MEDICAID AND QUEST PROVIDER PAYMENT AND REIMBURSEMENT RATES

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FOREWORD

This report was prepared in response to Senate Concurrent Resolution No. 77, S.D. 2, H.D. 1, "*Requesting the Legislative Reference Bureau to Conduct Two Studies of Recommended Procedures That Will Ensure That State-funded Health Care Payments Adequately Reimburse Providers Who Provide Services for, First, Medicaid or QUEST Recipients and, Second, for Injured Employees Under Workers Compensation Insurance*," that requested the Legislative Reference Bureau to conduct two separate studies of recommended procedures that will ensure that state-funded health care payments adequately reimburse providers who provide services for Medicaid or QUEST recipients and for injured employees under workers compensation insurance for the actual cost of health care services.

This study focuses on the Medicaid and QUEST provider payment and reimbursement rate study segment of S.C.R. No. 77, S.D. 2, H.D. 1.

The Bureau, as requested under the Concurrent Resolution, will be submitting a report on the adequacy of reimbursement rates for health care services under workers compensation insurance to the 2008 regular session.

The Bureau extends its appreciation to the Department of Human Services, Med-QUEST Division and the Hawaii Health Information Corporation for their cooperation in assisting the Bureau with the tasks requested by the Concurrent Resolution.

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December 2006

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Highlights

The critical financial condition of hospitals, long term care facilities, and other health care providers has been of growing concern to the Legislature and the public. Under the Medicaid and QUEST programs, the State pays for a considerable amount of health care and also controls certain types of payments made to providers for health care. Specifically, health care facilities and providers have been under increased financial and infrastructural pressure due in part to the following:

(1) Patient demand for diagnosis and treatment with the latest technology, which can be very expensive;

(2) The growing need for expensive institutionalized long term care as the baby boom generation ages;

(3) Health care facilities have incurred high costs related to hardening their facilities and updating their security protocols to mitigate potential terrorist threats and other emergencies;

(4) Providers are often receiving insufficient payments for health care from government payers, private insurance payers, and patients who do not have insurance; and

(5) Hawaii's hospitals have incurred more than $500,000,000 in losses due to bad debt and charity care since 2000.

As the State is a substantial payor in the provision of health care for the poor, elderly, and disabled, it is in the public's interest to ensure that health care payments made with state funds or controlled by the State are sufficient to cover costs of care.

Hawaii's Medicaid program has been in effect since January 1966. In August 1994, Hawaii's Medicaid program separated into two distinct methods of providing services for the two major groups of qualified recipients – Medicaid fee-for-service and QUEST recipients. Under the Medicaid fee-for-service program, providers bill Medicaid directly to be reimbursed for services provided to Medicaid-eligible recipients. The fee-for-service program currently services the State's aged, blind, and disabled population who meet Medicaid qualification requirements. The remaining group of beneficiaries (essentially persons under the age of sixty-five who are not blind or disabled but who otherwise qualify for Medicaid) have health care services provided through managed care health plans that are contracted by the Department of Human Services, Med-QUEST Division. This program is commonly known as the QUEST program. In addition to the two major groups of qualified recipients, the Department of Human Services, Med-QUEST Division, also provides medical assistance through smaller Medicaid-funded programs called QUEST-Net and QUEST Spenddown.

Hawaii's Medicaid program is funded through federal and state funds. Under federal law, although each state's Medicaid program is entitled to a minimum of fifty percent of federal reimbursement funds for qualifying Medicaid program-related costs, states have different federal matching rates to fund the services provided under their respective Medicaid programs. The percentage received from the federal government is known as the Federal Medical Assistance Percentage, or FMAP. From year-to-year, each state's Federal Medical Assistance Percentage rate is reviewed by the federal government and adjusted based upon a number of financial factors. For example, Alabama's Federal Medical Assistance Percentage for fiscal years 2005 and 2006 was 70.83% and 69.51%, respectively. For Hawaii, the federal matching funding rate for fiscal years 2005 and 2006 was just under sixty percent (58.47% and 58.81%, respectively).

In 2003, the estimated national average for Medicaid spending per child was $1,410, compared to $11,659 per disabled enrollee and $10,147 per elderly enrollee. These higher per capita expenditures for disabled and elderly beneficiaries reflect the intensive use of costly acute and long-term care services. In comparison, in state fiscal year 2004, Hawaii ranked fortieth among states with regard to state general fund expenditures ($322 million), and, when using total Medicaid payments made per enrollee as a measure (both federal and state payments under Medicaid, excluding disproportionate share hospital payments (DSH)), in 2003, Hawaii ranked thirty-eighth among states and the District of Columbia, spending an average of $1,413 on children, $2,163 on adults, $10,102 on the elderly, and $9,835 for the blind and disabled (average expenditure per enrollee – $3,462).

Generally speaking, the Medicaid fee-for-service reimbursement rates for the State of Hawaii are based on the federal Medicare Resource Based Relative Value Scale (MRBRVS) physician fee schedule, which is maintained by the U.S. Centers for Medicare and Medicaid Services. The current MRBRVS physician fee schedule is derived from the "relative value" of services provided and based on the resources they consume. The relative value of each service is quantifiable and is based on the concept that there are three components of each service: the amount of physician work that goes into the service, the practice expense associated with the service, and the professional liability expense for the provision of the service. The relative value of each service is multiplied by Geographic Practice Cost Indices (GPCIs) for each Medicare locality and then translated into a dollar amount by an annually adjusted conversion factor. The dollar amount derived from this calculation, with adjustments under certain circumstances, is the reimbursement a physician receives for the provision of a particular service.

According to the Department of Human Services, Hawaii's Medicaid reimbursement rate is approximately seventy-two percent of MRBRVS 2000 rates for Hawaii (sixty-eight percent + four percent for the State's general excise tax). In other words, if the MRBRVS 2000 establishes $100 as the reimbursement rate for a treatment code, the State of Hawaii would pay a health care provider $72 for the same treatment under its Medicaid program. Of that $72 amount, in 2006, the federal government would pay 58.81%, and the State would pay the remaining 41.19%. For Medicare Fee Schedule treatment codes established after the publication of MRBRVS 2000, the reimbursement rates for these treatments approximate seventy percent of MRBRVS 2006 for Hawaii.

QUEST reimbursement rates, unlike Medicaid fee-for-service reimbursement rates, are negotiated on a contracted plan basis in a managed care environment. However, dental services

for QUEST beneficiaries are provided under the Medicaid fee-for-service program. The Department of Human Services contracts with medical health plans selected through a competitive bidding process. Historically, QUEST providers have accepted Medicaid reimbursement rates and methodology when negotiating their contracts. Recipients who are eligible for QUEST are able to select a medical plan. The plans are responsible to ensure recipients receive medically necessary services that are a covered benefit, within their contracted network of qualified providers. The Department of Human Services, in turn, pays a monthly capitated amount to the medical plan for each member enrolled in its plan. The Department of Human Services pays a plan no more than the capitated amount, regardless of how many times a recipient seeks services within a plan or the type of service a recipient receives.

According to various health care providers, the system utilized by the Department of Human Services to calculate reimbursement rates to health care institutions and providers does not seem to be flawed, but is in need of timely rate adjustments to accurately reflect the cost of health care.

Since 2004, the Department of Human Services has been pursuing a program of enhancing federal financial participation (FFP) in the State's Medicaid program. The Department's program is intended to generate more federal dollars (matching funds) for reinvestment in improving Hawaii's health care system. The program involves amending the Medicaid State Plan through the process of obtaining federal approval of a State Plan Amendment and amending the Medicaid QUEST 1115 waiver (managed care demonstration project).

Currently, there is no means by which to accurately determine whether individual health care providers are being adequately reimbursed for the services they provide under Medicaid or QUEST.

According to an issue brief written for Thomson West's Health Policy Tracking Service in October 2006, beginning from 2004, eighteen states increased Medicaid provider reimbursement rates. By 2005, more states were increasing reimbursement rates. With the recovery of the national economy and revenue beginning to fill state treasuries, legislatures in the following nineteen states increased Medicaid provider reimbursement rates: Arizona, Arkansas, Florida, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, New Hampshire, North Carolina, Oklahoma, Tennessee, Utah, Virginia, and Washington. During 2006, fifteen states – California, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Mexico, Oklahoma, Utah, Vermont, Washington, Wisconsin, and Wyoming have passed legislation to increase or further increase the reimbursement rates to Medicaid providers and services in the areas of long-term care providers, hospitals, physicians, personal care services, dental services, mental health services, and wheelchair van services.

In order to improve reimbursements to individual health care providers to better cover the costs of providing services, the Bureau recommends that the Medicaid Fee Schedule be adjusted to cover such costs.

In order to bring hospitals up to the "break even point," the Hawaii Health Systems Corporation (HHSC) estimated that, for its facilities, it would cost the State approximately $21.8 million ($15.3 million (29% rate increase) for Medicaid, and $6.5 million (41% rate increase) for QUEST) just to cover costs for their Medicaid and QUEST populations for 2006. The Hawaii Health Information Corporation reported that, in order for the fourteen private hospitals that it keeps records on to break even for the Medicaid services provided, an appropriation of approximately $56.5 million (23.5% rate increase) would be required to offset losses incurred in fiscal year 2005-2006. The total amount for both HHSC and private hospitals would equal approximately $78.3 million. This $78.3 million only represents the amount needed by the hospitals to recover the costs incurred during the 2005-2006 fiscal year and does not represent previous fiscal year losses or the additional funding that would be necessary in subsequent fiscal years to allow the hospitals to keep pace with health care cost inflation.

Frequently Asked Questions

Are all Medicaid reimbursement rates determined in the same way?

No, when discussing Medicaid reimbursement rates, it is important to note that the Department of Human Services utilizes different reimbursement methodologies for different types of health care services. Section 346-59, Hawaii Revised Statutes, establishes the Medicaid Fee Schedule for non-institutional health care services, such as physician services, dental care, laboratory services, and medical equipment and supplies. However services provided in inpatient acute hospitals, federally qualified health centers, and rural health centers, and to a certain extent skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), are reimbursed through the Prospective Payment System (PPS). Furthermore, subacute nursing facilities are paid reimbursement rates that are negotiated by the Department of Human Services; and hospices and home health care agencies are reimbursed at Medicare rates. Prescription drugs are reimbursed at 10.5% below the average wholesale price plus a $4.67 dispensing fee and are not addressed by the Medicaid Fee Schedule established under section 346-59, Hawaii Revised Statutes. According to the Department of Human Services, the Medicaid Fee Schedule and the Proposed Payment System are the main methodologies used for reimbursement.

Why didn't the study include a listing of the ten most frequently used Medicaid and QUEST health procedures?

The Bureau found that, within the State of Hawaii, utilizing the basic parameter of "the ten most frequently used treatments" resulted in some Medicaid treatment codes that were anomalous and not representative of the study's purpose. For instance, one of the codes provided by the Department of Human Services as one of its most frequently utilized codes was A0425 – Ground Mileage per Statute Mile (sixth most frequent). Instead, the Department of Human Services Med-QUEST Division provided a list of Current Procedural Terminology (CPT) codes that would be more typically used by health care providers in evaluating and treating patients. Although these codes may or may not qualify as some of the "ten most frequently used treatment codes" as requested under the concurrent resolution, the CPT codes used in the study are a more indicative sample of the spirit of the concurrent resolution's intent.

How does Hawaii compare to other jurisdictions regarding provider payments and reimbursements for the ten most frequently used Medicaid and QUEST health procedures?

After contacting a number of agencies and conducting an internet search of various websites to determine whether any interstate comparative cost information was available, the Bureau was only able to find surveys conducted by the American Academy of Pediatrics that provided Medicaid reimbursement rates for commonly used pediatric services. Unfortunately, although the surveys provided comparative information between states' Medicaid reimbursement rates and what Medicare reimburses, the surveys did not provide any information on actual cost to a provider to provide the specific treatment. Thus there was no way to say whether the reimbursement rates were adequate.

What have other states done to address the problem of low reimbursement rates to Medicaid providers?

In 2005 and 2006, the vast majority of legislation passed in 2005 and 2006 that positively affected Medicaid reimbursement rates simply increased appropriations or reimbursement formulas for providers. For a more comprehensive digest of each state's legislation that increase Medicaid provider rates.

Has the State done anything recently to ensure that hospitals and providers are getting the most out of federal matching funding?

Since 2004, the Department of Human Services has been pursuing a program of enhancing federal financial participation (FFP) in the State's Medicaid program. The Department's program is intended to generate more federal dollars (matching funds) for reinvestment in improving Hawaii's health care system. The program involves:

(1) Amending the Medicaid State Plan through the process of obtaining federal approval of a State Plan Amendment; and

(2) Amending the Medicaid QUEST 1115 waiver (managed care demonstration project).

How can the State ensure that health care providers are adequately or at least better reimbursed for services provided to Medicaid and QUEST recipients?

The Legislature has a number of options at its disposal to periodically update reimbursements and payments to health care providers. One such option would be to establish a statutory requirement that the Department of Human Services biennially review Medicaid and QUEST reimbursement rates and submit reimbursement rate increase cost information and appropriation requirements to the Legislature for its review and appropriation of funds. Another option could include the establishment of a Medicaid Reimbursement Rate Review Commission whose specific charge would be to gather relevant information and submit biennial rate adjustment recommendations to the Legislature for its review and possible implementation.

The Legislature could also establish a statutory requirement that reimbursement rates track a percentage (possibly ninety-five percent, or even one hundred percent) of the Medicare Resource Based Relative Value Scale (MRBRVS) as it applies to Hawaii, as it does for health care services provided and compensated under the State's Workers' Compensation Law (see section 386-21(c), Hawaii Revised Statutes), except that, in accordance with federal requirements, Medicaid and QUEST reimbursement rates cannot exceed Medicare reimbursement rates. Thus, any amount paid as reimbursement in excess of a Medicare rate would be borne solely by the State.

Should adjustments be made to the State's Medicaid Fee Schedule? If so, by how much?

In order to ensure that health care providers are at least reimbursed to cover the costs of providing services, the Medicaid Fee Schedule should be adjusted to cover such costs. Unfortunately, because cost data on individual health care providers was not available, the Bureau must base its rate increase recommendation on what is provided under the Medicare Resource Based Relative Value Scale (MRBRVS) as it applies to Hawaii, the justification being that the federal government bases its Medicare reimbursement rates on the data it acquires from health care providers and adjusts it for Hawaii's economic circumstances. The Bureau recommends that the Legislature revise the Medicaid Fee Schedule up to, but not exceeding one hundred percent of, the MRBRVS for Hawaii rates, in order to ensure that the State does not have to solely cover the costs of any amounts that exceed the MRBRVS for a particular treatment code.

Would it be difficult to change the reimbursement rates contained in the Medicaid Fee Schedule?

The Director of Human Services noted that if the Legislature wanted to increase the payment amounts to providers under the Hawaii Medicaid Fee Schedule, all it would have to do is increase the amounts appropriated under program ID HMS 230 in the State Budget.

Would adjustments to the Medicaid Fee Schedule augment reimbursement for QUEST Services?

Yes, since QUEST service contracts are based on rates provided in the Medicaid Fee Schedule, if the fee schedule rates are increased, QUEST providers will similarly benefit from the increases.

Is the prospective payment system methodology flawed?

Generally speaking, the answer seems to be no. According to testimony submitted by the Director of Human Services on S.C.R. No. 77, S.D. 2, to the House Committees on Human Services and Health, the Prospective Payment System (PPS) methodology is defined in federal law, as well as in the Hawaii Administrative Rules, and is based on the actual costs of the provider to provide the service. In order to change these payment amounts for inpatient hospital services or skilled nursing facilities, the reimbursement rates for these facilities under the PPS system would need to rebased. The other option is to move to a different reimbursement methodology.

Hawaii Pacific Health commented that its member hospitals did not believe that the reimbursement methodology used by the Department of Human Services was flawed, but that it simply was not adequately adjusted to take into account that health care inflation is moving at a much more rapid pace than the consumer price index and, although all providers that are reimbursed under the PPS methodology get either a Consumer Price Index or Medicare Economic Index increase each year, these increases are far less than the actual increases in the cost of care.

Hawaii Pacific Health recommended that the Department of Human Services rebase all Medicaid and QUEST reimbursements based upon actual current costs for Hawaii hospitals. This would require a considerable one-time increase as a market adjustment to bring hospitals up to par. Once the market adjustment increases are in place, the Department of Human Services would have to then make annual adjustments based upon the Hospital Producer Price Index.

Would the rebasing of reimbursement rates be a difficult task to accomplish?

Hawaii Pacific Health stated that the Department of Human Services already has a process to conduct this market adjustment, as it has done it in the past, and that the Hawaii Health information Corporation has the hospital cost data to assist the Department of Human Services in rebasing its reimbursement rates.

How much would it cost to get hospitals to the "break even point?"

In order to bring hospitals up to the "break even point," the Hawaii Health Systems Corporation (HHSC) estimated that, for its facilities, it would cost the State approximately $21.8 million ($15.3 million (29% rate increase) for Medicaid, and $6.5 million (41% rate increase) for QUEST) just to cover costs for their Medicaid and QUEST populations for 2006. The Hawaii Health Information Corporation reported that, in order for the fourteen private hospitals that it keeps records on to break even for the Medicaid services provided, an appropriation of approximately $56.5 million (23.5% rate increase) would be required to offset losses in fiscal year 2005-2006. The total amount for both HHSC and private hospitals would equal approximately $78.3 million. This $78.3 million only represents the amount needed by the hospitals to recover the costs incurred during the 2005-2006 fiscal year and does not represent previous fiscal year losses or the additional funding that would be necessary in subsequent fiscal years to allow the hospitals to keep pace with health care cost inflation.

Can the State adjust reimbursement rates for federally qualified health centers (FQHCs) and rural health clinics (RHCs)

For FQHCs and RHCs, the Director of Human Services previously stated that payment of the PPS rate is mandated by federal law. Therefore, there can be no increase of reimbursement to FQHCs and RHCs because the federal law does not allow for rebasing of the rates.

Should the State enact a law that automatically adjusts Medicaid reimbursement rates to health care providers?

Any change in public policy to include regular adjustments to reimbursement rates adjustment to offset inflationary costs must be met with careful fiscal scrutiny. Deferring the discretion to implement or not implement a Medicaid Fee Schedule rate increase to an annual, biennial, or any other formula or mechanism that does not provide the Legislature with the ability to approve or disapprove of an increase in reimbursement rates could potentially pose a significant detrimental impact on the long term fiscal well being of the State's finances.

However, if health care providers and facilities are to continue to provide health care services to the neediest persons in the State, they must be adequately compensated for their services and not be required to provide such services at a financial loss. To the extent the state and federal government are financially able, each government should strive to mitigate the financial losses being incurred by health care providers and facilities that provide services under Medicaid.

Chapter 1

INTRODUCTION

Background

The critical financial condition of hospitals, long term care facilities, and other health care providers has been a growing concern of the Legislature and the public. Specifically, health care facilities and providers have been under increased financial and infrastructural pressure due in part to the following causes:

(1) Patient demand for diagnosis and treatment with the latest technology, which is very expensive;

(2) The growing need for expensive institutionalized long term care as the baby boom generation ages;

(3) Health care facilities have incurred high costs related to hardening their facilities and updating their security protocols to mitigate potential terrorist threats and other emergencies;

(4) Providers are often receiving insufficient payments for health care from government payers, private insurance payers, and patients who do not have insurance; and

(5) Hawaii's hospitals have incurred more than $500,000,000 in losses due to bad debt and charity care since 2000.

Under the Medicaid and QUEST programs, the State pays for a considerable amount of health care and also controls certain types of payments for health care made to providers. As a substantial payor in the provision of health care for the poor, elderly, and disabled, the Legislature believes that it is in the public interest to ensure that health care payments made with state funds or controlled by the State are sufficient to cover the actual costs of care.

To this end, during the 2006 Regular Session of the Twenty-third Legislature of the State of Hawaii, the Legislature adopted Senate Concurrent Resolution No. 77, S.D. 2, H.D. 1, "*Requesting the Legislative Reference Bureau to Conduct Two Studies of Recommended Procedures That Will Ensure That State-funded Health Care Payments Adequately Reimburse Providers Who Provide Services for, First, Medicaid or QUEST Recipients and, Second, for Injured Employees Under Workers Compensation Insurance.*" The measure is attached as Appendix A. Senate Concurrent Resolution No. 77, S.D. 2, H.D. 1, requests that the Legislative Reference Bureau conduct two separate studies of recommended procedures that will ensure that state-funded health care payments adequately reimburse providers who provide services for Medicaid or QUEST recipients and for injured employees under workers compensation insurance for the actual cost of health care services.

This study focuses on the Medicaid and QUEST provider payment and reimbursement rate study segment of S.C.R. No. 77, S.D. 2, H.D. 1.

The measure also requests that the Medicaid and QUEST provider payment and reimbursement rate study be completed and submitted not later than twenty days prior to the convening of the 2007 Regular Session and the workers compensation reimbursement rate study be completed and submitted not later than twenty days prior to the convening of the 2008 Regular Session.

For the Medicaid and QUEST provider payment and reimbursement rate study, S.C.R. No. 77, S.D. 2, H.D. 1, specifically requests that the Legislative Reference Bureau's study include:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to Medicaid providers adequately reimburse them for their actual costs;

(2) A comparison of rates for the ten most frequently used services in Medicaid and QUEST health care services, actual costs of those services, and the amount reimbursed to the provider;

(3) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(4) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used Medicaid and QUEST health procedures.

Methodology

Initially, letters were sent by the Legislative Reference Bureau to the Governor, the Director of Health, the Director of Human Services, the Insurance Commissioner, the Chief Executive Officer of the Healthcare Association of Hawaii, and the Chief Executive Officer of the Hawaii Medical Association apprising these officials of the Bureau's intention to conduct the Medicaid and QUEST study and to solicit the assistance of each agency and organization in obtaining the information necessary to complete the study. In addition, similar letters were also sent to:

(1) The Hawaii Health Information Corporation;

(2) Hawaii Pacific Health;

(3) The Medicaid/Med-Quest Division of the Department of Human Services;

(4) The Hawaii Long Term Care Association;

(5) The Hawaii Business Roundtable;

(6) The Insurance Commissioner; and

(7) The Hawaii Health Systems Corporation.

Each organization and agency was contacted soon thereafter to determine the type of information and assistance each entity was able to provide.

The National Conference of State Legislatures (NCSL) was also contacted to ascertain the existence of similar studies conducted either in other jurisdictions or on the national level and to request their assistance on gathering information regarding:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to Medicaid providers adequately reimburse them for their actual costs;

(2) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(3) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used Medicaid and QUEST health procedures.

The NCSL was also queried on any potential national contacts that the Bureau may find useful in measuring how Hawaii compares to other jurisdictions regarding Medicaid provider payments and reimbursements.

An internet search was also conducted on Medicaid provider payments and reimbursements during the same time period to serve as a cross-checking device in order to compare the internet-generated information against any findings that may be provided by NCSL.

Compilation and Analysis of Information and Data

All relevant information and data received was compiled and analyzed. The Bureau obtained clarification on any submitted information and data from the information or data provider. A list of the ten most frequently used services in Medicaid and QUEST health care services, actual costs of those services (in the case of Medicaid fee for service services), and the amount reimbursed to the provider was established.

Survey on How Hawaii Compares With Other Jurisdictions Regarding Certain Medicaid and QUEST Provider Payments and Reimbursements

The Bureau reviewed the most recent materials available from the Department of Human Services, the federal Centers for Medicare and Medicaid Services, and other resources to compare Hawaii's provider payment and reimbursement rates of the ten most frequently used services in Medicaid against the Medicaid provider payment and reimbursement rates of other jurisdictions.

Chapter 2

HAWAII'S MEDICAID AND QUEST PROGRAMS

Medicaid, Generally

Title XIX of the Social Security Act established a program that provides medical assistance for certain individuals and families with low income and resources. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments to assist states in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.[1] Since its enactment in 1965, Medicaid has improved access to health care for low-income individuals, financed innovations in health care delivery, and functioned as the nation's primary source of long-term care financing. Medicaid also plays a major role in the U.S. health care financing system, accounting for one of every six dollars spent on personal health care and more than forty percent of all spending on nursing home care.[2] In Hawaii, it provides medical care for Hawaii's residents who receive financial assistance payments and those with medical needs.[3]

Who Qualifies for Medicaid?

To qualify for Medicaid, an individual must meet financial criteria and also belong to one of the groups that are "categorically eligible" for the program, including children, parents of dependent children, pregnant women, people with disabilities, and the elderly. Federal law guarantees Medicaid eligibility for individuals within these groups who fall below specified income levels. At the same time, states have broad optional authority to extend Medicaid eligibility beyond these minimum standards. States have expanded Medicaid coverage extensively, but variably; as a result, Medicaid eligibility and coverage differ widely from state to state.

In 2003, Medicaid provided coverage to:

- 27 million children
- 14 million adults (primarily low-income working parents)
- 6 million seniors
- 8 million persons with disabilities[4]

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[1] Department of Human Services, Med-QUEST Division, State of Hawaii. Med-QUEST Medicaid Provider Manual. 2003. Chapter 1.1.1. 2003 (online at http://www.med-quest.us/providers/Reference/manual.html).

[2] Kaiser Family Foundation. Statehealthfacts.org. *The Medicaid Program at a Glance* (online at http://www.kff.org/medicaid/upload/7235.pdf). October 10, 2006.

[3] Department of Human Services, Med-QUEST Division, State of Hawaii. Medicaid Fee-For-Service Eligibility webpage. 2003 (online at http://www.med-quest.us/eligibility/medicaid/medicaid.html).

[4] Ibid.

How Medicaid Dollars are Proportionally Spent

The majority of Medicaid spending (seventy percent) is attributable to the elderly and people with disabilities, who make up only one-quarter of the Medicaid population. In fact, the 3.6% of Medicaid enrollees with annual spending exceeding $25,000 in 2001 accounted for nearly half (48.8%) of all Medicaid spending.

According to the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, in 2003, the estimated national average for Medicaid spending per child was $1,410, compared to $11,659 per disabled enrollee and $10,147 per elderly enrollee. These higher per capita expenditures for disabled and elderly beneficiaries reflect the intensive use of costly acute and long-term care services.[5] In comparison, the Henry J. Kaiser Family Foundation reported that, in state fiscal year 2004, Hawaii ranked fortieth among states with regard to state general fund expenditures ($322 million), and, when using total Medicaid payments made per enrollee as a measure (both federal and state payments under Medicaid, excluding disproportionate share hospital payments (DSH)), in 2003, Hawaii ranked thirty-eighth among states and the District of Columbia, spending and average of $1,413 on children, $2,163 on adults, $10,102 on the elderly, and $9,835 for the blind and disabled (average expenditure per enrollee – $3,462). For a more complete breakdown on how Hawaii's Medicaid dollars are apportioned, see Appendix B at the end of the report.

Of the $288 billion in total Medicaid spending (nationally) in 2004:[6]

- Acute-care services comprised over half (59%)
- Long-term care services made up 35%
- Payments for Medicare premiums accounted for about 2%

Medicaid accounts for nearly half of total long-term care spending and finances care for sixty percent of nursing home residents. While more than half of Medicaid long-term care spending goes toward institutional services, home and community-based services account for a growing proportion of Medicaid spending on long-term care.[7]

The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured also reported that, over the last several years, average annual increases in per capita Medicaid costs have been substantially lower than increases in private health insurance premiums.[8]

The two agencies went on to report that a large share of Medicaid spending (forty percent) is attributable to "dual eligibles," low-income Medicare beneficiaries who are also

[5] Ibid.

