

Discussion Papers

Recent Trends in Medicaid Physician Fees, 1993-1998

Stephen Norton

99-12

September 1999



Assessing
the New
Federalism

An Urban Institute
Program to Assess
Changing Social Policies

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Assessing the New Federalism

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia. Publications and the database are available free of charge on the Urban Institute's Web site: <http://www.urban.org>. This paper is one in a series of discussion papers analyzing information from these and other sources.

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Abstract

This study uses data on Medicaid physician fees in 1993 and 1998 to document variation in Medicaid fees across the country, describe changes in Medicaid fees, and contrast how Medicaid physician fees have changed relative to those in Medicare between 1993 and 1998. The results show that 1998 Medicaid fees vary widely, as has been documented in earlier studies, but that states with low average fees may pay more generously for selected services (e.g., obstetrics and preventive services). The growth in Medicaid fees between 1993 and 1998 was 4.6 percent nationwide, lagging behind the general rate of inflation. Medicaid fee growth was greater for primary care services than for other services studied. Relative to Medicare physician fees, Medicaid fees fell by 14.3 percent between 1983 and 1988. Medicaid's low fees and slow growth rates suggest that potential access problems among Medicaid enrollees remain a policy issue that should be monitored.

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Background

During the past decade, states have expanded the role of managed care within the Medicaid program as a means of expanding access and decreasing costs (Holahan et al. 1998). Between 1991 and 1997, Medicaid managed care (MMC) enrollment grew from less than 10 percent to almost 50 percent of Medicaid beneficiaries. This change has sparked interest in research on Medicaid payments to capitated health plans (Holahan et al. 1999). However, few states have extended MMC to disabled and elderly populations, which account for a disproportionate share of Medicaid spending relative to their numbers. In addition, many states that have moved to MMC have not chosen capitation. Instead, they are relying on primary care case managers (PCCMs) that often continue to be paid on a fee-for-service basis.¹ In 1997, over 70 percent of Medicaid enrollees in the United States received services in a fee-for-service (FFS) or PCCM system (Zuckerman 1997).

Given the continued reliance on fee-for-service payment within Medicaid, understanding the FFS component of Medicaid is still important to understanding the Medicaid program as a whole. In fact, significant expansions in Medicaid coverage in recent years may only translate into increased access if physician fees are high enough to ensure that physicians participate in the program. Research continues to suggest that physician fee levels affect both access and outcomes for Medicaid patients. A number of qualitative and quantitative studies show that physicians' decisions to provide care to Medicaid-enrolled patients are related both to Medicaid fee levels and to such fee levels relative to other insurance programs (Sloan, Cromwell, and Mitchell 1978; Mitchell 1991; Perloff, Kletke, and Necherman 1987; Showalter 1997; Wiener et

¹ Two states with major PCCM programs in 1998—Florida and Michigan—reported that the fees reflected in their surveys applied to both the PCCM and fee-for-service components of their Medicaid programs.

al. 1998). These studies show that, as Medicaid fee levels increase, physicians are more likely to participate in the program, and those participating may treat more Medicaid patients. Other work suggests that Medicaid fees affect the coordination of care for Medicaid patients (Fox and Phua 1995) or the site at which a Medicaid patient is treated (Gruber, Adams, and Newhouse 1997; Cohen and Cunningham 1995).

This study uses data on Medicaid fees in 1993 and 1998 and information on Medicare fees to provide policymakers and analysts with more recent documentation of trends in Medicaid fees. Updating work by Holahan (1991) and Norton (1995), this article provides new information on the variation in physician fees across the country, describes changes in Medicaid fees from 1993 to 1998, and evaluates Medicaid physician fees relative to Medicare physician fees in 1998 as well as changes in Medicaid physician fees relative to Medicare physician fees from 1993 to 1998.

Data Collection

A sample of physician services developed in a 1993 Urban Institute survey (Norton 1995) was reexamined in 1998. States were asked to provide their maximum Medicaid fees for 22 services effective January 1, 1998. Surveyed fees are listed in table 1 with their Current Procedural Terminology, Fourth Edition (CPT-4) codes and are grouped according to three broad types of physician services: primary care services, obstetric care, and other services that include hospital visits, surgery services, imaging services, and laboratory tests. Table 1 also provides information on the relative importance of each service surveyed. Column 1 provides 1988 Medicaid expenditures for each service as a percentage of total expenditures for the surveyed services. All national average values presented are weighted averages, using 1996 Medicaid enrollees in each state as the weights. Weighting by Medicaid enrollees allows us to compare the

Table 1: Mean, Maximum, Minimum Medicaid Fees and Standard Deviations: Selected States, 1998

