Medicaid Fees and the Medicare Fee Schedule: An Update

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This study analyzes changes in Medicaid physician fees from 1990 to 1993. Data were collected on maximum allowable Medicaid fees in 1993 and compared with similar 1990 Medicaid data as well as the fully phased-in Medicare Fee Schedule (MFS). The results suggest that, on average, Medicaid fees have grown roughly 14 percent, but considerable variation continues to exist in how well Medicaid programs pay across types of services, States, and census divisions. Medicaid fees remain considerably lower (27 percent for the average Medicaid enrollee) than fees under a fully phased-in MFS. Medicaid fees for primary-care services were, on average, 32 percent lower.

INTRODUCTION

Since the Medicaid program's inception, policymakers have been concerned with the factors that determine physicians' decisions to participate in Medicaid and the implications of these factors for access. Sloan, Cromwell, and Mitchell (1978) were among the first to document the relationships between physician participation in Medicaid and Medicaid fee levels, the level of Medicaid fees relative to other markets, and administrative costs created by Medicaid bureaucratic obstacles. Mitchell (1991) and Perloff, Kletke, and Necherman (1987) substantiated these results with more recent evaluations, which found that physician participation decisions were related to both Medicaid fee levels and such fee levels relative to other insurance programs. Despite the recognition of the importance of Medicaid fee levels in physician participation decisions, however, relatively little is known about recent changes in Medicaid fees and how they compare with other payers.

Understanding recent changes in Medicaid fees is of particular importance for two reasons. First, through a series of legislative actions beginning with the Omnibus Budget Reconciliation Act (OBRA) of 1987, the Federal Government has mandated that States provide services to pregnant women and children with incomes up to 133 percent of the Federal poverty level. Although the Medicaid expansions have provided insurance coverage to a large pool of low-income pregnant women and children, these expansions in coverage may only translate into increased access if physician fees are high enough to ensure that physicians participate in the Medicaid program. Recognizing this, OBRA 1989 required that States provide payment rates adequate to ensure access for this growing pool of eligible individuals. However, there is little documentation of the magnitude of increases in Medicaid fees since 1990. Although recent concerns regarding access have focused on the most vulnerable populations—pregnant women and children (Dubay et al., 1993; Kenney and Dubay, 1995)—these concerns are valid for all Medicaid-eligible populations.

Second, many States are now using or are contemplating using the resource-based relative value scale (RBRVS) for Medicaid payment. States can adopt

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Medicare's conversion factors, which convert relative values into payment rates, but this might be costly for some States. Holahan, Wade, and Gales, (1993) found, for example, that the adoption of the MFS in 1990 would have increased Medicaid costs substantially. Alternatively, States could set their conversion factors to maintain current payment levels. However, in the event that States attempt to maintain budget neutrality and Medicaid fees remain low relative to other payers, States may find themselves in the untenable position of being forced to increase Medicaid fees to ensure access.

This study uses Medicaid fees in 1990 and 1993 and information on what fees would be under a fully phased-in MFS to provide policymakers with more recent documentation of trends in Medicaid fee levels. Updating work by Holahan (1991), this article provides information on the variation in physician fees across the country, describes changes in Medicaid fees from 1990 to 1993, and evaluates 1993 Medicaid physician fees relative to other insurance markets by comparing them with fully phased-in MFS fees.[1] Because of recent concern regarding pregnant women and children, attention is focused, where possible, on those services used most by pregnant women and children, such as delivery and primary-care evaluation, and management fees. Because previous work (Holahan, 1991) indicated that there were significant differences in fee levels by census division of the country, information regarding regional variations in fees is also provided.

[1] HCFA established a 5-year transition period to a payment system based on the MFS to avoid precipitous changes in payments and potential disruptions in patient care. As a result, Medicare payments for services in a given year prior to full implementation in 1996 are different from MFS fees. Data issues made it difficult to identify Medicare payments for 1993, so the level of Medicaid fees relative to fully phased-in MFS fees was evaluated.

DATA COLLECTION AND METHODS

Medicaid and MFS Fees

A subsample of physician services collected in a 1991 Urban Institute survey (Holahan, 1991) of Medicaid fees was resurveyed in 1993. These services were selected on the basis of both Medicaid expenditures and service frequency from 1988 tape-to-tape files in California, Michigan, and Tennessee. States were asked to provide their maximum Medicaid fees for each of the services listed in Table 1 for the 1993 fiscal year. In those States that differentiated fees based on geographic location, provider type, specialty type, age of the patient, or site of service, an average of all provider fees was calculated.[2] Three exceptions were made. In Alaska, only fees from the Anchorage area were used because 80 percent of Medicaid claims were from that area. In New Mexico, Texas, and Minnesota, high-risk, nurse practitioner, and diagnosis-related fees were not used in the computation of an average fee in order to facilitate comparisons with other States. All national and regional fee values are weighted averages, using Medicaid enrollees in each State in 1993 as weights. Weighting by Medicaid enrollees allows us to assess the fees for services provided to the average Medicaid enrollee in a given area.

Table 1 displays the list of services surveyed and their *Current Procedural Terminology, Fourth Edition* (CPT-4) codes grouped according to six broad types of physician services, including primary-care services, hospital visits, obstetric care, surgery services, imaging serv-

[2] Thus, higher payments for services provided by pediatricians, for example, are represented in the service fees presented. In total, 11 States (Hawaii, Indiana, Iowa, Minnesota, Montana, New York, New Jersey, Pennsylvania, Virginia, Washington, and Wisconsin) provided different payment rates depending on the age of the patient and/or the physician specialty.

Table 1

Percent of Expenditures for Procedures[1] Within Type-of-Service Categories, by Eligibility Group: Selected States, 1993