[6] Kaiser Family Foundation. Statehealthfacts.org. *The Medicaid Program at a Glance* (online at http://www.kff.org/medicaid/upload/7235.pdf). October 10, 2006.

[7] Ibid.

[8] Ibid.

enrolled in Medicaid. Dual eligibles rely on Medicaid to pay for Medicare premiums and cost-sharing and to cover important services that Medicare does not cover, such as long-term care. As of January 2006, drug coverage for dual eligibles shifted from Medicaid to Medicare Part D prescription drug plans. Some states offer wrap-around coverage for drugs not covered or pay for new cost sharing amounts, but these expenses are not eligible for federal matching funds.[9]

Medicaid is also a key source of coverage for low-income working families, who often do not have access to health insurance through their jobs. More than one in four children in America relies on Medicaid for coverage, and two-thirds of all Medicaid enrollees are in low-wage working families.[10]

Hawaii's Medicaid Program

Hawaii's Medical Assistance Program, otherwise known as Medicaid, has been in effect since January 1966. In August 1994, Hawaii's Medicaid program separated into two methods of providing services for the two major groups of qualified recipients – Medicaid fee-for-service and QUEST recipients. Under the Medicaid fee-for-service program, providers bill Medicaid directly to be reimbursed for services provided to Medicaid-eligible recipients. The fee-for-service program currently services the State's aged, blind, and disabled population who meet Medicaid qualification requirements. The remaining group of beneficiaries (essentially persons under the age of sixty-five who aren't blind or disabled but who otherwise qualify for Medicaid) have health care services provided through managed care health plans that are contracted by the Department of Human Services, Med-QUEST Division. This program is commonly known as the QUEST program. In addition to the two major groups of qualified recipients, the Department of Human Services, Med-QUEST Division, also provides medical assistance through smaller Medicaid-funded programs called QUEST-Net and QUEST Spenddown.

As mentioned, "fee-for-service" means that physicians and hospitals bill for each eligible service provided to a Medicaid patient. The traditional fee-for-service arrangement can be more costly than managed care because it exercises less control over patient visits, has greater potential for unnecessary medical procedures or services, and has a greater chance of claims fraud.

Managed care, on the other hand, has been defined as "a health care delivery system with a single point of entry." Cost savings are achieved through a set monthly fee or "capitated payment" to a health plan, which assumes responsibility for any financial risk.[11]

A primary care physician, or "provider," participating in a managed care health care plan serves as a "gatekeeper" by deciding when a patient should be referred to a specialist or admitted to a hospital. The plan must manage the delivery of patient care at a cost covered by the plan's

[9] Ibid.

[10] Ibid.

[11] Auditor, State of Hawaii. *Follow up audit of the Department of Human Services' QUEST Demonstration Project*, p. 3, Honolulu: May 2003.

capitated fees or lose money. The plan's incentive is to maintain a balance between health care and costs by minimizing extraordinary or unnecessary expenses.[12]

Medicaid Fee-For-Service

As noted previously, coverage for individuals who are age sixty-five and over, or certified blind or disabled, is generally provided under Hawaii's Medicaid fee-for-service program where providers are paid directly for their services. For all other individuals, coverage is provided under the QUEST managed care program.[13]

Eligibility

To qualify for fee-for-service Medicaid, a person must meet all of the following requirements:

(1) Individuals must be United States citizens or qualified aliens;

(2) The individual must be a resident of Hawaii;

(3) The individual must provide a valid Social Security number;

(4) The individual must not be a resident of a public institution;

(5) The individual must be age sixty-five or older, certified blind by the State, or certified disabled under Social Security Administration's criteria; and

(6) The individual must not be eligible for Hawaii QUEST.

Individuals who are receiving financial assistance payments from the Department of Human Services under its Aid to the Aged, Blind, or Disabled Program are eligible for Medicaid. However, individuals who are not receiving financial assistance payments from the Department of Human Services may still be eligible for Medicaid fee-for-service benefits if the person otherwise meets the age and disability requirements of the Medicaid fee-for-service program and:

(1) The individual's countable income is not greater than Medicaid's income standards (The income standard used to determine eligibility will depend on the individual's coverage group. When an individual applies for Medicaid, the Department of Human Services will determine the individual's coverage group and use the income standard of that group to determine eligibility); or

[12] Ibid.

[13] Department of Human Services, Med-QUEST Division, State of Hawaii. Medicaid Fee-For-Service Eligibility webpage. 2003 (online at http://www.med-quest.us/eligibility/medicaid/medicaid.html). October 10, 2006.

(2) The individual's countable income is greater than the applicable income standard, but the individual's medical bills are greater than the amount over the medically needy standard; and

(3) The individual's countable assets such as cash, bank accounts, bonds, and other personal resources are not greater than the Medicaid asset standards (The asset standard is $2,000 for a household of one, $3,000 for two, and $250 for each additional person. Assets are not considered for children under age nineteen and pregnant women for the duration of their pregnancy).[14]

Hawaii QUEST

The other major program under Medicaid is the Hawaii QUEST, or QUEST, program. QUEST operates under the 1115 waiver program operated by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services. Section 1115 of the Social Security Act establishes requirements for experimental, pilot, or demonstration projects and allows states to reform their Medicaid programs. It also allows the Secretary of Health and Human Services to waive compliance with any requirements of certain federal statutes, including Medicaid statutes, for any projects that would promote the overall objectives of the Social Security Act.[15]

The two basic objectives of the QUEST program are to expand medical coverage to include populations previously ineligible for Medicaid and to contain costs by shifting from a fee-for-service to a managed care delivery system.[16]

Under the QUEST program, medical and mental health services are provided in a managed care environment. However, dental services to QUEST recipients are provided under the Medicaid fee-for-service program. The Department of Human Services contracts with medical health plans selected through a competitive bidding process. Recipients who are eligible for QUEST are able to select a medical plan. The plans are responsible for ensuring recipients receive medically necessary services that are a covered benefit, within their contracted network of qualified providers.

The Department of Human Services, in turn, pays a monthly capitated amount to the medical plan for each QUEST recipient enrolled in the plan. The Department of Human Services pays a plan no more than the capitated amount, regardless of how many times a recipient seeks services within a plan or the type of service a recipient receives. QUEST is

[14] Department of Human Services, Med-QUEST Division, State of Hawaii. Med-QUEST Medicaid Eligibility website. 2003 (online at http://www.med-quest.us/eligibility/medicaid/medicaid.html).

[15] Auditor, State of Hawaii. *Follow up audit of the Department of Human Services' QUEST Demonstration Project*, p. 1, Honolulu: May 2003.

[16] Ibid.

administered by the Department of Human Services, Med-QUEST Division, and is financed through the State of Hawaii and the federal Centers for Medicare and Medicaid Services.[17]

Eligibility

In order to qualify for QUEST, individuals who are age nineteen and older must:

(1) Be a U.S. citizen or qualified alien;

(2) Be a resident of Hawaii;

(3) Provide a valid Social Security Number;

(4) Be under age sixty-five;

(5) Not be a resident of a public institution;

(6) Not be certified as blind or disabled;

(7) Not be eligible for or receive health insurance from their employer (except for individuals covered under Section 1931 of the Social Security Act, General Assistance recipients, and Transitional Medical Assistance); and

(8) Meet an asset and income test.

For individuals who are under the age of nineteen to qualify for QUEST, the individual must:

(1) Be a United States citizen, qualified alien, or legal immigrant;

(2) Be a resident of Hawaii;

(3) Provide a valid Social Security number;

(4) Not be certified as blind or disabled;

(5) Not be a resident of a public institution; and

(6) Meet an income test.

[17] Department of Human Services, Med-QUEST Division, State of Hawaii. QUEST Eligibility webpage. 2003 (online at http://www.med-quest.us/eligibility/quest/quest.html) and Med-QUEST Medicaid Provider Manual. 2003. Chapter 1.2.3. 2003 (online at http://www.med-quest.us/providers/Reference/manual.html).

Income Limits for QUEST

Single adults must not have countable family income that is more than 100% of the current Federal Poverty Level (FPL). Adults with children under age nineteen must not have countable family income that is more than 200% of the FPL. Pregnant women must not have countable family income that is more than 185% of the FPL.

Asset Limits for QUEST

QUEST recipients cannot have more countable assets than the following respective amounts:

(1) $2,000 for a household of one;

(2) $3,000 for a household of two; and

(3) $250 for each additional person.

Asset limits do not apply to individuals under age nineteen or to pregnant women for the duration of the pregnancy plus sixty days.

Anyone may apply for QUEST. However, periodically when the enrollment in the program reaches 125,000 people, an enrollment cap will be put into place and no new persons will be enrolled. If enrollment is below 125,000 people on December 31 of each calendar year, the cap will be lifted. Should this occur, an open application period will be announced and it will take place in July of the following calendar year. An open application period will only occur once in a calendar year.[18] The enrollment cap does not apply to those individuals who would have been eligible for Medicaid prior to the waiver. According to the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), all protected groups, such as those whose income is less than the federal Aid to Families with Dependent Children program (AFDC) standard of assistance or pregnant women who meet income limits, cannot be denied access to the QUEST project regardless of the enrollment cap.[19]

As a managed care program, QUEST enrollees choose one medical plan and one dental plan to serve themselves and any family members who are in the program. All family members must enroll in the same medical and dental plan.

Some medical plans have a limit on the number of members they can accept. If the plan is already full, the QUEST enrollee will have to choose a different plan. If the enrollee does not make a choice, the enrollee will be assigned to a medical and dental plan.

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[18] Department of Human Services, Med-QUEST Division, State of Hawaii. Med-QUEST Medicaid Eligibility website. 2003 (online at http://www.med-quest.us/eligibility/medicaid/medicaid.html).

[19] Auditor, State of Hawaii. *Follow up audit of the Department of Human Services' QUEST Demonstration Project*, p. 2, Honolulu: May 2003.

Currently, there are six QUEST-participating medical plans – AlohaCare. HMSA, Kaiser Permanente, Kapiolani HealthHawaii, Queen's Hawaii and StraubCare Quantum. All six plans participate on Oahu, with at least two plans on each neighbor island.

Although dental services are provided on a fee-for-service basis, there are three dental plans made available to QUEST recipients. These dental plans are AlohaCare, DentiCare and HMSA, and the plans are available statewide, providing emergency dental care for individuals twenty-one years of age and older and full dental care for individuals under age twenty-one.

Under QUEST, the basic medical benefits are the same for everyone, but individuals under age twenty-one receive some extra services, such as vaccinations and certain types of tests.

There is also a "wraparound" mental health program for people who need special mental health care. This care is provided through a company called Community Care Services. The Department of Human Services requires that a Hawaii QUEST member first be evaluated to determine if the member is eligible for this special program.[20]

Generally Covered Services by Hawaii's Medicaid and QUEST Programs

Basic medical services covered by all Medicaid programs are:

- Inpatient hospital services
- Outpatient hospital services
- Rural health center (including federally-qualified health center) services
- Other laboratory and x-ray services
- Family Practice and Pediatric Nurse Practitioners' services
- Nursing facility (NF) services and home health services
- Early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21
- Family planning services and supplies
- Physician services and medical and surgical services of a dentist
- Nurse-Midwife services

Optional services that the State of Hawaii covers include:

- Podiatrist Services
- Optometrist Services

[20] Department of Human Services, Med-QUEST Division, State of Hawaii. Med-QUEST website. Last modified August 10, 2006 (online at http://www.hawaii.gov/dhs/health/medquest/).

- Psychologist Services
- Clinic Services
- Dental Services
- Physical Therapy
- Occupational Therapy
- Speech, Hearing and Language Disorders
- Prescribed Drugs
- Prosthetic Devices
- Eyeglasses
- Diagnostic Services
- Screening Services
- Preventive Services
- Rehabilitative Services
- ICF/MR (Intermediate Care Facility for the Mentally Retarded) Services
- Inpatient Psychiatric Services for Under Age 21
- Nursing Facility (NF) Services Under Age 21
- Emergency Hospital Services
- Transportation Services
- Targeted Case Management Services
- Hospice Care Services
- Respiratory Care Services

The services and items covered by the Medicaid program must be medically necessary for the diagnosis and treatment of the individual recipient. For services and items to be medically necessary services, they must meet the Department of Human Services' definition of being medically necessary, which is, "[t]hose covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law that follows standard medical practice and is deemed essential and appropriate for the diagnosis or treatment of a particular illness or injury."[21]

[21] Department of Human Services, Med-QUEST Division, State of Hawaii. Medicaid Provider Manual. Appendix 1, p. A17. October 18, 2002.

Services and Items Not Covered by Hawaii's Medicaid and QUEST Programs

General

- Services, procedures, drugs, devices, equipment and treatment that are experimental, investigational, or of generally unproven benefit, excluded by federal regulations or state rules and/or not medically necessary.

- All medical, surgical and/or psychiatric services, drugs (including hormones needed for changing the sex of an individual), equipment/devices and supplies related to gender reassignment.

- All medical and surgical procedures, therapies, supplies, drug equipment for the treatment of sexual dysfunction.

Medical and Surgical Services

- Stand-by services by stand-by physicians, telephone consultations, telephone calls, writing of prescriptions and "stat" charges.

- Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy and/or consortium services.

- Long term psychiatric institutional treatment.

- Routine foot care; treatment of flat feet.

- Physical exams for employment when the patient is self-employed or as a requirement for continuing employment (i.e. truck and taxi drivers' licensing, other physical exams as a requirement for continuing employment by the state or federal government or by private business.

- Physical exams, psychological evaluations and/or immunizations as a requirement for Hawaii or other states' drivers' licenses or for the purpose of securing life and other insurance policies or plans.

- Physical exams and/or immunizations for travel – domestic or foreign.

- In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures and all drugs and devices to treat infertility or enhance fertilization.

- Cosmetic surgery or treatment to improve appearance and not bodily function, including but not limited to cosmetic rhinoplasties, reconstructive/plastic surgery such as face lifts to improve appearance and not bodily function, lyposuction, paniculectomies, and other body sculpturing procedures, piercing of ears and other

body areas, electrolysis, hair transplantation or removal, tattooing or removal of tattoos.

- Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- Augmentation mammoplasties except following medically indicated mastectomies for carcinoma, precancerous conditions, or extensive fibrosis or traumatic amputation.
- Reduction mammoplasties unless there is medical documentation of intractable pain not amenable to other forms of treatment as a result of large pendulous breasts.
- Jejuno-ileal by-pass procedures for morbid obesity.
- Tuberculosis services when provided free to the general public.
- Hansen's disease treatment or follow-up.
- Treatment of persons confined to public institutions.
- Orthoptic training.
- Ambulatory Blood Pressure Monitoring.

Drugs

- Drugs not approved by the Food and Drug Administration (FDA).
- Drugs from manufacturers that do not have a current rebate agreement with the Health Care Financing Administration (HFCA) also called the Centers for Medicare and Medicaid Services (CMS).
- Drugs determined to be "less than effective" by the federal government. (Drug Efficacy Studies Implementation DESI 5 and 6).

Equipment, Supplies, and Devices

- Equipment, supplies and devices not primarily medical in nature.
- Penile and testicular prostheses and related services.
- Personal care items including but not limited to shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers and adhesives, shoes, slippers, clothing, laundry services, baby oil and powder, sanitary napkins, soaps, lip balm, band aids.
- Non-medical items, including but not limited to books, telephone, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, and fans.

- Educational supplies
- Standard household items, including but not limited to cooking utensils, blenders and furniture.
- Beds, including but not limited to lounge beds, bead beds, water beds, day beds; overbed tables, bed lifters, bed boards, beside rails, if not an integral part of a hospital bed.
- Food, health foods and food supplements.
- Tinted eyeglass lenses except for aphakia.
- Contact lenses for cosmetic purposes; bifocal contact lenses.
- Oversized lenses.
- Blended or progressive bifocal lenses.
- Tinted or absorptive eyeglass lenses (except for aphakia, albinism, glaucoma, medical photophobia).
- Trifocal lenses (except as a specific job requirement).
- Spare glasses.
- In the ear hearing aids, hearing aid glasses.[22]

QUEST-Net

To be eligible for QUEST-Net, beneficiaries must first have been enrolled in the QUEST or fee-for-service programs and subsequently lost coverage due to increasing income, assets, or other qualifying reasons. The income range for QUEST-Net can be up to 300% of the federal poverty level (FPL) and some members may have to pay a monthly premium share. QUEST-Net enrollment has increased from 1,931 recipients in July 2004 to 1,993 recipients in June 2005.

The QUEST-Net program offers beneficiaries limited health care benefits, although children in QUEST-Net receive the same complete benefits as the QUEST program, including EPSDT. Maternity benefits are not covered under the QUEST-Net program; however, once an adult female is determined pregnant, she may apply for the QUEST program and, when deemed eligible, receive full maternity benefits including prenatal vitamins.[23]

[22] Department of Human Services, Med-QUEST Division, State of Hawaii. Med-QUEST Medicaid Provider Manual. 2003. Chapter 1 and Appendix 1 (online at http://www.med-quest.us/providers/Reference/manual.html).

[23] Department of Human Services, State of Hawaii. Annual Report 2005, p. 47. 2005.

QUEST Spenddown

The QUEST Spenddown program provides medical and dental coverage to certain families and children who, because of their income, are not eligible for coverage under the QUEST program. QUEST Spenddown is also available to clients who are QUEST-Net recipients but who have a medical need for which QUEST-Net coverage is either exhausted or is not provided.

To qualify, a family's monthly gross income must be more than the FPL but not exceed 300% of the FPL for a family of applicable size. The family must also have monthly medical bills that are equal to or greater than the family's excess income (i.e. the amount over the 300% of the FPL threshold). The spenddown amount is the family's excess income amount. In any month that the family is eligible, the family is responsible to pay for medical bills up to the spenddown or excess income amount. Any remaining medical bills in excess of the spenddown amount will be paid by the QUEST Spenddown program if it is an eligible QUEST service.[24]

QUEST Expanded Access

The Department of Human Services, Med-QUEST Division is working on the integration of the Medicaid Fee-For-Service population into QUEST managed care plans effective July 1, 2008. The goal of QUEST Expanded Access is to amend the current Section 1115 managed care demonstration project, Hawaii QUEST, to include all aged (individuals 65 years and older), blind, and disabled individuals, and to expand the services to include long-term care services, both institutional and home and community based waiver services. The Med-QUEST Division is collaborating with government and community agencies in the design of the new program that will convert the aged, blind, and disabled population from fee-for-service into a managed care delivery system that will improve client access to quality health care as well as provide program stability and sustainability.

[24] Department of Human Services, State of Hawaii. Annual Report 2005, p. 47. 2005.

Chapter 3

HOW HAWAII'S MEDICAID AND QUEST REIMBURSEMENT RATES ARE FUNDED AND DETERMINED

How Hawaii's Medicaid Program is Funded

Hawaii's Medicaid program is funded through federal and state funds. Under federal law, although each state's Medicaid program is entitled to a minimum of fifty percent of federal reimbursement funds for qualifying Medicaid program-related costs, states have different federal matching rates to fund the services provided under their respective Medicaid programs. The percentage received from the federal government is known as the Federal Medical Assistance Percentage, or FMAP. From year-to-year, each state's Federal Medical Assistance Percentage rate is reviewed by the federal government and adjusted based on a number of financial factors. For example, Alabama's Federal Medical Assistance Percentage for fiscal years 2005 and 2006 was 70.83% and 69.51%, respectively. For Hawaii, the federal matching funding rate for Hawaii in fiscal years 2005 and 2006 was just under sixty percent (58.47% and 58.81%, respectively).[1]

Federal Medical Assistance Percentage (FMAP)

How it Works

The amount of federal payments to a state for medical services depends on two factors. The first is the actual amount spent that qualifies as matchable under Medicaid. In general, this means that:

- The expenditure is for a covered service;
- The service is provided by a qualified provider enrolled with the Medicaid program; and
- The service is provided to a person eligible for and enrolled in Medicaid at the time of service.

The second factor is the actual amount spent that qualifies as matchable under Medicaid and the Federal Medical Assistance Percentage (FMAP). The Federal Medical Assistance Percentage is computed from a formula that takes into account the average per capita income for each state relative to the national average.[2]

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[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Medicaid At-a-Glance 200*5 (Publication No. CMS-11024-05), p. 7. 2005.

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *HRSA Medicaid Primer* (online at http://www.hrsa.gov/medicaidprimer/). October 12, 2006.

The FMAP formula includes a multiplier that is intended to adjust for differences in state fiscal capacity and to reduce program benefit disparities across states by providing more federal funds to states with weaker tax bases. The formula is recalculated each year, based on per capita personal income (PCI) data, and the resulting FMAPs are published in the Federal Register. States with relatively low per capita income receive higher matching rates than states with higher per capita income. The FMAP for each state is based on the squared value of state per capita income (PCI) relative to the U.S. average. Currently, the formula is:

FMAP = 1.00 - .45 X [(State PCI)/(U.S. PCI)][2]

State and U.S. PCI in this formula are a three-year average of data from the National Income and Product Accounts (NIPA), published by the Department of Commerce. The three-year average is intended to improve stability in a state's FMAP over time. The .45 multiplier, established in federal statute, determines the average state share of total Medicaid expenses. A smaller multiplier would increase the federal share of program costs and a larger one would reduce the federal share. The statute also stipulates that no state shall bear more than fifty percent of total costs, regardless of the FMAP calculated through the formula.[3]

In essence, for every dollar a state spends on Medicaid, the federal government matches at a rate that varies year to year. For example, for fiscal year 2004, the rate for Alabama was 1:2.80 (73.70%) (See chart below for individual state FMAPs).

Federal Matching Rate (FMAP) for Medicaid and Multiplier[4]

	FY2005	FY2006	FY2007
United States	50.00%[1]	50.00%[1]	50.00%[1]
Alabama	70.83%	69.51%	68.85%
Alaska	57.58%[3]	50.16%	51.07%
Arizona	67.45%	66.98%	66.47%
Arkansas	74.75%	73.77%	73.37%
California	50.00%	50.00%	50.00%
Colorado	50.00%	50.00%	50.00%
Connecticut	50.00%	50.00%	50.00%
Delaware	50.38%	50.09%	50.00%
District of Columbia	70.00%[3]	70.00%[4]	70.00%[4]
Florida	58.90%	58.89%	58.76%
Georgia	60.44%	60.60%	61.97%
Hawaii	58.47%	58.81%	57.55%
Idaho	70.62%	69.91%	70.36%

[3] National Academy for State Health Policy. *Making Medicaid Work for the 21st Century*. Issue Brief #3, November 2004 (online at http://www.nashp.org/Files/IssueBrief3.pdf#search='fmap%20multiplier). October 12, 2006.

[4] Kaiser Family Foundation. Statehealthfacts.org. *Federal* Matching *Rate (FMAP) for Medicaid and Multiplier* (online at www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=). October 10, 2006.

	FY2005	FY2006	FY2007
Illinois	50.00%	50.00%	50.00%
Indiana	62.78%	62.98%	62.61%
Iowa	63.55%	63.61%	61.98%
Kansas	61.01%	60.41%	60.25%
Kentucky	69.60%	69.26%	69.58%
Louisiana	71.04%	69.79%	69.69%
Maine	64.89%	62.90%	63.27%
Maryland	50.00%	50.00%	50.00%
Massachusetts	50.00%	50.00%	50.00%
Michigan	56.71%	56.59%	56.38%
Minnesota	50.00%	50.00%	50.00%
Mississippi	77.08%	76.00%	75.89%
Missouri	61.15%	61.93%	61.60%
Montana	71.90%	70.54%	69.11%
Nebraska	59.64%	59.68%	57.93%
Nevada	55.90%	54.76%	53.93%
New Hampshire	50.00%	50.00%	50.00%
New Jersey	50.00%	50.00%	50.00%
New Mexico	74.30%	71.15%	71.93%
New York	50.00%	50.00%	50.00%
North Carolina	63.63%	63.49%	64.52%
North Dakota	67.49%	65.85%	64.72%
Ohio	59.68%	59.88%	59.66%
Oklahoma	70.18%	67.91%	68.14%
Oregon	61.12%	61.57%	61.07%
Pennsylvania	53.84%	55.05%	54.39%
Rhode Island	55.38%	54.45%	52.35%
South Carolina	69.89%	69.32%	69.54%
South Dakota	66.03%	65.07%	62.92%
Tennessee	64.81%	63.99%	63.65%
Texas	60.87%	60.66%	60.78%
Utah	72.14%	70.76%	70.14%
Vermont	60.11%	58.49%	58.93%
Virginia	50.00%	50.00%	50.00%
Washington	50.00%	50.00%	50.12%
West Virginia	74.65%	72.99%	72.82%
Wisconsin	58.32%	57.65%	57.47%
Wyoming	57.90%	54.23%	52.91%
Guam	50.00%[5]	50.00%[5]	50.00%[5]
Puerto Rico	50.00%[5]	50.00%[5]	50.00%[5]
Virgin Islands	50.00%[5]	50.00%[5]	50.00%[5]

Notes

FY2005: Effective from October 1, 2004 to September 30, 2005.
FY2006: Effective from October 1, 2005 to September 30, 2006.
FY2007: Effective from October 1, 2006 to September 30, 2007.

Sources

Federal Register, June 17, 2003 (Vol. 68, No. 116), pp. 35889-35890, at http://a257.g.akamaitech.net/ 7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/pdf/03-15274.pdf. FY2005: Federal Register, December 3, 2003 (Vol. 68, No. 232), pp. 67676-67678, at http://aspe.os.dhhs.gov/health/fmap05.htm. FY2006: Federal Register, November 24, 2004 (Vol. 69, No. 226), pp. 68372, at http://aspe.os.dhhs.gov/ health/fmap06.htm. FY2007: Federal Register, November 30, 2005 (Volume 70, Number 229), pp. 71856-71857, at http://aspe.os.dhhs.gov/health/fmap07.htm. KCMU estimates of the multiplier are based on the FMAP.

Footnotes for FMAP Chart:

1. The federal minimum FMAP is 50%.
2. The FMAP percentages for Alaska and the District of Columbia apply to their Medicaid programs, including DSH allotments, and to the calculation of their enhanced FMAPs under the SCHIP program. For other purposes, including programs remaining in Title IV of the Act, the percentage for Alaska is 54% and for DC is 50%.
3. The FMAP percentages for Alaska and the District of Columbia apply to their Medicaid programs, including DSH allotments, and to the calculation of their enhanced FMAPs under the SCHIP program. For other purposes, including programs remaining in Title IV of the Act, the percentage for Alaska is 53% and for DC is 50%.
4. The FMAP percentages for the District of Columbia were set for the state plan under titles XIX and XXI and for capitation payments and DSH attotments under those titles. For other purposes, including programs remaining in Title IV of the Act, the percentage for DC is 50%.
5. For purposes of Section 1118 of the Social Security Act, the percentage used under Titles I, X, XIV, and XVI and Part A of Title IV will be 75%.

FMAP Formula - What Works Well and What Doesn't

The National Academy for State Health Policy, an independent, nonprofit, nonpartisan academy of state health policymakers working to identify emerging issues, develop policy solutions, and improve state health policy and practice, states that the current FMAP formula has several benefits. The three-year average of per capita personal income (PCI) data used in the formula helps to improve the stability of each state's FMAP over time. While there are still fluctuations in FMAP rates from year to year, the relative stability of the rates helps states predict the amount of federal funding they will receive for Medicaid expenditures in a given year, information that is critical to the budgeting process. The minimum fifty percent federal matching rate assures states of a minimum level of federal support for the program. Thirteen states benefited from this provision in 2002. Another benefit of the current FMAP structure is that, during an economic downturn when the Options for Improving the FMAP Formula number of low-income people increases, federal Medicaid matching funds continue to be available on an open-ended basis to accommodate the resulting growth in the number of Medicaid enrollees. While the National Academy for State Health Policy states that the existing FMAP formula works fairly well for the majority of states, several concerns have been raised about it over the years. These concerns include:

(1) FMAPs are calculated on per capita income data that have a several year time lag. This means that a state facing a recession in 2003 may have a low FMAP because the calculation is based on data from 1998-2000, when the state's economy may have been significantly better. Conversely, states may get a higher FMAP during better economic times because the data being used is from a period when the state economy was in recession.