Category and Code	Procedure	Percent of Total Expenditures for Surveyed Services			Coefficient of Variation	
		Mean	Maximum	Minimum		
Primary Care						
99203	Office Visit, New Patient, 30 Minutes	6.1%	39.29	95.34	11.00	37.19
99213	Office Visit, Established Patient, 15 Minutes	35.1%	25.87	69.60	11.00	37.10
99214	Office Visit, Established Patient, 25 Minutes	4.2%	34.31	81.95	15.50	34.02
99244	Office Visit, New Patient, 60 Minutes	1.9%	70.11	198.16	24.00	44.75
93000	Electrocardiogram	1.4%	21.25	52.69	13.00	35.24
Obstetric Care						
59400	Total Obstetric Care, Vaginal Delivery ²	14.4%	1024.18	2258.36	435.50	32.27
59410	Vaginal Delivery Only ³	6.9%	697.39	1553.73	296.00	32.90
59515	Cesarean Delivery and Postpartum Care ³	3.9%	771.86	1780.22	417.50	35.58
59510	Total Obstetric Care, Cesarean Delivery ⁴	6.5%	1156.14	2547.05	557.00	30.80
Other Services						
<i>Hospital Visits</i>						
99222	Initial Hospital Care, New or Established Patient, 50 Minutes	3.1%	55.29	164.89	6.50	53.67
99254	Initial Inpatient Consultation, 80 Minutes ¹	1.9%	69.61	198.56	20.00	46.38
<i>Surgery</i>						
43235	Upper Gastrointestinal Endoscopy	1.1%	167.62	390.19	80.00	41.61
58120	Dilation and Curettage ⁵	0.9%	165.91	429.03	67.50	40.47
58150	Total Hysterectomy	1.2%	630.50	1723.56	240.00	40.85
66984	Cataract Removal with Lens Implant	1.1%	785.49	2289.59	440.00	51.18
69436-50	Bilateral Tympanostomy	0.0%	161.38	404.99	62.50	48.52
<i>Imaging</i>						
70450	Computerized Axial Tomography Scan, Head or Brain ⁶	0.9%	163.50	354.63	35.47	35.01
71020	X-Ray, Chest, Two Views ⁶	3.4%	23.10	55.75	14.58	37.53
76805	Echography, Pregnant Uterus ⁶	3.7%	84.56	209.90	36.00	37.36
<i>Laboratory Tests</i>						
81000	Urinalysis, Routine ⁷	0.9%	3.74	7.48	1.20	27.42
87081	Culture, Bacterial, Screening Only ⁷	0.6%	7.38	15.68	3.20	31.00
88305	Surgical Pathology ⁷	0.9%	40.61	105.64	8.98	42.72

Source: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey. Washington, DC, 1998.

1 Oklahoma did not cover procedure 99254 (initial inpatient consultation, 80 minutes).

2 Florida, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Mississippi, North Dakota, Ohio, Pennsylvania, South Carolina and West Virginia did not cover procedure 59400 (total obstetric care, vaginal delivery).

3 Mississippi did not cover procedures 59410 (vaginal delivery only) and 59515 (cesarean delivery and postpartum care).

4 Florida, Illinois, Kentucky, Maryland, Michigan, Mississippi, North Dakota, Ohio, Pennsylvania, South Carolina and West Virginia did not cover procedure 59510 (total obstetric care, cesarean delivery).

5 Pennsylvania did not cover procedure 58120 (dilation and curettage).

6 Mississippi did not cover procedures 70450 (computerized axial tomography scan, head or brain), 71020 (X-ray, chest, two views) and 76805 (echography, pregnant uterus).

7 Mississippi and Pennsylvania did not cover procedures 81000 (urinalysis, routine), 87081 (culture, bacterial, screening only) and 88305 (surgical pathology).

8 Based on expenditure data from 1988 Tape-To-Tape data in Tennessee, California and Georgia.

average fees for services provided to Medicaid enrollees in a given state to the average for the nation.

Of the 49 states (including the District of Columbia) with an FFS component to their Medicaid programs, five states declined to participate in this survey.² These states—Arkansas, Delaware, Montana, Nebraska, and Wyoming—accounted for 5.5 percent of the total Medicaid population in 1996. In addition, we received incomplete surveys from Mississippi and Pennsylvania. While providing data on most procedures, both states declined to assist in clearing up a number of potential reporting errors. Data for these states were excluded from the analysis, other than in the calculation of average fees by procedure (table 1). Because the data suggested some large changes in fees between 1993 and 1998, states in which average Medicaid fees or fees for subgroups of services increased or decreased substantially were recontacted to verify the fees reported. Alabama, Alaska, Florida, Maine, Virginia, and West Virginia all confirmed that the fees they reported were correct.³

As part of the survey, states were asked whether they adjusted payment rates for specific providers or services to meet policy objectives. A number of states reported that they reimburse providers at different levels depending on the type of physician performing the procedure, the geographic location of the physician and/or patient, the risk involved with the procedure, or the age of the patient. These adjustments were generally made to increase access to obstetric or preventive services or to those providers most likely to provide obstetric or preventive services, such as obstetricians and family practitioners or pediatricians. For example, some states provide

² Arizona and Tennessee declined to participate, as they have shifted almost all Medicaid program eligibles into capitated care arrangements.

³ Both Connecticut and Vermont were also contacted but did not respond to requests for data confirmation. Their data were used as originally reported.

higher reimbursement rates for free and community clinics; for pediatricians, obstetricians, and gynecologists; or for maternal and child health providers more generally.

In all, 12 states—California, Colorado, Connecticut, Florida, Hawaii, Illinois, Kansas, Minnesota, Missouri, New Jersey, Pennsylvania, and Wisconsin—adjusted rates for specific preventive or obstetric services, or for particular providers most likely to provide preventive or obstetric services. In addition, three states indicated that they allowed higher rates in rural than in urban areas. For example, for a specific set of preventive services, Alabama increased fees by \$1 per service. In Utah, physicians in rural counties are reimbursed at 112 percent of their fee schedule amount. In Wisconsin, providers in health-professional-shortage areas receive increased reimbursements, as much as \$20 more per service.⁴ In those states with differentiated fees, an average of all provider fees was calculated.

Analysis Variables

State-Level Medicaid Fee Indices and Fee Changes between 1993 and 1998. To evaluate average Medicaid fees as well as changes in average fee levels between 1993 and 1998, we calculated state and national average fees using a subset of our surveyed procedures. Fees for total obstetric care (reported in table 1) were not included in computing indices of fee levels or changes because many states reported providing global fees in 1993 but not in 1998. As a result, the average fee for each state was computed using 19 procedures broadly representative of the range of Medicaid services.⁵ To calculate state-level average fees, each individual fee was

⁴ More detailed information is available from the author.

⁵ These 19 procedures are broadly representative of the Medicaid services most often provided to Medicaid recipients and include all services listed in table 1, with the exception of total obstetric care for vaginal or cesarean delivery (59400 and 59510) and bilateral tympanostomy (69436-50).

weighted by total Medicaid expenditures obtained from the Health Care Financing Administration (HCFA)'s 1988 Medicaid Tape-to-Tape files.

