

**Report on the Maryland Medical Assistance Program and Maryland
Children's Health Program – Reimbursement Rates Fairness Act
September 2004**

I. Introduction

Chapter 464 (Senate Bill 481) of the 2002 Session directed the Department of Health and Mental Hygiene to establish a process to annually set the fee-for-service reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program in a manner that ensures participation of providers. The legislation further stipulated that in developing the rate setting process, the Department shall take into account community rates as well as annual medical inflation, or utilize the Resource Based Relative Value Scale (RBRVS) methodology used in the federal Medicare program or the American Dental Association Current Dental Terminology (CDT-3) codes. The legislation also directed that each year, the Department should submit a report to the Governor and various House and Senate committees on the following:

1. Progress in establishing the rate setting process mentioned above;
2. Comparison of Maryland's Medicaid reimbursement rates with that of other states;
3. The schedule for bringing Maryland's reimbursement rates to a level that assures provider participation in the Medicaid program; and
4. Estimated costs of implementing the schedule in item 3 and proposed changes to the fee-for-service reimbursement rates.

In September 2001, the Department prepared the first annual report in response to Chapter 702 (House Bill 1071) of the 2001 Session analyzing the reimbursement rates being paid by the Maryland Medicaid and Children's Health Programs. This is the fourth annual report.

The Department's 2001 report showed that Maryland's Medicaid reimbursement rates in 2001 were, on average, about 36 percent of 2001 Medicare rates. The report also included the results of a survey conducted by the American Academy of Pediatrics in 1998/1999 that showed, for a subset of procedures, Maryland ranked 47th among Medicaid programs in the country in physician reimbursement. Based on the results of the 2001 report, the Governor and the legislature appropriated an additional \$50 million total funds (\$25 million state funds) for physician fees in the Medicaid program for the fiscal year beginning July 2002. The additional funding raised overall average Medicaid reimbursement rates in Maryland to 62 percent of 2002 Medicare rates. The overall average currently stands at about 60 percent of 2004 Medicare rates. The increase was targeted to evaluation and management procedure codes used largely by primary care and office-based specialty care providers.

The Department used the Medicare physician payment methodology to allocate the new fees and to determine the new physician fee schedule. Since July 2002, Maryland Medicaid has been reimbursing physicians for the full practice and malpractice expense components for Evaluation and Management procedures, and has covered, within State resources, a portion of the work component. Reimbursement rates for the codes that were targeted by the additional funding

increased from an average of 33 percent to an average of 80 percent of 2002 Medicare fees. The average reimbursement rate for these procedure codes is about 77 percent of 2004 Medicare fees.

Comparisons to the Medicare physician fee schedule are fluid. Medicare rates are adjusted annually according to a complex formula designed to control overall spending, while accounting for factors that affect the cost of providing care. In some years, including 2002, overall Medicare rates have actually decreased. However, following legislative mandates, Medicare physician fees were increased by 1.6 percent in 2003 and by 1.5 percent in 2004 [1].

The remainder of this report is organized into four sections. Section Two provides background information on Maryland Medicaid reimbursement issues. Section Three provides an assessment of Maryland Medicaid fees compared to Medicare and other states' fees, and reviews the Department's progress in adjusting payment rates for oral health services as well as for physicians' services at trauma centers. Section Four provides an analysis of physician participation after the rate increase. Section Five discusses future fee increases.

II. Background

In recent years, the Maryland Medicaid program has undergone significant expansion. Medicaid enrollment of children has grown by over 150,000 since 1998, due primarily to the implementation of the Maryland Children's Health Program (MCHP). The demographics of this newly eligible population increase the need for primary care physicians, especially pediatricians and family practitioners. The rise in total Medicaid population has increased the number of Medicaid patients within each physician's practice. As a result, the share of Medicaid revenues and their importance to the viability of participating physicians' practices has increased.

The Maryland Medicaid Advisory Committee and policymakers had raised concerns about the low level of reimbursement rates for physicians who provide services for Maryland's Medicaid program. In addition, there have been concerns about the impact of physicians' reimbursement on access to care for Medicaid enrollees. This issue affects the Maryland Medicaid managed care (HealthChoice) program as well because most managed care organizations' (MCOs') payment rates to physicians are tied to the Medicaid fee-for-service fee schedule.