(2) The NIPA personal income measure is not a good measure of state tax capacity. One of the key sources of state revenue, severance taxes that are levied on minerals taken from the ground, is not reflected in the NIPA measure. NIPA includes income that is nontaxable, such as private non-profit organizations and private trust funds, and also excludes significant sources of state revenue, such as residents' realized capital gains. Therefore, it does not adequately represent the tax base of many states or their ability to contribute to the program. In addition, it does not capture differences in the cost of health care in various states.

(3) The formula does not take beneficiary need into account. For example, a state with a high per capita income may also have a large population of people living below the poverty level. Such a state could argue that it should receive a higher FMAP to account for the disproportionate size of its poor population which is more likely to rely upon Medicaid to meet its health care needs.[5]

Different Medicaid Reimbursement Rates and Methodologies

When discussing Medicaid reimbursement rates, it is important to note that the Department of Human Services utilizes different reimbursement methodologies for different types of health care services. Section 346-59, Hawaii Revised Statutes, establishes the Medicaid Fee Schedule for non-institutional health care services, such as physician services, dental care, laboratory services, and medical equipment and supplies. However services provided in inpatient acute hospitals, federally qualified health centers and rural health centers, and to a certain extent, skilled nursing facilities (SNFs) and intermediate care facilities (ICFs), are reimbursed through the Prospective Payment System (PPS). Furthermore, subacute nursing facilities are paid reimbursement rates that are negotiated by the Department of Human Services; and hospices and home health care agencies are reimbursed at Medicare rates. Prescription drugs are reimbursed at 10.5% below the average wholesale price + a $4.67 dispensing fee and are not addressed by the Medicaid Fee Schedule established under section 346-59, Hawaii Revised Statutes. According to the Department of Human Services, the Medicaid Fee Schedule and the Proposed Payment System are the main methodologies used for reimbursement. The following chart outlines the various reimbursement methodologies.[6]

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[5] National Academy for State Health Policy. *Making Medicaid Work for the 21st Century*. Issue Brief #3, November 2004 (online at http://www.nashp.org/Files/IssueBrief3.pdf#search='fmap%20multiplier). October 12, 2006.

[6] Letter from Lillian B. Koller, Director of Human Services, State of Hawaii, to the Legislative Reference Bureau dated July 7, 2006.

Reimbursement of Different Types of Services in Hawaii FFS Medicaid Provided by Department of Human Services (6/22/06)

Type of Service	Payment Methodology	Basis of Methodology	Updating of Reimbursement Rates
Non-institutional Services (includes physician services, dental services, laboratory services, medical equipment and supplies, etc.)	Medicaid Fee Schedule	Medicaid State Plan HRS §346-59	Medicaid Fee Schedule is updated globally, according to legislative appropriation. But reimbursement of certain services cannot exceed Medicare rates.
Inpatient Acute Hospital	Prospective Payment System (PPS)	Medicaid State Plan	Updates based on annual cost reports
Nursing Facilities [Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs)]	Currently combination of PPS and acuity based reimbursement based on Medicare MDS (Minimum Data Set) data ********** 2005 - 75% PPS and 25% MDS acuity 2006 - 50% PPS and 50% MDS acuity 2007 - 25% PPS and 75% MDS acuity 2008 - 100% MDS acuity	Medicaid State Plan HRS §346D-1.5	Quarterly updates based on the combination of Medicare annual cost report and MDS data.
Nursing Facilities (Subacute)	Rates negotiated by Department; pending cost reports	Medicaid State Plan	Updates are negotiated, pending cost reports
Hospice	Medicare Rates	Medicaid State Plan	Updates based on Medicare rates
Home Health Agencies	Medicare rates when Medicare paid by encounters	Medicaid State Plan	Negotiated by Department
Prescription Drugs	10.5% below the average wholesale price + $4.67 dispensing fee	Medicaid State Plan	Updates based on average wholesale price
Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)	FQHC Prospective Payment System (PPS)	Medicaid State Plan	Adjustments as provided by Federal law and State Plan

Medicaid Fee Schedule

Under section 346-59, Hawaii Revised Statutes, the Department of Human Services is required to adopt administrative rules under chapter 91, Hawaii Revised Statutes, concerning payment for non-institutional health care services such as physician services, dental care, laboratory services, and medical equipment and supplies.

Section 346-59(a), Hawaii Revised Statutes, states, in part, that, "[t]he department shall determine the rates of payment due to all providers of medical care, and pay such amounts in accordance with the requirements of the appropriations act and the Social Security Act, as amended. Payments to critical access hospitals for services rendered to medicaid beneficiaries shall be calculated on a cost basis using medicare reasonable cost principles."[7]

Section 346-59(b), Hawaii Revised Statutes, states, in part, that, "[r]ates of payment to providers of medical care who are individual practitioners, including doctors of medicine, dentists, podiatrists, psychologists, osteopaths, optometrists, and other individuals providing services, shall be based upon the Hawaii medicaid fee schedule. The amounts paid shall not exceed the maximum permitted to be paid individual practitioners or other individuals under federal law and regulation, the medicare fee schedule for the current year, the state limits as provided in the appropriation act, or the provider's billed amount."[8]

In 2001, the Legislature amended section 346-59(b), Hawaii Revised Statutes, also to limit the reimbursement amounts contained in the Medicaid Fee Schedule established by the Department of Human Services by requiring that "[t]he appropriation act shall indicate the percentage of the medicare fee schedule for the year 2000 to be used as the basis for establishing the Hawaii medicaid fee schedule. For any subsequent adjustments to the fee schedule, the legislature shall specify the extent of the adjustment in the appropriation act."[9]

The Appropriation Act of 2000, required the Department of Human Services to use "sixty per cent of the most recent available profile of the customary fees of health care practitioners, adjusted to the seventy-fifth percentile within the limits of this appropriation, in establishing fees for individual practitioners for health care payments (HMS 230), in fiscal year 1999-2000 and in fiscal year 2000-2001."[10]

With respect to the payment rates for other noninstitutional items and services, section 346-59, Hawaii Revised Statutes, requires that the amount not exceed the current Medicare payment, the state limits as provided in the state appropriation act, the rate determined by the Department of Human Services, or the provider's billed amount.[11] That section of law further provides that payments to health maintenance organizations and prepaid health plans with which the Department of Human Services executes risk contracts for the provision of medical care to

[7] Hawaii Revised Statutes, section 346-59(a). 2006.

[8] Hawaii Revised Statutes, section 346-59(b). 2006.

[9] Hawaii Revised Statutes, section 346-59(b). 2006; see Act 29, Session Laws of Hawaii 2001.

[10] Act 281, section 4(21), Session Laws of Hawaii 2000.

[11] Hawaii Revised Statutes, section 346-59(c).

eligible public assistance recipients may be made on a prepaid basis. The rate of payment per participating recipient is fixed by contract, as determined by the Department of Human Services and the health maintenance organization or the prepaid health plan. The contract cost cannot exceed the maximum permitted by federal rules and must be less than the federal maximum when funds appropriated by the Legislature for the contract require a lesser rate.[12]

Generally speaking, the Medicaid Fee-For Service reimbursement rates for the State of Hawaii are based on the federal Medicare Resource Based Relative Value Scale (MRBRVS) physician fee schedule,[13] which was implemented by the Centers for Medicare and Medicaid Services (CMS) on January 1, 1992. The MRBRVS physician fee schedule replaced the Medicare physician payment system of "customary, prevailing, and reasonable" (CPR) charges under which physicians were reimbursed according to the historical record of the charge for the provision of each service. The current MRBRVS physician fee schedule is derived from the "relative value" of services provided and based on the resources they consume. The relative value of each service is quantifiable and is based on the concept that there are three components of each service: the amount of physician work that goes into the service, the practice expense associated with the service, and the professional liability expense for the provision of the service. The relative value of each service is multiplied by Geographic Practice Cost Indices (GPCIs) for each Medicare locality and then translated into a dollar amount by an annually adjusted conversion factor. The dollar amount derived from this calculation, with adjustments under certain circumstances, is the reimbursement a physician receives for the provision of a particular service. According to the American Academy of Pediatrics, over seventy-four percent of public and private payors, including other state Medicaid programs, have adopted components of the MRBRVS to reimburse physicians, while many other payors are exploring its implementation.[14] For more detailed information on how the MRBRVS is calculated, see appendix C.

According to the Department of Human Services, Med-QUEST Division, Hawaii's Medicaid reimbursement rate is approximately seventy-two percent of MRBRVS 2000 rates for Hawaii (sixty-eight percent + four percent for the State's general excise tax). In other words, if the MRBRVS 2000 establishes $100 as the reimbursement rate for a treatment code, the State of Hawaii would pay a health care provider $72 for the same treatment under its Medicaid program. Of that $72 amount, in 2006, the federal government would pay 58.81%, (see earlier discussion of FMAP) and the State would pay the remaining 41.19%. For Medicare Fee Schedule treatment codes established after the publication of MRBRVS 2000, the reimbursement rates for these treatments approximate seventy percent of MRBRVS 2006 for Hawaii.[15]

[12] Hawaii Revised Statutes, section 346-59(d). 2006.

[13] More specific reimbursement formulas for medical providers and entities are contained in Title, 17, Chapter 1739, Hawaii Administrative Rules.

[14] American Academy of Pediatrics, "2006 RBRVS What is it and How it Affects Pediatrics" (online at www.aap.org/visit/RBRVSbrochure.pdf). 2006

[15] Telephone interview with Department of Human Services, Med-QUEST Division, Medical Standards Branch Acting Administrator, State of Hawaii, August 2006.

Prospective Payment System

The Medicare Prospective Payment System (PPS) was introduced by the federal government in October 1983, as a way to change hospital behavior through financial incentives that encourage more cost-efficient management of medical care. Generally, in a PPS, the payment rate for a product or service may be determined by the following general formula:

> *Payment rate = Initial base payment amount x update factor x input–price adjustment factor x relative value of the product or service x other rate adjustment factors*[16]

According to a 2005 United States Government Accountability Office report:

- The initial base payment amount is usually a dollar amount for a specific year that reflects policymakers' decisions on the unit of payment for the unit of service (e.g., visit, episode of care, day) and the appropriate initial level of payment for the average unit;

- The update factor adjusts the initial base amount for inflation and other factors to set the base level of payment for the rate year;

- The input-price adjustment factor raises or lowers the base amount to reflect geographic price differences, such as differences in wages;

- The relative value adjusts the base amount to reflect the expected relative costliness of the particular product or service compared with that of the average unit of that product or service.

- One or more additional rate adjustment factors designed to reflect certain characteristics of the provider, the service, or the specific patient may be applied to the payment rate. For example, the payment rate may be adjusted on the basis of patients' severity of illness or condition treated by a provider, referred to as case-mix.

In addition, some systems include an adjustment to mitigate the financial risk of providers who incur unusually large costs. This adjustment may be in the form of an outlier payment in which additional payments are made to the provider for cases that exceed a specified threshold.[17]

Under a PPS, hospitals are paid a pre-determined rate for each Medicaid admission. Each patient is classified into a Diagnosis Related Group (DRG) on the basis of clinical information. Except for certain patients with exceptionally high costs (called outliers), the hospital is paid a flat rate for the DRG, regardless of the actual services provided. Similarly, under a PPS, a health

[16] United States Government Accountability Office. *Health Centers and Rural Clinics; State and Federal Implementation Issues for Medicaid's New Payment System* (GAO-05-452), p. 47. June 2005.

[17] Ibid.

care provider's payment is based on predetermined rates and is unaffected by the provider's actual costs or the amount of money charged for products or services. An important objective of a PPS is to create incentives for providers to operate more efficiently. This is done by making providers responsible for the difference between what they are paid and their actual costs. Therefore, providers whose costs exceed the predetermined payment rate will experience a loss and those whose costs are less than the payment rate will profit.[18]

Diagnoses and procedures must be documented by the attending physician in the patient's medical record. They are then coded by hospital personnel. The coding process is extremely important since it essentially determines what DRG will be assigned for a patient. Coding an incorrect principal diagnosis or failing to code a significant secondary diagnosis can dramatically affect reimbursement.

According to the American Hospital Directory, an online resource that provides data for over six thousand hospitals, the DRG classification system is a useful tool for managing inpatient quality measurements and operating costs. It groups patients by diagnostic category for analysis and provides several key measurements of resource utilization (e.g. average length of stay vs. published national averages).

There are over 490 DRG categories defined by the Centers for Medicare and Medicaid Services. Each category is designed to be "clinically coherent." In other words, all patients assigned to a DRG are deemed to have a similar clinical condition. The Prospective Payment System is based on paying the average cost for treating patients in the same DRG.

Each year, the Centers for Medicare and Medicaid Services makes technical adjustments to the DRG classification system that incorporate new technologies and refine its use as a payment methodology. The Centers for Medicare and Medicaid Services also annually assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year. The national average charge for each DRG is compared to the overall average. This ratio is published annually in the Federal Register for each DRG. A DRG with a weight of 2.0000 means that charges were historically twice the average; a DRG with a weight of 0.5000 was half the average.

The hospital's payment rate is defined by federal regulations and is updated annually to reflect inflation, technical adjustments, and budgetary constraints. There are separate rate calculations for large urban hospitals and other hospitals. There are also technical adjustments for local wage variations, teaching hospitals, and hospitals with a disproportionate share of financially indigent patients.

The average DRG weight for all of a hospital's Medicare volume is called the case mix index (CMI). This index is very useful in analysis since it indicates the relative severity of a patient population and is directly proportional to DRG payments. When making comparisons among various hospitals or patient groups, the case mix index can be used to adjust indicators such as average charges. (Case mix adjusted average charges would be actual charges divided

[18] Ibid.

by the CMI. Such adjustments are sometimes referred to as "average charges for a weight of 1.0000.")[19]

The history, design, and classification rules of the DRG system, as well as its application on patient discharge data and updating procedures, are presented in the Centers for Medicare and Medicaid Services' *DRG Definitions Manual*.

QUEST Reimbursement Rates

QUEST reimbursement rates, unlike Medicaid fee for service reimbursement rates, are negotiated on a contracted plan basis. As stated previously in this report, under the QUEST program, medical and mental health services are provided in a managed care environment. However, dental services for QUEST beneficiaries are provided under the Medicaid fee-for-service program. The Department of Human Services contracts with medical health plans selected through a competitive bidding process. Historically, QUEST providers have accepted Medicaid reimbursement rates and methodology when negotiating their contracts.[20] Recipients who are eligible for QUEST are able to select a medical plan. The plans are responsible to ensure recipients receive medically necessary services that are a covered benefit, within their contracted network of qualified providers.

The Department of Human Services, in turn, pays a monthly capitated amount to the medical plan for each member enrolled in their plan. The Department of Human Services pays a plan no more than the capitated amount, regardless of how many times a recipient seeks services within a plan or the type of service a recipient receives.

Does the Existing Process to Determine Medicaid Reimbursement Rates Need to be Altered?

In assessing the need to change the way the State calculates its Medicaid reimbursement rates in order to ensure that it adequately compensates health care providers for services rendered to Medicaid and QUEST beneficiaries, the Bureau asked various interest groups that were contacted for this study whether they believed the Department of Human Services' existing methodologies for calculating the Medicaid reimbursement rates needed to be altered.

The Hawaii Health Systems Corporation, a public benefit corporation established by Act 262, Session Laws of Hawaii 1996, as an agency of the State of Hawaii and consisting of twelve facilities in five different regions across the State, recommended that the Legislature fund the State's Medicaid program sufficiently to increase payments to the extent that the Medicaid payments would be equivalent to the costs of providing care to Medicaid and QUEST

[19] American Hospital Directory (online at http://www.ahd.com/pps.html). October 6, 2006.

[20] Letter dated June 15, 2006, from Thomas M. Driskell, Jr. President and CEO, Hawaii Health Systems Corporation to the Legislative Reference Bureau regarding the HHSC's response to the Bureau's request for information regarding S.C.R. No.77, S.D. 2, H.D. 1.

beneficiaries. The Hawaii Health Systems Corporation went on to recommend that any new reimbursement methodology include a mechanism to increase reimbursements to keep pace with inflation.

Comments submitted by Hawaii Pacific Health, an organization consisting of private health care institutions (Kapiʻolani Medical Center at Pali Momi, Kapiʻolani Medical Center for Women and Children, Straub Clinic and Hospital, and Wilcox Health), on Senate Concurrent Resolution No. 77 (2006), seemed to agree with the recommendation of the Hawaii Health Systems Corporation and added that they believe that the process the Department of Human Services uses to reimburse hospitals is not flawed. However, Hawaii Pacific Health stated that reimbursement rates have not been adequately adjusted on an annual basis to account for health care inflation. According to Hawaii Pacific Health, health care costs are increasing significantly faster than the consumer price index due, in part, to new technology, pharmaceuticals, and other lifesaving improvements in medical care. Hawaii Pacific Health further stated that the Department of Human Services has not increased reimbursement rates for subacute care since 1998 and has only adjusted reimbursement rates for professional fees, outpatient surgery procedures, and ancillary fees for laboratory, radiology, physical therapy, and speech therapy twice since 1990.[21]

Based on the information provided by the Hawaii Health Systems Corporation and Hawaii Pacific Health, and with the exceptions of the Medicaid Fee Schedule being substantially tied to MRBRVS 2000 rates and the absence of a mechanism to adjust the reimbursement rates to offset the costs attributable to inflation, the Bureau believes that the system utilized by the Department of Human Services to calculate reimbursement rates to health care institutions and providers is not flawed, but is in need of timely rate adjustments to accurately reflect the cost of health care.

[21] Hawaii Pacific Health. Comments submitted on June 8, 2006, on S.C.R. No. 77, S.D. 2, H.D. 1 (2006).

Chapter 4

RECENT STATE ACTIONS TAKEN TO INCREASE REIMBURSEMENTS TO MEDICAID AND QUEST PROVIDERS

Since 2004, the Department of Human Services has been pursuing a program of enhancing federal financial participation (FFP) in the State's Medicaid program. The Department's program is intended to generate more federal dollars (matching funds) for reinvestment in improving Hawaii's health care system. The program involves:

(1) Amending the Medicaid State Plan through the process of obtaining federal approval of a State Plan Amendment; and

(2) Amending the Medicaid QUEST 1115 waiver (managed care demonstration project).

State Plan Amendment

Any amendment to Hawaii's Medicaid State Plan requires federal adoption of a State Plan Amendment (SPA). Hawaii's SPA allows the State to capture additional federal matching funds with which the Department of Human Services can make supplemental payments to public hospitals and supplemental payments to hospital-based nursing homes (public and private); the SPA also complies with Medicare law by reducing the State's co-payments for hospital services provided to Medicare customers for whom the State must make co-payments under Medicare law. These changes have been approved by the federal Centers for Medicare and Medicaid Services (CMS) and have been in effect since September 1, 2003.

Supplemental Payments to Public Hospitals

The SPA authorizes federal participation in payments to public hospitals under the Hawaii Health Systems Corporation for the difference between the regular Medicaid rate and the cost of serving Medicaid customers. This applies only to care reimbursed on a fee-for-service basis that currently covers approximately 40,000 aged, blind, or disabled Medicaid customers statewide. Since state funds are being used to subsidize the Hawaii Health Systems Corporation for these losses, the Department of Human Services has determined that it would possible to earn additional federal financial participation (FFP) under the SPA if the Hawaii Health Systems Corporation certifies and submits its Medicaid expenditure information to the Department of Human Services, stating that the expenditures are, in fact, already being made. The Department of Human Services reports the Hawaii Health Systems Corporation's losses as qualified expenditures similar to any other Medicaid program expenses to the Centers for Medicare and

Medicaid Services and receives federal matching funds equivalent to approximately sixty percent of the reported expenditures.[1]

Based on HHSC estimates, the federal share of the supplemental payments will be approximately $3 million for the state fiscal year ending June 30, 2004, and $3.7 million per year thereafter until full implementation of the anticipated QUEST expansion, which will eliminate virtually all fee-for-service inpatient hospital days. The Department of Human Services' current timetable for QUEST expansion, which will move most of the aged, blind, and disabled Medicaid customers from fee-for-service to managed care to improve their quality of care and contain the State's escalating Medicaid costs, is projected to start on or after July 1, 2008.[2] Under the QUEST expansion, the State will continue to receive comparable FFP through the QUEST 1115 waiver, not the SPA.

Supplemental Payments to Hospital-Based Nursing Homes

The SPA also authorizes FFP in supplemental payments to public and private hospital based nursing facilities. These facilities will experience a reduction in their regular Medicaid reimbursement rates as a result of the new rate system implemented pursuant to the Medicaid Reimbursement Equity Law, section 346D-1.5, Hawaii Revised Statutes, which requires the Medicaid rates for institutional nursing care to be based on acuity of care instead of cost reimbursement. In other words, Medicaid reimbursement rates will be based on the level of care, rather than on a per capita basis. The SPA supplemental payments are intended to ease the transition to the new payment system for these facilities (to prevent a spike in revenue losses that would threaten hospital closures and diminish quality of care) and will be phased out by the end of state fiscal year 2008.[3]

For state fiscal year 2004 (ten months) and state fiscal year 2005, the qualifying facilities received, as they had prior to section 346D-1.5, Hawaii Revised Statutes, the difference between their Medicaid rate and their costs of serving Medicaid customers. Beginning with state fiscal year 2006, the facilities will receive a supplement based on a percentage of the difference between their new rate and what their rate would have been under the old system. The percentages are: seventy-five percent in state fiscal year 2006; fifty percent in state fiscal year 2007; and twenty-five percent in state fiscal year 2008.[4]

In the case of Hawaii Health Systems Corporation facilities, the State has been subsidizing their losses. Accordingly, the federal share of the supplemental payments can be earned through certification of expenditures already being made by the Hawaii Health Systems

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[1] Letter dated June 15, 2006, from Thomas M. Driskell, Jr. President and CEO, Hawaii Health Systems Corporation to the Legislative Reference Bureau regarding the HHSC's response to the Bureau's request for information regarding S.C.R. No. 77, S.D. 2, H.D. 1.

[2] Telephone interview with Acting Administrator, Department of Human Services, Med-QUEST Division, Medical Standards Branch, State of Hawaii. November 8, 2006.

[3] Letter from Lillian B. Koller, Director of Human Services, to Senator Brian T. Taniguchi, Chair, Senate Ways and Means Committee, regarding the Department of Human Services' Medicaid revenue enhancement program, dated March 11, 2005.

[4] Ibid.

Corporation. In the case of the private hospital based facilities, the supplemental payments will require a new contribution by the State.

Reduced Medicare Co-Payments

As noted previously, the SPA also complies with Medicare law by reducing the State's co-payments for hospital services provided to Medicare customers for whom the State must make co-payments under Medicare law. Federal law requires the State Medicaid program to make co-payments for certain Medicaid customers ("dual eligibles") who also qualify for and receive Medicare services. Currently, approximately 36,000 Medicaid customers statewide are Medicaid-Medicare "dual eligibles."[5]

Prior to the SPA, Hawaii made these co-payments to hospitals at the full amount. However, federal law permits a state to limit its co-payment obligation based on the Medicaid reimbursement rate for the services provided by Medicare. The SPA takes advantage of this option, which will result in a reduction in annual Medicaid co-payments estimated to be $2 million per year. The Department of Human Services estimated that this change will result in a savings to the State of $800,000 per year (the State share of the co-payments not made).[6]

According to the Department of Human Services, hospitals will be entitled to recover seventy-five percent of the unpaid co-payment amounts from the Medicare program, which reimburses facilities for bad debts, including co-payments chargeable to but not paid by or on behalf of Medicare customers. As of March 2005, the Department of Human Services had already notified the Medicare Fiscal Intermediary of the change and the expected impact on Medicare reimbursement of the hospitals. In order to prevent a loss in revenues from the reduced co-payments to hospitals, the Department of Human Services agreed to implement the reduced co-payments after the department was permitted by the Centers for Medicare and Medicaid Services to begin making "Disproportionate Share Hospital (DSH)-Like" supplemental payments to hospitals under the Medicaid QUEST 1115 waiver amendment that was approved by the Centers for Medicare and Medicaid Services in February 2006.[7]

QUEST Waiver Amendment for "Disproportionate Share Hospital (DSH)-Like" Payments to Hospitals

The Department of Human Services has submitted a proposal to amend its current Medicaid QUEST 1115 waiver (managed care demonstration project) to permit direct payments to hospitals (public and private) to help cover their otherwise unreimbursed costs for serving Medicaid customers in the QUEST program as well as for uninsured or indigent customers. This requested amendment is intended to get more federal dollars as "DSH-Like" payments to hospitals because these payments would simulate for Hawaii the "Disproportionate Share Hospital" reimbursements that other states receive by federal allotment provided in federal law.

[5] Ibid.

[6] Ibid.

[7] Ibid.

Disproportionate Share Hospital reimbursements are an important source of federal funding that are distributed to hospitals as extra payments for treating a disproportionate share of indigent patients.

The Department of Human Services' proposal for "DSH-Like" payments to hospitals had been under review by the Centers for Medicare and Medicaid Services since January 2004 and was approved in February 2006. The approved waiver allows Hawaii to continue making direct payments to hospitals to defray the costs of treating uninsured patients. Under the waiver agreement, Hawaii will receive $15 million each year over the next six years.[8]

For Hawaii Health Systems Corporation hospitals, whose costs are being subsidized by the State, the amendment would earn additional federal funds for the State through the certification of expenditures already being made by the Hawaii Health Systems Corporation. This means that new federal dollars would be available to the State based on existing state spending. In the case of the private hospital based facilities, the "DSH-Like" payments will constitute a new contribution by the State, funded with new federal dollars drawn down by the Hawaii Health Systems Corporation certifying its state expenditures on unreimbursed costs for serving Medicaid QUEST customers and other uninsured or indigent customers.[9]

For the private hospitals, the waiver amendment contemplates payments pursuant to a formula that has been developed by the private hospitals themselves. The amount of funds to be paid is to be determined by the State each year, subject to a maximum payment amount specified in the federal approval. The State is required to contribute up to approximately forty percent of the total payment to the private hospitals. This payment will offset the modest losses to the private hospitals from the change in the Medicare co-payment amounts under the SPA (see above) and, more importantly, would assist the private hospitals in covering a portion of their uncovered costs for serving indigent customers.[10]

[8] News Release, *DHS Receives Federal Approval to Expand Healthcare Coverage to an Additional 29,000 Adults and Children*, issued by the Department of Human Services dated February 3, 2006.

[9] Letter from Lillian B. Koller, Director of Human Services, to Senator Brian T. Taniguchi, Chair, Senate Ways and Means Committee, regarding the Department of Human Services' Medicaid revenue enhancement program, dated March 11, 2005.

[10] Ibid.

Chapter 5

ATTEMPTING A COMPARISON OF RATES

Senate Concurrent Resolution No. 77, S.D. 2, H.D. 1, directed the Bureau to conduct a comparison of rates for the ten most frequently used services in Medicaid and QUEST health care services to identify the actual costs of those services and the amounts reimbursed to the provider.

Difficulties Encountered

Although the concurrent resolution specifically requested that the Bureau identify the ten most frequently used services in Medicaid and QUEST health care services, determine the actual costs of each service, and report the amounts reimbursed to the provider of the service, the Bureau encountered significant difficulty in obtaining useful data for some of the requested fields of information.