Medicaid-to-Medicare Fee Ratios. Following previous work (Holahan 1991; Norton 1995), summary measures of relative fees for 1998 by type of service were created by multiplying the Medicaid-to-Medicare fee ratios for each service by Medicaid expenditure weights. Medicare fees in 1998 were computed using the Medicare Fee Schedule (MFS) formula. To compute Medicare fees, we used the 1998 relative value unit (RVU) values and the MFS formula published in the October 31, 1997, Federal Register.⁶ Expenditure weights were developed based on prior work with 1988 Tape-to-Tape data.⁷ Similarly, the Medicaid-to-Medicare fee ratio across all surveyed services was computed by combining the fees based on these same expenditure weights.⁸ The summary measure of relative fees for 1993 is not presented in our analysis of changes in Medicaid-to-Medicare fee ratios across the time period, but it is available upon request.

Results

Medicaid Fees in 1998

Table 1 shows the national average fee for each procedure surveyed, the maximum and minimum fees, and the coefficients of variation across all states. The coefficients of variation suggest that there is variation in what states pay for a given service, though this varies by type of service. Variation was highest among surgical services and lowest among obstetric services.

⁶ The MFS includes only RVUs for physician services. Therefore, we used charge data from the 1998 Clinical Laboratory Fee Schedule to estimate total RVUs by taking a ratio of the prevailing charge to the 1998 Medicare conversion factor for nonsurgical services. State-level 1998 geographic adjustment factors were then used to adjust these calculated Medicare fees.

⁷ Norton 1995.

⁸ Norton (1995) computed Medicaid-to-Medicare ratios for 1993 as well. However, those computed for this analysis are based on a more limited set of services. As a result, the results from 1993 are not comparable to those presented here.

Column 1 of table 2 provides a state-level index of average Medicaid fees (the national average is 1.00). Average fee values ranged from a low of .51 in New Jersey (49 percent below the national average) to a high of 2.34 in Alaska. Alabama, Alaska, Connecticut, Georgia, Idaho, Iowa, Nevada, Washington, and West Virginia all had Medicaid fees that were 25 percent greater than the national weighted-average fee. Three states—Missouri, New Jersey, and Rhode Island—had Medicaid fees that were at least 25 percent lower than the national average fee. The states with the largest Medicaid programs in the country—New York and California—had fees that were more than 20 percent below the national average.

Table 2 also provides average fees for selected preventive care and obstetric services, those used most by the populations for which Medicaid was expanded considerably in the early and mid-1990s—pregnant women and children. As table 2 illustrates, there is a significant variation in fees for both a 30-minute office visit for a new patient as well as a 15-minute visit for an established patient. Medicaid fees in Alaska for a 30-minute office visit for a new patient are almost nine times higher than Medicaid fees in New York. Similarly, the fee for the 15-minute visit is more than six times higher in Texas than it is in New York. With respect to obstetric services, fees for a vaginal delivery ranged from over \$1,500 in Alaska to \$296 in New Jersey.

These results highlight two important characteristics of the Medicaid FFS reimbursement environment. First, the level of payment varies considerably across the country. Thus, the incentives faced by physicians to participate in the Medicaid program are likely to vary considerably. Second, though a state may have low fee levels generally, this does not necessarily mean that the state has low fee levels for specific services that may be of interest to

Table 2: Medicaid Fee Index and Medicaid Fees for Selected Procedures: United States, 1998

State	Medicaid Fee Index, All Services *	Office Visit, New Patient, 30 Minutes, (99203)	Office Visit, Established Patient, 15 Minutes (99213)	Vaginal Delivery Only (59410)	Cesarean Section Only (59515)
Alabama	1.27	50.50	30.50	1000.00	1000.00
Alaska	2.34	95.34	53.52	1553.73	1780.22
California	0.77	46.00	16.56	480.60	480.64
Colorado	1.11	49.11	31.50	773.57	898.60
Connecticut	1.51	35.50	28.75	1204.85	1429.50
District of Columbia	1.13	30.00	18.00	900.00	950.00
Florida	1.15	43.92	25.00	950.00	950.00
Georgia	1.35	53.14	30.29	901.00	1200.00
Hawaii	0.85	60.70	25.66	337.80	675.65
Idaho	1.30	49.43	33.26	776.15	1164.22
Illinois	1.09	25.80	18.55	772.50	927.00
Indiana	1.03	46.85	25.98	698.37	809.02
Iowa	1.30	33.47	21.05	951.72	951.72
Kansas	1.01	28.75	19.50	690.19	940.91
Kentucky	1.18	48.86	27.06	900.00	900.00
Louisiana	1.11	32.40	24.30	774.00	990.00
Maine	0.96	38.66	28.94	700.00	709.79
Maryland	1.12	37.00	31.00	895.00	948.00
Massachusetts	0.98	49.51	33.54	592.00	637.00
Michigan	0.80	35.89	21.00	540.00	540.00
Minnesota	1.21	40.07	27.32	607.20	1062.60
Missouri	0.73	25.00	18.75	550.00	600.00
Nevada	1.78	55.02	34.06	1092.54	1529.83
New Hampshire	1.21	38.00	27.00	965.00	965.00
New Jersey	0.51	20.75	15.50	296.00	417.50
New Mexico	1.20	54.79	31.16	629.46	1040.21
New York	0.76	11.00	11.00	630.00	734.00
North Carolina	1.18	57.57	32.30	808.01	922.06
North Dakota	1.20	58.73	32.70	814.23	946.71
Ohio	0.91	37.83	27.48	642.33	683.46
Oklahoma	0.97	34.97	20.91	700.00	800.00
Oregon	0.99	42.75	23.75	725.10	725.10
Rhode Island	0.67	29.00	20.64	450.00	450.00
South Carolina	0.94	30.00	21.50	700.00	700.00
South Dakota	1.23	49.00	28.70	650.00	1030.00
Texas	1.14	47.57	69.60**	700.00	700.00
Utah	0.95	42.77	23.87	703.84	703.84
Vermont	1.10	33.20	25.80	846.20	846.20
Virginia	1.09	53.78	30.54	742.62	862.60
Washington	1.25	62.03	34.79	994.65	994.65
West Virginia	1.43	51.99	29.34	1107.44	1285.83
Wisconsin	1.23	34.88	31.28	783.62	960.40
Weighted Mean	1.00	40.01	26.46	695.89	775.30
Minimum	0.51	11.00	11.00	296.00	417.50
Maximum	2.34	95.34	69.60	1553.73	1780.22
Coefficient of Variation	30.29	35.52	36.70	33.05	35.50

Source: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey. Washington, D.C., 1998.