Prior to July 2002, physician fees had not increased for over a decade, while reimbursement rates for most other Medicaid-covered services had increased. The majority of Medicaid expenditures are for components of health care (inpatient and outpatient hospital, nursing home, pharmacy, etc.) whose reimbursement rates increase regularly. For example, the Health Services Cost Review Commission (HSCRC) considers inflation in its annual review of hospital rates. Nursing home rates are also automatically adjusted annually in accordance with state law to reflect increasing costs. The greatest component of prescription drug costs, ingredient fees, has increased as the costs of inputs rise. Fees for many other providers, including Federally Qualified Health Centers, Home Health Agencies, and Medical Day Care Providers are also adjusted annually.

III. Analysis of Maryland Medicaid Fees

A. Comparisons with Medicare Fees

After the fee increase, we compared Maryland Medicaid's payment rates with the Medicare program's 2002 and 2004 average payments in Maryland. The analysis indicated that Maryland's Medicaid reimbursement rates before the July 2002 fee increase were, on average, about 41 percent of 2002 Medicare rates for procedures that matched. In 2002, Medicare physician fees decreased by 5.4 percent compared to 2001. After the increase in Medicaid fees for Evaluation and Management procedures in July 2002, Maryland Medicaid's overall physician reimbursement rates were, on average, about 62 percent of 2002 Medicare rates. They currently stand at about 60 percent of Medicare rates for 2004.

However, there is a wide variation in the fees for individual procedures compared to Medicare fees. Fees for some procedures are much lower than Medicare fees, while fees for other procedures are close to Medicare fees. As discussed earlier, reimbursement rates for the 140 Evaluation and Management procedures targeted by the additional funding increased from an average of 33 percent to an average of 80 percent of Medicare fees for 2002, and an average of 77 percent of Medicare fees for 2004. However, Maryland Medicaid fees for about 4,200 procedures that match Medicare fees (excluding Evaluation and Management procedures, radiology and laboratory procedures, and procedures with zero Medicare fee) were on average 37 percent of Medicare fees for 2002, and currently stand at 38 percent of Medicare fees for 2004 (note: the increase from 37 to 38 percent of Medicare is because Medicare RVUs and reimbursement rates for some specific procedures have decreased from their 2002 levels).

B. Comparisons with Other States

Like Maryland, the neighboring states have their own Medicaid fee schedules. Our review of literature indicates that most states, including Maryland, had previously used different relative value studies as benchmarks for setting their physician fees. The relative value studies were precursors to the Medicare Resource Based Relative Value Scale method.

We compared Maryland Medicaid fees for some of the high-volume procedures with neighboring states' Medicaid fees and with the corresponding Medicare fees. Earlier we discussed the results of an American Academy of Pediatrics' 1998/1999 survey of Medicaid reimbursement rates across the country. The American Academy of Pediatrics conducted a similar survey in 2001. Based on the 2001 survey data and Maryland's new fees for Evaluation and Management procedures, Maryland's rank is 13. Ranks of neighboring states are: Delaware: 6, District of Columbia: 47, Pennsylvania: 46, Virginia: 15, and West Virginia: 11.

The American Academy of Pediatrics survey results for high-volume Evaluation and Management procedures for the neighboring states are shown in Table 1, along with the corresponding Maryland Medicaid rates and 2004 Medicare fees for each listed procedure. The last column of Table 1 shows the minimum fee range for private, non-Medicare charges. It is important to note that fee charges are not the same as the payment received as reimbursement from insurance companies or private pay patients, but rather, what physicians would like to receive for their services.