Category and Code[2]	Procedure	All Non-Elderly Persons	Infants	Children	Young Females	Non-Elderly Adults	Disabled Persons
				Percent			
Primary Care	Surveyed Procedures	49.2	66.2	80.6	23.7	61.5	58.2
99203	Office Visit, New Patient, 30 Minutes	10.4	18.9	13.7	11.5	10.6	3.5
99205	Office Visit, New Patient, 60 Minutes	3.8	2.7	2.6	7.3	5.3	2.4
99213	Office Visit, Established Patient, 15 Minutes	59.5	66.4	67.1	57.1	59.1	47.5
99214	Office Visit, Established Patient, 25 Minutes	7.1	5.4	7.0	7.6	7.3	7.0
99244	Office Consult, New or Established Patient, 60 Minutes	3.2	3.1	1.6	3.2	4.5	4.9
99283	Emergency Visit, New or Established Patient, Moderate Severity	2.9	3.0	2.8	4.2	2.2	2.3
90843	Psychiatric Visit, 20-30 Minutes	2.6	0.0	0.8	1.7	1.3	7.4
90844	Psychiatric Visit, 45-50 Minutes	8.2	0.1	3.9	5.7	4.7	20.9
93000	Electrocardiogram	2.3	0.4	0.5	1.7	5.0	4.1
Hospital Visits	Surveyed Procedures	11.6	24.9	7.6	4.6	15.0	24.6
99222	Initial Hospital Care, New or Established Patient, 50 Minutes	22.2	26.5	28.0	31.9	19.6	16.8
99231	Subsequent Hospital Care, New or Established Patient, 15 Minutes	37.3	36.8	31.1	30.2	36.3	41.8
99232	Subsequent Hospital Care, New or Established Patient, 25 Minutes	27.1	28.5	23.5	21.3	25.6	29.7
99254	Initial Inpatient Consultation, 80 Minutes	13.4	8.3	17.4	16.6	18.6	11.7
Obstetric Care	Surveyed Procedures	26.4	0.3	1.5	60.2	6.3	1.9
59400	Total Obstetric Care, Vaginal Delivery	45.4	35.5	49.5	46.9	42.4	42.4
59410	Vaginal Delivery Only	21.7	21.8	22.0	22.3	18.1	19.2
59515	Cesarean Delivery and Postpartum Care	12.3	27.2	11.8	11.4	15.6	14.4
59510	Total Obstetric Care, Cesarean Delivery	20.5	15.5	16.7	19.4	24.0	24.0
Surgery	Surveyed Procedures	4.2	1.4	3.2	2.0	7.3	6.6
43235	Upper Gastrointestinal Endoscopy	22.7	4.2	4.4	17.4	33.5	33.0
58120	Dilation and Curettage	17.0	0.0	0.6	44.5	15.0	5.7
58150	Total Hysterectomy	22.9	0.0	0.1	35.5	33.1	10.6
66984	Cataract Removal With Lens Implant	21.0	0.4	1.2	1.7	17.9	47.9
69437	Tympanostomy	16.3	95.4	93.7	0.9	0.5	2.8
Imaging	Surveyed Procedures	6.7	6.4	4.9	7.7	7.1	6.7
70450	Computerized Axial Tomography Scan, Head or Brain	10.9	16.4	17.6	2.6	17.3	23.8
71020	X-Ray, Chest, Two Views	42.8	83.6	77.8	12.4	69.7	70.9
76805	Echography, Pregnant Uterus	46.3	0.0	4.5	85.0	13.1	5.3
Laboratory Tests	Surveyed Procedures	2.0	0.7	2.2	1.8	2.8	2.0
81000	Urinalysis, Routine	39.2	19.3	36.7	35.3	49.4	48.3
87081	Culture, Bacterial, Screening Only	24.2	65.2	55.2	17.0	12.0	6.8
88305	Surgical Pathology	36.3	15.5	8.1	47.7	38.6	44.9

[1] Specific procedures included in The Urban Institute 1993 Medicaid Fee Survey.

[2] Codes given are from the *Current Procedural Terminology, Fourth Edition.*

NOTES: Percentages have been calculated using 1988 Medicaid expenditure data. Age categories for groups are as follows: Infants are under 1 year of age. Children are females 1-14 years of age and males 1-19 years of age. Young females are those 15-34 years of age. Non-elderly adults are females 35-64 years of age and males 20-64 years of age.

SOURCE: Health Care Financing Administration: Medicaid Tape-to-Tape files, 1988.

ices, and laboratory tests. Expenditures for each service as a percentage of total expenditures within broad types of physician services in 1988 are also presented to demonstrate the relative importance of each service. As Table 1 indicates, the bulk of expenditures for our surveyed services is accounted for by primary care. For example, 49.2 percent of these expenditures for the non-elderly population are for primary care. The share of expenditures accounted for by surgical services, however, is relatively small. Table 1 also suggests that expenditures on services differ considerably by enrollee group. For example, 80.6 percent of these expenditures for children were for primary care. For young females 15-34 years of age, more than 60 percent of total expenditures on surveyed procedures are accounted for by obstetric services.

MFS fees in 1993 were computed using the MFS formula and represent a fully phased-in fee schedule rate. For this study, the 1993 relative value unit (RVU) values published in the November 25, 1992, *Federal Register* were used. Because the MFS included only RVUs for physician services, RVUs for lab services were computed based on 1993 charges. The charge data used to estimate total RVUs for lab services are from the 1993 Diagnostic Laboratory Fee Schedule national limits. These data include a list of 1993 laboratory codes and their respective national prevailing charge screens for office-based lab services. RVUs were derived by taking the ratio of the prevailing charge to the 1993 Medicare conversion factor for non-surgical services. State-level geographic practice cost indexes reflecting congressionally mandated quarter work values were used to adjust the MFS fees.

Crosswalk of Service Definitions

Direct comparison of Medicaid fee data from 1990 and 1993 is difficult because of changes in CPT-4 codes. Effective in 1992, the definitions for all evaluation and management services, including hospital and office visits, were substantially revised. Therefore, a crosswalk developed by HCFA was used to link 1990 service codes to clinically equivalent 1993 codes. Surveyed services affected by this crosswalk included three office visits, a hospital visit, and two consultations. Because there were no data available to link all of the 1993 codes, it was not possible to accurately link four services to 1990 codes; these codes included a 30-minute office visit for a new patient (99205), an emergency visit of moderate severity (99283), a 15-minute subsequent hospital care visit (99231), and a 25-minute subsequent hospital care visit (99232). These services are included in the analysis of 1993 fees but not in the comparison of 1990 and 1993 fees.[3] (The crosswalk is explained in more detail in the Technical Note at the end of this article.)

Summary Measures of Medicaid Fees

In order to evaluate the average fees for State Medicaid programs, two measures were computed. The first measure is based on the entire set of survey services and is used in the evaluation of 1993 fees. Surveyed fees for each service were combined in proportion to their Medicaid expenditures and normalized with a national average to create a Medicaid fee index for each State. For the second measure used in

[3] In addition, by 1993, the service 69437 was deleted from CPT-4. In order to compare 1990 and 1993 fees for this service, States were asked to provide fees for service 69437-50, which, in 1993, was the clinical equivalent of service 69437.

the evaluation of the growth in Medicaid fees from 1990 to 1993, a subsample of fees was used because it was not possible to compare some services from 1990 to 1993.[4]

Comparison of MFS and Medicaid Fees

To evaluate changes in Medicaid fees relative to the MFS, indexes reflecting Medicaid fees as a proportion of MFS fees were computed for individual services, for each type of service, and for all services. A simple ratio was taken between the Medicaid and MFS fees to evaluate differences by service. A summary measure of relative fees for 1993 by type of service was created by multiplying the Medicaid-to-MFS-fee ratios for each service by the expenditure weights developed in Table 1 within each type of service. Similarly, the Medicaid-to-MFS-fee ratio across all survey services was computed by combining the fees based on the expenditure weights in Table 1.