The Bureau found that, within the State of Hawaii, utilizing the basic parameter of "the ten most frequently used treatments" resulted in some Medicaid treatment codes that were anomalous and not representative of the study's purpose. For instance, one of the codes provided by the Department of Human Services as one of its most frequently utilized codes was A0425 – Ground Mileage per Statute Mile (sixth most frequent). In addition, information gleaned from the United States Department of Health and Human Services Centers for Medicare and Medicaid Services, under its leading Medicare Part B treatment codes, did have national data (percentages) on which treatment codes were utilized most frequently under Medicare Part B, and total dollar amounts of allowed charges, but did not have any similar data on Medicaid treatment codes.

Although some cost information was available locally through the Hawaii Health Information Corporation for participating hospitals, specifically Diagnosis-Related Group (DRG), not Current Procedural Terminology (CPT) codes, no similar cost information was available for individual health care providers. The Department of Human Services stated that such information is unique to each health care provider's practice and would have to be requested from each individual provider.[1]

When the Bureau requested the information from the Hawaii Medical Association, a professional, membership organization for physicians, residents, and medical students in the State of Hawaii that is part of the American Medical Association (AMA) and is the parent organization for Hawaii's five regional medical societies, the Hawaii Medical Association responded that, since such information is considered proprietary, neither the Hawaii Medical

[1] Letter from Lillian B. Koller, Director of Human Services, State of Hawaii, to the Legislative Reference Bureau dated July 7, 2006.

Association nor the American Medical Association collects data on the individual cost aspects of treatments covered by Medicaid treatment codes.[2]

The Bureau then contacted the National Conference of State Legislatures (NCSL) to see if it possessed such information or was aware of any resources that would have the information. Unfortunately, the National Conference of State Legislatures responded that, due to the complex nature of Medicaid reimbursement, it did not possess, nor was it aware of, any resources that would have such information readily available.[3]

The Bureau also contacted the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for administering the Medicare and Medicaid programs to determine whether the federal government had such information available. The Centers for Medicare and Medicaid Services also reported that they did not keep track of Medicaid costs in that manner.[4]

After conducting an internet search of various websites to determine whether any interstate comparative cost information was available, the Bureau was able to find surveys conducted by the American Academy of Pediatrics that provided Medicaid reimbursement rates for commonly used pediatric services. Unfortunately, although the surveys provided comparative information between states' Medicaid reimbursement rates and what Medicare reimburses, the surveys did not provide any information on actual cost to a provider to provide the specific treatment.[5] Thus there was no way to say whether the reimbursement rates were adequate. In addition, some of the reimbursement rates reported in the American Academy of Pediatrics for certain treatment codes were considerably higher than what was reported by the Department of Human Services, Med-QUEST Division (e.g., the American Academy of Pediatrics reported the reimbursement rates for CPT codes 99201, 99202, 99203, 99211, 99212, 99213, 99214, and 99215 in Hawaii at $95 per treatment for each treatment code, while the Department of Human Services reported Hawaii's reimbursement rate at $32.30, $49.42, $68.82, $21.90, $30.81, $36.84, $56.46, and $83.57, respectively, for each treatment code). The Department of Human Services explained that these discrepancies occur due to the fact that, because the information was provided by the American Academy of Pediatrics, the figures reflect what pediatricians would receive as Medicaid reimbursement under the federally-mandated comprehensive early and periodic screening, diagnosis and treatment (EPSDT) program. This program is required of all states that participate in Medicaid. In Hawaii, EPSDT covers recipients in both QUEST and Medicaid fee-for-service from age zero to twenty (essentially children). Since the purpose of this program is to provide preventative medical services to avoid the proliferation of more costly medical conditions, enhanced payment is

[2] Telephone interviews and e-mail correspondences with the Executive Director of the Hawaii Medical Association. August 29 and September 7, 2006.

[3] E-mail correspondence with Ms. Melissa Hansen, National Conference of State Legislatures, July 12, 2006.

[4] E-mail correspondences and telephone interviews with Mr. Eddie H. Martin, Centers for Medicare and Medicaid Services, August 2006.

[5] American Academy of Pediatrics. *Medicaid Payment of Commonly Used Pediatric Services, 2004/05,* and *Medicaid Reimbursement Survey, 2004/05 – Hawaii* (online at http://www.aap.org/research/medreim0405.htm). October 10, 2006.

provided by both Medicaid and QUEST for these comprehensive visits.[6] Nevertheless, given the American Academy of Pediatrics's method of calculation, it is uncertain how reliable its information is as a reflection of a state's actual reimbursement rate.

With regard to Diagnosis-Related Group (DRG) codes, the Bureau was able to obtain some information on the ten most frequently utilized DRG codes through a survey conducted by the Agency for Health Care Policy and Research. Unfortunately, the last survey conducted by the Agency for Health Care Policy and Research on this issue was in 1992.[7]

The Bureau considered the feasibility of obtaining such information from individual health care providers. The staff of the Department of Human Services, Med-QUEST Division, Medical Standards Branch opined that such a exercise would probably be too labor-intensive and provide too many variables, since individual health care providers probably do not have the time or the ability to break down their cost of doing business by each treatment they provide.[8]

With respect to determining cost information on the ten most frequently utilized services under QUEST, because, as stated earlier in this report, QUEST operates as a managed care health plan, determining actual costs per treatment code is unfeasible since QUEST health plans are paid on a monthly capitated basis, which requires the health plan to assume responsibility for any financial risk that may be caused by over utilization. However, a review of the Department of Human Services' comments on Senate Concurrent Resolution No. 77, S.D. 2, and discussions with the Department of Human Services, Med-QUEST Division staff, indicate that, generally speaking, contracted capitated payments negotiated with QUEST health plan providers are based on the Medicaid Fee-For-Service reimbursement rates for the various treatment codes.[9]

Other Jurisdictions' Efforts to Ensure that Medicaid Providers are Being Adequately Reimbursed for their Actual Costs

A review of internet resources maintained by the Centers for Medicare and Medicaid Services, the Kaiser Family Foundation, and others, as well as research requests to the National Conference of State Legislatures and other organizations revealed that, by and large, between 2001 – 2004, efforts to reform state Medicaid programs focused on cost containment rather than determining whether Medicaid reimbursement rates were adequately compensating health care providers. In other words, during that time period, states were more focused on cutting their Medicaid costs, which include reimbursing health care providers for their services, rather than

[6] E-mail correspondence with Acting Administrator, Department of Human Services, Med-QUEST Division, Medical Standards Branch. October 10, 2006.

[7] Agency for Health Care Policy and Research, *Most Frequent Diagnoses and Procedures for DRGs, by Insurance Status*. Abstract of Research Note 4, Healthcare Cost and Utilization Project (HCUP-3). 1992 (online at http://www.ahrq.gov/data/hcup/rn4.htm).

[8] Telephone interview with Acting Administrator, Department of Human Services, Med-QUEST Division, Medical Standards Branch, State of Hawaii. August 2006.

[9] Comments submitted by of Lillian B. Koller, Director of Human Services, on S.C.R. No. 77, S.D. 2, on July 19, 2006, and telephone interviews with Acting Administrator, Department of Human Services, Med-QUEST Division, Medical Standards Branch, State of Hawaii. August 2006.

contemplating ways to better reimburse the health care providers for their services. In addition, based on the problems associated with obtaining cost information from health care providers as discussed in this chapter, and due to the fact that each state's Medicaid program is unique, the Bureau was unable to determine how any other jurisdictions ensured that state-funded payments to Medicaid providers adequately reimbursed them for their actual costs incurred.

However, according to an issue brief written for Thomson West's Health Policy Tracking Service in October 2006, out of twenty-seven states that enacted Medicaid reimbursement rate legislation in 2004, eighteen states increased provider rates while eleven reduced them. By 2005, more states were increasing reimbursement rates. With the recovery of the national economy and revenue beginning to fill state treasuries, legislatures in nineteen states increased provider reimbursement rates. The nineteen states that increased rates are Arizona, Arkansas, Florida, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, New Hampshire, North Carolina, Oklahoma, Tennessee, Utah, Virginia, and Washington.[10]

The following table lists the states that enacted legislation regarding reimbursement rates in the 2004 and 2005 legislative sessions.

Table 1[11]

2004 and 2005 Legislative Activity Regarding Reimbursement Rates

Source: Health Policy Tracking Service, a service of Thomson West, October 2006		
Year	Decreased or Froze Certain Reimbursement Rates	Increased Certain Reimbursement Rates
2004	AZ, CA, CO, CT, FL, GA, IL, ME, MD, MT, VA	AZ, CA, CO, FL, GA, IL, IA, KY, MD, MA, MI, MS, NJ, SC, UT, VA, WA, WY
2005	CT, MI, NH, NC, OH, VT, WI	AZ, AR, FL, IL, IA, KY, LA, ME, MD, MA, MS, MO, NH, NC, OK, TN, UT, VA, WA

According to the Health Policy Tracking Service's issue brief, the National Conference of State Legislatures reported that states have recovered from the budget crises that tied legislators' hands during the previous five years. The issue brief reported that numerous state legislatures are acting on measures to increase Medicaid provider reimbursement. Thus far in 2006, fifteen states – California, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Mexico, Oklahoma, Utah, Vermont, Washington, Wisconsin, and Wyoming – have passed legislation to increase the rates for providers and services in the areas of long-term care providers, hospitals, physicians, personal care services, dental services, mental health services, and wheelchair van services.[12]

[10] Johnson, Patrick, *Medicaid Reimbursement*, Health Policy Tracking Service Issue Brief, Thomson West, October 2, 2006, p. 1.

[11] Ibid, p. 2.

[12] Ibid, p. 3.

The following table lists the states that have increased rates for particular providers.

Table 2[13]

2006 Legislative Activity: Increased Reimbursement Rates

Source: Health Policy Tracking Service, a service of Thomson West, October 2006						
LTC	**Physicians**	**Hospitals**	**Personal Care**	**Dental**	**Others**	**Studies**
OK	MD	CO	ME	MS	CA	CA
VA	MI	LA	MD	NM	ME	ME
WA	NM	MA	MI	VT	MA	MD
WI	OK	OK	NH		MS	MN
WY	VA	VT			UT	
	WY				VA	
					WA	

Upon a review of the legislation descriptions provided in the Thomson West issue brief, the vast majority of legislation passed in 2005 and 2006 that positively affected Medicaid reimbursement rates simply increased appropriations or reimbursement formulas for providers. For a more comprehensive digest of each state's legislation that increased Medicaid provider rates, see Appendix J at the end of this report.

[13] Ibid, p. 4.

Chapter 6

HOW THE STATE OF HAWAII COMPARES WITH OTHER STATES WITH REGARD TO MEDICAID FUNDING AND REIMBURSEMENT RATES

Although the Bureau was unable to obtain comparative cost information on the ten most frequently used Medicaid and QUEST health procedures for the reasons stated in Chapter 6, the Bureau did obtain some information on what the various states pay for certain frequently used health procedures, a recent state-by-state comparison on Medicaid payments per enrollee, and recent Medicaid expenditure information as a percentage of total state spending.

As a part of the Bureau's discussions with the Department of Human Services Med-QUEST Division, the Division provided the Bureau with a list of Current Procedural Terminology (CPT) codes that would be more typically used by health care providers in evaluating and treating patients. Although these codes may or may not qualify as some of the "ten most frequently used treatment codes" as requested under the concurrent resolution, the Med-QUEST Division opined, and the Bureau agreed, that the CPT codes provided by the Division are a more indicative sample of the spirit of the concurrent resolution's intent.

The Med-QUEST Division provided the following codes in the following categories:

Psychotherapy

90806 – Individual Psychotherapy (45-50 minutes face-to-face)

Office and Other Outpatient Services

99203 – New patient, low complexity

99204 – New patient, moderate complexity

99213 – Established patient, low complexity

99214 – Established patient, moderate complexity

Hospital Care

99223 – Initial hospitalization, per day, high complexity

99231 – Subsequent hospitalization, per day, low complexity

99232 – Subsequent hospitalization, per day, moderate complexity

99233 – Subsequent hospitalization, per day, high complexity

Emergency Care

99283 – ED (emergency department) visit, moderate complexity

99284 – ED visit, detailed

For these particular treatment codes, the Bureau extracted the following information from a study conducted by the American Academy of Pediatrics entitled, *Medicaid Payment for Commonly Used Pediatric Services, 2004/05*:

Treatment Code	Hawaii's Rate	Highest Rate	Lowest Rate
90806	$75.00	$98.58 (Oklahoma)	$37.00 (New Jersey)
99203	$95.00* ($49.42)	$99.00 (South Carolina)	$20.00 (Pennsylvania)
99204	$95.00* ($99.17)	$143.00 (South Carolina)	$20.00 (Pennsylvania)
99213	$95.00* ($36.84)	$95.00 (Hawaii)	$20.00 (Pennsylvania)
99214	$95.00* ($56.46)	$95.00 (Hawaii)	$20.00 (Pennsylvania)
99223	$116.67	$174.00 (South Carolina)	$28.00 (Missouri)
99231	$27.32	$40.00 (South Carolina)	$10.00 (New York)
99232	$42.31	$63.00 (South Carolina)	$10.00 (New York)
99233	$56.39	$102.64 (Utah)	$10.00 (New York)
99283	$48.05	$71.00 (South Carolina)	$17.00 (New York)
99284	$73.66	$110.00 (South Carolina)	$17.00 (New York)

** The $95.00 figure reflects what pediatricians would receive as Medicaid reimbursement under the federally-mandated comprehensive early and periodic screening, diagnosis and treatment (EPSDT) program. The figures in parentheses reflect the non EPSDT reimbursement rate.*

As evidenced by the various reimbursement rates paid by the states for the individual treatment codes, Hawaii generally falls in the middle with regard to the amount reimbursed under its Medicaid program.

The complete American Academy of Pediatrics' report, *Medicaid Payment for Commonly Used Pediatric Services, 2004/05*, as well as the Academy's *Medicaid Reimbursement Survey, 2004/05*, is attached to this report as appendices D and E.

In the 2004 State Expenditure Report of the National Association of State Budget Officers (NASBO), the professional organization for all state budget officers of the fifty states and U.S. territories, it was estimated that Hawaii's Medicaid expenditures as a percentage of its total expenditures was 10.7% in Fiscal Year 2003, 10.8% in Fiscal Year 2004, and 10.0% in Fiscal Year 2005, making Hawaii second only to Wyoming as the state spending the lowest

percentage of its total expenditures on Medicaid. However, it should be noted that the report is not adjusted to account for the fact that the State of Hawaii expends a significant amount of state funds on programs (e.g. public education) that are not normally funded on the state level in other states. Consequently, Hawaii's ranking as the second lowest Medicaid spending state may be slightly misrepresented. Tennessee was the highest at 34.2% of its total expenditures being spent on its Medicaid program in Fiscal Year 2003, 35.2% in Fiscal Year 2004, and 35.2% in Fiscal Year 2005. On the average, states allocated 22% in Fiscal Year 2003, 22.3% in Fiscal Year 2004, and 22.5% in Fiscal Year 2005 of its total expenditures to Medicaid.[1] The complete listing of all states' expenditures is attached to this report as appendix F.

The Bureau also found that the Henry J. Kaiser Family Foundation operates a website, statehealthfacts.org, which serves as a useful tool in obtaining general and comparative information on state health care policies and expenditures.

The Henry J. Kaiser Family Foundation reports that, in state fiscal year 2004, Hawaii ranked fortieth among states with regard to state general fund expenditures for Medicaid ($322 million). During the same fiscal year, California expended a little over $11 billion in state general funds and led the nation in state general fund expenditures on Medicaid. Wyoming expended the least among states with $36 million in state general fund expenditures. The complete list is attached to this report as appendix G.

The Henry J. Kaiser Family Foundation also reported that, when using total Medicaid payments made per enrollee as a measure (both federal and state payments under Medicaid, excluding disproportionate share hospital payments (DSH)), in 2003, Hawaii ranked thirty-eighth among states and the District of Columbia, spending and average of $1,413 on children, $2,163 on adults, $10,102 on the elderly, and $9,835 for the blind and disabled (average expenditure per enrollee – $3,462). In comparison, New York was ranked first, spending an average of $1,885 on children, $3,418 on adults, $21,903 on the elderly, and $24,888 on the blind and disabled (average expenditure per enrollee – $7,583). Arizona was fiftieth, spending an average of $1,443 on children, $1,293 on adults, $7,531 on the elderly, and $10,924 on the blind and disabled (average expenditure per enrollee – $2,525). Moreover, the national average (including the District of Columbia) was $1,467 on children, $1,872 on adults, $10,799 on the elderly, and $12,265 on the blind and disabled (average expenditure per enrollee – $4,072).[2] (For the entire state-by-state breakdown, see appendix E at the end of this report.)

[1] Table 29, Medicaid Expenditures as a Percent of Total Expenditures. 2004 State Expenditure Report. National Association of State Budget Officers, p. 50
(online at http://www.nasbo.org/Publications/PDFs/2004ExpendReport.pdf).

[2] Henry J. Kaiser Family Foundation, statehealthfacts.org. *Medicaid Payments per Enrollee, FY 2003* (online at http://www.statehealthfacts.org). October 10, 2006.

Chapter 7

RECOMMENDATIONS ON UPDATING REIMBURSEMENTS TO KEEP PACE WITH INFLATION

The concurrent resolution also requested that the Bureau include a recommendation or recommendations on a method of updating payments and reimbursements to Medicaid and QUEST health care providers every two years to keep pace with inflation. The Bureau believes that any such recommendation would require legislation to be enacted to effectuate a mandatory adjustment to keep pace with inflation.

Process to Review and Update Medicaid Reimbursement Rates

The Bureau believes that the Legislature has a number of options at its disposal to biennially update reimbursements and payments to health care providers. One such option would be to establish a statutory requirement that the Department of Human Services biennially review Medicaid and QUEST reimbursement rates and submit reimbursement rate increase cost information and appropriation requirements to the Legislature for its review and appropriation of funds. Another option could include the establishment of a Medicaid Reimbursement Rate Review Commission whose specific charge would be to gather relevant information and submit biennial rate adjustment recommendations to the Legislature for its review and possible implementation.

The Legislature could also establish a statutory requirement that reimbursement rates track a percentage (possibly ninety-five percent, or even one hundred percent) of the Medicare Resource Based Relative Value Scale (MRBRVS) as it applies to Hawaii, as it does for health care services provided and compensated under the State's Workers' Compensation Law (see section 386-21(c), Hawaii Revised Statutes),[1] except that, in accordance with federal requirements, Medicaid and QUEST reimbursement rates cannot exceed Medicare reimbursement rates. Any amount paid in excess of a Medicare rate would be borne solely by the State.[2]

Updating the Prospective Payment System Methodology

According to testimony submitted by the Director of Human Services on S.C.R. No. 77, S.D. 2, to the House Committees on Human Services and Health, the Prospective Payment System (PPS) methodology is defined in federal law, as well as in the Hawaii Administrative Rules, and is based on the actual costs of the provider to provide the service. In order to change

[1] Section 386-21(c), Hawaii Revised Statutes, establishes that the Workers' Compensation Medical Fee Schedule shall not exceed 110% of the MRBRVS for Hawaii.

[2] Testimony of Lillian B. Koller, Director of Human Services, on S.C.R. No. 77, S.D. 2, on April 19, 2006, before the House Committees on Human Services and Health.

these payment amounts for inpatient hospital services or skilled nursing facilities, the reimbursement rates for these facilities under the PPS system would need to rebased. The other option is to move to a different reimbursement methodology.

As stated previously, Hawaii Pacific Health commented that its member hospitals did not believe that the reimbursement methodology used by the Department of Human Services was flawed, it simply was not adequately adjusted to take into account that health care inflation is moving at a much more rapid pace than the consumer price index and, although all providers that are reimbursed under the PPS methodology get either a Consumer Price Index or Medicare Economic Index increase each year, these increases are far less than the actual increases in the cost of care.[3]

Hawaii Pacific Health recommended that the Department of Human Services rebase all Medicaid and QUEST reimbursements based upon actual current costs for Hawaii hospitals. This would require a considerable one-time increase as a market adjustment to bring hospitals up to par. Once the market adjustment increases are in place, the Department of Human Services would have to then make annual adjustments based upon the Hospital Producer Price Index. The Hospital Producer Price Index is produced and maintained by the United States Bureau of Labor Statistics and is part of a family of indexes that measure the average change over time in the prices received by domestic producers of goods and services (in this case, hospital prices). The Hospital Producer Price Index measures price changes from the perspective of the seller (a hospital). This contrasts with other measures, such as the Consumer Price Index, which measures price change from the purchaser's perspective.[4]

Hawaii Pacific Health also stated that the Department of Human Services already has a process to conduct this market adjustment, as it has done it in the past, and that the Hawaii Health Information Corporation has the hospital cost data to assist the Department of Human Services in rebasing its reimbursement rates to reflect how the rate of health care inflation is outpacing the Consumer Price Index.[5] The Bureau recommends that the Department of Human Services conduct another market adjustment and submit its cost recommendations to the Legislature for its consideration.

In order to bring hospitals up to the "break even point," the Hawaii Health Systems Corporation (HHSC) estimated that, for its facilities, it would cost the State approximately $21.8 million ($15.3 million (29% rate increase) for Medicaid, and $6.5 million (41% rate increase) for QUEST) just to cover costs for their Medicaid and QUEST populations for 2006. The Hawaii Health Information Corporation reported that, in order for the fourteen private hospitals that it keeps records on to break even for the Medicaid services provided, an appropriation of

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[3] Letter dated June 8, 2006, from Virginia Pressler, M.D., Senior Vice President for Strategic Business Development, regarding Hawaii Pacific Health's response to the Bureau's request for information regarding S.C.R. No. 77, S.D. 2, H.D. 1.

[4] Healthcare Financial Management Association, HFMA News article, *Hospital PPI Rose 4.9% in Past 12 Months*. Thursday, September 21, 2006 (online at http://www.hfma.org/hfmanews/PermaLink,guid,dfa631c7-c783-4da8-bc37-a7c91b00737d.aspx).

[5] Letter dated June 8, 2006, from Virginia Pressler, M.D., Senior Vice President for Strategic Business Development, regarding Hawaii Pacific Health's response to the Bureau's request for information regarding S.C.R. No. 77, S.D. 2, H.D. 1.

approximately $56.5 million (23.5% rate increase) would be required to offset losses in fiscal year 2005-2006.[6] The total amount for both HHSC and private hospitals would equal approximately $78.3 million. This $78.3 million only represents the amount needed by the hospitals to recover the costs incurred during the 2005-2006 fiscal year and does not represent previous fiscal year losses or the additional funding that would be necessary in subsequent fiscal years to allow the hospitals to keep pace with health care cost inflation.

To determine what the periodic inflationary adjustment rate should be, it would be prudent for the Legislature to develop public policy regarding how Medicaid reimbursement rate adjustments could better reflect the actual impact of health care inflation. To this end, either requiring the Department of Human Services or another entity (such as a Medicaid Reimbursement Rate Review Commission) to also track and biennially report on the difference between the Consumer Price Index or Medicare Economic Index increases and the actual increases in health care inflation would assist the Legislature in determining public policy on this matter.

Adjusting Reimbursement Rates for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

For FQHCs and RHCs, the Director of Human Services testified that payment of the PPS rate is mandated by federal law. Therefore, there can be no increase of reimbursement to FQHCs and RHCs because the federal law does not allow for rebasing of the rates.[7]

Adjustments to the State's Medicaid Fee Schedule

In order to ensure that health care providers are at least reimbursed to cover the costs of providing services, the Bureau recommends that the Medicaid Fee Schedule be adjusted to cover such costs. Unfortunately, because cost data on individual health care providers was not available, the Bureau must base its rate increase recommendation on what is provided under the Medicare Resource Based Relative Value Scale (MRBRVS) as it applies to Hawaii, the justification being that the federal government bases its Medicare reimbursement rates on the data it acquires from health care providers and adjusts it for Hawaii's economic circumstances. The Bureau recommends that the Legislature revise the Medicaid Fee Schedule up to, but not exceeding, the MRBRVS for Hawaii rates, in order to ensure that the State does not have to solely cover the costs of any amounts that exceed the MRBRVS for a particular treatment code.

The Director of Human Services testified that if the Legislature wanted to increase the payment amounts to providers under the Hawaii Medicaid Fee Schedule, all it would have to do is increase the amounts appropriated under program ID HMS 230 in the State Budget.[8]

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[6] Medicaid Charge, Cost, and Payment Data for Private Acute Hospitals. Hawaii DataBank. Hawaii Health Information Corporation. (See Appendix I at the end of this report for complete figures.)

[7] Testimony of Lillian B. Koller, Director of Human Services, on S.C.R. No. 77, S.D. 2, on April 19, 2006, before the House Committees on Human Services and Health.

[8] Ibid.

The Bureau believes that such an increase would benefit all fee-for-service as well as QUEST providers.

Adjustments for QUEST Services Reimbursement

As stated by the Hawaii Health Systems Corporation, the funding provided by the Department of Human Services to the individual QUEST plans does not enable the QUEST plans to pay full costs for services rendered, requiring providers to provide services at substantial losses, or to decline to contract with the QUEST plans, leaving QUEST beneficiaries without services.[9]

However, since QUEST service contracts are based on rates provided in the Medicaid Fee Schedule, if the fee schedule rates are increased, QUEST providers will similarly benefit from the increases.

Closing

Any change in public policy to include regular adjustments to reimbursement rates to offset inflationary costs must be met with careful fiscal scrutiny. Deferring the discretion to implement or not implement a Medicaid Fee Schedule rate increase to an annual, biennial, or any other formula or mechanism that does not provide the Legislature with the ability to approve or disapprove of an increase in reimbursement rates could potentially pose a significant detrimental impact on the long term fiscal well being of the State's finances.

However, if health care providers and facilities are to continue to provide health care services to the neediest persons in the State, they must be adequately compensated for their services and not be required to provide such services at a financial loss. To the extent the state and federal government are financially able, each government should strive to mitigate the financial losses being incurred by health care providers and facilities that provide services under Medicaid.

[9] Letter dated June 15, 2006, from Thomas M. Driskell, Jr. President and CEO, Hawaii Health Systems Corporation to the Legislative Reference Bureau regarding the HHSC's response to the Bureau's request for information regarding S.C.R. No. 77, S.D. 2, H.D. 1.

THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

S.C.R. NO. 77 S.D. 2 H.D. 1

SENATE CONCURRENT RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO CONDUCT TWO STUDIES OF RECOMMENDED PROCEDURES THAT WILL ENSURE THAT STATE-FUNDED HEALTH CARE PAYMENTS ADEQUATELY REIMBURSE PROVIDERS WHO PROVIDE SERVICES FOR, FIRST, MEDICAID OR QUEST RECIPIENTS AND, SECOND, FOR INJURED EMPLOYEES UNDER WORKERS COMPENSATION INSURANCE.