Table 1 - Fees for High-Volume Evaluation and Management Procedures

CPT Code	Description	DC ^a	VA ^b	PA ^b	DE ^b	W. VA ^b	MD ^c	Medi Care ^d	Min Private Fee ^e
99201	New Patient, office visit	\$25	\$29	\$25	\$38	\$35	\$29	\$38	\$56
99202	New Patient, expanded office visit	\$30	\$45	\$20	\$59	\$55	\$51	\$67	\$74
99203	New Patient, low complexity	\$30	\$63	\$20	\$83	\$77	\$77	\$99	\$97
99204	New Patient, intermediate complexity	\$35	\$91	\$20	\$120	\$110	\$109	\$140	\$142
99205	New Patient, high complexity	\$59	\$114	\$30	\$149	\$136	\$139	\$178	\$182
99211	Established Patient, office visit	\$15	\$14	\$20	\$19	\$19	\$17	\$22	\$29
99212	Establish. Patient, expanded office visit	\$18	\$24	\$20	\$32	\$29	\$30	\$39	\$45
99213	Established Patient, low complexity	\$18	\$34	\$20	\$44	\$39	\$42	\$55	\$62
99214	Establish. Patient, intermed. complexity	\$30	\$52	\$20	\$68	\$61	\$66	\$85	\$92
99215	Established Patient, high complexity	\$41	\$77	\$20	\$101	\$87	\$97	\$123	\$136
99242	Office Visit, straightforward decision	\$33	\$65	\$30	\$85	\$77	\$73	\$94	\$134
99243	Office Visit, low complexity	\$43	\$83	\$30	\$109	\$97	\$97	\$125	\$161
99244	Office Visit, intermediate complexity	\$60	\$115	\$49	\$151	\$134	\$137	\$176	\$207
99245	Office Visit, high complexity	\$65	\$149	\$49	\$196	\$168	\$178	\$227	\$271

^a American Academy of Pediatrics Survey of Medicaid Reimbursement (1998/1999)

^b American Academy of Pediatrics Survey of Medicaid Reimbursement (2001)

^c Fee schedule as of July 2002

^d Medicare Fee schedule for 2004

^e 2003 Physicians Fee & Coding Guide, MAG Mutual Healthcare Consultants

C. Trauma Center Payment Issues

Trauma centers are facing serious financial constraints nationwide due in large part to the high percentage of uninsured patients served in trauma centers. If the patient is uninsured, physicians are not compensated for their services. Trauma physicians, therefore, rely more heavily on public insurance for their income. This, coupled with the fact that Medicaid's rates for trauma services tend to be low and malpractice insurance costs have risen over the years, has placed significant staffing challenges on trauma centers.

In addition to low reimbursement levels, trauma physicians typically are not compensated for being on-call to respond to accidents and other trauma cases. Physicians are increasingly unwilling to devote long hours to standing by for no compensation. For instance, in Hagerstown, not enough doctors agreed to be on-call, which led to Washington County Hospital having to close its trauma center in June 2002. After agreeing to pay physicians a stand-by fee, the hospital eventually was able to reopen its trauma center.

In response, the Maryland legislature passed and the Governor signed into law Senate Bill 479, which created a Trauma and Emergency Medical Fund that is financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility over the Fund. Based on the new legislation, Maryland Medicaid is required to pay physicians 100 percent of the

Medicare rate (the Baltimore-facility Medicare rate) when they provide trauma care to Medicaid's fee-for-service and HealthChoice programs enrollees. The enhanced Medicaid fee is limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons and neurosurgeons. In addition, the enhanced Medicaid fee only applies to services rendered in a Maryland Institute for Emergency Medical Services Systems (MIEMSS)-designated trauma center for patients who are placed on Maryland's Trauma Registry, which is also administered by MIEMSS. MHCC and HSCRC will fully cover the additional outlay of general funds that the Maryland Medicaid program will incur due to enhanced trauma fees (50 percent of the difference between 100 percent of Medicare rates and Medicaid's current rates). MHCC will pay physicians directly for uncompensated care and on-call services.

D. Reimbursement for Oral Health Services

Historically, the Maryland Medicaid program has had low dental fees. Despite some recent changes, the rates continue to lag behind commercial reimbursement rates. Unlike physician services, no federal public program, such as Medicare, exists which could serve as a benchmark for oral health service rates. However, the American Dental Association publishes a survey reporting the national and regional average charges for about 165 most commonly used dental procedures, offering data for comparisons.