Limitations

Some results presented should be interpreted with caution. Variation in Medicaid surgical fees is likely to reflect both varying State payment rates as well as differences in global surgical packages. Moreover, in three States, there was insufficient information to compare changes in Medicaid fees from 1990 to 1993. In Rhode Island, 1990 Medicaid fee data were unavailable. For Texas, 1990 fee data from Holahan (1991) were for Harris County only, whereas the 1993 Medicaid fee data collected were for all of Texas. In Alaska, fee data for 1993 are from Anchorage only. For these three States, therefore, comparisons of 1990 with 1993 are inappropriate.

In addition, to the extent that the HCFA crosswalk does not reflect actual changes in the way physicians code services, some of the differences in fees for primary-care services and hospital visits from 1990 to 1993 may reflect changes in the service code definition. Second, more current tape-to-tape data were not available to recompute expenditure weights based on current utilization patterns. Thus, Table 1 is likely to underrepresent the proportion of expenditures in the Medicaid population for certain services that could not be linked completely, such as 99205, 99283, 99231, and 99232.

RESULTS

Variation in 1993 Medicaid Fees

Table 2 presents the national average fee weighted by the number of enrollees in each State, the maximum and minimum fees, and the coefficients of variation for each service in the survey across all States. In general, the coefficients of variation are quite high, suggesting that there is a great deal of variation in what States pay for a given service. The magnitude of this variation, however, differs by type of service. The variation in fees for obstetric care is relatively small but still suggests considerable differences across States. The coefficients of variation for primary-care services are moderate, with an electrocardiogram (99203) and a 25-minute office visit for established patients (99214) having the lowest coefficients. With regard to hospital visits and surgery, the variance in fees is some-

[4] The average fee was computed with the following 22 procedures: 99203, 99213, 99214, 99244, 99254, 90843, 90844, 93000, 99222, 59410, 59515, 43235, 58120, 58150, 66984, 69437, 70450, 71020, 76805, 81000, 87081, and 88305. Fees for global procedures for obstetric services were not included because many States did not provide a global fee for these services in 1990. Including these values would inflate the change in fees from 1990 to 1993 considerably. Fees for 99205, 99232, 99231, and 99283 were not included because these fees were not comparable between 1990 and 1993, given available information.

Table 2

Mean, Maximum, and Minimum Medicaid Fees and Coefficients of Variation:[1] Selected States, 1993

Category and Code[2]	Procedure	Mean	Maximum	Minimum	Coefficient of Variation
Primary Care	Surveyed Procedures				
99203	Office Visit, New Patient, 30 Minutes	$35.50	$76.03	$11.00	34.06
99205	Office Visit, New Patient, 60 Minutes	52.83	125.00	18.00	43.81
99213	Office Visit, Established Patient, 15 Minutes	21.81	76.03	11.00	31.11
99214	Office Visit, Established Patient, 25 Minutes	30.86	80.00	15.00	28.93
99244	Office Consult, New or Established Patient, 60 Minutes	67.02	200.00	24.00	40.58
99283	Emergency Visit, New or Established Patient, Moderate Severity[3]	30.89	116.00	8.00	44.44
90843	Psychiatric Visit, 20-30 Minutes[4]	27.86	80.00	11.83	40.75
90844	Psychiatric Visit, 45-50 Minutes	47.48	110.00	18.00	34.34
93000	Electrocardiogram	23.65	69.00	13.00	30.66
Hospital Visits	Surveyed Procedures				
99222	Initial Hospital Care, New or Established Patient, 50 Minutes	52.88	111.00	14.17	43.50
99231	Subsequent Hospital Care, New or Established Patient, 15 Minutes	21.49	84.00	6.75	45.77
99232	Subsequent Hospital Care, New or Established Patient, 25 Minutes	26.70	61.50	6.75	41.41
99254	Initial Inpatient Consultation, 80 Minutes	66.70	200.00	20.00	41.49
Obstetric Care	Surveyed Procedures				
59400	Total Obstetric Care, Vaginal Delivery	1,001.29	1,500.00	435.50	19.39
59410	Vaginal Delivery Only	636.09	1,150.00	296.00	26.39
59515	Cesarean Delivery and Postpartum Care	724.85	1,600.00	417.50	30.32
59510	Total Obstetric Care, Cesarean Delivery	1,095.89	2,592.36	557.00	22.57
Surgery	Surveyed Procedures				
43235	Upper Gastrointestinal Endoscopy	197.88	450.00	80.00	33.53
58120	Dilation and Curettage	174.20	550.00	60.00	41.72
58150	Total Hysterectomy	659.81	2,200.00	240.00	37.13
66984	Cataract Removal With Lens Implant	927.64	3,000.00	440.00	39.34
69437	Tympanostomy	184.00	621.00	66.00	50.44
Imaging	Surveyed Procedures				
70450	Computerized Axial Tomography Scan, Head or Brain	179.91	651.26	43.20	35.42
71020	X-Ray, Chest, Two Views	25.20	154.21	13.88	46.32
76805	Echography, Pregnant Uterus	83.55	173.19	30.00	29.45
Laboratory Tests	Surveyed Procedures				
81000	Urinalysis, Routine	4.02	8.18	1.20	30.39
87081	Culture, Bacterial, Screening Only	7.51	16.23	1.35	28.78
88305	Surgical Pathology	43.93	116.00	10.85	42.62

[1] Specific procedures included in The Urban Institute 1993 Medicaid Fee Survey.
[2] Codes given are from the *Current Procedural Terminology, Fourth Edition.*
[3] The District of Columbia did not cover an emergency visit of moderate severity for a new or established patient (99283).
[4] Wisconsin and Oregon did not cover a 20-30 minute psychiatric visit (90843).

SOURCE: Urban Institute 1993 Medicaid Fee Survey. Washington, DC., 1993.

what higher. Fees for imaging services exhibit considerable variation as well.