WHEREAS, the critical financial condition of hospitals, long term care facilities, and other health care providers has been well-documented recently in a series of articles by Helen Altonn that were published by the Honolulu Star-Bulletin and an article by Rob Perez that was published by the Honolulu Advertiser; and

WHEREAS, these articles made the following points:

(1) Patients demand to be diagnosed and treated with the latest technology, which is very expensive;

(2) The need for expensive institutionalized long term care is substantial and is expected to grow as the "baby boomers" age;

(3) Health care facilities have incurred high costs related to potential terrorist threats and other emergencies;

(4) Providers are receiving insufficient payments for health care from government payers, private insurance payers, and patients who do not have insurance; and

(5) Hawaii’s hospitals have incurred more than $500,000,000 in losses due to bad debt and charity care since 2000; and

WHEREAS, the State pays for a considerable amount of health care and also controls certain types of payments for health care made to providers; and

WHEREAS, it is in the public interest to ensure that health care payments made with state funds or controlled by the State are sufficient to cover the actual costs of care; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-Third Legislature of the State of Hawaii, Regular Session of 2006, the House of Representatives concurring, that the Legislative Reference Bureau is requested to conduct two separate studies of recommended procedures that will ensure that state-funded health care payments adequately reimburse providers who provide services for, first, Medicaid or QUEST recipients and, second, for injured employees under workers compensation insurance for the actual cost of health care services; and

BE IT FURTHER RESOLVED that the Legislature requests that the first study conducted by the Legislative Reference Bureau include:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to Medicaid providers adequately reimburse them for their actual costs;

(2) A comparison of rates for the ten most frequently used services in Medicaid and QUEST health care services, actual costs of those services, and the amount reimbursed to the provider;

(3) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(4) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used Medicaid and QUEST health procedures; and

BE IT FURTHER RESOLVED that interested parties are requested to submit relevant information and data applicable to determining reimbursement rates for providers of services for Medicaid or QUEST recipients to the Legislative Reference Bureau not later than May 31, 2006; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to report findings and recommendations as to the first study to the Legislature no later than twenty days prior to the convening of the Regular Session of 2007; and

BE IT FURTHER RESOLVED that the Legislature requests that the second study conducted by the Legislative Reference Bureau include:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to worker compensation providers adequately reimburse them for their actual costs;

(2) A comparison of rates for the ten most frequently used services in worker compensation services, actual costs of those services, and the amount reimbursed to the provider;

(3) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(4) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used worker compensation health procedures; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to report findings and recommendations as to the second study to the Legislature no later than twenty days prior to the convening of the Regular Session of 2008; and

BE IT FURTHER RESOLVED that certified copies of this concurrent resolution be transmitted to the Governor, the Director of Health, the Director of Human Services, the

Insurance Commissioner, the Department of Labor and Industrial Relations, the Director of the Legislative Reference Bureau, the Chief Executive Officer of the Healthcare Association of Hawaii, and the Chief Executive Officer of the Hawaii Medical Association.

Appendix B

Hawaii & United States

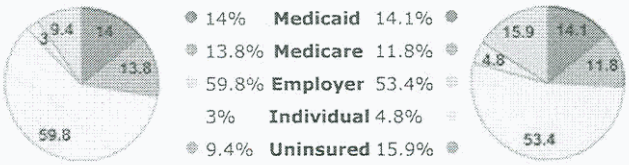
State Medicaid Fact Sheet
The Kaiser Commission on Medicaid and the Uninsured

Total Residents, 2004-2005

HI: 1,239,660 **US:** 292,947,440

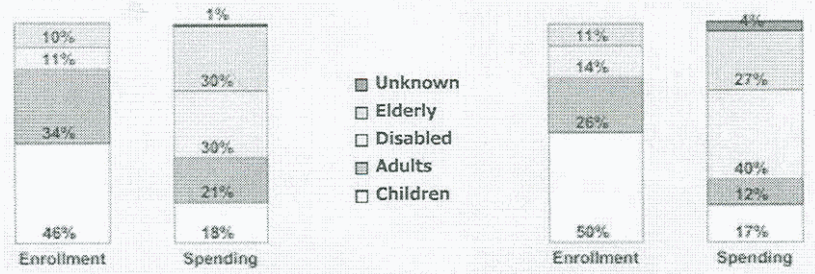
Distribution By Insurance Status, 2004-2005

Hawaii **United States**



14%	**Medicaid**	14.1%	
13.8%	**Medicare**	11.8%	
59.8%	**Employer**	53.4%	
3%	**Individual**	4.8%	
9.4%	**Uninsured**	15.9%	

Medicaid Enrollment and Spending by Group, FY2005



Hawaii		United States	
0.22M	**$0.8B**	**55.07M**	**$232.9B**

	Number		Percent		Notes
	HI	US	HI	US	
Demographic Profile, 2004-2005					
Total Residents	1,239,660	292,947,440	-	-	-
Income					
Poor: Below Federal Poverty Level (FPL)	195,930	50,658,400	16	17	% of total residents
Near-Poor: 100-199% of the FPL	208,980	55,241,860	17	19	% of total residents
Non-Poor: 200% of the FPL and above	834,740	187,047,180	67	64	% of total residents
Median Annual Income, 2003-2005	$57,572	$46,037	-	-	-
Age					
Children (0-18)	311,320	77,908,220	25	27	% of total residents
Poor Children	59,950	17,721,680	19	23	% of total children
Adults (19-64)	746,750	179,534,430	60	61	% of total residents
Poor Adults	108,490	28,177,220	15	16	% of total adults
Elderly (65+)	181,590	35,504,790	15	12	% of total residents
Poor Elderly	27,490	4,759,500	15	13	% of total elderly
Race/Ethnicity					
White	239,280	195,289,750	19	67	% of total residents
Black	20,460	35,539,910	2	12	% of total residents
Hispanic	81,670	43,077,110	7	15	% of total residents
Other	898,250	19,040,670	72	6	% of total residents
Non-Citizen	84,920	21,757,770	7	7	% of total residents
Population Living in Non-Metropolitan Areas	335,220	48,327,760	27	16	% of total residents
Health Insurance Coverage of the Nonelderly, 2004-2005					
Medicaid	114,940	34,802,750	11	14	% of Nonelderly
Children	67,360	20,354,580	59	58	% of Medicaid
Adults	47,570	14,448,170	41	42	% of Medicaid
Uninsured	113,350	46,118,230	11	18	% of Nonelderly
Children	17,310	9,035,420	15	20	% of uninsured
Adults	96,040	37,082,810	85	80	% of uninsured
Poor: Below Federal Poverty Level (FPL)	47,030	16,749,520	41	36	% of uninsured
Near-Poor: 100-199% of the FPL	21,640	13,345,370	19	29	% of uninsured
Employer Sponsored Insurance	738,390	156,430,100	70	61	% of Nonelderly
Individual Insurance	35,800	13,928,090	3	5	% of Nonelderly
Other Public	55,590	6,163,480	5	2	% of Nonelderly

	Number		Percent		Notes
	HI	US	HI	US	
Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2004-2005					
Uninsured	-	-	-0.4	0.3	% point change
Medicaid	-	-	0.0	-0.1	% point change
Employer-Sponsored	-	-	-1.2	-0.3	% point change
Individually Purchased	-	-	0.9	-0.1	% point change
Medicaid Enrollment					
Total Enrollment, FY2003	216,100	55,071,200	17	19	% of total residents
Children	98,300	27,263,000	45.5	49.6	% of Medicaid enrollees
Adults	72,400	14,257,300	33.5	25.6	% of Medicaid enrollees
Blind and Disabled	23,100	7,679,200	10.7	14.2	% of Medicaid enrollees
Elderly	22,400	5,871,700	10.4	10.5	% of Medicaid enrollees
% Enrolled in Managed Care, 2004	-	-	79.9	62.9	% in managed care
Medicaid Expenditures					
Total Medicaid Spending in Millions, FY2005	$1,044	$305,337	-	-	Including DSH
Disproportionate Share Hospital Payments (DSH)	$0	$17,089	0.0	5.6	% of total spending
Acute Care	$710	$182,604	67.9	59.8	% of total spending
Rx Drugs	$95	$30,658	13.4	16.8	% of acute care spending
Long Term Care (LTC)	$335	$105,644	32.1	34.6	% of total spending
Nursing Home	$203	$46,949	60.8	44.4	% of LTC spending
Home/Personal Care	$123	$41,277	36.7	39.1	% of LTC spending
Per Enrollee Medicaid Spending, FY2003					
Total	$3,462	$4,072	-	-	-
Children	$1,413	$1,467	18.4	17.2	% of total spending
Adults	$2,163	$1,872	20.8	11.5	% of total spending
Blind and Disabled	$9,835	$12,265	30.1	40.3	% of total spending
Elderly	$10,102	$10,799	30	27.2	% of total spending
Unknown	-	-	-	-	% of total spending
Other Medicaid Spending Measures					
Federal Contribution per State Dollar, FY2006	$1.43	$1.00	58.8	≥50	federal matching rate
General Fund Spending on Medicaid, SFY2004	-	-	8.4	16.9	% of general fund spending
Medicaid Eligibility Levels by Annual Income and FPL, 2005					
Working Parents	$18,510	$10,849	100	67	% of federal poverty level
Pregnant Women	$34,244	$21,400	185	133	% of federal poverty level
Infants	$37,020	$21,400	200	133	% of federal poverty level
Children 1-5	$37,020	$21,400	200	133	% of federal poverty level
Children 6-19	$37,020	$16,090	200	100	% of federal poverty level
Medicaid and Medicare Dual Eligibles					
Total Dual Eligible Enrollment, 2003	-	-	11	14	% Medicaid enrollees
Total Dual Eligible Spending in Millions, 2003	-	-	31	40	% of all Medicaid spending
Total Medicare Enrollment, 2005	179,649	42,394,926	14	14	% of total residents
Estimated Annual "Clawback" Payment, 2006	$20,033,724	$6,605,675,559	-	-	-
SCHIP					
Eligibility Income Level for Family of 3, 2005	-	-	-	-	% of federal poverty level
Current SCHIP Enrollment, December 2004	13,719	3,949,578	25.8	0.6	% growth, 2003-2004
Total SCHIP Spending, FY2004	$14,129,111	$6,633,813,360	-	-	-

This fact sheet was printed on November 20, 2006. Additional Medicaid Fact Sheets available at http://www.kff.org/MFS/.

Sources and Notes

All data are drawn directly from ***statehealthfacts.org***, Kaiser's continuously updated database for state-level health data. More detailed notes and sources are available by following the online links from each topic on the fact sheet.

Demographic Profile

Total Residents, Income, Age, Race/Ethnicity, Citizenship, Population Living in Non-Metropolitan Areas

Source: KCMU and Urban Institute analysis of the Current Population Surveys, March 2005 and 2006.
Notes: These demographic data may differ from Census Bureau figures due to grouping by health insurance unit (HIU) rather than household. A Metropolitan Statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 population. A Non-Metropolitan Statistical Area lacks at least one urbanized area of 50,000 or more inhabitants.

Median Annual Income

Source: U.S. Census Bureau, Current Population Survey, 2004, 2005, and 2006 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2003-2005

Health Insurance Coverage

Medicaid, Uninsured, Medicaid, Employer-Sponsored Insurance, Individual Insurance, Other Public, Percentage Point Change in the Rate of Coverage of the Nonelderly Population (0-64 years old)

Source: KCMU and Urban Institute analysis of the Current Population Survey, March 2005 and 2006.
Notes: State figures are based on pooled 2004 and 2005 data; U.S. figures are based on 2005 data.

Medicaid

Total Enrollment

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2003.

% Enrolled in Managed Care

Source: Medicaid Managed Care Penetration Rates by State as of December 31, 2004, CMS, DHHS.

Total Medicaid Spending in Millions

Source: Urban Institute estimates for KCMU based on CMS Form 64 for FY2005.
Notes: All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments; do not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about $316.5 billion in FY2005.

Per Enrollee Medicaid Spending and Distribution by Group

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2003.

Multiplier and Federal Matching Rate

Source: KCMU calculations based on the FMAPs as published in the Federal Register.
Notes: The multiplier is based on the FMAP and represents the amount of federal funds a state receives for every dollar it spends on Medicaid. The rate varies year to year and is based on each state's relative per capita income. It ranges from a low of 50% to 76%, averaging roughly 60% nationally. For FY2006, the rate for Alabama was 1:2.30 (69.51%).

State Medicaid Spending as % of State General Fund

Source: 2004 State Expenditure Report, National Association of State Budget Officers
Notes: A state's general fund is the predominant fund for financing a state's operations.

Medicaid Eligibility Levels

Source: In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families, The Center on Budget and Policy Priorities for KCMU, October 2005; and Medicaid Eligibility, DHHS, CMS.
Notes: All dollar figures represent the annual income for a family of three. For Working Parents, the U.S. figures represent the median annual income in dollars and as a percent of the FPL. For other groups, the U.S. figures represent the federal minimum annual income in dollars and as a percent of the FPL.

Medicaid and Medicare Dual Eligibles

Sources: *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Urban Institute for KCMU, July 2005. CMS Statistics: Medicare State Enrollment, CMS. *An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit*, KCMU, March 2006.

SCHIP

Eligibility Income Level for a Family of Three

Source: In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families, The Center on Budget and Policy Priorities for KCMU, October 2005; and *Medicaid Eligibility*, DHHS, CMS.
Notes: The levels are for separate SCHIP programs only. The following states do not have a separate SCHIP program: AK, AR, DC, HI, LA, MN, MO, NE, NM, OH, OK, RI, SC, TN, WI.

Current SCHIP Enrollment

Source: Collected by Health Management Associates for KCMU. Data as of December 2004.
Notes: Figures represent the current monthly enrollment. AR and TN phased out their Medicaid expansion programs in September 2002.

Total SCHIP Spending

Source: FY2004 SCHIP Expenditures (state and federal), CMS, Special Data Request.

Abbreviations

CMS: Centers for Medicare and Medicaid Services
DHHS: U.S. Department of Health and Human Services
FMAP: Federal Medical Assistance Percentage
FPL: Federal Poverty Level (The FPL for 48 states was $16,090 for a family of 3 in 2005; Alaska $20,110 and Hawaii $18,510.)
KCMU: The Kaiser Commission on Medicaid and the Uninsured
MSIS: Medicaid Statistical Information System
SCHIP: State Children's Health Insurance Program

Source: Fact sheet compiled and printed by the Henry J. Kaiser Family Foundation and available online at www.kff.org/mfs/medicaid.

Appendix C

***FEBRUARY 8, 2006:
UPDATED WITH NEW MEDICARE CONVERSION FACTOR
(EFFECTIVE RETROACTIVE TO JANUARY 1, 2006)***

2006 RBRVS

WHAT IS IT
AND
HOW DOES IT AFFECT PEDIATRICS?

The Centers for Medicare and Medicaid Services (CMS) implemented the Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule on January 1, 1992. The Medicare RBRVS physician fee schedule replaced the Medicare physician payment system of "customary, prevailing, and reasonable" (CPR) charges under which physicians were reimbursed according to the historical record of the charge for the provision of each service. The current Medicare RBRVS physician fee schedule is derived from the "relative value" of services provided and based on the resources they consume. The relative value of each service is quantifiable and is based on the concept that there are three components of each service: the amount of physician work that goes into the service, the practice expense associated with the service, and the professional liability expense for the provision of the service. The relative value of each service is multiplied by Geographic Practice Cost Indices (GPCIs) for each Medicare locality and then translated into a dollar amount by an annually adjusted conversion factor. The dollar amount derived from this calculation, with adjustments under certain circumstances, is the reimbursement a physician receives for the provision of a particular service. It is critical to note that over 74% of public and private payors, including state Medicaid programs, have adopted components of the Medicare RBRVS to reimburse physicians, while many other payors are exploring its implementation.

ELEMENTS OF THE RBRVS

Physician Work (Work)

The physician work component of the Medicare RBRVS physician fee schedule is maintained and updated by CMS with input from the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is composed of 29 members, consisting of 23 representatives from major medical specialty societies, as well as representatives from the American Medical Association, the American Osteopathic Association, the Health Care Professionals Advisory Committee (HCPAC), and the CPT Editorial Panel. The American Academy of Pediatrics (AAP) holds one of the 23 seats designated for medical specialty society representation. CMS reviews and, if necessary, modifies the RUC-recommended relative value units of physician work and establishes payment policy, which is published in the *Federal Register* (http://www.cms.hhs.gov/physicians/pfs/).

The physician work component represents approximately 55% of the total relative value units (RVUs) for each service. Physician work is divided into pre-service, intra-service, and post-service periods that equal the total value of work for each service. The total value of physician work contained in the Medicare RBRVS physician fee schedule for each service consists of the following components:

- Physician time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment

- Psychological stress associated with physician's concern about the iatrogenic risk to the patient

Practice Expense (PE)

The four-year transition to resource-based practice expense RVUs is was completed in 2002. CMS uses many sources and methodologies to determine practice expense RVUs. Beginning in 1998, some CPT codes were assigned two (2) practice expense RVUs: a lesser one for procedures performed in a facility (ie, a hospital, skilled nursing facility, or ambulatory surgical center) and a greater one for procedures/services performed at a non-facility site (ie, doctor's office or patient's home). This policy continues for 2006.

Professional Liability Insurance (PLI) Or Malpractice (MP)

Professional liability insurance (malpractice) expense relative values amount to approximately 3% of the physician fee schedule payment. CMS replaced the cost based malpractice expense relative values with resource-based malpractice RVUs in 2000. The end result of its computations was to retain the same total malpractice RVUs as they were under the charge based system.

Medicare Global Period

On the Medicare physician fee schedule, each CPT code is assigned a designation in the Medicare "global period" column. Medicare global periods define the postoperative period for procedures and affect how follow-up services are reported for a given CPT code. The Medicare global period designations are defined as follows:

Global Period Designation	Definition	Explanation (Example)
000	Zero-day global period	Payment for a 0-day global code includes the procedure/service plus any associated care provided on the same day of service (eg, 54150)
010	Ten-day global period	Payment for a 10-day global code includes the procedure/service plus any associated follow-up care for 10 days (eg, 24640)
090	Ninety-day global period	Payment for a 90-day global code includes the procedure/service plus any associated follow-up care for 90 days (eg, 25600)
XXX	The global concept does not apply	Payment for an XXX code includes only the procedure/service (eg, 90471)
ZZZ	Code related to another service that is always included in the global period of another service	Payment for a ZZZ code includes only the procedure/service; ZZZ codes are usually add-on codes to XXX codes (eg, 90472)
YYY	The global period is to be set by the carrier	This designation is usually reserved for unlisted surgery codes (eg, 24999)

Components of a Medicare global period including the following:

- Pre-operative visits: Pre-operative visits *after the decision is made to operate* beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures

- Intra-operative services: Intra-operative services that are normally a usual and necessary part of a surgical procedure

- Complications following surgery: All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room

Payors that adopt Medicare's RBRVS RVUs should also be following Medicare policy with respect to global periods.

Geographic Practice Cost Indices (GPCIs)

The Geographic Practice Cost Indices (GPCIs) reflect the relative costs associated with physician work, practice, and malpractice expenses in a Medicare locality compared to the national average relative costs.

- Cost of Living GPCI: Applied to physician work relative values
- Practice Cost GPCI: Applied to practice expense relative values
- Malpractice GPCI: Applied to professional liability insurance relative values

2006
Geographic Practice Cost Indices (GPCIs) By Medicare Locality

Medicare Locality Name	Work	Practice Expense	Malpractice
Alabama	1.000	0.846	0.752
Alaska	1.017	1.103	1.029
Arizona	1.000	0.992	1.069
Arkansas	1.000	0.831	0.438
Marin/Napa/Solano, CA	1.035	1.340	0.651
San Francisco, CA	1.060	1.543	0.651
San Mateo, CA	1.073	1.536	0.639
Oakland/Berkeley, CA	1.054	1.371	0.651
Santa Clara, CA	1.083	1.540	0.604
Ventura, CA	1.028	1.179	0.744
Los Angeles, CA	1.041	1.156	0.954
Anaheim/Santa Ana, CA	1.034	1.236	0.954
Rest of CA	1.007	1.053	0.733
Colorado	1.000	1.014	0.803
Connecticut	1.038	1.170	0.900
DC + MD/VA Suburbs	1.048	1.250	0.926
Delaware	1.012	1.018	0.892
Fort Lauderdale, FL	1.000	0.988	1.703
Miami, FL	1.008	1.046	2.269
Rest of FL	1.000	0.934	1.272
Atlanta, GA	1.010	1.089	0.966
Rest of GA	1.000	0.872	0.966
Hawaii/Guam	1.005	1.111	0.800
Idaho	1.000	0.868	0.459
East St. Louis, IL	1.000	0.939	1.750
Suburban, Chicago, IL	1.018	1.115	1.652
Chicago, IL	1.025	1.126	1.867
Rest of IL	1.000	0.872	1.193
Indiana	1.000	0.906	0.436
Iowa	1.000	0.868	0.589
Kansas	1.000	0.878	0.721
Kentucky	1.000	0.854	0.873
New Orleans, LA	1.000	0.946	1.197
Rest of LA	1.000	0.847	1.058
Southern Maine	1.000	1.013	0.637
Rest of Maine	1.000	0.886	0.637
Baltimore/Surrounding Counties, MD	1.012	1.078	0.947
Rest of MD	1.000	0.980	0.760
Metropolitan Boston	1.030	1.329	0.823
Rest of Massachusetts	1.007	1.103	0.823
Detroit, MI	1.037	1.054	2.744
Rest of MI	1.000	0.921	1.518
Minnesota	1.000	1.005	0.410

Medicare Locality Name	Work	Practice Expense	Malpractice
Mississippi	1.000	0.839	0.722
Metropolitan Kansas City, MO	1.000	0.975	0.946
Metropolitan St. Louis, MO	1.000	0.955	0.941
Rest of MO	1.000	0.802	0.892
Montana	1.000	0.844	0.904
Nebraska	1.000	0.875	0.454
Nevada	1.003	1.043	1.068
New Hampshire	1.000	1.027	0.942
Northern New Jersey	1.058	1.220	0.973
Rest of NJ	1.043	1.119	0.973
New Mexico	1.000	0.887	0.895
Rest of NY	1.000	0.917	0.677
Manhattan, NY	1.065	1.298	1.504
NYC Suburbs/Long Island, NY	1.052	1.280	1.785
Poughkeepsie/ Northern NYC Suburbs, NY	1.014	1.074	1.167
Queens, NY	1.032	1.228	1.710
North Carolina	1.000	0.920	0.640
North Dakota	1.000	0.860	0.602
Ohio	1.000	0.933	0.976
Oklahoma	1.000	0.854	0.382
Portland, OR	1.002	1.057	0.441
Rest of OR	1.000	0.925	0.441
Metropolitan Philadelphia, PA	1.016	1.104	1.386
Rest of PA	1.000	0.902	0.806
Puerto Rico	1.000	0.698	0.261
Rhode Island	1.045	0.989	0.909
South Carolina	1.000	0.893	0.394
South Dakota	1.000	0.876	0.365
Tennessee	1.000	0.879	0.631
Brazoria, TX	1.020	0.961	1.298
Dallas, TX	1.009	1.062	1.061
Galveston, TX	1.000	0.952	1.298
Houston, TX	1.016	1.014	1.297
Beaumont, TX	1.000	0.860	1.298
Fort Worth, TX	1.000	0.989	1.061
Austin, TX	1.000	1.046	0.986
Rest of TX	1.000	0.865	1.138
Utah	1.000	0.937	0.662
Vermont	1.000	0.968	0.514
Virgin Islands	1.000	1.014	1.003
Virginia	1.000	0.940	0.579
Seattle (King County), WA	1.014	1.131	0.819
Rest of WA	1.000	0.978	0.819
West Virginia	1.000	0.819	1.547
Wisconsin	1.000	0.918	0.790
Wyoming	1.000	0.853	0.935

Medicare Conversion Factor (CF)

The Medicare Conversion Factor (CF) is a national value that converts the total RVUs into payment amounts for the purpose of reimbursing physicians for services provided. Since January 1, 1998, there has been one Medicare conversion factor, as specified by the Balanced Budget Act of 1997. Anesthesia has a separate conversion factor, but is paid using a different formula. The Medicare CF is updated annually. Medicare Conversion Factors in past years have been $36.6137 (2000), $38.2581 (2001), $36.1992 (2002), $36.7856 (2003), $37.3374 (2004), and $37.8975 (2005).

2006 Medicare Conversion Factor = ~~$36.1770~~ {NOTE: On 2/8/06, the Deficit Reduction Act reversed the 2006 4.4% reduction in the Medicare conversion factor, reverting to the 2005 conversion factor of $37.8975 effective retroactive to January 1, 2006.}

Additional components of the Medicare RBRVS physician fee schedule factored into the reimbursement structure include the following:

- MEI: The allocation of RVUs to pools for physician work, practice expense, and malpractice, have been revised to correspond with the Medicare Economic Index. Work is now allocated 55% of the total RVU, practice expense is 42%, and malpractice is 3%.
- HPSA: Incentive payments for physician services provided to patients in Health Professional Shortage Areas (HPSAs), which are medically underserved communities, urban and rural locations that have a documented shortage of medical professionals.
- Non-Par Physician: Reduced payments for physicians, called "nonparticipating" physicians, who do not accept "assignment," the Medicare approved amount that consists of the 80% Medicare payment and the 20% patient copayment, as payment in full for services rendered to Medicare recipients.
- Budget Neutrality: Statutory guidelines indicating that revisions to the RVUs for physician services may not alter physician expenditures within the Medicare RBRVS physician fee schedule by more than $20 million from the principal expenditures that would have resulted if the RVU adjustments were never initiated.

HOW TO USE THE RBRVS

CMS publishes RVUs for CPT codes in the *Federal Register*. To calculate the Medicare physician reimbursement for a service, the relative value units for each of the three components of the Medicare RBRVS physician fee schedule are multiplied by their corresponding GPCIs to account for geographic differences in resource costs. The sum of these calculations is then multiplied by a dollar conversion factor. When determining payment, it is important to take into consideration all the mechanisms within the Medicare RBRVS physician fee schedule incorporated into the final reimbursement for physician services. Please note that third-party payors other than Medicare may not use all of the elements of the RBRVS to determine physician reimbursement. For example, they may use their own CF or not factor in the GPCIs.

Example: Level 3 office visit for the evaluation and management of an established patient in Marco Island, Florida ("Rest of Florida" Medicare Locality).

Remember, in order for the physician to code 99213, the appropriate patient history, medical examination, and physician decision-making process must be documented.

The following RVUs, GPCIs, and CF are based on the information provided by CMS in the *Federal Register* on November 21, 2005.

CPT Code 99213		Location: Marco Island, Florida ("Rest of Florida" Medicare Locality)	
Work RVU	0.67	Work GPCI	1.000
Non-Facility Practice Expense RVU	0.69	Practice Expense GPCI	0.934
Malpractice RVU	0.03	Malpractice GPCI	1.272

METHOD 1 (NON-GEOGRAPHICALLY ADJUSTED & USING NON-MEDICARE CONVERSION FACTOR)

This is an example of a physician reimbursement mechanism in a non-facility setting that takes into consideration the total RVU from the Medicare RBRVS but excludes all other components of the physician fee schedule. Often the total RVU is multiplied by a payor-specific conversion factor that is not associated with the Medicare established CF.

STEP 1
Add together the physician work, non-facility practice expense, and malpractice expense RVUs to obtain the total non-facility RVU for the office visit.

Total non-facility RVU for CPT code 99213 =
Work RVU + Non-Facility Practice Expense RVU + Malpractice RVU
(0.67) + (0.69) + (0.03) = 1.39

STEP 2
Multiply the total Medicare RVU for CPT code 99213 by a non-Medicare, payor-specific primary care conversion factor (which may or may not be different than the Medicare conversion factor of **~~$36.1770~~ $37.8975**).

For example: Payor-specific primary care conversion factor = $38.00

Total physician reimbursement for the provision of CPT code 99213 by this third-party payor =
(Total Medicare RVU) x (Payor CF)
(1.39) x (38.00) = $52.82

Note: In some cases, payors will not use the Medicare total RVUs for a service in their calculation of physician reimbursement. Instead, they may apply their own relative value adjustments.

METHOD 2 (GEOGRAPHICALLY ADJUSTED & USING MEDICARE CONVERSION FACTOR)

This is an example of the Medicare RBRVS physician fee schedule reimbursement in a non-facility setting for CPT code 99213 in Marco Island, Florida. The following example assumes that a physician has accepted assignment and is practicing in an area of the country that does not have a shortage of medical professionals.