During the 2003 session of the General Assembly, the legislature included budgetary language in House Bill 40 which stated: "It is also the intent of the General Assembly that \$7.5 million of the funds included in the CY 2004 Managed Care rates for dental services be restricted to increasing fees for restorative procedures." The \$7.5 million funding increase was based on a University of Maryland Dental School analysis of the impact of increasing certain restorative procedure fees to the American Dental Association (ADA) 50th percentile levels.

In compliance with the budgetary language, effective March 1, 2004 MCOs were required to reimburse their contracted providers at the ADA 50th percentile levels for twelve restorative procedure codes. At the same time, Medicaid increased fee-for-service rates to the ADA 50th percentile levels for the same restorative procedures.

1. Medicaid Fee-For-Service Dental Rates

The following Table 2 shows the progress Maryland has made in improving reimbursement to dentists for some of the more common services. On average, Medicaid tripled reimbursement rates for dentists in July 2000, and then increased reimbursement for twelve restorative procedures in 2004. The last column shows the average fee charged by dentists in 2001 in the South Atlantic Region [6]. It is important to note, however, that the South Atlantic Average is based on the fees charged by dentists for the service performed, which does not equate to the average payment received as reimbursement from insurance companies or private pay patients.

Table 2 - Oral Health Reimbursement Schedule - Selected Procedures

CDT-3	CDT-2	Description	MA Fee before 7/1/00 rate increase	MA Fee after 7/1/00 rate increase	MA Fee after 3/1/04 restorative rate increase	South Atlantic Average Charge
D0120	00120	Periodic oral evaluation	\$5	\$15	\$15	\$26
D0220	00220	Intraoral periapical first film	\$3	\$9	\$9	\$15
D0272	00272	Bitewings-two films	\$3	\$15	\$15	\$25
D0330	00330	Panoramic film	\$21	\$42	\$42	\$67
D1110	01110	Prophylaxis-adult	\$12	\$36	\$36	\$53
D1120	01120	Prophylaxis-child	\$8	\$24	\$24	\$40
D1201	01201	Topical application of fluoride with prophylaxis	\$17	\$35	\$35	\$51
D1203	01203	Topical application of fluoride - no prophylaxis	\$17	\$14	\$14	\$21
D1351	01351	Sealant-per tooth	\$3	\$9	\$9	\$30
D1510	01510	Space maintainer – fixed – unilateral	\$42	\$84	\$84	\$191
D1515	01515	Space maintainer – fixed – bilateral	\$48	\$144	\$144	\$263
D2110	02110	Amalgam – one surface, primary	\$11	\$33	\$33	\$63
D2120	02120	Amalgam – two surfaces, primary	\$17	\$42	\$42	\$78
<i>D2140</i>	<i>02140</i>	<i>Amalgam – one surface, permanent</i>	\$13	\$37	\$70	\$72
<i>D2150</i>	<i>02150</i>	<i>Amalgam - two surfaces, permanent</i>	\$19	\$45	\$88	\$89
<i>D2330</i>	<i>02330</i>	<i>Resin – one surface – anterior</i>	\$13	\$39	\$84	\$86
<i>D2331</i>	<i>02331</i>	<i>Resin – two surfaces – anterior</i>	\$19	\$48	\$102	\$106
<i>D2332</i>	<i>02332</i>	<i>Resin – three surfaces – anterior</i>	\$22	\$56	\$125	\$129
D2385	02385	Resin – one surface, posterior - permanent	\$13	\$39	\$39	\$95
D2386	02386	Resin – two surfaces, posterior, permanent	\$19	\$48	\$48	\$125
<i>D2930</i>	<i>02930</i>	<i>Prefabricated stainless steel crown - primary</i>	\$27	\$75	\$154	\$160
D3220	03220	Therapeutic pulpotomy	\$16	\$60	\$60	\$107
D9230	09230	Analgesia	\$6	\$18	\$18	\$32

Note: The South Atlantic average charge is based on data from the 2001 American Dental Association survey. The procedures identified in italics are among the 12 restorative procedures targeted for the 2004 restorative fee increase.