*See Appendix 1 for services included in All Services Index.

**Subsequent to publication, Texas notified us that they had reported the incorrect fee for CPT code 99213. The correct fee should have been \$26.87.

policymakers. While a state Medicaid program might pay less on average than other states across the country, fees for obstetric or preventive services could be much higher relatively.

Changes in Medicaid Fees: 1993–98

Table 3 provides information on changes in average Medicaid fees as well as fees by type of service. Between 1993 and 1998, the average Medicaid fee increased by 4.6 percent across the nation. In contrast, general prices for goods, as measured by the consumer price index, increased by approximately 11 percent between 1993 and 1998 (Bureau of Labor Statistics Web page 1999). In real terms, Medicaid physician fees declined nationally between 1993 and 1998.

With some exceptions, states that increased fees during this time period tended to be those with smaller Medicaid programs. Nine states—Colorado, Connecticut, Illinois, Maine, Nevada, North Dakota, Vermont, Washington, and Wisconsin—experienced an average fee increase of 20 percent or more. In 13 states, however, average fees declined across the time period. The largest decreases occurred in Hawaii, Indiana, Kentucky, Louisiana, Virginia, and West Virginia, all of which experienced a decrease of more than 10 percent in the average fee. California and New York experienced no change or a slight reduction in Medicaid fees across the study period. In Texas, fees grew by approximately 12 percent, slightly faster than changes in the cost of living.

Fees for primary care services grew most quickly across the country, though this varied by state. Table 3 provides growth rates from 1993 to 1998 for primary care, obstetric care, and other services. On average, states increased their primary care fees by over 17 percent across the study period. Ten states—Colorado, Connecticut, Maine, New Mexico, North Dakota, Ohio, South Dakota, Texas, Virginia, and Wisconsin—increased primary care fees by at least 30 percent across the study period. Texas increased primary care fees by over 90 percent.

However, some states experienced a significant reduction in Medicaid fees for primary care services. Four states—Alaska, Louisiana, Oklahoma, and West Virginia—and the District of Columbia experienced reductions of 10 percent or more in fees for primary care services.

Fees for obstetric care increased by 7.5 percent between 1993 and 1998. Ten states—Alaska, Colorado, Connecticut, Illinois, Maine, Nevada, North Dakota, South Dakota, Washington, and Wisconsin—increased their fees for obstetric services by at least 30 percent across the study period. Maine increased its fees by over 56 percent. Four states—Alabama, Hawaii, Louisiana, and Virginia—experienced declines of 10 percent or more. Thirteen states did not change their fees for obstetric services across the time period.

Medicaid fee levels for other services were also declining across the time period. Payment rates for these services (including hospital-based, surgical, and lab services) declined by almost 8 percent. The majority of states reduced fee levels for these services. Five states—Florida, Indiana, Kentucky, Virginia, and West Virginia—experienced declines of over 30 percent.

Table 4 summarizes changes in the landscape of Medicaid fee levels across the study period. While the majority of states experienced increases in fees across the study period, states were much more likely to increase fees for primary care services than for any other service. Slightly more than 70 percent of surveyed states increased fees for primary care services. And a majority of states increased primary care fees by more than 10 percent, roughly equivalent to the rate of general inflation across the time period. Consistent with policy initiatives that emphasize preventive services, states were most likely to increase primary care fees. Approximately 60 percent of surveyed states experienced reductions in payment levels for other services across the study period. The reduction in fees for other services may reflect the increasing movement to

Table 3: Change in Medicaid Fees 1993-1998: All Services and Preventive, OB, and Other Services