Table 3 illustrates the variation in Medicaid fees across divisions and States in terms of a normalized average-enrollee-weighted Medicaid fee.[5] The East South Central, South Atlantic, and West South Central Divisions have the highest Medicaid fees. The lowest average fees occur in the Middle Atlantic and East North Central Divisions. Across States, average fee-index values range from a low of 0.49 in New Jersey to 1.45 in Alabama, a more-than-twofold variation across States. Alabama, the District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Massachusetts, Montana, Nevada, Virginia, Washington, West Virginia, and Wyoming all had Medicaid fees that were 20 percent greater than the national weighted average fee. The States with the lowest fees were Hawaii, Illinois, Maine, Michigan, Mississippi, New Jersey, Ohio, Rhode Island, and Utah.

[5] National and regional values are weighted using 1992 Medicaid enrollees for each State from HCFA -Form 2082 data.

Table 3

Medicaid Fee Index and Medicaid Fees for Selected Procedures: United States, 1993

Census Division[1] and State	Medicaid Fee Index, All Services	Office Visit New Patient[2] (99203)	Office Visit Established Patient[2] (99213)	Global Vaginal Delivery (59400)	Global Cesarean Delivery (59510)
National Average	1.00	$35.50	$21.81	$1,001.29	$1,095.89
New England	0.89	25.58	22.65	925.32	1,025.45
Connecticut	1.12	26.00	19.50	910.00	1,663.00
Maine	0.81	24.77	22.36	909.00	909.00
Massachusetts	1.21	41.00	34.56	1,316.00	1,361.00
New Hampshire	1.02	36.00	25.00	1,000.00	1,000.00
Rhode Island	0.69	18.00	18.00	750.00	750.00
Vermont	0.92	27.00	21.00	945.00	945.00
Middle Atlantic	0.86	13.72	12.83	922.62	946.74
New Jersey	0.49	19.50	15.00	435.50	557.00
New York	0.93	11.00	11.00	1,037.00	1,037.00
Pennsylvania	1.06	22.50	22.50	1,092.50	1,092.50
South Atlantic	1.16	39.70	27.10	1,105.54	1,234.82
Delaware	0.98	34.00	21.00	981.00	981.00
District of Columbia	1.37	30.00	25.00	1,500.00	1,550.00
Florida	1.03	35.00	25.00	1,000.00	1,000.00
Georgia	1.35	51.24	30.26	1,205.00	1,605.00
Maryland	1.24	37.00	31.00	1,317.00	1,370.00
North Carolina	1.15	47.01	26.53	1,160.50	1,266.00
South Carolina	0.96	30.00	20.00	990.00	990.00
Virginia	1.32	30.00	24.20	1,200.00	1,441.00
West Virginia	1.28	52.50	40.50	897.50	1,238.83
East South Central	1.20	35.01	25.93	1,186.64	1,274.16
Alabama	1.45	28.47	26.75	1,500.00	1,500.00
Kentucky	1.33	39.00	30.00	1,310.00	1,310.00
Mississippi	0.86	28.48	18.33	852.98	935.27
Tennessee	1.15	40.00	27.00	1,100.00	1,300.00
West South Central	1.09	45.15	27.73	1,106.66	1,157.37
Arkansas	1.00	59.00	33.00	940.00	940.00
Louisiana	1.28	36.00	27.00	1,234.00	1,474.00
Oklahoma	1.02	34.97	30.70	1,000.00	1,100.00
Texas	1.08	47.57	26.87	1,108.97	1,108.97
East North Central	0.86	30.61	19.69	817.03	947.10
Illinois	0.86	25.05	18.00	808.20	958.20
Indiana	0.97	33.21	23.92	769.20	1,076.80
Michigan	0.84	35.89	21.00	857.18	857.18
Ohio	0.79	31.21	17.59	767.98	867.98
Wisconsin	1.01	29.66	22.74	925.82	1,213.38
West North Central	1.04	28.83	20.16	1,012.55	1,191.26
Iowa	1.03	31.35	19.72	848.51	1,160.28
Kansas	1.19	25.00	17.00	1,400.00	1,000.00
Minnesota	1.14	35.20	24.00	953.81	1,409.21
Missouri	0.95	20.00	17.00	1,075.00	1,125.00
Nebraska	0.96	39.34	25.29	844.00	1,200.00
North Dakota	0.92	41.00	21.40	830.80	1,030.80
South Dakota	0.90	31.70	21.10	682.00	1,120.00
Mountain	1.08	39.75	24.62	992.64	1,301.24
Colorado	1.01	35.00	24.08	961.78	1,402.39
Idaho	1.15	44.57	30.00	1,074.27	1,300.00
Montana	1.26	51.13	23.39	1,170.45	1,530.00
Nevada	1.28	47.50	29.40	1,104.97	1,406.92
New Mexico	1.07	36.02	23.48	937.14	1,343.79
Utah	0.86	36.85	20.82	849.00	849.00
Wyoming	1.36	50.98	28.80	1,260.00	1,575.00

See footnotes at end of table.

Table 3—Continued

Medicaid Fee Index and Medicaid Fees for Selected Procedures: United States, 1993

Census Division[1] and State	Medicaid Fee Index, All Services	Office Visit New Patient[2] (99203)	Office Visit Established Patient[2] (99213)	Global Vaginal Delivery (59400)	Global Cesarean Delivery (59510)
Pacific	0.95	$47.16	$18.93	$1,007.80	$1,051.39
Alaska	1.90	76.03	76.03	1,394.00	2,592.36
California	0.89	46.00	16.56	961.20	961.27
Hawaii	0.86	60.70	25.66	630.20	1,042.80
Oregon	0.96	40.93	18.06	926.79	1,091.16
Washington	1.32	52.91	31.93	1,450.15	1,650.12
Minimum	0.49	11.00	11.00	435.50	557.00
Maximum	1.90	76.03	76.03	1,500.00	2,592.36
Coefficient of Variation	19.51	34.06	31.11	19.38	22.57

[1] Figures shown for each division are weighted averages of each State within that division.
[2] Numbers in parentheses are codes from the *Current Procedural Terminology, Fourth Edition.*

SOURCE: Urban Institute 1993 Medicaid Fee Survey. Washington, DC., 1993.

These fees were less than the national average by 14 percent or more.[6]

In addition, Table 3 provides detailed information on the variation in fees for selected primary-care and obstetric services, which together account for more than 50 percent of the Medicaid expenditures for those services used in the computation of the Medicaid fee index. The New England, Middle Atlantic, and West North Central Divisions have the lowest fees for a 30-minute office visit for a new patient (99203), and the West South Central, Mountain, and Pacific Divisions have the highest fees. Across States, the fee for a 30-minute office visit for a new patient in Hawaii was almost six times that for the same service in New York. States with the highest fees for a 30-minute office visit were in Arkansas, Georgia, Washington, and West Virginia. The lowest fees were in Rhode Island, New York, New Jersey, Missouri, and Pennsylvania. In general, these results were similar with regard to a 15-minute office visit for an established patient (99213).