STEP 1

Multiply the physician work, non-facility practice expense, and malpractice RVUs by the appropriate GPCIs; add the figures thus obtained to get the total geographically adjusted RVUs for the office visit.

Total non-facility RVUs for CPT code 99213 (geographically adjusted) =
(Work RVU x Work GPCI) + (Non-Facility Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)
(0.67 x 1.000) + (0.69 x 0.934) + (0.03 x 1.272)
(0.67) + (0.64446) + (0.03816) = 1.35262

STEP 2

Multiply the total geographically adjusted RVUs by the Medicare CF to obtain the physician reimbursement for the office visit.

2006 Medicare Conversion Factor (CF) = ~~**$36.1770**~~ **$37.8975**

Total Medicare payment for the provision of CPT code 99213 in Marco Island, Florida =
Total geographically adjusted RVUs for CPT code 99213 x 2006 CF
(1.35262 x ~~**$36.1770**~~ **$37.8975**) = ~~**$48.93**~~ **$51.26**

In this example, a physician practicing in Marco Island, Florida would receive ~~**$48.93**~~ **$51.26** for providing the level 3 physician office visit for a Medicare beneficiary.

A table that provides RVUs for a series of CPT codes commonly used by pediatricians has been included for further clarification and interpretation. Please refer to this table to determine Medicare RVUs for other services and procedures.

CONCLUDING REMARKS

In today's rapidly changing health care environment, it is crucial to understand the Medicare RBRVS physician fee schedule. Many third-party payors, including state Medicaid programs, Blue Cross Blue Shield carriers, and managed care organizations are utilizing variations of the Medicare RBRVS to determine physician reimbursement and even capitation rates. In order for a physician to succeed in the changing marketplace, measurements of the costs involved in providing services will need to be ascertained; these costs include physician income and benefits, practice expenses, malpractice premiums, as well as the frequency of services provided. Once this information is determined and the appropriate RVUs for each service are obtained, a physician will be able to calculate the costs involved in the provision of each service, as well as the average cost per service provided and per member per month (PMPM) estimates.

For further information, please contact the Division of Health Care Finance and Quality Improvement at dhcfqi@aap.org.

Developed by the Committee on Coding and Nomenclature, with contributions by Linda Walsh and Teri Salus.

2006 MEDICARE RELATIVE VALUE UNITS (RVUs)

CPT Code	Descriptor	Work RVU	Non-Facility Practice Expense RVU	Facility Practice Expense RVU	Malpractice RVU	Total Non-Facility RVUs/$	Total Facility RVUs/$	Medicare Global Period
	Office or Other Outpatient Services, New Patient							
99201	Problem-focused history and exam/straightforward	0.45	0.49	0.15	0.03	0.97/$36.76	0.63/$23.88	XXX
99202	Expanded problem-focused history and exam/straightforward	0.88	0.79	0.31	0.05	1.72/$65.18	1.24/$46.99	XXX
99203	Detailed history and exam/low complexity	1.34	1.13	0.48	0.09	2.56/$97.02	1.91/$72.38	XXX
99204	Comprehensive history and exam/moderate complexity	2.00	1.50	0.71	0.12	3.62/$137.19	2.83/$107.25	XXX
99205	Comprehensive history and exam/high complexity	2.67	1.78	0.95	0.15	4.60/$174.33	3.77/$142.87	XXX
	Office or Other Outpatient Services, Established Patient							
99211	May or may not require physician presence, minimal	0.17	0.39	0.06	0.01	0.57/$21.60	0.24/$9.10	XXX
99212	Problem-focused history and exam/straightforward	0.45	0.54	0.16	0.03	1.02/$38.66	0.64/$24.25	XXX
99213	Expanded problem-focused history and exam/low complexity	0.67	0.69	0.24	0.03	1.39/$52.68	0.94/$35.62	XXX
99214	Detailed history and exam/moderate complexity	1.10	1.03	0.41	0.05	2.18/$82.62	1.56/$59.12	XXX
99215	Comprehensive history and exam/high complexity	1.77	1.32	0.65	0.08	3.17/$120.14	2.50/$94.74	XXX
	Office or Other Outpatient Consultations							
99241	Problem focused	0.64	0.64	0.22	0.05	1.33/$50.40	0.91/$34.49	XXX
99242	Expanded problem-focused	1.29	1.04	0.46	0.10	2.43/$92.09	1.85/$70.11	XXX
99243	Detailed	1.72	1.39	0.63	0.13	3.24/$122.79	2.48/$93.99	XXX
99244	Comprehensive/moderate complexity	2.58	1.83	0.92	0.16	4.57/$173.19	3.66/$138.70	XXX
99245	Comprehensive/high complexity	3.42	2.28	1.24	0.21	5.91/$223.97	4.87/$184.56	XXX
	Prolonged Physician Service With Face-To-Face Patient Contact; Outpatient							
99354	Prolonged physician service; first hour	1.77	0.77	0.66	0.08	2.62/$99.29	2.51/$95.12	ZZZ
99355	Prolonged physician service; each additional 30 minutes	1.77	0.75	0.62	0.07	2.59/$98.15	2.46/$93.23	ZZZ
	Preventive Medicine Services, New Patient							
99381	Preventive visit, new, age under 1 yr	+1.19	1.50	0.45	0.05	2.74/$103.84	1.69/$64.05	XXX
99382	Preventive visit, new, age 1–4	+1.36	1.54	0.52	0.05	2.95/$111.80	1.93/$73.14	XXX
99383	Preventive visit, new, age 5–11	+1.36	1.48	0.52	0.05	2.89/$109.52	1.93/$73.14	XXX
99384	Preventive visit, new, age 12–17	+1.53	1.55	0.59	0.06	3.14/$119.00	2.18/$82.62	XXX
99385	Preventive visit, new, age 18–39	+1.53	1.55	0.59	0.06	3.14/$119.00	2.18/$82.62	XXX
	Preventive Medicine Services, Established Patient							
99391	Preventive visit, est, age under 1 yr	+1.02	1.02	0.39	0.04	2.08/$78.83	1.45/$54.95	XXX
99392	Preventive visit, est, age 1–4	+1.19	1.09	0.45	0.05	2.33/$88.30	1.69/$64.05	XXX
99393	Preventive visit, est, age 5–11	+1.19	1.06	0.45	0.05	2.30/$87.16	1.69/$64.05	XXX
99394	Preventive visit, est, age 12–17	+1.36	1.13	0.52	0.05	2.54/$96.26	1.93/$73.14	XXX
99395	Preventive visit, est, age 18–39	+1.36	1.16	0.52	0.05	2.57/$97.40	1.93/$73.14	XXX
	Immunization Administration							
90471	Immunization admin; one vaccine	0.17	0.31	N/A	0.01	0.49/$18.57	N/A	XXX
90472	Immunization admin; each additional vaccine	0.15	0.13	N/A	0.01	0.29/$10.99	N/A	ZZZ
90473	Immunization admin by intranasal/oral route; one vaccine	0.17	0.19	0.07	0.01	0.37/$14.02	0.25/$9.47	XXX
90474	Immunization admin by intranasal/oral route; each additional vaccine	0.15	0.10	0.06	0.01	0.26/$9.85	0.22/$8.34	ZZZ

CPT Code	Descriptor	Work RVU	Non-Facility Practice Expense RVU	Facility Practice Expense RVU	Malpractice RVU	Total Non-Facility RVUs/$	Total Facility RVUs/$	Medicare Global Period
	Immunization Administration Under Age 8 With Physician Counseling							
90465	Immunization admin, first injection	0.17	0.31	N/A	0.01	0.49/$18.57	N/A	XXX
90466	Immunization admin, each addition injection	0.15	0.13	N/A	0.01	0.29/$10.99	N/A	ZZZ
90467	Immunization admin by intranasal/oral route, first administration	0.17	0.17	0.09	0.01	0.35/$13.26	0.27/$10.23	XXX
90468	Immunization admin by intranasal/oral route, each additional administration	0.15	0.11	0.06	0.01	0.27/$10.23	0.22/$8.34	ZZZ
	Vision & Hearing Screening							
99173	Screening of visual acuity, quantitative, bilateral	0*	0*	0*	0*	0*	0*	XXX
92551	Screening test, pure tone, air only	0*	0*	0*	0*	0*	0*	XXX
92552	Pure tone audiometry (threshold); air only	0.00	0.44	N/A	0.04	0.48/$18.19	N/A	XXX
	Developmental Testing							
96110	Developmental testing; limited with interpretation and report	0.00	0.18	N/A	0.18	0.36/$13.64	N/A	XXX
96111	Developmental testing; extended with interpretation and report, per hour	2.60	1.05	N/A	0.18	3.83/$145.15	N/A	XXX
	Care Plan Oversight							
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 15-29 minutes	0*	0*	0*	0*	0*	0*	XXX
99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home; 30 minutes or more	0*	0*	0*	0*	0*	0*	XXX
	Pulmonary Procedures							
94640	Airway inhalation treatment	0.00	0.30	N/A	0.02	0.32/$12.13	N/A	XXX
94664	Demonstration/evaluation	0.00	0.31	N/A	0.04	0.35/$13.26	N/A	XXX
	Newborn Care							
99431	Initial care, normal newborn	1.17	N/A	0.38	0.05	N/A	1.60/$60.64	XXX
99432	Newborn care not in hospital	1.26	0.93	0.40	0.07	2.26/$85.65	1.73/$65.56	XXX
99433	Subsequent normal newborn care	0.62	N/A	0.20	0.02	N/A	0.84/$31.83	XXX
99435	Newborn admit/discharge same day	1.50	N/A	0.59	0.06	N/A	2.15/$81.48	XXX
99436	Attendance at delivery	1.50	N/A	0.47	0.06	N/A	2.03/$76.93	XXX
99440	Newborn resuscitation	2.93	N/A	0.93	0.12	N/A	3.98/$150.83	XXX
	Initial Hospital Care							
99221	Detailed history and exam	1.28	N/A	0.45	0.07	N/A	1.80/$68.22	XXX
99222	Comprehensive history and exam/moderate complexity	2.14	N/A	0.74	0.10	N/A	2.98/$112.93	XXX
99223	Detailed history and exam/high complexity	2.99	N/A	1.03	0.13	N/A	4.15/$157.27	XXX
	Subsequent Hospital Care							
99231	Problem-focused history and exam/low complexity	0.64	N/A	0.23	0.03	N/A	0.90/$34.11	XXX
99232	Expanded problem-focused history and exam/moderate complexity	1.06	N/A	0.37	0.04	N/A	1.47/$55.71	XXX
99233	Detailed history and exam/high complexity	1.51	N/A	0.52	0.06	N/A	2.09/$79.21	XXX
	Discharge Day Management							
99238	Discharge; 30 minutes or less	1.28	N/A	0.54	0.05	N/A	1.87/$70.87	XXX
99239	Discharge; more than 30 minutes	1.75	N/A	0.73	0.07	N/A	2.55/$96.64	XXX

CPT Code	Descriptor	Work RVU	Non-Facility Practice Expense RVU	Facility Practice Expense RVU	Malpractice RVU	Total Non-Facility RVUs/$	Total Facility RVUs/$	Medicare Global Period
	Observation Care							
99217	Observation care discharge	1.28	N/A	0.53	0.06	N/A	1.87/$70.87	XXX
99218	Initial observation care, per day	1.28	N/A	0.44	0.06	N/A	1.78/$67.46	XXX
99219	Initial observation care, per day	2.14	N/A	0.72	0.10	N/A	2.96/$112.18	XXX
99220	Initial observation care, per day	2.99	N/A	1.03	0.14	N/A	4.16/$157.65	XXX
	Prolonged Physician Service With Face-To-Face Patient Contact; Inpatient							
99356	Prolonged physician service; first hour	1.71	N/A	0.62	0.07	N/A	2.40/$90.95	ZZZ
99357	Prolonged physician service; each additional 30 minutes	1.71	N/A	0.63	0.08	N/A	2.42/$91.71	ZZZ
	Critical Care							
99291	First 30-74 minutes	3.99	2.58	1.28	0.21	6.78/$256.95	5.48/$207.68	XXX
99292	Each additional 30 minutes	2.00	0.90	0.64	0.11	3.01/$114.07	2.75/$104.22	ZZZ
	Pediatric Critical Care Patient Transport							
99289	24 months of age or less; first 30-74 minutes	4.79	N/A	1.45	0.24	N/A	6.48/$245.58	XXX
99290	24 months of age or less; each additional 30 minutes	2.40	N/A	0.81	0.12	N/A	3.33/$126.20	ZZZ
	Inpatient Pediatric and Neonatal Critical Care							
99293	Pediatric (29 days-24 mos); initial	15.98	N/A	4.76	1.12	N/A	21.86/$828.44	XXX
99294	Pediatric (29 days-24 mos); subsequent	7.99	N/A	2.41	0.45	N/A	10.85/$411.19	XXX
99295	Neonatal (28 days or less); initial	18.46	N/A	5.39	1.16	N/A	25.01/$947.82	XXX
99296	Neonatal (28 days or less); subsequent	7.99	N/A	2.55	0.32	N/A	10.86/$411.57	XXX
	Continuing Intensive Care Services							
99298	Subsequent intensive care (<1,500 grams present body weight)	2.75	N/A	0.93	0.17	N/A	3.85/$145.91	XXX
99299	Subsequent intensive care (1,500-2,500 grams present body weight)	2.50	N/A	0.86	0.16	N/A	3.52/$133.40	XXX
99300	Subsequent intensive care (2501-5000 grams present body weight)	2.40	N/A	0.84	0.15**	N/A	3.39/$128.47	XXX
	Moderate (Conscious) Sedation Provided by the Same Physician Performing the Diagnostic or Therapeutic Service							
99143	Under 5 years of age, first 30 minutes intra-service time	0*	0*	0*	0*	0*	0*	XXX
99144	Age 5 years or older, first 30 minutes intra-service time	0*	0*	0*	0*	0*	0*	XXX
99145	Each additional 15 minutes intra-service time	0*	0*	0*	0*	0*	0*	ZZZ
	Moderate (Conscious) Sedation Provided by a Physician Other than the Health Care Professional Performing the Diagnostic or Therapeutic Service							
99148	Under 5 years of age, first 30 minutes intra-service time	0*	0*	0*	0*	0*	0*	XXX
99149	Age 5 years or older, first 30 minutes intra-service time	0*	0*	0*	0*	0*	0*	XXX
99150	Each additional 15 minutes intra-service time	0*	0*	0*	0*	0*	0*	ZZZ
	Orthopaedic Procedures							
20150	Excise epiphyseal bar	13.67	N/A	7.05	2.03	N/A	22.75/$862.17	090
20664	Halo brace application	8.05	N/A	7.06	1.74	N/A	16.85/$638.57	090
23500	Clavicle fracture	2.08	2.88	2.53	0.30	5.26/$199.34	4.91/$186.08	090
24640	Nursemaid elbow	1.20	1.85	0.80	0.12	3.17/$120.14	2.12/$80.34	010

CPT Code	Descriptor	Work RVU	Non-Facility Practice Expense RVU	Facility Practice Expense RVU	Malpractice RVU	Total Non-Facility RVUs/$	Total Facility RVUs/$	Medicare Global Period
25600	Closed treatment of clavicle fracture; without manipulation	2.63	4.10	2.98	0.42	7.15/$270.97	6.03/$228.52	090
27036	Excision of hip joint/muscle	12.86	N/A	10.03	2.26	N/A	25.15/$953.12	090
	Cardiology Procedures							
93303	Echo transthoracic	1.30	4.35	N/A	0.27	5.92/$224.35	N/A	XXX
93315	Echo transesophageal	2.78	1.01	1.01	0.09	3.88/$147.04	3.88/$147.04	XXX
93530	Right heart catheterization, congenital	4.22	18.89	N/A	1.34	24.45/$926.59	N/A	000
	Gastroenterology Procedures							
43235	Upper GI endoscopy, diagnostic	2.39	5.18	1.02	0.19	7.76/$294.08	3.60/$136.43	000
	Radiology Procedures							
76885	Ultrasound exam, infant hips	0.74	1.76	N/A	0.13	2.63/$99.67	N/A	XXX
76886	Ultrasound exam, infant hips	0.62	1.62	N/A	0.11	2.35/$89.06	N/A	XXX
	Urology Procedures							
54150	Circumcision, using clamp or other device; newborn	1.81	4.36	0.70	0.16	6.33/$239.89	2.67/$101.19	000
54152	Circumcision, using clamp or other device; except newborn	2.31	N/A	1.20	0.19	N/A	3.70/$140.22	0.10
54162	Lysis of excision of penile post-circumcision adhesions	3.00	4.66	1.44	0.21	7.87/$298.25	4.65/$176.22	0.10

Note: Information for table extracted from the *Federal Register*, November 21, 2005

Key:

Work RVU = physician work RVU; non-facility practice expense RVU = practice expense RVU for services provided in a non-facility (eg, physician's office or patient's home) setting; facility practice expense RVU = practice expense RVU for services provided in a facility (eg, hospital or ambulatory surgical center) setting; malpractice RVU = malpractice expense (professional liability insurance) RVU; total non-facility RVU = the sum of the work, non-facility practice expense, and malpractice liability RVUs; total facility RVU = the sum of the work, facility practice expense, and malpractice liability RVUs; $ = Non-geographically adjusted Medicare reimbursement; Medicare Global Period = Medicare global periods define the postoperative period for procedures and affect how follow-up services are reported for a given CPT code

*Some CPT codes do not have published RVUs on the Medicare physician fee schedule. Individual payor payment policies apply (ie, they are "carrier priced"). The AAP works with the AMA RUC and CMS to have values assigned and published for all CPT codes.

**The November 21, 2005 *Federal Register* listed an incorrect malpractice RVU for code 99300. Therefore, the 0.15 RVU has been inserted as an approximation of the correct value. This value will be clarified once CMS publishes an update/errata to the 2006 Medicare RBRVS.

+Indicates RVUs are not used for Medicare payment

Source: http://www.pcc.com/clients/aaprbrvsbrochure06.pdf

Appendix D

Medicaid Payment

for Commonly Used Pediatric Services, 2004/05

This report includes Medicaid paymemt rates (effective July 1, 2004) provided by Medicaid directors in 45 states and the District of Columbia for the 2004/05 AAP Medicaid Reimbursement Survey. Tennessee does not have a fee-for-service Medicaid program. Alaska, Delaware, Indiana and Michigan have not provided payment rates to date. Contact Suk-fong Tang, PhD, Department of Practice, with comments about the report; contact Dan Walter, Division of State Government Affairs, for Medicaid questions and advocacy advice.

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Abbreviations used in this report:

MP: Manually priced, i.e., Carrier will establish payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

BR: By report , i.e., Carrier will establish payment amounts for these services on a case-by-case basis following review of documentation, such as an operative report

BO: Bundled with other services, i.e., Payment for covered services is always bundled into payment for other services not specified. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.

OM: Other method.

NC: Not covered.

NA: Not applicable.

NP: Information not provided by state.

NL: Information not provided by state, nor found on Medicaid fee schedule posted on state's web site.

Preventive Medicine Services

State*	**99381** New Patient under 1 yr	**99382** New Patient 1 through 4	**99383** New Patient 5 through 11	**99384** New Patient 12 through 17	**99385** New Patient 18 through 39
Alabama	$70.00	$70.00	$70.00	$70.00	$70.00
Arizona	$101.24	$109.05	$106.86	$116.17	$116.17
Arkansas	$41.00	$41.00	$41.00	$41.00	$41.00
California	$45.33	$47.13	$54.83	$65.78	NC
Colorado	$55.05	$55.05	$55.05	$55.05	$55.05
Connecticut	$90.00	$90.00	$90.00	$90.00	$90.00
Dist of Columbia	$80.00	$45.00	$45.00	$60.00	$60.00
Florida	$71.59	$71.59	$71.59	$71.59	$71.59
Georgia	NC	NC	NC	NC	NC
Hawaii	$95.00	$95.00	$95.00	$95.00	$95.00
Idaho	$94.04	$101.51	$99.51	$108.16	$108.16
Illinois	$32.15	$32.15	$32.15	$32.15	$32.15
Iowa	$86.29	$92.62	$91.99	$102.38	$99.25
Kansas	$40.00	$35.00	$35.00	$35.00	$35.00
Kentucky	$69.85	$79.91	$79.91	$89.97	$84.63
Louisiana	$51.00	$51.00	$51.00	$51.00	$51.00
Maine	$47.15	$48.48	$50.40	$49.87	$45.43
Maryland	$83.10	$89.42	$87.56	$95.06	$95.06
Massachusetts	$67.04	$67.04	$67.04	$67.04	$67.04
Minnesota	$40.77	$34.82	$37.90	$39.79	$42.48
Mississippi	$80.78	$89.40	$85.74	$93.37	$93.37
Missouri	$60.00	$60.00	$60.00	$60.00	$60.00
Montana	$76.63	$82.80	$81.21	$88.43	$88.43
Nebraska	$76.19	$80.20	$88.22	$96.24	$104.26
Nevada	$59.07**	$59.07**	$59.07**	$59.07**	$59.07**
New Hampshire	$40.00	$40.00	$40.00	$42.00	$36.00
New Jersey[1]	$32.30	$32.30	$32.30	$32.30	$32.30
New Mexico	$113.15	$113.15	$113.15	$113.15	$113.15
New York	$30.00	$30.00	$30.00	$30.00	$30.00
North Carolina	$80.33	$80.33	$80.33	$80.33	$80.33
North Dakota	$84.32	$91.12	$89.42	$96.90	$96.90
Ohio	$50.70	$57.61	$57.51	$64.52	$61.21
Oklahoma	$83.53	$90.23	$88.47	$96.20	$96.20
Oregon	$71.36	$76.81	$75.26	$81.74	$81.74
Pennsylvania	$20.00	$20.00	$35.00	$20.00	$50.00
Rhode Island	$37.00	$37.00	$37.00	$42.00	$27.24
South Carolina	$52.00	$47.00	$47.00	$47.00	$71.25
South Dakota	$35.10	$38.00	$38.75	$35.93	$43.19
Texas[2]	NA	NA	NA	NA	NA
Utah[3]	$60.29	$68.42	$68.42	$76.56	$72.73
Vermont	$47.28	$52.83	$60.12	$65.55	$85.28
Virginia	$70.60	$76.01	$71.47	$80.91	$80.91
Washington	$75.65	$83.67	$87.07	$93.56	$95.77
West Virginia	$74.64	$80.36	$78.86	$86.08	$86.08
Wisconsin	$56.96	$56.96	$56.96	$56.96	$56.96
Wyoming	$89.82	$96.73	$94.75	$102.98	$102.98

Note: Where multiple rates are reported by the state, the highest non-facility rate is presented in this report unless noted otherwise. * Tennessee does not have a fee-for-service Medicaid program. Alaska, Delaware, Indiana and Michigan have not provided payment rates to date. ** EPSDT providers only, else not covered. [1] NJ offers enhanced payment (shown in Table) for specialists only. Payment rates for non-specialists are generally 10-15% less. [2] TX pays high volume providers 1.9% over regular rates; high-volume specialists are paid 6.1% higher. [3] Utah pays enhanced rates (112% of shown rates) for rural providers.

Preventive Medicine Services

State*	**99391** Est. Patient under 1 yr	**99392** Est. Patient 1 through 4	**99393** Est. Patient 5 through 11	**99394** Est. Patient 12 through 17	**99395** Est. Patient 18 through 39
Alabama	$70.00	$70.00	$70.00	$70.00	$70.00
Arizona	$76.96	$86.27	$85.17	$94.08	$95.17
Arkansas	$41.00	$41.00	$41.00	$41.00	$41.00
California	$34.69	$37.39	$43.85	$54.83	NC
Colorado	$40.15	$40.15	$40.15	$40.15	$40.15
Connecticut	$90.00	$90.00	$90.00	$90.00	$90.00
Dist of Columbia	$30.00	$30.00	$30.00	$45.00	$45.00
Florida	$71.59	$71.59	$71.59	$71.59	$71.59
Georgia	NC	NC	NC	NC	NC
Hawaii	$95.00	$95.00	$95.00	$95.00	$95.00
Idaho	$71.49	$80.12	$79.13	$79.13	$89.91
Illinois	$32.15	$32.15	$32.15	$32.15	$32.15
Iowa	$70.42	$77.75	$77.44	$87.60	$85.41
Kansas	$26.00	$26.00	$26.00	$25.00	$17.00
Kentucky	$60.06	$69.85	$69.85	$79.91	$75.38
Louisiana	$51.00	$51.00	$51.00	$51.00	$51.00
Maine	$43.75	$44.50	$45.25	$46.50	$47.74
Maryland	$62.87	$70.38	$69.44	$77.31	$78.24
Massachusetts	$57.01	$63.65	$62.77	$67.04	$67.04
Minnesota	$29.37	$29.84	$29.84	$33.16	$32.44
Mississippi	$61.58	$69.19	$68.54	$76.15	$76.81
Missouri	$60.00	$60.00	$60.00	$60.00	$60.00
Montana	$58.59	$65.82	$65.01	$71.99	$72.78
Nebraska	$64.16	$68.17	$72.18	$76.19	$80.20
Nevada	$59.07**	$59.07**	$59.07**	$59.07**	$59.07**
New Hampshire	$55.42	$55.42	$55.42	$55.42	$36.00
New Jersey[1]	$32.30	$32.30	$32.30	$32.30	$32.30
New Mexico	$64.15	$64.15	$64.15	$64.15	$64.15
New York	$30.00	$30.00	$30.00	$30.00	$30.00
North Carolina	$80.33	$80.33	$80.33	$80.33	$80.33
North Dakota	$63.92	$71.74	$71.06	$78.88	$79.56
Ohio	$44.18	$51.12	$51.12	$58.36	$58.66
Oklahoma	$63.43	$71.16	$70.28	$78.17	$79.05
Oregon	$53.98	$60.46	$59.69	$66.17	$66.95
Pennsylvania	$20.00	$20.00	$20.00	$20.00	$20.00
Rhode Island	$27.00	$27.00	$27.00	$27.00	$27.00
South Carolina	$52.00	$47.00	$47.00	$47.00	NC
South Dakota	$28.26	$29.69	$29.95	$32.68	$33.40
Texas[2]	NA	NA	NA	NA	NA
Utah[3]	$50.72	$58.85	$58.85	$66.99	$63.88
Vermont	$41.85	$41.85	$47.28	$52.83	$41.89
Virginia	$53.59	$60.04	$59.26	$65.45	$66.22
Washington	$57.75	$66.29	$69.98	$76.65	$79.38
West Virginia	$56.88	$63.81	$62.90	$69.83	$70.73
Wisconsin	$56.96	$56.96	$56.96	$56.96	$56.96
Wyoming	$68.10	76.33	$75.34	$83.90	$84.88

Note: Where multiple rates are reported by the state, the highest non-facility rate is presented in this report unless noted otherwise. * Tennessee does not have a fee-for-service Medicaid program. Alaska, Delaware, Indiana and Michigan have not provided payment rates to date. ** EPSDT providers only, else not covered. [1] NJ offers enhanced payment (shown in Table) for specialists only. Payment rates for non-specialists are generally 10-15% less. [2] TX pays high volume providers 1.9% over regular rates; high-volume specialists are paid 6.1% higher. [3] Utah pays enhanced rates (112% of shown rates) for rural providers.