2. HealthChoice Dental Fees

MCOs are required to develop and maintain an adequate network of oral health providers who can deliver the full scope of oral health services. MCOs are not required to pay their oral health providers at Medicaid fee-for-service rates (except in the case of the twelve restorative procedures described above), although some use the Medicaid fee schedule as the basis for their own fee schedules. Most MCOs have sub-capitation arrangements with vendors to provide dental services for HealthChoice enrollees.

IV. Physician Participation in Maryland Medicaid Program

Physicians' claims data pertaining to the year before and year after fee increase were analyzed for number of physicians who had either partial or full participation in the Medicaid program. Physicians who had less than 50 patients were considered partial participant in the Medicaid program. Physicians were considered full participants in the Medicaid program if they had visits with at least 50 patients during the year. Table 3 shows percentage changes in numbers of participating primary care physicians in fee-for-service (FFS), MCO networks, and total Medicaid program.

Table 3 - Percent Increase in Number of Participating Primary Care Physicians After the Fee Increase

	FFS	MCO Networks	Total Medicaid
Partial Participation	7.4%	0.1%	5.1%
Full Participation	10.1%	0.3%	2.0%

Following the increase in reimbursement rates, physicians substantially increased their participation in the fee-for-service program. Prior to the fee increase, many MCOs had sufficient numbers of primary care physicians in their networks. Therefore, they did not substantially increase the number of their contracting primary care physicians. This led to a modest overall increase in the number of primary care physicians who participate in the Medicaid program.

Table 4 shows percentage changes in numbers of physicians of all specialties (including primary care) who participate in fee-for-service (FFS), MCO networks, and total Medicaid program. As the data in Table 4 indicate, there were significant increases in participation of physicians in fee-for-service, MCO networks, and total Medicaid program.

Table 4 - Percent Increase in Number of Physicians (All Specialties) After the Fee Increase

	FFS	MCO Networks	Total Medicaid
Partial Participation	7.3%	5.3%	7.7%
Full Participation	8.6%	6.6%	7.1%

Caveats for Tables 3 and 4:

It should be noted that percent increases in number of physicians with partial participation in Medicaid in Tables 3 and 4, represent change in:

- Number of physicians who did not participate in the Medicaid program before the fee increase, and after the fee increase started to partially participate in the program, minus
- Number of physicians who were partially participating the program before the fee increase, and decided to fully participate in the program after the fee increase.

Similarly, percent increases in number of physicians with full participation in tables 3 and 4 represent change in

- Number of physicians who were partially participating the program before the fee increase, and decided to fully participate in the program after the fee increase, plus
- Number of physicians who did not participate in the Medicaid program before the fee increase, and after the fee increase started to fully participate in the program.

It is important to note that increases in physician participation may also be partially attributable to steady Medicaid enrollment growth. As the Medicaid population grows, it is reasonable to expect that more physicians will opt to participate in the program.

V. Future Fee Increases

The additional funds provided in 2002 were used to significantly increase reimbursement rates for Evaluation and Management procedure codes commonly used for office visits by both primary care physicians and specialists. However, as indicated in Section IV.A., Maryland Medicaid's reimbursement rates for about 4,200 non-Evaluation and Management codes remain well below the rates paid by Medicare. Table 5 compares Maryland's current Medicaid rates with Medicare rates in 2004, rates paid by other states, and the minimum of private charges for a sample of common, non-Evaluation and Management procedures. As the data in Table 5 show, Maryland Medicaid's reimbursement rates are very low for some of these procedure codes. Therefore, the state could allocate any additional funds that become available to increasing reimbursement rates for these procedures. **Preliminary estimates indicate that it would cost about \$30 million (total funds) to increase fees for these procedures to a minimum of 40 percent of Medicare fees, and it would cost about \$45 million (total funds) to increase them to a minimum of 50 percent of Medicare fees.**

Once reimbursement rates for all procedures performed by physicians are raised to a certain level of Medicare, or are adjusted to correspond to usual, customary, and reasonable (UCR) fees, additional funds could be targeted to maintain their parity with Medicare and UCR fees.