Despite exhibiting relatively lower variation than the primary-care fees, variation in the obstetric fees presented in Table 3 is considerable as well. Across divisions, the lowest fees for a global vaginal delivery (59400) are concentrated in the New England, Middle Atlantic, and East North Central Divisions, whereas the South Atlantic, East South Central, and West South Central Divisions had, on average, the highest fees for this service. Across States, the difference between the high and low fees for global vaginal deliveries is considerable. Alabama, the District of Columbia, Kansas, Kentucky, and Massachusetts have relatively high fees. On the other hand, Hawaii, New Jersey, Rhode Island, and South Dakota have surprisingly low fees for vaginal deliveries. The District of Columbia's fee for a vaginal delivery is more than three times that of New Jersey's. With a few exceptions, fees for a global cesarean delivery follow similar patterns. Most notably, although Connecticut's fee for a vaginal delivery is below the national average, their fee for a global cesarean delivery is almost $600 higher than the national average.

Two other findings should be noted. First, States with higher-than-average Medicaid fee index values do not necessar-

[6] A deflated index not presented in this analysis indicates that there is even greater variation in Medicaid fees after adjusting for differences in the cost of practice. This results from the fact that a number of States with high fee-index values are in divisions that are characterized by relatively low practice costs. Conversely, many States with low fee-index values are in areas with relatively high costs of practice.

ily have higher fees for both primary-care and obstetric services. The District of Columbia, for example, has relatively high fees for obstetric services but lower-than-average fees for a 30-minute office visit for a new patient (99203). Similarly, Virginia's fees for a 30-minute office visit for a new patient are relatively low, yet fees for obstetric services are considerably higher than the national average. Second, almost all States allowed global billing in 1993 for obstetric services. Although previous surveys of Medicaid fees found that several States paid for pre- and postpartum visits on a per visit basis, almost all States now provide physicians with the opportunity to bill on a global basis.

Change in Medicaid Fees: 1990-93

The percent change in the average Medicaid fee for all services in 1990 and 1993 was computed, and this information is presented in Table 4. Nationally, the average Medicaid fee increased approximately 14 percent from 1990 to 1993 across the United States. However, there is considerable variation in growth rates across both divisions and States. The Middle Atlantic and Pacific Divisions experienced very small growth in fees. The South Atlantic and East South Central Divisions experienced the greatest increases in Medicaid fees.

Across States, the largest increases in the average Medicaid fee occurred in Montana, Pennsylvania, and West Virginia; these States were well below the national average in 1990. By 1993, these States were well above the national average (Table 4). This illustrates that some States with relatively low average Medicaid fees in 1990 increased their fees substantially by 1993. On the other hand, some States did not match this growth. In Maine, Georgia, South Carolina, California, and Oregon, average Medicaid fees actually declined from 1990 to 1993. Perhaps more important, some of the smallest increases (or actual decreases) in average Medicaid fees occurred in some of the larger States that in 1990 had relatively low average fees, compared with the national average. For example, California, New Jersey, and New York experienced small increases or actual decreases in average Medicaid fees across the study period and, as a result, remained well below the national average in 1993.

Table 4 also provides growth rates in fees from 1990 to 1993 for a 30-minute office visit with an established patient (99203) and a routine vaginal delivery (59410), two important Medicaid services likely affected by legislation requiring adequate fee levels to ensure access. On average across the Nation, Medicaid fees increased by more than 25 percent for a vaginal delivery only and 20.2 percent for a 30-minute office visit for an established patient. The Middle Atlantic and Mountain Divisions experienced the smallest increases in fees for a 30-minute office visit for an established patient. In New England, the fees for this service, on average, decreased. In general, States in the South Atlantic Division increased their fees the most for this service. With regard to fees for a vaginal delivery only, the New England and Pacific Divisions experienced the smallest increases in fees, and States in the East South Central Division experienced, on average, the largest growth in fees for this service.

Two States—Pennsylvania and West Virginia—more than doubled their fees for a vaginal delivery. Roughly 50 percent of the States increased their fees by at least 25 percent. However, 11 States did not increase their fees. For a 30-minute office visit for an established patient, more than 50 percent of the States increased their fees by at least 15 percent. Delaware, Georgia, Kentucky, Maryland, North

Table 4

Medicaid Fees and Percent Change in Fees for All Services and Selected Services: United States, 1990-93