	Preventive Medicine Services		*Office and Other Outpatient Services*		
	99401	**99402**	**99201**	**99202**	**99203**
State*	Individual counseling, 15 minutes	Individual counseling, 30 minutes	New patient, office visit	New patient, expanded office visit	New patient, low complexity
Alabama	$13.00	$13.00	$33.00	$53.00	$75.00
Arizona	$40.97	$69.17	$35.87	$64.15	$95.36
Arkansas	$10.26	$9.86	$27.00	$41.00	$59.00
California	NC	NC	$22.90	$34.30	$57.20
Colorado	$9.02	$12.01	$24.78	$43.26	$64.29
Connecticut	$34.63	$58.03	$33.12	$53.04	$79.25
Dist of Columbia	$175.00	NC	$25.00	$32.97	$48.77
Florida	$23.44	$38.92	$32.44	$33.73	$50.60
Georgia	NC	NC	$35.13	$54.57	$76.53
Hawaii	BO	BO	$95.00	$95.00	$95.00
Idaho	$38.38	$64.89	$31.67	$57.27	$85.56
Illinois	MP	MP	$27.95	$32.00	$41.00
Iowa	NP	NP	$35.82	$56.23	$79.15
Kansas	$17.00	$17.00	$30.91	$35.00	$42.33
Kentucky	NC	NC	$22.05	$35.29	$48.86
Louisiana	NC	NC	$21.95	$39.92	$59.73
Maine	$5.00	$20.00	$21.92	$26.89	$38.66
Maryland	NC	NC	$28.53	$51.44	$76.80
Massachusetts	NC	NC	$25.88	$46.40	$69.18
Minnesota	$10.30	$20.60	$31.26	$35.05	$41.68
Mississippi	$19.90	$20.00	$29.69	$53.31	$79.34
Missouri	NC	NC	$23.00	$38.00	$42.00
Montana	$31.04	$52.93	$27.22	$48.81	$72.60
Nebraska	NC	NC	$26.07	$38.10	$56.14
Nevada	$35.08	NC	$29.54	$53.54	$80.31
New Hampshire	$15.00	$25.00	$18.00	$30.00	$38.00
New Jersey[1]	NC	NC	$23.50	$23.50	$32.30
New Mexico	NC	NC	$34.27	$55.57	$78.19
New York	NC	NC	$30.00	$30.00	$30.00
North Carolina	NC	NC	$33.21	$59.14	$87.95
North Dakota	NC	NC	$30.26	$53.04	$79.56
Ohio	NC	$36.01	$21.81	$34.42	$48.01
Oklahoma	$34.30	$57.44	$29.93	$52.39	$78.50
Oregon	$29.06	$48.79	$24.65	$44.12	$65.39
Pennsylvania	NC	NC	$20.00	$20.00	$20.00
Rhode Island	NC	NC	NP	NP	$29.00
South Carolina	$7.00	$20.00	$45.00	$70.00	$99.00
South Dakota	NL	NL	$29.24	$37.20	$49.00
Texas[2]	NA	NA	$22.64	$35.73	$48.28
Utah[3]	$22.76	$28.00	$23.93	$39.56	$52.40
Vermont	$11.76	$23.52	$22.98	$31.12	$44.36
Virginia	NC	NC	$24.99	$44.58	$66.22
Washington	$25.39	$42.62	$33.57	$58.91	$88.37
West Virginia	$30.10	$51.17	$25.58	$46.65	$70.13
Wisconsin	NC	NC	$28.23	$48.89	$81.22
Wyoming	NC	NC	$34.64	$55.93	$83.57

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Office and Other Outpatient Services

State*	99204 New patient, moderate complexity	99205 New patient, high complexity	99211 Established patient, office visit	99212 Established patient, problem-focused office visit	99213 Established patient, low complexity
Alabama	$108.00	$135.00	$16.00	$29.00	$39.00
Arizona	$134.70	$171.12	$21.00	$37.33	$52.21
Arkansas	$80.00	$125.00	$13.00	$25.00	$33.00
California	$68.90	$82.70	$12.00	$18.10	$24.00
Colorado	$95.48	$124.54	$12.18	$22.54	$39.56
Connecticut	$112.63	$143.21	$21.63	$33.23	$43.37
Dist of Columbia	$69.36	$88.28	$15.00	$19.37	$27.11
Florida	$71.59	$90.42	$12.48	$26.45	$32.56
Georgia	$110.51	$137.12	$17.46	$29.67	$40.70
Hawaii	$95.00	$95.00	$95.00	$95.00	$95.00
Idaho	$122.09	$155.70	$18.61	$33.62	$46.84
Illinois	$66.40	$70.85	$12.30	$24.25	$28.35
Iowa	$114.60	$142.87	$17.61	$30.50	$42.05
Kansas	$62.93	$79.01	$11.25	$19.78	$27.00
Kentucky	$73.04	$91.89	$10.57	$19.15	$27.06
Louisiana	$85.06	$108.44	$12.82	$30.13	$36.13
Maine	$57.66	$66.88	$13.17	$19.85	$28.94
Maryland	$109.12	$138.63	$17.12	$30.39	$42.18
Massachusetts	$98.08	$124.27	$15.83	$27.67	$38.24
Minnesota	$71.07	$104.23	$14.21	$23.69	$28.42
Mississippi	$112.70	$143.87	$16.94	$30.82	$43.21
Missouri	$50.00	$50.00	$15.00	$25.00	$31.00
Montana	$103.01	$131.31	$15.66	$28.27	$39.62
Nebraska	$80.20	$104.26	$14.04	$24.06	$36.09
Nevada	$113.85	$144.62	$17.85	$31.69	$44.00
New Hampshire	$57.00	$72.00	$16.41	$27.84	$38.14
New Jersey[1]	$32.30	$32.30	$16.00	$23.50	$23.50
New Mexico	$113.15	$140.97	$17.45	$30.15	$41.53
New York	$30.00	$30.00	$30.00	$30.00	$30.00
North Carolina	$124.72	$158.30	$19.34	$34.88	$47.79
North Dakota	$112.88	$143.14	$18.02	$31.62	$43.86
Ohio	$70.32	$87.97	$13.43	$24.74	$34.35
Oklahoma	$111.73	$141.72	$17.74	$31.40	$43.25
Oregon	$93.16	$118.90	$14.53	$25.69	$36.07
Pennsylvania	$20.00	$20.00	$20.00	$20.00	$20.00
Rhode Island	$45.00	$46.00	NP	$20.64	NP
South Carolina	$143.00	$179.00	$22.00	$38.00	$53.00
South Dakota	$68.00	$85.50	$11.70	$20.75	$28.70
Texas[2]	$70.64	$87.83	$11.73	$19.64	$29.52
Utah[3]	$76.56	$95.71	$11.24	$20.82	$28.71
Vermont	$70.53	$82.18	$17.90	$30.00	$35.17
Virginia	$93.53	$118.78	$14.69	$26.02	$36.33
Washington	$125.01	$157.89	$20.21	$35.28	$48.64
West Virginia	$99.63	$127.92	$14.74	$26.78	$37.92
Wisconsin	$118.15	$163.25	$13.00	$23.41	$32.30
Wyoming	$118.77	$151.01	$18.42	$32.90	$45.73

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	Office and Other Outpatient Services				
State*	**99214** Established patient, moderate complexity	**99215** Established patient, high complexity	**92551** Screening test, hearing evaluation	**92567** Tympanometry, hearing evaluation	**99173** Screening test, visual acuity
Alabama	$61.00	$92.00	$15.75	$13.00	$5.00
Arizona	$81.45	$118.27	$15.87	$21.43	BR
Arkansas	$64.00	$106.00	$9.00	$15.00	$22.10
California	$37.50	$57.20	$10.20	NC	NC
Colorado	$52.64	$84.48	$10.64	$8.68	$10.08
Connecticut	$68.02	$99.84	$8.02	$11.28	$29.44
Dist of Columbia	$42.24	$61.53	$8.25	$11.51	$15.00
Florida	$48.27	$62.76	NC	$12.13	NC
Georgia	$62.71	$93.46	$8.05	$18.47	NC
Hawaii	$95.00	$95.00	$10.13	$17.78	BO
Idaho	$73.70	$108.48	$13.37	$17.22	MP
Illinois	$42.50	$48.00	$15.20	$15.20	$7.45
Iowa	$64.97	$97.23	$13.74	$17.75	BR
Kansas	$45.00	$68.00	$13.83	$17.73	$5.00
Kentucky	$41.97	$66.39	$12.24	$14.87	$60.00
Louisiana	$51.00	$75.30	NC	NC	$22.5
Maine	$42.50	$58.00	$9.01	$5.50	NC
Maryland	$66.14	$96.83	$4.00	$4.50	$4.80
Massachusetts	$59.86	$87.14	$22.14	$15.81	$19.54
Minnesota	$53.06	$75.80	$8.91	$13.15	$7.72
Mississippi	$67.76	$99.18	$8.82	$16.14	$8.82
Missouri	$40.00	$50.00	$5.00	NC	NC
Montana	$62.06	$90.60	$9.42	$15.18	NC
Nebraska	$54.14	$78.20	$14.04	$11.69	OM
Nevada	$68.62	$100.93	$8.62	$17.85	NC
New Hampshire	$58.74	$67.00	$5.00	$8.00	$5.00
New Jersey[1]	$23.50	$23.50	NC	$5.00	$5.00
New Mexico	$64.15	$95.95	$11.56	$17.75	$41.17
New York	$30.00	$30.00	$5.00	$10.00	NC
North Carolina	$75.06	$109.53	$9.31	$18.70	NC
North Dakota	$68.00	$99.28	$7.14	$17.00	$70.00
Ohio	$52.57	$81.04	$6.27	$14.67	NC
Oklahoma	$67.35	$98.39	$17.58	$12.55	$6.84
Oregon	$56.31	$82.52	$11.71	$14.79	$7.27
Pennsylvania	$20.00	$20.00	$8.00	$12.00	$30.00
Rhode Island	$27.00	$32.00	$8.00	NP	NC
South Carolina	$81.00	$122.00	$9.02	$11.58	NC
South Dakota	$44.70	$66.60	$8.20	$10.40	NL
Texas[2]	$41.46	$63.83	$15.00	$16.00	NA
Utah[3]	$43.79	$67.47	$43.79	$14.11	NC
Vermont	$50.02	$80.42	$15.10	$16.45	$4.50
Virginia	$56.69	$82.20	$9.66	$14.94	$64.63
Washington	$75.35	$109.60	$10.18	$12.92	BO
West Virginia	$59.29	$87.89	$13.65	$15.05	NC
Wisconsin	$56.67	$74.46	OM	$17.03	MP
Wyoming	$71.72	$105.28	$11.00	$22.77	NC

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Newborn Care

State*	**99431** Initial newborn care	**99433** Subsequent newborn care	**99435** Admit and discharge on same day
Alabama	$50.00	$32.00	$68.00
Arizona	$59.60	$31.27	$76.71
Arkansas	$98.33	NC	$98.33
California	$49.30	$27.30	NC
Colorado	$57.06	$35.50	$80.75
Connecticut	$29.44	$15.47	$37.94
Dist of Columbia	$75.00	$36.00	$75.00
Florida	$33.48	$17.58	$43.11
Georgia	$64.89	$34.66	$83.17
Hawaii	$95.00	$95.00	$95.00
Idaho	$55.00	$29.23	$71.80
Illinois	$38.75	MP	$42.55
Iowa	$67.36	$35.97	$86.33
Kansas	$75.00	NC	$75.00
Kentucky	$68.73	$36.33	$88.02
Louisiana	$54.00	$45.00	$54.00
Maine	$46.81	$21.59	$58.00
Maryland	$47.34	$25.18	$62.19
Massachusetts	$58.59	$31.64	$69.64
Minnesota	$49.82	$23.17	BR
Mississippi	$51.26	$26.96	$65.98
Missouri	NC	$22.50	NC
Montana	$46.49	$24.45	$59.83
Nebraska	$88.22	$40.10	$102.26
Nevada	$50.16	$26.77	$65.56
New Hampshire	$55.42	$25.00	$67.50
New Jersey[1]	$39.70	$23.50	$39.70
New Mexico	$58.13	$30.54	$74.82
New York	$10.00	$6.00	$10.00
North Carolina	$55.93	$29.44	$75.03
North Dakota	$50.32	$26.52	$64.60
Ohio	$55.41	$28.83	$70.21
Oklahoma	$49.91	$26.33	$64.33
Oregon	$41.52	$21.80	$53.46
Pennsylvania	$42.00	$17.00	$42.00
Rhode Island	$38.18	$24.00	NP
South Carolina	$54.00	$29.00	$69.00
South Dakota	$68.00	$29.19	NL
Texas[2]	$63.03	$30.45	$85.92
Utah[3]	$56.46	$29.43	$71.30
Vermont	$89.25	$29.40	NC
Virginia	$41.23	$21.64	$53.08
Washington	$54.80	$28.77	$70.56
West Virginia	$45.15	$23.47	$58.09
Wisconsin	$107.36	$33.20	$108.31
Wyoming	$108.90	$34.75	$99.00

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Immunizations

State*	Does state provide vaccine through a universal immunization program?	**90471** One immunization administration	**90472** Each additional immunization administration	**90473** One immunization administration, oral or intranasal	**90645-8** - Hemophilus Influenza B
Alabama	Yes	$5.00	NC	NC	$8.00
Arizona	NP	$8.08	$5.52	NA	NC
Arkansas	Yes	NC	NC	NC	$8.69
California	Yes	$4.46	NC	NC	$23.50
Colorado	Yes	NC	NC	NC	$6.50
Connecticut	Yes	$4.00	$3.25	$2.00	$21.76
Dist of Columbia	Yes	$4.28	$3.04	NA	NA
Florida	Yes	$5.20	$5.20	NC	$34.02
Georgia	NP	NC	NC	NC	$100.63
Hawaii	Yes	$4.00	$4.00	$4.00	$4.00
Idaho	No	$3.37	$3.37	$3.37	$24.00
Illinois	Yes	MP	MP	MP	$6.40
Iowa	Yes	$4.95	$4.95	BR	$23.04
Kansas	Yes	$10.00	$10.00	$10.00	VFC
Kentucky	Yes	NC	NC	NC	$3.30
Louisiana	Yes	$9.45	$9.45	NC	$9.45
Maine	NP	$5.00	$5.00	NC	$40.00
Maryland	No	$10.00[a]	NA	NA	$24.32
Massachusetts	Yes	$15.78[b]	$1.30	$15.78[c]	NC
Minnesota	NP	$8.50	$1.50	NC	$8.50
Mississippi	Yes	$6.44	$4.60	NC	NC
Missouri	NP	$5.00	$5.00	$2.00	SSV
Montana	Yes	$5.78	$3.94	$5.78	$23.52
Nebraska	Yes	$4.96	$4.96	$4.96	VFC
Nevada	Yes	$3.69	$3.69	$13.85	$22.46
New Hampshire	Yes	$3.00	$5.00	$3.00	$0.01
New Jersey[1]	Yes	$11.50	$11.50	$5.00	$25.79
New Mexico	NP	NC	NC	NC	$9.85
New York	Yes	OM	OM	OM	VFC
North Carolina	Yes	$13.71	$13.71	NC	NA
North Dakota	Yes	$8.00	NC	NC	$8.00
Ohio	Yes	$5.00	$5.00	$5.00	NA
Oklahoma	Yes	$13.33	$13.33	$13.33	$33.67
Oregon	NP	$5.45	$3.89	$0.01	$21.76
Pennsylvania	NP	NP	NP	NP	$10.00
Rhode Island	NP	NA	NA	NA	NA
South Carolina	Yes	$13.00	$13.00	NC	VAFAC
South Dakota	NP	$7.00	$7.00	NC	$7.00
Texas[2]	Yes	NA	NA	NA	NA
Utah[3]	Yes	NP	NP	NP	NP
Vermont	NP	$6.23	$6.00	NA	$28.00
Virginia	Yes	NC	NC	NC	$10.75
Washington	Yes	$5.00	$3.00	NC	$21.76
West Virginia	Yes	$5.41	$3.61	NC	$12.00
Wisconsin	Yes	NA	NA	NA	$3.21
Wyoming	Yes	$4.95	$9.90	NC	$10.00

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Immunizations

State*	**90657** Influenza virus (6-35 months)	**90658** Influenza virus (3+ years)	**90660** Influenza virus, intranasal use	**90669** Pneumococcal conjugate vaccine	**90700** DTaP (< 7 years)
Alabama	NC	NC	NC	NC	$8.00
Arizona	$8.02	$16.03	NA	$72.32	$20.05
Arkansas	$8.69	$8.69	$25.79	$8.69	$8.69
California	$25.00	$25.00	NC	$77.47	$25.82
Colorado	$6.50	$6.50	NC	$6.50	$6.50
Connecticut	$18.95	$9.95	$51.75	$10.14	$20.05
Dist of Columbia	NA	NA	NA	NA	NA
Florida	$22.76	$21.89	NC	$74.40	$45.77
Georgia	$8.00	$9.22	NC	$8.00	$10.00
Hawaii	$4.00	$4.00	$4.00	$4.00	$4.00
Idaho	$8.31	$8.50	$4.81	$58.75	$23.00
Illinois	$5.65	$5.65	MP	$6.40	$6.40
Iowa	$5.13	$8.02	$50.60	$63.29	$16.67
Kansas	VFC	VFC	VFC	VFC	VFC
Kentucky	$3.30	$3.30	$3.30	$3.30	$3.30
Louisiana	$9.45	$9.45	NC	$9.45	$9.45
Maine	$9.95	$9.95	$48.00	$152.25	$17.76
Maryland	$10.00	$10.00	$8.02	By invoice	$22.41
Massachusetts	$10.09	$10.09	OM	NC	NC
Minnesota	$5.04	$9.95	$26.72	MNVP	MNVP
Mississippi	9.95	$9.95	NC	NC	NC
Missouri	SSV	SSV	SSV	SSV	SSV
Montana	$4.45	$10.10	$15.94	NC	$12.81
Nebraska	VFC	VFC	$51.18	VFC	VFC
Nevada	$7.03	$62.10	$8.34	$16.30	$12.75
New Hampshire	$5.38	$5.38	$57.50	$0.01	$0.01
New Jersey[1]	BR	$11.02	$68.13	BR	22-98
New Mexico	$16.74	$9.95	NC	$26.60	$9.85
New York	VFC	VFC	NA	VFC	VFC
North Carolina	NA	NA	NA	NA	NA
North Dakota	$8.00	$8.00	$8.00	$8.00	$8.00
Ohio	NA	NA	NA	NA	NA
Oklahoma	$2.00	$7.50	$7.50	$72.50	$19.84
Oregon	$15.19	$15.19	$0.01	$15.19	$15.19
Pennsylvania	$10.00	$10.00	$10.00	$10.00	$10.00
Rhode Island	NA	NA	NA	NA	NA
South Carolina	$3.71	$4.05	NC	VAFAC	VAFAC
South Dakota	$9.00	$9.00	NL	$7.00	$7.00
Texas[2]	NA	NA	NA	NA	NA
Utah[3]	NP	NP	NP	NP	NP
Vermont	$9.94	$9.95	$54.91	$80.46	$20.05
Virginia	$8.50	$8.50	NC	$62.09	$19.43
Washington	$3.10	$9.00	NC	$65.47	$20.05
West Virginia	$4.50	$4.50	NC	$12.00	$12.00
Wisconsin	$7.49	$7.49	$54.31	$3.21	$3.28
Wyoming	$10.00	$10.00	NC	$10.00	$10.00

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Immunizations

State*	90701 DTP	90702 DT (< 7 years)	90707 Measles, mumps, rubella	90713 IPV	90716 Varicella	90718 Td (³ 7 years)
Alabama	NC	$8.00	$8.00	$8.00	$8.00	$8.00
Arizona	$21.70	$20.61	$34.93	$23.00	$57.86	$10.31
Arkansas	$18.00	$8.69	$8.69	$8.69	$8.69	$8.69
California	$21.26	$10.93	$38.27	$28.94	$48.94	$10.93
Colorado	NC	$6.50	$6.50	$6.50	$6.50	$6.50
Connecticut	MP	$10.00	$34.93	$23.00	$57.86	$10.31
Dist of Columbia	NA	NA	NA	NA	NA	NA
Florida	$27.56	$17.54	$54.21	$55.78	$77.14	$16.37
Georgia	NC	$18.55	$40.48	$46.25	$67.36	$11.36
Hawaii	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00
Idaho	$17.23	$6.33	$30.00	$18.00	$46.00	$5.00
Illinois	$6.40	$2.70	$39.70	$6.40	$46.60	$2.70
Iowa	$21.83	$2.50	$36.98	$20.75	$44.46	$6.19
Kansas	VFC	VFC	VFC	VFC	VFC	VFC
Kentucky	$3.30	$3.30	$3.30	$3.30	$3.30	$3.30
Louisiana	$9.45	$9.45	$9.45	$9.45	$9.45	$9.45
Maine	$11.97	$3.92	$27.29	$43.00	$56.54	$3.92
Maryland	$10.00	$10.00	$36.03	$23.65	$61.91	$9.03
Massachusetts	NC	NC	$40.71	$25.71	$68.83	NC
Minnesota	NC	MNVP	MNVP	MNVP	MNVP	MNVP
Mississippi	NC	NC	NC	NC	NC	NC
Missouri	SSV	SSV	SSV	SSV	SSV	SSV
Montana	NP	$13.50	$35.96	$21.65	$63.23	$9.25
Nebraska	BR	BR	VFC	VFC	$67.36	VFC
Nevada	$28.03	$8.62	$33.23	$9.96	$57.23	$8.31
New Hampshire	$2.00	$2.00	$0.01	$0.01	$0.01	$2.00
New Jersey[1]	$16.34	$3.29	$54.63	$32.17	$82.78	$15.52
New Mexico	$21.93	$9.85	$9.85	$9.85	$9.85	$9.85
New York	VFC	VFC	VFC	VFC	VFC	VFC
North Carolina	NA	NA	NA	NA	NA	NA
North Dakota	$8.00	$8.00	$8.00	$8.00	$8.00	$8.00
Ohio	NA	NA	NA	NA	NA	NA
Oklahoma	$16.00	$5.00	$32.00	$18.48	$75.00	$7.50
Oregon	NP	$15.19	$34.93	$23.00	$57.86	$15.19
Pennsylvania	$10.00	$10.00	$10.00	$10.00	$10.00	$10.00
Rhode Island	NA	NA	NA	NA	NA	NA
South Carolina	VAFAC	VAFAC	VAFAC	VAFAC	VAFAC	VAFAC
South Dakota	$7.00	NL	$7.00	$7.00	$44.68	$7.00
Texas[2]	NA	NA	NA	NA	NA	NA
Utah[3]	NP	NP	NP	NP	NP	NP
Vermont	$16.67	$7.53	$34.93	$23.00	$57.86	$12.20
Virginia	$12.00	$1.25	$39.96	$31.06	$60.69	$4.25
Washington	$18.21	$4.60	$34.93	$23.00	$57.86	$10.31
West Virginia	NC	$12.00	$12.00	$12.00	$12.00	$12.00
Wisconsin	$12.62	$13.95	$3.28	$3.28	$3.21	$16.27
Wyoming	$10.00	$10.00	$10.00	$10.00	$10.00	$10.00

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	Immunizations		*Evaluation and Management*		
	90721	**90744**	**99217**	**99218**	**99219**
State*	DTaP, HIB	Hepatitis B, (pediatric/ adolescent age)	Observation care discharge, day management	Initial observation care, low severity	Initial observation care, intermediate severity
Alabama	$8.00	$8.00	$44.00	$46.00	$76.00
Arizona	$43.70	$86.85	$69.59	$65.94	$110.26
Arkansas	$8.69	$8.69	$41.00	$48.00	$69.00
California	$35.13	$27.70	$45.30	$44.00	$69.60
Colorado	$48.88	$6.50	$37.49	$19.60	$79.24
Connecticut	$43.70	$27.05	$34.57	$32.58	$54.49
Dist of Columbia	NA	NA	$34.00	$37.00	$60.00
Florida	$46.08	$30.34	$39.14	$37.04	$82.83
Georgia	NC	$65.34	$57.41	$60.29	$98.89
Hawaii	$4.00	$4.00	$50.53	$53.33	$87.31
Idaho	$45.00	$23.50	$61.04	$61.04	$101.92
Illinois	$35.25	$6.40	MP	$69.55	$69.55
Iowa	$41.04	$51.34	$60.36	$63.19	$103.78
Kansas	VFC	VFC	$39.07	$63.99	$69.76
Kentucky	$3.30	$3.30	$46.90	$51.39	$81.70
Louisiana	$9.45	$9.45	NC	$42.68	$71.20
Maine	$28.13	$85.00	$16.70	$16.61	$20.96
Maryland	$44.66	$24.36	$52.88	$52.88	$88.21
Massachusetts	NC	NC	$47.19	$47.22	$77.88
Minnesota	MNVP	MNVP	BR	BR	BR
Mississippi	NC	NC	$59.44	$56.62	$94.68
Missouri	SSV	SSV	$12.00	$20.00	$25.00
Montana	$41.13	$68.38	$53.99	$51.37	$85.87
Nebraska	VFC	VFC	$36.09	$48.12	$86.22
Nevada	$23.40	$22.46	$55.69	$55.69	$93.23
New Hampshire	$10.00	$0.01	$30.00	$33.79	$53.59
New Jersey[1]	NC	BO	$23.50	NC	NC
New Mexico	$9.85	$9.85	$59.48	$62.29	$102.29
New York	VFC	VFC	$6.00	$10.00	$10.00
North Carolina	NA	NA	$65.12	$62.12	$103.33
North Dakota	$8.00	$8.00	$58.48	$55.42	$92.14
Ohio	NA	NA	$31.70	$34.60	$55.79
Oklahoma	MP	$42.00	$58.04	$55.10	$91.57
Oregon	$15.19	$15.19	$45.93	$45.93	$76.55
Pennsylvania	$10.00	$10.00	NA	NA	NA
Rhode Island	NA	NA	NP	NP	NP
South Carolina	VAFAC	$17.35	$75.00	$79.00	$130.00
South Dakota	$7.00	$7.00	$41.88	$57.77	$86.70
Texas[2]	NA	NA	$45.55	$45.68	$71.05
Utah[3]	NP	NP	$44.74	$49.05	$78.95
Vermont	$43.70	$27.05	$31.12	$39.42	$70.53
Virginia	NC	$40.95	$48.18	$45.61	$76.27
Washington	NC	$24.49	$42.39	$40.13	$66.88
West Virginia	$48.48	$12.00	$49.96	$49.96	$83.97
Wisconsin	$6.56	$3.21	$41.33	$60.03	$66.13
Wyoming	$7.00	$10.00	$58.56	$58.56	$97.71