State	All Services*			Primary Care*			Obstetric Care*			Other Services*		
	Average Fee, 1993	Average Fee, 1998	Percent Change	Average Fee, 1993	Average Fee, 1998	Percent Change	Average Fee, 1993	Average Fee, 1998	Percent Change	Average Fee, 1993	Average Fee, 1998	Percent Change
National Average	146.15	152.83	4.57%	26.05	30.59	17.44%	674.29	724.62	7.46%	154.37	142.38	-7.76%
Alabama	215.28	194.16	-9.81%	29.43	36.02	22.42%	1150.00	1000.00	-13.04%	163.46	144.28	-11.74%
Alaska	321.64	357.95	11.29%	80.98	66.83	-17.48%	1185.15	1635.67	38.01%	445.20	379.28	-14.81%
California	118.41	118.44	0.03%	23.03	23.03	0.00%	480.61	480.61	0.00%	156.39	156.53	0.09%
Colorado	134.81	170.40	26.41%	27.67	37.13	34.20%	619.53	818.80	32.16%	134.68	145.28	7.87%
Connecticut	167.17	231.11	38.24%	21.97	30.60	39.30%	855.81	1286.12	50.28%	149.56	149.56	0.00%
District of Columbia	179.48	172.67	-3.79%	27.22	22.17	-18.54%	918.09	918.09	0.00%	151.93	137.00	-9.82%
Florida	165.41	175.05	5.83%	28.26	30.24	7.04%	800.00	950.00	18.75%	157.52	109.01	-30.80%
Georgia	208.94	206.03	-1.39%	37.27	37.22	-0.13%	1009.17	1009.17	0.00%	195.78	184.16	-5.94%
Hawaii	147.97	129.25	-12.65%	35.10	35.12	0.05%	546.18	460.02	-15.78%	209.65	181.42	-13.47%
Idaho	177.10	199.27	12.52%	34.59	38.29	10.71%	826.62	916.54	10.88%	174.31	205.15	17.69%
Illinois	133.86	165.94	23.97%	20.72	21.35	3.03%	604.26	828.39	37.09%	156.53	161.22	3.00%
Indiana	174.82	156.92	-10.24%	29.31	32.45	10.73%	704.80	738.40	4.77%	245.20	146.66	-40.19%
Iowa	180.62	199.21	10.29%	23.96	25.35	5.81%	840.19	951.72	13.27%	207.48	217.73	4.94%
Kansas	160.24	154.58	-3.53%	20.68	23.01	11.29%	827.65	780.89	-5.65%	140.31	137.35	-2.11%
Kentucky	207.02	180.35	-12.88%	34.70	33.82	-2.55%	900.00	900.00	0.00%	254.43	149.02	-41.43%
Louisiana	189.16	169.76	-10.26%	32.35	29.11	-10.00%	946.82	852.14	-10.00%	162.48	144.27	-11.21%
Maine	98.09	146.72	49.57%	23.78	32.55	36.85%	450.00	703.54	56.34%	89.37	124.45	39.25%
Maryland	171.60	171.60	0.00%	32.59	32.59	0.00%	914.17	914.17	0.00%	108.95	108.95	0.00%
Massachusetts	153.29	149.62	-2.39%	38.53	39.23	1.81%	608.28	608.28	0.00%	188.43	171.92	-8.76%
Michigan	122.13	122.13	0.00%	25.63	25.63	0.00%	540.00	540.00	0.00%	132.31	132.32	0.01%
Minnesota	181.89	184.20	1.27%	30.84	34.95	13.32%	771.95	771.95	0.00%	233.02	232.12	-0.38%
Missouri	110.59	111.69	1.00%	18.05	20.37	12.87%	568.09	568.09	0.00%	89.13	87.81	-1.48%
Nevada	215.67	271.62	25.94%	35.76	41.39	15.75%	937.59	1250.74	33.40%	266.03	305.68	14.90%
New Hampshire	162.84	184.28	13.16%	29.05	31.60	8.80%	842.56	965.00	14.53%	121.78	134.64	10.56%
New Jersey	78.08	78.56	0.62%	17.42	17.98	3.22%	339.95	339.95	0.00%	84.91	85.47	0.66%
New Mexico	165.63	183.08	10.54%	26.72	36.46	36.44%	661.15	778.05	17.68%	238.54	220.50	-7.56%
New York	119.86	116.28	-2.98%	12.35	12.35	0.00%	698.90	667.62	-4.48%	68.81	71.58	4.01%
North Carolina	164.18	180.40	9.88%	32.92	39.98	21.47%	776.67	849.27	9.35%	153.78	161.79	5.20%
North Dakota	142.04	182.96	28.81%	28.67	40.57	41.50%	572.35	862.16	50.64%	187.32	163.54	-12.69%
Ohio	118.83	138.99	16.97%	20.81	31.10	49.46%	536.18	657.21	22.57%	133.08	122.34	-8.07%
Oklahoma	153.07	147.77	-3.46%	32.55	25.49	-21.69%	736.18	736.18	0.00%	132.12	128.28	-2.90%
Oregon	141.39	151.84	7.40%	24.26	29.56	21.84%	632.70	725.10	14.60%	162.46	140.69	-13.40%
Rhode Island	93.60	102.02	9.00%	18.91	23.22	22.80%	425.00	450.00	5.88%	97.10	106.62	9.80%
South Carolina	140.72	143.32	1.85%	23.54	24.74	5.13%	700.00	700.00	0.00%	124.57	132.05	6.00%
South Dakota	157.02	188.06	19.76%	26.43	35.53	34.42%	603.54	787.47	30.48%	236.20	237.71	0.64%
Texas	155.39	174.52	12.32%	33.33	64.83	94.53%	700.00	700.00	0.00%	159.42	158.33	-0.69%
Utah	130.43	144.49	10.78%	25.97	29.77	14.66%	567.02	703.84	24.13%	150.10	122.19	-18.60%
Vermont	137.51	168.59	22.60%	24.29	29.84	22.85%	688.00	846.20	22.99%	116.35	140.99	21.19%
Virginia	214.97	167.30	-22.18%	28.52	37.49	31.45%	961.68	786.02	-18.27%	267.98	149.86	-44.08%
Washington	155.48	190.78	22.70%	37.00	41.30	11.64%	747.29	994.65	33.10%	124.68	120.45	-3.39%
West Virginia	259.50	219.02	-15.60%	46.40	36.27	-21.83%	1074.55	1171.98	9.07%	341.19	149.45	-56.20%
Wisconsin	153.80	188.49	22.55%	27.24	35.52	30.42%	638.95	847.57	32.65%	201.74	206.42	2.32%
Minimum	78.08	78.56	-0.22	12.35	12.35	-0.22	339.95	339.95	-0.18	68.81	71.58	-56.20%
Maximum	321.64	357.95	0.50	80.98	66.83	0.95	1185.15	1635.67	0.56	445.20	379.28	39.25%
Coeff. of Variation	30.33	30.29		40.39	33.23		28.81	32.83		46.55	39.77	

Source: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey. Washington, D.C., 1998.

*See Appendix 1 for services included in the All Services Index.

Table 4: Change in Medicaid Fees by Type of Service, 1993-1998

Percent of States with Changes in Fees				
Type of Service	Any Increase	Any Decrease	Increase of Greater than 10%	Decrease of Greater than 10%
All Services	66.7%	33.3%	42.9%	14.3%
Primary Care	73.8%	26.2%	54.8%	9.5%
Obstetric Care	54.8%	45.2%	45.2%	7.1%
Other Services	40.5%	59.5%	11.9%	28.6%

Source: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey. Washington, DC, 1998.