Census Division[1] and State	All Services			Office Visit, Established Patient, 30 Minutes (99203)[2]			Vaginal Delivery Only (59410)[2]		
	1990 Fee	1993 Fee	Percent Change	1990 Fee	1993 Fee	Percent Change	1990 Fee	1993 Fee	Percent Change
National Average	$123.39	$138.97	13.67	$30.74	$35.21	20.19	$526.71	$639.83	25.84
New England	127.00	142.03	11.30	34.54	33.99	-1.30	520.58	597.26	7.36
Connecticut	135.09	157.28	16.43	27.50	26.00	-5.46	609.70	609.70	0.00
Maine	99.04	93.84	-5.26	23.25	24.77	6.54	500.00	450.00	-10.00
Massachusetts	128.79	146.79	13.98	42.00	41.00	-2.38	433.00	592.00	36.72
New Hampshire	145.42	154.61	6.32	35.00	36.00	2.86	810.00	810.00	0.00
Rhode Island	NA	NA	NA	NA	NA	NA	NA	NA	NA
Vermont	119.90	129.75	8.21	26.00	27.00	3.85	625.00	688.00	10.08
Middle Atlantic	102.15	108.57	6.95	13.57	13.72	1.06	574.68	613.90	12.59
New Jersey	73.46	74.45	1.34	20.75	19.50	-6.02	320.00	296.00	-7.50
New York	111.70	113.25	1.38	11.00	11.00	0.00	679.00	679.00	0.00
Pennsylvania	89.95	146.78	63.19	18.00	22.50	25.00	312.50	800.00	156.00
South Atlantic	149.46	172.48	21.20	29.75	39.70	52.98	631.94	835.53	44.58
Delaware	106.32	138.29	30.08	20.05	34.00	69.58	500.00	680.00	36.00
District of Columbia	165.56	168.16	1.57	30.00	30.00	0.00	900.00	900.00	0.00
Florida	140.15	156.57	11.71	35.00	35.00	0.00	500.00	800.00	60.00
Georgia	203.92	198.58	-2.62	32.10	51.24	59.63	901.00	901.00	0.00
Maryland	152.72	161.11	5.49	21.00	37.00	56.96	895.00	895.00	0.00
North Carolina	129.92	156.25	20.26	31.26	47.01	76.19	550.00	738.50	34.27
South Carolina	142.61	133.03	-6.72	30.00	30.00	0.00	700.00	700.00	0.00
Virginia	171.15	203.66	18.99	27.00	30.00	11.11	670.00	864.00	28.96
West Virginia	86.39	250.39	189.83	10.00	52.50	425.00	330.00	1,121.88	239.96
East South Central	123.54	171.36	38.05	28.99	35.01	25.90	534.94	828.08	60.11
Alabama	140.84	201.87	43.33	22.50	28.47	26.53	700.00	1,150.00	64.29
Kentucky	139.89	198.21	41.69	24.00	39.00	62.50	650.00	900.00	38.46
Mississippi	106.63	121.39	13.84	22.00	28.48	29.46	531.20	575.05	8.26
Tennessee	111.79	162.99	45.80	40.00	40.00	0.00	362.50	725.00	100.00
West South Central	141.81	164.26	16.58	33.67	40.52	22.18	607.17	726.45	21.29
Arkansas	115.18	154.35	34.02	42.00	59.00	40.48	367.08	452.00	23.13
Louisiana	159.03	180.24	13.34	36.00	36.00	0.00	760.00	860.00	13.16
Oklahoma	132.24	145.01	9.66	24.00	34.97	45.71	525.00	700.00	33.33
Texas	NA	NA	NA	NA	NA	NA	NA	NA	NA
East North Central	114.39	126.86	11.83	25.20	30.61	23.50	455.51	542.50	22.64
Illinois	123.25	126.87	2.94	25.05	25.05	0.00	550.00	550.00	0.00
Indiana	164.52	166.49	1.20	36.30	33.21	-8.52	591.60	591.60	0.00
Michigan	99.85	116.14	16.31	25.30	35.89	41.48	380.79	540.00	41.81
Ohio	100.14	113.74	13.58	22.06	31.21	41.48	400.00	500.00	25.00
Wisconsin	110.97	147.62	33.03	22.51	29.66	31.76	371.99	590.74	58.81
West North Central	123.73	143.50	17.00	26.03	28.83	9.31	454.23	630.44	40.00
Iowa	151.35	169.49	11.98	28.32	31.35	10.70	644.32	761.49	18.19
Kansas	118.37	153.14	29.37	25.00	25.00	0.00	450.00	900.00	100.00
Minnesota	159.00	173.47	9.10	30.00	35.20	17.33	457.93	607.20	32.60
Missouri	88.41	105.00	18.77	20.00	20.00	0.00	390.00	550.00	41.03
Nebraska	113.82	140.40	23.36	32.38	39.34	21.50	441.00	507.00	14.97
North Dakota	120.97	137.31	13.51	30.00	41.00	36.67	400.00	500.00	25.00
South Dakota	121.66	149.67	23.02	28.40	31.70	11.62	346.50	444.00	28.14
Mountain	129.54	152.65	19.73	38.54	39.75	3.39	505.24	603.20	25.16
Colorado	118.01	127.33	7.90	32.75	35.00	6.87	487.65	520.84	6.81
Idaho	165.23	168.05	1.71	41.33	44.57	7.84	700.00	700.00	0.00
Montana	109.14	175.39	60.71	48.02	51.13	6.48	419.20	726.75	73.37
Nevada	196.79	206.51	4.94	47.46	47.50	0.08	824.73	828.29	0.43
New Mexico	131.49	159.02	20.94	34.22	36.02	5.26	476.39	510.24	7.11
Utah	95.91	126.46	31.86	39.30	36.85	-6.23	325.16	567.02	74.38
Wyoming	145.30	198.62	36.70	50.00	50.98	1.96	525.00	787.50	50.00

See footnotes at end of table.

Table 4—Continued

Medicaid Fees and Percent Change in Fees for All Services and Selected Services: United States, 1990-93

Census Division[1] and State	All Services			Office Visit, Established Patient, 30 Minutes (99203)[2]			Vaginal Delivery Only (59410)[2]		
	1990 Fee	1993 Fee	Percent Change	1990 Fee	1993 Fee	Percent Change	1990 Fee	1993 Fee	Percent Change
Pacific	114.58	116.85	2.17	44.51	46.81	7.28	474.70	501.45	6.67
Alaska	NA	NA	NA	NA	NA	NA	NA	NA	NA
California	114.59	112.54	-1.79	46.00	46.00	0.00	480.60	480.60	0.00
Hawaii	129.77	145.23	11.92	53.69	60.70	13.06	291.20	472.80	62.36
Oregon	134.32	133.64	-0.51	39.74	40.93	2.99	611.33	573.23	-6.23
Washington	107.83	146.63	35.98	30.88	52.91	71.34	424.68	674.95	58.93
Minimum	73.46	74.45	-6.72	10.00	11.00	-8.52	291.20	296.00	-10.00
Maximum	203.92	250.39	189.83	53.69	60.70	425.00	901.00	1,150.00	239.96
Coefficient of Variation	20.50	23.48	—	36.03	32.94	—	27.03	26.71	—

[1] Figures shown for each division are weighted average of each State within that division.
[2] Numbers in parentheses are codes from the *Current Procedural Terminology, Fourth Edition.*

NOTE: NA is not available.

SOURCE: Urban Institute 1993 Medicaid Fee Survey. Washington, DC., 1993.

Carolina, West Virginia, and Washington all increased their fees for this service by more than 50 percent.

1993 Medicaid Fees and MFS

Although these results suggest that Medicaid physician fees have grown considerably from 1990 to 1993, it is important to determine the level of Medicaid fees relative to other payers. For this purpose, the relationship between 1993 Medicaid and fully phased-in MFS fees across all services and by broad type-of-service groups was examined. Table 5 presents the ratio of Medicaid-to-MFS-fee indexes, weighted by Medicaid enrollees across all services and by type of service. The first column suggests that Medicaid fees across the United States are roughly 73 percent of comparable MFS fees. However, there was considerable variation in this relationship across both divisions and States. The New England, Middle Atlantic, and Pacific Divisions had fees for all surveyed Medicaid services that were less than 65 percent of comparable MFS fees. On average, States in the East South Central Division had the highest fees relative to MFS fees.