Table 5 - Fees for High-Volume, Non-Evaluation and Management Procedures

CPT Code	Description	DC^a	VA^b	PA^b	DE^b	W. VA^b	MD^c	Medi Care^d	Min Private Fee^e
31500	Intubation Endotracheal Emergency	\$66	\$88	\$72	\$115	\$85	\$31	\$117	\$258
31622	Bronchoscopy	\$117	\$162	\$166	\$212	\$171	\$113	\$277	\$662
32020	Insertion of Chest Tube	\$130	\$169	\$211	\$220	\$160	\$42	\$223	\$555
36489	Insertion of Catheter, Vein	\$47	\$95	\$88	\$125	\$132	\$36	\$259	NA
36620	Insertion of Catheter, Artery	\$36	\$45	\$58	\$58	\$40	\$21	\$56	\$190
43239	Upper GI Endoscopy, Biopsy	\$123	\$174	\$212	\$228	\$187	\$234	\$336	\$698
44950	Appendectomy	\$267	\$381	\$302	\$496	\$398	\$206	\$588	\$1,375
62270	Spinal Puncture, Lumbar, Diagnostic	\$35	\$88	\$42	\$116	\$131	\$18	\$167	\$184
69436	Tympanostomy, General Anesthesia	\$81	\$108	\$99	\$141	\$107	\$83	\$168	\$497
92551	Pure Tone Hearing Test, Air Only	\$8	\$9	\$8	\$17	\$14	\$4	NA	\$28
92567	Tympanometry, Hearing Evaluation	\$6	\$15	\$12	\$20	\$16	\$5	\$23	\$36
93303	Transthoracic Echocardiography	\$117	\$163	NA	\$214	\$163	\$38	\$230	\$495
93307	Echocardiography, Real Time	\$113	\$152	\$158	\$199	\$150	\$34	\$211	\$427
93320	Doppler Echocardiography	\$50	\$66	\$107	\$87	\$66	\$52	\$93	\$310
93510	Left Heart Catheterization	\$108	\$1,219	\$188	\$1,596	\$1,252	\$80	\$1,801	NA
94010	Spirometry: Breathing Capacity Test	\$16	\$21	\$15	\$28	\$18	\$13	\$34	\$69

^a American Academy of Pediatrics Survey of Medicaid Reimbursement (1998/1999)

^b American Academy of Pediatrics Survey of Medicaid Reimbursement (2001)

^c Fee schedule as of July 2002

^d Medicare Fee schedule for 2004

^e 2003 Physicians Fee & Coding Guide, MAG Mutual Healthcare Consultants

References and Notes

- 1 Centers for Medicare and Medicaid Services (CMS) and Medicare Payment Advisory Commission (MedPac) publications. Section 601 of the Medicare Prescription Drug, Improvement and Modernization Act (MPDIMA) of 2003, Public Law 108-173, specified that the annual update of conversion factors for 2004 and 2005 would not be less than 1.5 percent.
- 2 Menges, J., Park, C., Babcock, J., Chimento, L., Haught, R., and Ho, S., of The Lewin Group (2001) 'Comparing Physician and Dentist Fees among Medicaid Programs', *Medical Policy Institute*. <http://www.chcf.org/documents/medical/ComparingPhysicianAndDentistFees.pdf>
- 3 'Medicaid Reimbursement Survey' – (1998/1999, 2001), *American Academy of Pediatrics*, <http://www.aap.org/research/medreimintro.htm>
- 4 Norton, S. (1999) 'Recent Trends in Medicaid Physician Fees, 1993-1998', *The Urban Institute*. <http://www.urban.org/UploadedPDF/discussion99-12.pdf>
- 5 Zuckerman, S., McFeeters, J. Cunningham, P. and Nichols, L. (2004) 'Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation', *Health Affairs – Web Exclusive*, pp W4-374 – W4-384, June 23, 2004.
- 6 South Atlantic Region consists of: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia.

Appendix 1

Medicare Resource Based Relative Value Scale¹

Medicare payments for physician services are made according to a fee schedule. For about 10,000 physician services, Medicare RBRVS assigns the associated relative value units and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending upon the place of service that each procedure is performed. Medicare fees for some procedures are lower if they are performed in hospitals or skilled nursing facilities, than if they are performed in offices or other places. Implementation of RBRVS resulted in increased payments to office-based procedures, and reduced payments to procedures that are provided in the hospital settings.