Medicare's resource-based relative value scale (RBRVS) payment system (PPRC 1995) or state efforts to control costs by balancing increases in primary care fees with reductions in other fees.

Medicaid Fee Levels Relative to Medicare, 1998

Medicaid fee levels have increased only slightly from 1993 to 1998. The impact of such a change on access to services is likely driven by the level of Medicaid fees relative to fees in other markets. Ideally, we would compare Medicaid fees to those in both the Medicare and private markets. However, private fee data are unavailable. To begin to understand this relationship between Medicaid and other markets, table 5 presents the ratio of Medicaid-to-Medicare fees in 1998, weighted by Medicaid enrollees across all services and by type of service.⁹

For the services surveyed, the data suggest that Medicaid fees across the United States were 64 percent of Medicare fees in 1998. Six states—California, Michigan, Missouri, New Jersey, New York, and Rhode Island—and the District of Columbia had Medicaid fees that were 50 percent or less than a comparable group of Medicare fees. Though most states had Medicaid fees that were much lower than Medicare fees, some states had Medicaid fees that were roughly comparable to Medicare. In Idaho, Nevada, North Carolina, North Dakota, and South Dakota, Medicaid fees were 85 percent or more of a comparable group of Medicare fees. In two states, Alaska and Texas, Medicaid fees were on average higher than Medicare fees.

Medicaid fees for primary care services were on average 62 percent of MFS fees. Seven states—California, Illinois, Michigan, Missouri, New Jersey, New York, and Rhode Island—and the District of Columbia had fees for primary care services that were less than 50 percent of MFS

⁹ As mentioned previously, the basket of services presented in these tables is different from that presented in Norton 1995. As a result, the two analyses are not comparable.

fees. Alaska and Texas, again, were the only two states with fees for these services that were higher than MFS fees. Five other states—Idaho, Nevada, North Carolina, North Dakota, and Washington—had fees equal to 80 percent or more of comparable MFS fees.

Medicaid fees for obstetric and other services were also considerably lower than Medicare fees. Nationally, Medicaid obstetric fees were 68 percent of fees computed from the MFS.¹⁰ Five states—Alabama, Alaska, Connecticut, Nevada, and West Virginia—had Medicaid fees that were higher than Medicare fees. Seven other states—Georgia, Idaho, Iowa, Kentucky, New Hampshire, North Dakota, and Washington—had fees that were at least 90 percent of Medicare fees. In contrast, five states—California, Hawaii, Michigan, New Jersey, and Rhode Island—had fees that were 50 percent or less than comparable MFS fees. Medicaid fees for other services were 65 percent of a comparable set of Medicare fees. Despite the reductions in Medicaid fees for other services noted above, five states—Alaska, Idaho, Minnesota, Nevada, and South Dakota—had fees for this group of services that were equal to or higher than Medicare fees.

Changes in Medicaid Fee Levels Relative to Medicare, 1993–98

Although Medicaid fees are generally much lower than Medicare fees, Medicaid fees did increase for many states and services over the 1993–98 time period. To assess how these Medicaid fee increases could affect Medicaid patient access, it is important to measure these changes in Medicaid fees relative to changes occurring in the Medicare FFS environment.

Across this time period, Medicare fees for some services were increasing.¹¹ In the event that

¹⁰ Although Medicare pays for very little obstetric care, the RBRVS upon which the MFS is based was developed so that it can be applied to all physician services. Therefore, the Medicare obstetric fee should be viewed as the fee derived from RBRVS using the Medicare conversion factor and geographic adjustment factors.

¹¹ A comparison of the conversion factors and relative value units in 1993 and 1998 indicates that with Medicare both the conversion factors and the relative value units were used in computing many Medicare primary care fees. For the

Table 5: 1998 Medicaid to Medicare Fee Ratios for All Services and Selected Services

State	All Services*	Primary Care*	Obstetric Care*	Other Services*
National Average	0.64	0.62	0.68	0.65
Alabama	0.78	0.77	1.01	0.68
Alaska	1.26	1.18	1.34	1.42
California	0.47	0.42	0.43	0.63
Colorado	0.75	0.76	0.80	0.71
Connecticut	0.64	0.58	1.10	0.54
District of Columbia	0.48	0.40	0.79	0.51
Florida	0.61	0.59	0.85	0.53
Georgia	0.81	0.75	0.97	0.88
Hawaii	0.63	0.62	0.40	0.78
Idaho	0.90	0.84	0.95	1.00
Illinois	0.52	0.43	0.75	0.62
Indiana	0.72	0.67	0.76	0.80
Iowa	0.72	0.56	0.99	0.97
Kansas	0.60	0.50	0.77	0.76
Kentucky	0.77	0.71	0.92	0.83
Louisiana	0.67	0.60	0.84	0.74
Maine	0.66	0.69	0.70	0.57
Maryland	0.64	0.67	0.84	0.49
Massachusetts	0.71	0.74	0.54	0.71
Michigan	0.50	0.48	0.45	0.56
Minnesota	0.80	0.70	0.76	1.05
Missouri	0.46	0.45	0.55	0.44
Nevada	0.97	0.81	1.15	1.25
New Hampshire	0.67	0.63	0.91	0.62
New Jersey	0.34	0.33	0.30	0.38
New Mexico	0.81	0.78	0.77	0.92
New York	0.30	0.24	0.57	0.30
North Carolina	0.85	0.83	0.88	0.88
North Dakota	0.89	0.87	0.90	0.93
Ohio	0.65	0.65	0.63	0.64
Oklahoma	0.61	0.55	0.77	0.67
Oregon	0.65	0.60	0.73	0.72
Rhode Island	0.44	0.45	0.40	0.45
South Carolina	0.59	0.54	0.74	0.64
South Dakota	0.87	0.78	0.84	1.09
Texas	1.19	1.46	0.68	0.79
Utah	0.63	0.62	0.72	0.62
Vermont	0.69	0.62	0.85	0.78
Virginia	0.78	0.77	0.79	0.81
Washington	0.80	0.83	0.96	0.61
West Virginia	0.84	0.77	1.18	0.83
Wisconsin	0.81	0.76	0.82	0.96
Minimum	0.30	0.24	0.30	0.30
Maximum	1.26	1.46	1.34	1.42
Coefficient of Variation	29.90	34.00	31.95	34.68

Source: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey. Washington, D.C., 1998.