Across States, Arkansas, Nebraska, West Virginia, and Wyoming had Medicaid fees that were 10 percent higher than MFS fees for a similar group of services. For most States, however, the Medicaid index was considerably less than a comparable MFS fee index. For example, New Jersey, New York, and Rhode Island all paid Medicaid fees that were 50 percent below MFS fees for the same group of services.[7]

Although, in general, Medicaid fees for surveyed services were considerably lower than MFS fees, there was some variation in the relationship between Medicaid and MFS fee levels by type of service. From a national perspective, Medicaid fees for primary-care services were 68 percent of MFS fees, slightly less than those for all services. The Middle Atlantic Division had fees for primary-care services that were less than 50 percent of comparable MFS fees. Across States, New Jersey, New York, and Rhode Island had Medicaid primary-care fees that were less than 50 percent of MFS fees. These findings are consistent with previous work that showed that 1990 Medicaid fees

[7] In New York State, the very low value of fees relative to MFS fees is in part attributable to extremely high practice-cost expenses, which are explicitly recognized in the MFS.

Table 5

Medicaid to Medicare Fee Ratios for All Services and Selected Services: United States, 1993

Census Division[1] and State	All Services	Primary Care	Hospital Visits	Surgery	Lab Services	Imaging Services	Obstetric Care
National Average	0.73	0.68	0.57	1.00	0.77	0.80	0.88
New England	0.62	0.62	0.42	0.74	0.61	0.56	0.67
Connecticut	0.61	0.53	0.46	0.85	0.59	0.56	1.02
Maine	0.63	0.67	0.41	0.58	0.66	0.46	0.62
Massachusetts	0.90	0.97	0.61	1.04	0.72	0.85	0.75
New Hampshire	0.78	0.77	0.66	0.69	0.68	0.55	1.11
Rhode Island	0.47	0.47	0.31	0.61	0.52	0.43	0.51
Vermont	0.72	0.66	0.53	0.65	1.31	0.76	0.97
Middle Atlantic	0.42	0.36	0.19	0.48	0.38	0.47	0.76
New Jersey	0.42	0.41	0.30	0.48	0.51	0.43	0.42
New York	0.38	0.31	0.14	0.43	0.33	0.43	0.82
Pennsylvania	0.69	0.62	0.35	0.89	0.52	0.82	1.07
South Atlantic	0.90	0.85	0.72	1.18	0.82	0.87	1.16
Delaware	0.72	0.64	0.62	1.04	0.71	0.86	0.89
District of Columbia	0.69	0.64	0.41	0.73	0.43	0.74	1.08
Florida	0.78	0.74	0.59	0.94	0.60	0.82	1.00
Georgia	1.07	1.01	1.02	1.21	1.06	1.05	1.37
Maryland	0.80	0.82	0.31	0.70	0.72	0.52	1.16
North Carolina	0.94	0.90	0.90	0.99	0.82	0.94	1.13
South Carolina	0.70	0.67	0.26	0.97	0.62	0.60	1.03
Virginia	0.95	0.79	0.86	1.87	1.38	0.93	1.33
West Virginia	1.44	1.36	1.26	2.85	1.06	1.27	1.53
East South Central	0.94	0.86	0.63	1.32	1.00	1.03	1.23
Alabama	0.91	0.84	0.64	1.06	0.36	0.72	1.62
Kentucky	1.08	0.98	0.72	2.16	1.13	1.01	1.29
Mississippi	0.74	0.67	0.65	0.73	1.06	1.05	0.89
Tennessee	0.97	0.90	0.57	1.25	1.27	1.21	1.15
West South Central	0.92	0.88	0.84	1.07	0.98	0.96	1.03
Arkansas	1.14	1.14	0.96	1.54	1.13	1.27	0.92
Louisiana	0.96	0.85	0.75	1.32	1.03	1.11	1.32
Oklahoma	0.92	0.94	0.65	0.94	1.02	0.67	1.08
Texas	0.88	0.85	0.89	0.98	0.95	0.94	0.96
East North Central	0.68	0.62	0.50	1.07	0.71	0.80	0.76
Illinois	0.62	0.56	0.37	0.97	0.65	0.70	0.78
Indiana	0.95	0.84	0.92	1.77	1.20	0.98	1.02
Michigan	0.62	0.61	0.61	0.74	0.51	0.62	0.62
Ohio	0.63	0.57	0.31	1.06	0.70	0.86	0.72
Wisconsin	0.84	0.75	0.66	1.45	0.87	1.17	0.86
West North Central	0.79	0.68	0.61	1.19	0.89	1.16	0.97
Iowa	0.81	0.64	0.64	1.73	1.01	0.85	1.22
Kansas	0.76	0.61	0.33	1.14	1.29	1.16	1.14
Minnesota	0.95	0.82	1.03	1.54	0.83	1.26	1.07
Missouri	0.56	0.52	0.27	0.62	0.66	0.62	0.77
Nebraska	1.15	0.90	0.75	1.24	1.06	3.49	0.81
North Dakota	0.91	0.85	0.98	1.14	0.98	1.21	0.85
South Dakota	0.90	0.77	0.93	1.74	1.15	1.21	0.92
Mountain	0.87	0.80	0.66	1.26	1.11	0.97	0.99
Colorado	0.74	0.73	0.46	0.86	1.03	0.71	0.85
Idaho	1.01	0.99	0.68	1.15	1.02	0.99	1.21
Montana	0.95	0.84	0.90	1.22	1.03	1.08	1.32
Nevada	1.06	0.94	0.87	1.82	1.19	1.33	1.23
New Mexico	0.89	0.75	0.62	1.59	1.53	1.34	0.93
Utah	0.77	0.75	0.71	1.15	0.77	0.63	0.81
Wyoming	1.10	0.98	0.98	1.94	1.23	1.23	1.28

See footnote at end of table.

Table 5—Continued

Medicaid to Medicare Fee Ratios for All Services and Selected Services: United States, 1993

Census Division[1] and State	All Services	Primary Care	Hospital Visits	Surgery	Lab Services	Imaging Services	Obstetric Care
Pacific	0.64	0.61	0.55	0.91	0.78	0.70	0.66
Alaska	1.79	1.92	1.16	2.46	0.93	1.74	1.36
California	0.59	0.54	0.54	0.90	0.79	0.68	0.61
Hawaii	0.86	0.82	0.87	1.56	0.81	0.89	0.67
Oregon	0.71	0.62	0.60	1.08	0.90	0.84	0.89
Washington	0.89	0.96	0.47	0.72	0.72	0.68	1.01
Minimum	0.38	0.31	0.14	0.43	0.33	0.43	0.42
Maximum	1.79	1.92	1.26	2.85	1.53	3.49	1.62
Coefficient of Variation	29.56	31.51	43.86	40.92	33.28	37.71	30.07

[1] Figures shown for each division are weighted averages of each State within that division.