The Resource Based Relative Value Scale determines relative weights (relative value units) for all procedures. These weights reflect resource requirements of each procedure performed by the physicians. The Medicare physician fees are adjusted to reflect the variations in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice expense). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component by the GPCI for that component.

The resulting weights are multiplied by a conversion factor to determine the payment for each procedure. The Centers for Medicare and Medicaid Services (CMS), annually updates the conversion factor based on the Sustainable Growth Rate system, which ties the updates to growth in the national economy, as a measure of change in funds available for payments to physicians. The Sustainable Growth Rate system is based on formulas designed to control overall spending while accounting for factors that affect the costs of providing care.

Calculating the update to the conversion factor is a two step process. First, CMS estimates the Sustainable Growth Rate (SGR), which is the target rate of growth in total Medicare spending for physician services. SGR is a function of the percentage changes in:

- a) Input prices for physician services,
- b) Traditional (fee-for-service) Medicare enrollment,
- c) Real Gross Domestic Product per capita, and
- d) Spending attributable to changes in law and regulations.

The second step in the process is to calculate the update to conversion factor. This update is a function of:

- a) Change in Medicare Economic Index (MEI) which measures the change in input prices for producing physician services.

¹ Source: Centers for Medicare and Medicaid Services (CMS) and Medicare Payment Advisory Commission (MedPac) publications.

- b) An adjustment factor that increases or decreases the update as needed to align actual spending with the SGR target, and
- c) Other adjustments, such as budget neutrality adjustments required by law.

Currently, there are efforts underway to change the Sustainable Growth Rate (SGR) law, and to update payment for physician services by the projected change in costs of providing services, minus an adjustment for productivity growth.

The conversion factor for year 2000 was \$36.6137. The conversion factor for 2001 was \$38.2581, which represents a 4.5 percent increase over the year 2000 conversion factor. The conversion factor for 2002 decreased by 5.4 percent from its 2001 value to \$36.1992. The conversion factor for 2003 increased by 1.6 percent from its 2002 value to \$36.7856. The conversion factor for 2004 increased by 1.5 percent from its 2003 value to \$37.3374.

Appendix 2

Rate of Non-Federal Physicians per 100,000 Civilian Population, 2001

Rank		Nonfederal Physicians per 100,000 Population
Average	United States	268
1	District of Columbia	680
2	Massachusetts	426
3	New York	395
4	Maryland	382
5	Connecticut	364
6	Rhode Island	352
7	Vermont	343
8	Pennsylvania	332
9	New Jersey	331
10	Hawaii	283
11	Maine	282
12	Michigan	278
13	Illinois	277
14	Ohio	270
15	Minnesota	268
16	Delaware	265
17	Missouri	262
18	Louisiana	256
19	California	255
19	New Hampshire	255
21	Virginia	254
21	Washington	254
23	Florida	253
24	Colorado	251
25	Tennessee	250
26	West Virginia	249
27	Oregon	247
28	Wisconsin	245
29	North Carolina	239
30	Nebraska	231
31	North Dakota	229
32	Kansas	227
33	New Mexico	223
34	South Carolina	222
35	Kentucky	219
35	Montana	219

37	Arizona	217
38	Texas	214
39	Indiana	213
40	Georgia	212
41	Iowa	209
42	Alabama	207
43	South Dakota	205
43	Utah	205
45	Oklahoma	200
46	Alaska	199
47	Arkansas	197
48	Nevada	189
49	Wyoming	183
50	Mississippi	176
51	Idaho	166
	Puerto Rico	248
	Guam	143
	Virgin Islands	128

Notes: Nonfederal physicians are members of the US physician population that are employed in the private sector. They represent 98% of total physicians. The US total excludes nonfederal physicians in the U.S. Territories.

Sources: Calculation based on American Medical Association, Physicians Professional Data as of 2001, copyright 2002; 2001 civilian population data: Annual Population Estimates by State, July 1, 2001 Population, U.S. Census Bureau

From: Kaiser Family Foundation State Health Facts Online: <http://statehealthfacts.kff.org>