growth of Medicaid fees nationally, the growth of Medicare fees, or the rising cost of operating a practice.

Many states view cuts in Medicaid provider rates, including physician fees, as one of the first policy options to consider when the economy deteriorates and budgetary pressures emerge, making Medicaid the least attractive tier of third-party payers. However, research has shown that small increases or decreases in Medicaid fees will not necessarily dramatically alter beneficiary access.[26–28] Nonetheless, persistently low Medicaid fees are likely to be a structural barrier to broad-based access to care in medical and dental offices. In fact, studies have shown that only about 50 percent of physicians and 40 percent of private dental practices in the state accept Medi-Cal patients, limiting access and potentially shifting the burden of care to more expensive settings, such as emergency departments and hospitals.

Appendix: Geographic Adjustment Factors

STATE	GEOGRAPHIC ADJUSTMENT FACTOR
Alabama	0.924
Alaska	1.045
Arizona	0.987
Arkansas	0.914
California	1.078
Colorado	0.993
Connecticut	1.094
Delaware	1.013
District of Columbia	1.124
Florida	1.012
Georgia	0.983
Hawaii	1.050
Idaho	0.932
Illinois	1.036
Indiana	0.947
Iowa	0.929
Kansas	0.938
Kentucky	0.932
Louisiana	0.951
Maine	0.959
Maryland	1.047
Massachusetts	1.085
Michigan	1.022
Minnesota	0.976
Mississippi	0.928

STATE	GEOGRAPHIC ADJUSTMENT FACTOR
Missouri	0.946
Montana	0.928
Nebraska	0.929
Nevada	1.018
New Hampshire	1.005
New Jersey	1.107
New Mexico	0.952
New York	1.089
North Carolina	0.956
North Dakota	0.921
Ohio	0.973
Oklahoma	0.922
Oregon	0.972
Pennsylvania	0.995
Rhode Island	1.031
South Carolina	0.939
South Dakota	0.925
Texas	0.974
Utah	0.962
Vermont	0.974
Virginia	0.992
Washington	1.000
West Virginia	0.939
Wisconsin	0.953
Wyoming	0.933

Endnotes

1. California HealthCare Foundation, *Physician Participation in Medi-Cal, 2001,* June 2003 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20731).
2. California HealthCare Foundation, *Denti-Cal Facts and Figures: A Look at California's Medicaid Dental Program,* May 2007 (www.chcf.org/topics/view.cfm?itemID=131431).
3. Norton, S., and S. Zuckerman. 2000. "Trends In Medicaid Physician Fees, 1993–1998." *Health Affairs* 19(4): 222–232.
4. California HealthCare Foundation, *Comparing Physician and Dentist Fees Among Medicaid Programs,* June 2001 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20412).
5. Zuckerman, S., et al. "Changes in Medicaid Physician Fees, 1998–2003: Implications For Physician Participation." *Health Affairs* (published online June 23, 2004).
6. The 10 percent rate cut was implemented by the California Department of Health Care Services on July 1, 2008 as mandated by Section 14105.19 of the Welfare and Institutions Code. As written, the rate cut would result in a reduction in all physician payments of 10 percent from the value indicated in state fee schedules. However, on August 18, 2008, the U.S. District Court issued an injunction against portions of the payment reduction bill, including reductions in payments to physicians. As the reduced rates were only in effect temporarily, the reduction is not included in this analysis. *See* "Ten Percent Provider Payment Injunction Update," Department of Health Care Services, September 26, 2008. (files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_9757.asp).
7. The physician services surveyed in 2003 were expanded from the 1993 and 1998 Urban Institute surveys, as new services were introduced and service volume changed over time. In 2003, the earlier list was augmented with 12 additional services that were included in a study by the Lewin Group for the California HealthCare Foundation, *Comparing Physician and Dentist Fees Among Medicaid Programs,* June 2001. Fees for two services, CPT codes 81000, urinalysis, and 87081, a culture, were dropped from the study because Medicare no longer reimburses for these services; therefore, the fees cannot be compared to Medicare fees.
8. In the 2003 study and in a 2009 *Health Affairs* article, also by the Urban Institute, the surveyed services are divided into three categories: primary care, obstetrical care, and other services. However, all the same procedures are included in the analysis. California does not reimburse for vaginal deliveries with postpartum care, CPT 59410, or caesarian deliveries with postpartum care, CPT 59515; therefore, these procedures are not included in Tables 1, 2, and 4. They are, however, included in calculations of indices for other states.
9. Medi-Cal enrolled children with special health care needs receive care through the California Children's Services (CCS) program. Medi-Cal pays a 39 percent premium above standard rates to CCS-certified physicians serving CCS-enrolled children. This adjustment is not accounted for in this analysis. The average fee derived in this study for primary care and hospital services accounts for Medi-Cal fees for children not enrolled in CCS, which are roughly 9.1 percent above fees for those services for adults.
10. Cohen, J., and P. Cunningham. Spring 1995. "Medicaid Physician Fee Levels and Children's Access to Care." *Health Affairs* 14(1): 255–262.
11. Cunningham, P.J., and L.M. Nichols. 2005. "The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective." *Medical Care Research and Review* 62(6): 676–696.
12. The service-specific expenditures are based on 1) the 2000 calendar year files and 2) aggregating expenditures for the specific services for the 20 states with the largest Medicaid expenditures.
13. The authors were not able to determine, from the available data, the share of total spending for Medicaid physician services accounted for by the services in this study.

14. Relative Value Units (RVUs) were determined from the 2008 Clinical Diagnostic Fee Schedule by dividing the national limit fee for a given service by the 2008 Physician Conversion Factor for RVUs of $38.087.

15. Medicare County Enrollment as of July 1, 2007 (www.cms.hhs.gov/medicareenrpts).

16. It may be possible to compare the 2008 Medicaid dental fees to data from the California HealthCare Foundation report, *Comparing Physician and Dentist Fees Among Medicaid Programs,* June 2001, but this analysis was not performed for this study (www.chcf.org/topics/medi-cal/index.cfm?itemID=20412).

17. The Medi-Cal fee for cataract removal with lens implant was also considerably higher than the Medicare fee in 2000 as reported in *Comparing Physician and Dentist Fees Among Medicaid Programs,* June 2001 (www.chcf.org/topics/medi-cal/index.cfm?itemID=20412).

18. See note 3.

19. See note 4.

20. See note 5.

21. Consumer Price Index historical data available at data.bls.gov/PDQ/outside.jsp?survey=cu.

22. Ibid.

23. On January 1, 2009, New York raised its Medicaid physician fees substantially, and they are now much closer to the national average. This change would place New York above California in fee rankings. The policy is a major change for a state that has had historically low Medicaid physician fees. These new fees are not reflected here because they were introduced after the target date for data collection in this study (July 1, 2008); therefore, their inclusion would not be consistent with data from other states.

24. American Dental Association, *Medicaid Reimbursement for New England Region—Using Marketplace Principles to Increase Access to Dental Services,* March 2004 (www.ada.org/prof/advocacy/issues/medicaid_newengland.pdf).

25. See note 2.

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