SOURCE: Urban Institute 1993 Medicaid Fee Survey. Washington, DC. Urban Institute, 1993.

for primary care were considerably lower than Medicare-allowed charges (Holahan, 1991). However, three States—Arkansas, Georgia, and West Virginia—had Medicaid primary-care fees that were higher than MFS fees. From the national perspective, Medicaid paid 57 percent of MFS fees for hospital visits. Nonetheless, there were a few Medicaid programs that paid higher fees for hospital visits compared with MFS fees, including Georgia, Minnesota, and West Virginia.

The level of Medicaid fees relative to MFS fees for surgical services, obstetric care, and imaging tests was much higher than that for primary-care services. On average, Medicaid fees for surveyed surgical services were equivalent to MFS fees. The East South Central Division paid 32 percent more than the MFS for these services. However, two divisions, New England and the Middle Atlantic, had fees for surgical services that were less than 80 percent of comparable MFS fees. Across States, Medicaid fees in New York and New Jersey were less than one-half of MFS fees.

From the national perspective, Medicaid fees for obstetric care were, on average, roughly 88 percent of MFS fees. With the exception of the New England, Middle Atlantic, East North Central, and Pacific Divisions, all had fees for obstetric services that were, on average, at least 97 percent of comparable MFS fees. Although more than one-half of the States set obstetric fees that were higher than fully phased-in MFS fees, States with the largest Medicaid programs had relatively low fees. Five States—Alabama, Georgia, Louisiana, Virginia, and West Virginia—set Medicaid fees that were 30 percent higher than MFS levels. However, New Jersey and California had fees that were 61 percent or less of MFS fees.

CONCLUSIONS

Perhaps the most important result of this study is that there has been considerable growth in Medicaid fees from 1990 to 1993. From the national perspective, Medicaid fees for all services in the survey increased approximately 14 percent during this time. These results are similar to those reported by the Physician Payment Review Commission (1994) and may reflect States' attempts to ensure adequate access to primary-care and obstetric physician services for Medicaid enrollees. Medicaid fees for a vaginal delivery increased more than 25 percent from 1990 to 1993. Similarly, Medicaid fees for a 30-minute office visit for an established patient increased on average by 20.2 percent. Despite an average increase, however, Medicaid fees decreased over the time period in two large States, California and New York.

Another important finding is that there exists considerable variation in Medicaid fee levels and, as a result, the generosity of fee levels relative to the MFS across divisions and States and by type of service. The New England, Middle Atlantic, East North Central, and Pacific Divisions had the lowest 1990 Medicaid fees on average, experienced the lowest growth in fees, and as a result, had 1993 Medicaid fees that were low relative to MFS fees. Within these divisions, however, there were some exceptions to these trends. Massachusetts, Indiana, and Pennsylvania, for example, all experienced higher growth in Medicaid fees than the other States within their respective divisions and had 1993 Medicaid fees that were higher relative to comparable MFS fees. Similarly, the South Atlantic and East South Central Divisions experienced, on average, the greatest growth in Medicaid fees and also had high Medicaid fees relative to MFS fees in 1993. However, some States within the South Atlantic Division did not have fees that were high relative to the MFS. South Carolina, for example, experienced an actual decline in average Medicaid fees from 1990 to 1993 and had fees that were 70 percent of comparable MFS fees.

In our type-of-service analysis, Medicaid fees for most services were found to remain below comparable MFS fees. On average, Medicaid fees for obstetric services were 88 percent of MFS fees. Medicaid fees for surgical services were, on average, roughly equivalent to the MFS, in part a result of the shift in surgical fees inherent in the MFS. However, the ratio of Medicaid to MFS fees for primary-care services was low in comparison to the ratio of Medicaid to MFS fees for obstetric care and surgical services.

There are two important policy implications of these results. First, there remains reason for some concern regarding access to physician services for persons who are eligible for Medicaid. From the national perspective, Medicaid fees, on average, were 73 percent of MFS fees. Medicaid fees for primary-care and obstetric services remain much lower than MFS fees. Although individual States may have increased fees considerably for these services, fees paid for these services provided to the average Medicaid enrollee were relatively low. The magnitude of the difference between the MFS and Medicaid fees for primary services is in part a function of attempts by HCFA to increase payment for primary-care services for the Medicare population and in part a function of the fact that Medicaid fees for primary care have not grown as quickly as fees for obstetric care.

Although it was not possible to compare Medicaid fees with actual Medicare payments, these results provide some guidance for policymakers. Given Medicaid fee levels that are relatively low compared with a fully phased-in MFS and previous research suggesting that physician decisions to participate in Medicaid are a function of relative market fee levels, newly eligible Medicaid enrollees may continue to face access problems in some areas. It is important to note that those areas in which Medicaid fees are low relative to MFS fees are concentrated in the New England, Middle Atlantic, and Pacific Divisions, where a significant portion of persons eligible for Medicaid reside.

Second, as was shown in earlier work (Holahan, Wade, and Gates, 1993), these updated results suggest that requiring States to increase Medicaid fees to approximate MFS fees would have a differential effect across divisions and among States, given the variation in 1993 Medicaid fee levels. Those States, primarily in the Southeast, that currently pay physicians relatively well would be less affected by such a policy than States with low fees. Those States with low fees, including many States in the New England, Middle Atlantic, and East North Central Divisions, would

experience large increases in program costs in the absence of offsetting factors. Although surgical fees under Medicaid are virtually equivalent to MFS fees, primary-care fees are, on average, less than 70 percent of fully phased-in MFS fees, suggesting that the largest increase in program costs would result from requiring States to adopt the MFS for primary-care services. However, although costly, States may be forced to adopt these payment levels to ensure access to primary-care services.

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TECHNICAL NOTE

Both the comparison of fees in 1990 and 1993 and the construction of expenditure weights were constrained by changes in the CPT-4 service codes for office and hospital visits in 1992. Because of changes in CPT-4 codes, a crosswalk between 1990 and 1993 codes was required. Certain service codes, including 99232, 99231, and 99283, could not be compared across the time period because of insufficient information in The Urban Institute's 1991 fee survey and thus were dropped from the 1990-93 comparative analyses. However, expenditure weights (Table 1) were developed based on the available information. Table 6 shows the codes that were crosswalked using the HCFA allocation rules.

Table 6

New and Old Service Codes and Their Weights

New Code	Description	Old Code	Weight
99203	Office Visit, New Patient	90015	100
99205	Office Visit, New Patient	90020	30
99213	Office Visit, Established Patient	90050 90060	100 100
99214	Office Visit, Established Patient	90070	100
99222	Hospital Visit, Established Patient	90215 90220	100 50
99231	Subsequent Hospital Visit	90250 90260	80 50
99232	Subsequent Hospital Visit	90250 90260	20 50
99283	Emergency Visit	90550 90515	50 50

SOURCE: (*Federal Register*, 1992).

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