*See Appendix 1 for services included in these indices.

Medicaid fees were increasing less quickly than fees in the Medicare market, the incentives for physicians to participate in the Medicaid program could diminish. Although systematic data on private fees are not available, the period covered by this study was one in which private payers were aggressively seeking discounts from providers. As such, it could be that Medicaid fees were not falling (and could have been increasing) relative to private payers. This would have tempered any adverse access effects that may have been occurring relative to Medicare.

Table 6 presents the change in the ratio of Medicaid to MFS fees between 1993 and 1998. Between 1993 and 1998, Medicaid fees fell relative to Medicare fees. For all services, Medicaid fees declined relative to Medicare fees by approximately 14 percent between 1993 and 1998. For all but four states—Maine, North Dakota, Ohio, and Texas—the ratio of Medicaid to Medicare fees declined. And for some states, it declined precipitously. In seven states—Alaska, Louisiana, Maryland, Massachusetts, New Jersey, New York, and West Virginia—and the District of Columbia, the ratio of Medicaid to Medicare fees fell by 30 percent or more. Fees for obstetric care and other services follow similar patterns.

Because many states significantly increased fees for Medicaid primary care services, the ratio of Medicaid to Medicare fees for primary care services declined by less than it did for the other services. Over the time period, the ratio of Medicaid to Medicare primary care fees declined by 11 percent. Seven states—Connecticut, New Mexico, North Dakota, Ohio, South Dakota, Texas, and Virginia—experienced increases in the primary care ratio. However, in Alaska, the District of Columbia, and West Virginia, the ratio fell by 40 percent or more. The increasing gap between Medicaid and Medicare fees overall is due in large part to Medicare's

primary care fees presented here, Medicare fees increased by approximately 30 percent across the time period.

efforts to significantly increase payments for primary care services over this time period. Though Medicaid programs have increased fees for primary care services, they have not done so at a rate that would keep pace with changes in the Medicare market.

Discussion

The period between 1993 and 1998 has been a volatile one for Medicaid physician payment. States have significantly altered the manner in which they develop fee-for-service payment rates and the level of FFS payments, and they have increased their reliance on capitated arrangements for care. At the same time, physician fees have changed in both the Medicaid and Medicare markets. Changes in access and outcomes for those enrolled in the Medicaid program across this period need to be addressed in the context of these changes in fees.

The results suggest that incentives faced by a physician to participate in the Medicaid program vary considerably across the country. On average, Medicaid fees are quite low relative to the Medicare market. However, there is a great deal of variation among the states. In a very few states, Medicaid fees were higher, on average, than Medicare fees for a similar bundle of services. Such wide variation is likely a function of how states have balanced the competing demands of state budget limits, the generosity of the state Medicaid eligibility criteria, and the level of physician participation in Medicaid, which can be an important source of pressure to increase payment rates. Regardless of the source of variation, physicians in different states face very different fee environments.

And the Medicaid fee environment has changed between 1993 and 1998. States increased fees, on average, by roughly 4 percent, significantly less than the rate of inflation across the time period. However, almost 43 percent of surveyed states increased average fees at roughly the rate of inflation. Where there were significant increases in fees, the changes were

Table 6: Percentage Change in Medicaid-to-Medicare Fee Ratios, 1993 to 1998

State	All Services*	Primary Care*	Obstetric Care*	Other Services*
National Average	-14.3%	-10.7%	-25.0%	-15.5%
Alabama	-15.8%	-9.2%	-37.6%	-8.4%
Alaska	-30.4%	-40.6%	-0.8%	-12.9%
California	-25.6%	-28.8%	-30.9%	-17.2%
Colorado	-9.1%	-7.4%	-14.6%	-9.9%
Connecticut	-0.6%	4.8%	2.8%	-15.4%
District of Columbia	-41.5%	-47.2%	-37.0%	-30.8%
Florida	-15.2%	-13.7%	-10.6%	-22.5%
Georgia	-19.8%	-21.0%	-25.9%	-12.5%
Hawaii	-22.7%	-22.2%	-39.5%	-17.4%
Idaho	-0.6%	-7.7%	-8.3%	24.9%
Illinois	-18.3%	-24.6%	-7.7%	-12.4%
Indiana	-11.9%	-4.9%	-11.2%	-24.1%
Iowa	-13.7%	-19.0%	-19.0%	-0.9%
Kansas	-12.7%	-8.6%	-27.2%	-9.3%
Kentucky	-27.3%	-27.2%	-29.4%	-26.3%
Louisiana	-32.9%	-33.6%	-39.1%	-26.8%
Maine	3.9%	-0.7%	11.8%	14.5%
Maryland	-30.3%	-31.2%	-35.8%	-19.9%
Massachusetts	-31.0%	-32.2%	-35.5%	-25.5%
Michigan	-29.3%	-30.3%	-40.2%	-20.4%
Minnesota	-9.5%	-8.7%	-23.1%	-4.3%
Missouri	-7.2%	-4.6%	-21.7%	-1.5%
Nevada	-1.3%	-8.2%	7.1%	7.4%
New Hampshire	-17.9%	-20.2%	-22.7%	-6.4%
New Jersey	-33.1%	-34.1%	-40.4%	-27.2%
New Mexico	-5.4%	4.8%	-13.3%	-18.7%
New York	-36.4%	-35.7%	-44.3%	-27.5%
North Carolina	-10.7%	-9.2%	-23.3%	-5.9%
North Dakota	14.7%	21.9%	22.0%	-2.1%
Ohio	6.7%	17.5%	-9.8%	-5.8%
Oklahoma	-22.4%	-33.4%	-14.6%	7.2%
Oregon	-11.1%	-7.9%	-18.2%	-13.2%
Rhode Island	-6.3%	-6.2%	-21.3%	3.1%
South Carolina	-14.4%	-18.5%	-26.9%	8.7%
South Dakota	-0.9%	4.8%	-4.6%	-8.3%
Texas	32.8%	65.5%	-27.3%	-12.5%
Utah	-15.7%	-14.8%	-13.4%	-19.3%
Vermont	-5.7%	-7.4%	-11.8%	2.3%
Virginia	-15.3%	0.9%	-38.1%	-28.4%
Washington	-6.0%	-11.2%	5.2%	5.1%
West Virginia	-40.2%	-42.0%	-25.5%	-44.7%
Wisconsin	-10.7%	-5.8%	-15.0%	-17.2%
Minimum	-41.5%	-47.2%	-44.3%	-44.7%
Maximum	32.8%	65.5%	22.0%	24.9%
Coeff. of Variation	-104.19	-188.18	-62.64	-89.12

Source: Urban Institute 1998 Medicaid Managed Care Payment and Implementation Survey. Washington, D.C., 1998.

*See Appendix 1 for services included in these indices.

driven primarily by significant increases in fees for primary care services and, to a lesser extent, by increases in fees for obstetric services. Almost 75 percent of states increased fees for primary care services. Slightly more than 54 percent of surveyed states increased fees at or above the rate of inflation.

Consistent with many states' adoption of the Medicare RBRVS as the basis for determining physician payments under Medicaid, the increases in fees for preventive services and, to some extent, obstetric services, have come at the expense of fees paid for other services (including hospital visits and surgery, imaging, and lab services).¹² This change in the structure of Medicaid fees may be the direct result of the movement to RBRVS, or it may be that the movement to RBRVS was the result of policymakers' desire to increase fees for primary care relative to those for other services. Whatever the motivation, the evidence suggests that, coincident with significant expansions in coverage to children, there has been a significant shift in emphasis toward preventive services. The impact of this should be improved access for preventive services relative to what it otherwise would have been.

Nonetheless, it is problematic that despite these increases in primary care fees, Medicaid fees relative to the Medicare market remain low, and, for most states, they are falling over time in real terms even for preventive services. While a number of states with smaller Medicaid programs, such as Maine, have experienced significant increases in fees, those with the largest Medicaid programs are experiencing real declines in fees and falling fees relative to those in the Medicare market. An important exception to this trend in states with large Medicaid programs is

¹² Many states have implemented the Medicare RBRVS system, which has the effect of shifting resources away from specialty toward preventive care services. As of 1995, 19 states had adopted the Medicare RBRVS (Arizona, Florida, Georgia, Indiana, Iowa, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Utah, and Washington (PPRC 1995; Norton et al. 1995).

Texas, which experienced a significant increase in fees relative to fees in the Medicare market.

Thus, there is continued concern regarding access to physician services for persons eligible for Medicaid. The Medicaid programs with the largest enrollment have very low fees and/or are experiencing significant declines in their fees relative to the Medicare FFS market. These states are also expanding significantly into capitated arrangements for many of their Medicaid beneficiaries. Are states controlling the growth in Medicaid physician fees in order to enhance payments to MMC plans? Or, are states holding down FFS payment rates to provide an incentive to traditional Medicaid providers to join MMC networks? Moreover, to understand how the FFS and managed care sides of the program may be interacting, it is necessary to know the level and rates of change in physician payments made through MMC plans. To the extent that some beneficiaries appear likely to remain in FFS Medicaid for the foreseeable future, it would be important to maintain efforts to collect information on FFS physician payments.

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Appendix 1: Fee Analysis Groups, 1998 (for Tables 2 through 6)

Overall Fee Index and 'All Services' Include

99203 Office Visit, New Patient, 30 Minutes
99213 Office Visit, Established Patient, 15 Minutes
99214 Office Visit, Established Patient, 25 Minutes
99244 Office Visit, New Patient, 60 Minutes
99254 Initial Inpatient Consultation, 80 Minutes
93000 Electrocardiogram
99222 Initial Hosp. Care, New or Establ. Patient, 50 Min.
59410 Vaginal Delivery Only
59515 Cesarean Delivery and Postpartum Care
43235 Upper Gastrointestinal Endoscopy
58120 Dilation and Curettage
58150 Total Hysterectomy
66984 Cataract Removal with Lens Implant
70450 Computerized Axial Tomography Scan, Head or Brain
71020 X-Ray, Chest, Two Views
76805 Echography, Pregnant Uterus
81000 Urinalysis, Routine
87081 Culture, Bacterial, Screening Only
88035 Surgical Pathology

Primary Care Fees Include

99203 Office Visit, New Patient, 30 Minutes
99213 Office Visit, Established Patient, 15 Minutes
99214 Office Visit, Established Patient, 25 Minutes
99244 Office Visit, New Patient, 60 Minutes
93000 Electrocardiogram

Obstetric Care Fees Include

59410 Vaginal Delivery Only
59515 Cesarean Delivery and Postpartum Care

Other Fees Include

99222 Initial Hosp. Care, New or Establ. Patient, 50 Minutes
99254 Initial Inpatient Consultation, 80 Minutes
43235 Upper Gastrointestinal Endoscopy
58120 Dilation and Curettage
58150 Total Hysterectomy
66984 Cataract Removal with Lens Implant
70450 Computerized Axial Tomography Scan, Head or Brain
71020 X-Ray, Chest, Two Views
76805 Echography, Pregnant Uterus
81000 Urinalysis, Routine
87081 Culture, Bacterial, Screening Only
88035 Surgical Pathology

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