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Evaluation and Management

State*	**99220** Initial observation care, high severity	**99354** Prolonged service, 1st hour, face-to-face	**99355** Same as 99354, each additional 30 minutes	**99356** Prolonged service, inpatient, 1st hour, face-to-face	**99357** Same as 99356, each additional 30 minutes
Alabama	$103.00	$69.00	$68.00	$61.00	$61.00
Arizona	$154.54	$96.32	$95.59	$89.34	$89.70
Arkansas	$106.00	$106.00	$50.00	$106.00	$50.00
California	$87.40	$52.30	$49.90	$42.20	$39.40
Colorado	$58.80	$43.09	$19.54	$42.28	$19.07
Connecticut	$76.46	$47.93	$47.54	$44.27	$44.27
Dist of Columbia	$63.84	$78.41	$59.31	$45.02	$45.23
Florida	$86.23	$53.78	$53.37	$50.02	$50.44
Georgia	$132.67	$90.61	$88.37	$79.12	$79.72
Hawaii	$116.67	MP	MP	MP	MP
Idaho	$142.76	$111.55	$104.38	$81.72	$82.37
Illinois	$69.55	MP	MP	MP	MP
Iowa	$139.66	$94.50	$92.31	$83.05	$83.59
Kansas	$89.60	$55.21	$43.71	$53.87	$17.00
Kentucky	$103.48	$66.39	$66.39	$67.00	$67.00
Louisiana	$99.70	NC	NC	NC	NC
Maine	$34.70	$46.27	$20.00	$46.27	$20.00
Maryland	$123.65	$113.19	$92.86	$70.77	$71.54
Massachusetts	$98.05	NC	NC	NC	NC
Minnesota	BR	$72.30	$36.15	$73.23	$36.61
Mississippi	$132.72	$82.34	$81.77	$76.66	$76.95
Missouri	$28.00	$100.00	$50.00	$100.00	$50.00
Montana	$120.38	$74.79	$74.28	$69.55	$69.83
Nebraska	$108.27	$80.20	$40.10	$88.22	$44.11
Nevada	$130.46	$96.62	$74.46	$73.46	$73.39
New Hampshire	$75.00	$54.00	$33.95	$50.00	$33.13
New Jersey[1]	NC	$66.20	$33.10	$66.20	$33.10
New Mexico	$137.60	$93.21	$91.03	$81.86	$82.42
New York	$10.00	$25.00	$12.50	$25.00	$12.50
North Carolina	$145.18	$91.21	$90.31	$83.82	$84.39
North Dakota	$129.20	$80.58	$79.90	$74.80	$75.48
Ohio	$73.01	NC	NC	NC	NC
Oklahoma	$128.44	$80.00	$79.42	$74.52	$75.11
Oregon	$107.20	$85.38	$79.67	$61.50	$61.76
Pennsylvania	NA	NA	NA	NA	NA
Rhode Island	NP	NP	NP	NP	NP
South Carolina	$174.00	$83.09	NC	$67.00	NC
South Dakota	$110.40	$56.14	$23.80	$78.90	$41.62
Texas[2]	$96.43	$47.46	$21.55	$47.46	$21.55
Utah[3]	$103.12	$63.18	$62.25	$60.63	$60.86
Vermont	$88.71	$62.27	$31.13	$68.50	$32.34
Virginia	$106.93	$66.74	$66.22	$61.84	$32.10
Washington	$93.85	$58.72	$58.26	$54.41	$54.63
West Virginia	$117.08	$90.90	$85.18	$67.12	$67.12
Wisconsin	$75.70	MP	MP	$88.09	$88.09
Wyoming	$136.86	$108.24	$101.00	$78.30	$78.96

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Evaluation and Management

State*	**99358** Prolonged service, 1st hour, not face-to-face	**99359** Same as 99358, each additional 30 minutes	**99361** Team medical conference, 30 minutes	**99362** Team medical conference, 60 minutes
Alabama	NC	NC	NC	NC
Arizona	BR	BR	$41.00	$90.00
Arkansas	NC	NC	NC	NC
California	$50.00	NC	NC	NC
Colorado	NC	NC	NC	NC
Connecticut	NC	NC	NC	NC
Dist of Columbia	MP	MP	NC	NC
Florida	NC	NC	NC	NC
Georgia	NC	NC	NC	NC
Hawaii	MP	MP	NC	NC
Idaho	NC	NC	NC	NC
Illinois	MP	MP	MP	MP
Iowa	BR	NP	NP	NP
Kansas	$5.18	NA	$30.00	NA
Kentucky	NC	NC	NC	NC
Louisiana	NC	NC	NC	NC
Maine	NC	NC	$31.25	$62.50
Maryland	NC	NC	NC	NC
Massachusetts	NC	NC	NC	NC
Minnesota	BR	BR	$30.90	$51.50
Mississippi	NC	NC	NC	NC
Missouri	NC	NC	NC	NC
Montana	BO	BO	BO	BO
Nebraska	NC	NC	NC	NC
Nevada	NC	NC	NC	NC
New Hampshire	$33.10	NC	$15.00	$30.00
New Jersey[1]	NC	NC	NC	NC
New Mexico	NC	NC	$26.76	$53.52
New York	NP	NP	NP	NP
North Carolina	NC	NC	$31.03	$62.04
North Dakota	NC	NC	NC	NC
Ohio	NC	NC	NC	NC
Oklahoma	$75.11	$75.11	MP	$200.00
Oregon	$0.01	$0.01	$26.46	$39.70
Pennsylvania	NA	NA	NA	NA
Rhode Island	OM	NC	NC	NC
South Carolina	NC	NC	NC	NC
South Dakota	$55.23	NL	NL	NL
Texas[2]	NA	NA	NA	NA
Utah[3]	$80.60	$40.18	$45.99	$80.60
Vermont	NC	NC	NC	NC
Virginia	NC	NC	$21.63	$43.28
Washington	BO	BO	$41.03	$72.32
West Virginia	NC	NC	NC	NC
Wisconsin	NC	NC	NC	NC
Wyoming	$60.00	$30.00	$39.00	$98.00

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Evaluation and Management

State*	99371 Telephone call – simple or brief	99372 Telephone call - intermediate	99373 Telephone call – complex or lengthy	99374 Supervision of patient under home health agency care	99375 Same as 99374, 30 minutes or more
Alabama	NC	NC	NC	$26.00	NC
Arizona	BR	BR	BR	$68.67	$124.04
Arkansas	NC	NC	NC	NC	NC
California	NC	NC	NC	NC	NC
Colorado	NC	NC	NC	NC	NC
Connecticut	NC	NC	NC	$40.82	NC
Dist of Columbia	NC	NC	NC	NC	NC
Florida	NC	NC	NC	NC	NC
Georgia	NC	NC	NC	NC	NC
Hawaii	NC	NC	NC	NC	NC
Idaho	NC	NC	NC	NC	NC
Illinois	MP	MP	MP	MP	MP
Iowa	NP	NP	NP	NP	NP
Kansas	NA	NA	NA	NA	NC
Kentucky	NC	NC	NC	NC	NC
Louisiana	NC	NC	NC	$1.00	NC
Maine	NC	NC	NC	NC	NC
Maryland	NC	NC	NC	NC	NC
Massachusetts	NC	NC	NC	NC	NC
Minnesota	BO	BO	BO	NC	BO
Mississippi	NC	NC	NC	NC	NC
Missouri	NC	NC	NC	NC	NC
Montana	BO	BO	BO	BO	NL
Nebraska	$2.59	$2.59	$2.59	NC	NC
Nevada	NC	NC	NC	$82.46	$105.85
New Hampshire	$5.00	$10.00	$15.00	NC	NC
New Jersey[1]	NC	NC	NC	NC	NC
New Mexico	NC	NC	NC	NC	NC
New York	NP	NP	NP	NP	NP
North Carolina	NC	NC	NC	NC	$115.52
North Dakota	NC	NC	NC	$57.12	$103.70
Ohio	NC	NC	NC	NC	NC
Oklahoma	MP	MP	MP	$56.76	$102.84
Oregon	$10.82	$10.82	$10.82	$68.25	$87.19
Pennsylvania	NA	NA	NC	NC	NC
Rhode Island	NC	NC	NC	NC	NA
South Carolina	$4.75	NC	NC	NC	NC
South Dakota	NL	NL	NL	NL	NL
Texas[2]	NA	NA	NA	NA	NA
Utah[3]	$7.43	$18.35	$36.70	$41.81	$56.91
Vermont	NC	NC	NC	NC	NC
Virginia	NC	NC	NC	$47.67	$70.83
Washington	$6.35	$12.70	$19.27	BO	$76.17
West Virginia	NC	NC	NC	NC	$92.40
Wisconsin	NC	NC	NC	NC	NC
Wyoming	$36.00	$37.50	NC	$85.87	NC

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	Newborn Care		*Hospital Care*		
State*	**99436** Physician attendance at delivery	**99440** Newborn resuscitation	**54150** Circumcision; newborn	**99221** Initial hospitalization, per day, low complexity	**99222** Initial hospitalization, per day, moderate complexity
Alabama	$81.00	$123.00	$114.00	$46.00	$76.00
Arizona	$111.55	$75.25	$149.01	$66.67	$110.99
Arkansas	$89.19	$96.00	$57.00	$59.00	$84.00
California	$64.70	$115.00	NC	$34.30	$73.20
Colorado	$80.58	$112.42	$38.11	$54.35	$88.37
Connecticut	$37.15	$73.59	$69.08	$32.98	$54.89
Dist of Columbia	$40.00	$56.40	$78.45	$34.00	$56.40
Florida	$42.49	$83.09	$173.19	$37.25	$61.95
Georgia	$82.53	$162.57	$154.83	$60.29	$99.20
Hawaii	$45.00	$45.00	$84.95	$53.33	$87.63
Idaho	$70.49	$144.21	$264.27	$61.70	$102.57
Illinois	$77.50	$83.70	$94.50	$33.90	$51.40
Iowa	$85.70	$168.80	$157.06	$63.19	$104.10
Kansas	$48.51	$131.37	$55.80	$42.77	$69.54
Kentucky	$85.68	$172.13	$67.93	$50.53	$84.07
Louisiana	NC	$135.00	$81.00	$43.12	$71.64
Maine	$60.20	$95.95	$58.43	$37.87	$63.05
Maryland	$60.65	$126.27	$18.00	$53.65	$88.98
Massachusetts	$54.02	$124.94	$101.15	$47.82	$79.37
Minnesota	BR	$102.74	$54.84	$54.07	$100.42
Mississippi	$64.85	$128.18	$93.40	$57.19	$95.25
Missouri	$50.00	$150.00	$33.60	$20.00	$25.00
Montana	$64.65	$116.19	$85.24	$51.88	$86.42
Nebraska	$102.26	$112.28	$80.10	$50.13	$88.22
Nevada	$64.31	$132.00	$143.71	$56.62	$93.85
New Hampshire	$67.32	$70.00	$80.00	$56.00	$86.00
New Jersey[1]	$39.70	$66.20	$16.00	$32.30	$32.30
New Mexico	$73.48	$145.34	$107.22	$62.29	$102.61
New York	NP	$25.00	$12.00	$10.00	$10.00
North Carolina	$71.04	$139.22	$213.72	$62.68	$103.99
North Dakota	$63.92	$124.44	$92.14	$55.76	$92.82
Ohio	$70.67	$148.58	$104.74	$34.52	$55.71
Oklahoma	$63.43	$123.84	$70.35	$55.39	$92.16
Oregon	$52.94	$103.50	$192.80	$46.45	$77.07
Pennsylvania	NC	$52.50	$79.00	$29.50	$29.50
Rhode Island	NP	$33.00	$25.20	NP	$44.00
South Carolina	$75.26	$134.00	$65.16	$79.00	$130.20
South Dakota	$87.70	$135.60	NL	$62.04	$86.30
Texas[2]	$85.92	$126.88	$50.75	$52.10	$82.65
Utah[3]	$71.78	$156.48	$82.54	$48.80	$78.71
Vermont	NC	$57.41	$58.66	$42.61	$70.53
Virginia	$52.05	$103.07	$77.04	$46.12	$76.78
Washington	$45.79	$90.45	$67.10	$40.58	$67.33
West Virginia	$57.49	$113.47	$198.66	$50.56	$84.28
Wisconsin	MP	$92.48	$60.03	$60.03	$66.13
Wyoming	$125.00	$150.00	$115.00	$59.22	$98.37

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Hospital Care

State*	99223 Initial hospitalization, per day, high complexity	99231 Subsequent hospitalization, per day, low complexity	99232 Subsequent hospitalization, per day, mod complexity	99233 Subsequent hospitalization, per day, high complexity	99238 Hospital discharge, day management, 30 min or under
Alabama	$103.00	$24.00	$37.00	$52.00	$44.00
Arizona	$154.50	$33.11	$54.72	$77.81	$69.55
Arkansas	$129.00	$33.00	$46.00	$62.00	$48.00
California	$80.10	$27.50	$37.80	$45.80	$37.60
Colorado	$113.29	$28.28	$41.83	$58.27	$49.39
Connecticut	$76.49	$16.43	$27.10	$38.52	$34.61
Dist of Columbia	$78.45	$16.92	$16.92	$39.71	NC
Florida	$86.23	$18.62	$30.55	$43.74	$39.14
Georgia	$132.67	$30.80	$48.02	$67.47	$57.11
Hawaii	$116.67	$27.32	$42.31	$56.39	$50.28
Idaho	$143.23	$30.92	$50.91	$72.47	$62.82
Illinois	$69.00	$16.40	$24.90	$35.05	$29.65
Iowa	$139.66	$32.26	$50.46	$71.00	$60.13
Kansas	$89.13	$27.00	$32.94	$45.88	$38.86
Kentucky	$107.67	$25.89	$38.86	$53.99	$45.76
Louisiana	$99.87	NC	NC	$50.53	$43.73
Maine	$74.99	$23.96	$31.78	$49.78	$29.48
Maryland	$124.11	$26.86	$44.10	$62.84	$54.87
Massachusetts	$110.78	$23.96	$39.40	$56.08	$48.77
Minnesota	$112.01	$30.12	$34.76	$92.90	$40.94
Mississippi	$132.75	$28.48	$47.03	$66.88	$59.46
Missouri	$28.00	$37.50	$45.00	$52.50	$24.00
Montana	$120.41	$25.83	$42.67	$60.64	$54.02
Nebraska	$114.29	$30.08	$48.12	$80.20	$72.18
Nevada	$130.77	$28.31	$46.46	$66.16	$57.23
New Hampshire	$30.00	$22.00	$30.00	$42.00	$54.95
New Jersey[1]	$32.30	$23.50	$23.50	$23.50	$23.50
New Mexico	$137.60	$31.81	$49.72	$69.95	$59.24
New York	$10.00	$10.00	$10.00	$10.00	$6.00
North Carolina	$144.94	$31.39	$51.41	$73.06	$65.22
North Dakota	$129.20	$27.88	$45.90	$65.62	$58.48
Ohio	$72.66	$17.49	$26.45	$37.06	$31.62
Oklahoma	$128.59	$27.87	$45.60	$65.23	$58.20
Oregon	$107.20	$23.10	$38.15	$54.24	$48.79
Pennsylvania	$42.00	$17.00	$17.00	$17.00	$17.00
Rhode Island	$46.00	$17.00	NP	$29.72	NP
South Carolina	$174.00	$40.00	$63.00	$89.00	$75.00
South Dakota	$110.39	$31.63	$44.54	$59.60	$43.42
Texas[2]	$104.47	$27.55	$39.55	$53.19	$47.46
Utah[3]	$102.64	$24.87	$37.32	$102.64	$44.74
Vermont	$85.37	$27.93	$39.42	$77.40	$31.12
Virginia	$106.93	$22.93	$37.88	$53.85	$48.18
Washington	$93.85	$20.18	$33.32	$47.38	$42.39
West Virginia	$116.78	$24.78	$41.53	$58.99	$52.67
Wisconsin	$75.70	$20.42	$25.56	$40.02	$37.59
Wyoming	$137.19	$29.61	$48.69	$69.42	$60.21

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Consultations

State*	99241 Office consultation, problem focused	99242 Office consultation, straightforward decision	99243 Office consultation, low complexity	99244 Office consultation, moderate complexity	99245 Office consultation, high complexity
Alabama	$41.00	$60.00	$76.00	$106.00	$138.00
Arizona	$49.67	$90.98	$119.86	$169.67	$219.05
Arkansas	$53.00	$66.00	$92.00	$109.00	$112.00
California	$30.60	$47.20	$59.50	$81.40	$102.20
Colorado	$36.99	$58.16	$75.46	$105.92	$142.69
Connecticut	$25.25	$45.88	$60.54	$84.43	$110.19
Dist of Columbia	$32.00	$46.36	$61.29	$86.98	$112.69
Florida	$28.04	$51.28	$67.81	$95.86	$123.28
Georgia	$48.05	$78.78	$100.50	$139.12	$180.61
Hawaii	$44.04	$71.19	$90.55	$124.60	$161.44
Idaho	$43.67	$81.04	$107.90	$153.67	$199.40
Illinois	$32.15	$40.20	$51.30	$71.40	$92.80
Iowa	$49.00	$81.13	$103.82	$144.50	$187.90
Kansas	$29.14	$45.86	$59.44	$83.37	$112.35
Kentucky	$34.96	$55.41	$71.58	$101.10	$136.07
Louisiana	$67.50	$76.50	$90.00	$112.50	$135.00
Maine	$27.76	$43.32	$56.78	$67.25	$100.00
Maryland	$39.37	$72.77	$96.72	$137.13	$177.55
Massachusetts	$35.60	$65.43	$87.03	$123.05	$159.10
Minnesota	$46.35	$60.25	$78.79	$113.55	$135.18
Mississippi	$41.05	$75.65	$99.92	$142.20	$184.12
Missouri	$16.50	$20.00	$20.00	$28.00	$50.00
Montana	$37.64	$69.22	$91.38	$129.86	$168.04
Nebraska	$48.12	$68.17	$88.22	$112.28	$152.38
Nevada	$41.23	$76.31	$100.93	$143.08	$185.24
New Hampshire	$31.00	$42.00	$65.00	$78.00	$102.00
New Jersey[1]	$44.00	$64.70	$91.10	$91.10	$91.10
New Mexico	$47.41	$80.20	$102.57	$142.65	$185.44
New York	$20.00	$20.00	$20.00	$20.00	$20.00
North Carolina	$45.51	$83.38	$111.21	$157.18	$203.56
North Dakota	$41.14	$75.48	$99.96	$141.78	$182.58
Ohio	$24.07	$38.89	$50.14	$70.13	$92.99
Oklahoma	$40.65	$74.37	$98.79	$140.28	$180.97
Oregon	$33.48	$62.28	$82.26	$117.00	$151.80
Pennsylvania	$30.00	$30.00	$30.00	$49.00	$49.00
Rhode Island	NP	$37.00	$37.00	$49.00	$51.00
South Carolina	$61.00	$101.00	$130.00	$181.00	$235.00
South Dakota	$49.92	$61.63	$81.69	$108.15	$132.50
Texas[2]	$35.19	$55.10	$71.19	$99.83	$132.56
Utah[3]	$34.21	$55.27	$71.06	$99.29	$131.59
Vermont	$47.56	$65.74	$91.91	$115.03	$154.44
Virginia	$34.53	$63.13	$83.23	$117.75	$152.02
Washington	$30.38	$55.31	$73.22	$103.38	$133.53
West Virginia	$35.21	$66.82	$87.89	$125.81	$163.74
Wisconsin	$47.09	$57.53	$78.49	$98.09	$99.08
Wyoming	$43.10	$79.29	$105.28	$149.37	$193.45

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	Consultations		*Pathology and Lab*		
	99254	**99255**	**81000**	**81002**	**86580**
State*	Initial inpatient consultation, moderate complexity	Initial inpatient consultation, high complexity	Urinalysis, non-automated with microscopy	Urinalysis, non-automated without microscopy	Tuberculosis, intradermal
Alabama	$95.00	$130.00	$4.00	$3.00	$6.00
Arizona	$140.01	$192.53	$4.43	$3.57	$10.31
Arkansas	$109.00	$112.00	$4.52	$3.66	$8.00
California	$65.01	$86.25	$3.50	$2.83	$8.08
Colorado	$106.65	$144.68	$4.15	$3.36	$8.61
Connecticut	$69.35	$95.33	$4.15	$3.49	$5.87
Dist of Columbia	$71.30	$96.08	$2.00	$2.00	$5.47
Florida	$78.07	$107.79	$3.00	$1.50	$5.22
Georgia	$123.04	$167.90	$3.99	$3.21	$8.13
Hawaii	$108.71	$148.14	$4.37	$3.54	$5.15
Idaho	$129.35	$178.35	$4.37	$3.54	$8.01
Illinois	$66.40	$87.10	$3.50	$2.60	$4.00
Iowa	$129.00	$176.19	$4.37	$3.54	$8.87
Kansas	$83.99	$113.93	$4.37	$3.01	$4.37
Kentucky	$101.47	$137.65	$4.47	$3.15	$6.95
Louisiana	$112.50	$135.00	$3.71	$3.00	$6.06
Maine	$67.44	$101.06	$3.84	$3.42	$5.76
Maryland	$113.19	$155.89	$4.00	$2.00	$2.60
Massachusetts	$100.52	$138.48	$3.54	$2.87	$7.51
Minnesota	$113.55	$135.18	$4.43	$3.57	$7.01
Mississippi	$119.84	$164.83	$4.70	$3.80	$7.82
Missouri	$28.00	$50.00	NC	NC	NC
Montana	$108.79	$149.62	$4.42	$3.57	$7.35
Nebraska	$120.30	$160.40	$4.43	$3.57	$17.77
Nevada	$118.77	$163.39	$4.60	$3.72	$13.33
New Hampshire	$78.00	$102.00	$3.50	$2.83	$5.44
New Jersey[1]	$91.10	$91.10	$1.20	$1.00	$4.00
New Mexico	$127.18	$173.69	$4.36	$3.52	$6.04
New York	$20.00	$20.00	$4.00	$2.00	$5.00
North Carolina	$130.68	$180.16	$4.43	$3.57	$8.79
North Dakota	$116.62	$161.16	$4.43	$3.57	$5.00
Ohio	$68.10	$92.32	$4.37	$3.26	$4.89
Oklahoma	$115.88	$160.02	$4.21	$3.12	$5.94
Oregon	$97.31	$133.90	$3.23	$2.62	$7.01
Pennsylvania	$49.00	$49.00	$4.37	$3.65	$5.20
Rhode Island	$54.00	$55.00	$2.66	$2.14	$5.16
South Carolina	$161.00	$220.00	$3.06	$2.68	$5.65
South Dakota	$120.02	$148.37	$4.37	$3.54	$7.58
Texas[2]	$100.65	$132.02	$4.37	$3.54	$7.36
Utah[3]	$96.18	$130.40	$4.09	$3.35	$5.28
Vermont	$88.20	$117.60	$7.26	$4.15	$11.86
Virginia	$96.88	$133.21	$4.37	$3.54	$7.21
Washington	$85.01	$116.98	$3.53	$2.85	$6.35
West Virginia	$106.55	$146.28	$4.43	$3.29	$6.18
Wisconsin	$87.84	$98.09	$4.37	$3.54	$7.07
Wyoming	$124.36	$171.41	$3.53	$2.84	$8.55

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	Pathology and Lab		*Mental Health*		
	87081	**87880**	**90801**	**90804**	**90806**
State*	Throat culture	Rapid Streptococcus screen	Psychiatric diagnostic interview examination	Individual psychotherapy, 20-30 minutes face-to-face	Individual psychotherapy, 45-50 minutes face-to-face
Alabama	$8.00	$14.00	$93.00	$41.00	$63.00
Arizona	$9.26	$16.76	$150.12	$64.70	$97.04
Arkansas	$9.47	$12.87	$86.00	$56.63	$88.13
California	$7.33	$10.27	$73.29	$29.18	$46.44
Colorado	$8.70	$15.75	$75.60	$39.19	$59.29
Connecticut	$8.70	$15.75	$70.07	$30.26	$45.24
Dist of Columbia	$4.00	$7.00	$77.38	$33.41	$49.95
Florida	$5.50	$11.50	$84.56	$36.42	$54.63
Georgia	$8.33	$15.08	$119.16	$53.03	NC
Hawaii	$9.16	$16.58	$104.43	$46.62	$75.00
Idaho	$6.81	$16.10	$36.99	$36.99	$55.50
Illinois	$5.80	$15.70	$67.50	$27.55	$47.50
Iowa	$8.09	$16.58	$126.04	$55.96	$85.74
Kansas	$7.35	$7.50	$30.00	$60.00	$90.00
Kentucky	$9.31	$16.43	$85.01	$42.23	$65.73
Louisiana	$7.74	$16.58	$77.14	NC	$76.70
Maine	$5.40	$13.00	$82.28	$36.80	$73.60
Maryland	$8.50	$16.50	$40.50	$21.00	$40.50
Massachusetts	$7.42	$12.83	$46.59	$47.36	$70.78
Minnesota	$8.47	$16.76	$43.47	$35.91	$75.60
Mississippi	$8.33	$15.08	$128.76	$55.45	$83.45
Missouri	NC	NC	$35**	$35**	$70**
Montana	$7.93	$16.75	$128.58	$55.37	$83.27
Nebraska	$9.26	$16.76	OM	OM	OM
Nevada	$9.15	$17.07	$125.23	$55.39	$83.08
New Hampshire	$6.38	$4.83	$65.00	$32.50	$72.00
New Jersey[1]	$9.00	$12.00	$37.00	$19.00	$37.00
New Mexico	$9.12	$16.51	$124.05	$55.11	$84.43
New York	$5.20	$3.75	$45.00	$27.00	$54.00
North Carolina	$8.06	$16.01	$141.38	$60.57	$91.43
North Dakota	$7.94	$16.76	$126.82	$54.74	$81.94
Ohio	$9.16	$16.58	$65.38	$36.69	$57.10
Oklahoma	$8.80	$15.92	$126.43	$42.23	$63.59
Oregon	$6.78	$12.27	$131.40	$65.72	$98.58
Pennsylvania	$5.20	$6.30	NC	NC	NC
Rhode Island	$5.56	$10.06	$36.00	NP	NP
South Carolina	$6.89	$12.27	$64.87	$35.96	$55.94
South Dakota	$6.09	NL	$75.60	$27.50	$50.00
Texas[2]	$9.16	$16.58	$125.00	$41.19	$64.10
Utah[3]	$3.45	$15.75	$88.04	$39.72	$61.01
Vermont	$9.48	$26.68	$75.99	$33.25	$53.58
Virginia	$9.16	$16.58	$104.10	$44.83	$67.25
Washington	$7.38	$13.36	$39.45	$59.17	NC
West Virginia	$9.26	$16.76	$113.77	$49.06	$73.74
Wisconsin	$9.16	$16.58	$80.13	$40.06	$80.13
Wyoming	$5.78	$16.58	$87.00	$58.00	$87.00

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Pathology and Lab

State*	**90808** Individual psychotherapy, 75-80 minutes face-to-face	**90862** Pharmacologic management	**90887** Interpretation or explanation of results	**96110** Developmental testing, Limited	**96111** Developmental testing, Extended
Alabama	$97.00	$33.00	$36.00	$32.00	$44.00
Arizona	$145.04	$50.89	$86.83	$14.26	$143.47
Arkansas	$148.51	$40.00	$12.96	NC	$63.38
California	$74.44	$23.22	NC	$54.90	$62.30
Colorado	$89.23	$88.37	$130.65	$34.32	$45.78
Connecticut	$67.46	$23.88	$36.60	$75.13	$75.13
Dist of Columbia	$74.47	$26.38	$25.00	$20.00	$39.00
Florida	$81.42	$28.67	$48.98	NC	NC
Georgia	NC	NC	NC	$45.29	$62.10
Hawaii	$110.09	$38.28	NC	NC	NC
Idaho	$82.77	$48.45	$44.50	$27.10	$57.19
Illinois	$64.80	$22.45	MP	$16.10	$16.10
Iowa	$131.62	$45.63	NP	$59.84	$59.84
Kansas		$90.00	$14.23	$31.50	$31.50
Kentucky	$110.27	$39.02	NC	$32.19	$49.92
Louisiana	NC	$35.38	NC	NC	NC
Maine	$89.38	$49.55	NC	$58.38	$137.81
Maryland	$63.00	$13.00	NC	$12.50	$75.00
Massachusetts	$104.43	$37.82	$54.89	NC	NC
Minnesota	$96.39	$60.48	$39.31	BR	BR
Mississippi	$124.74	$43.68	NP	$9.88	$122.00
Missouri	NC	$12.50	NC	NC	$35.00
Montana	$124.43	$43.62	BO	$9.42	$110.93
Nebraska	OM	OM	OM	$25.53	$105.46
Nevada	$122.77	$44.31	NC	$58.46	NC
New Hampshire	$100.00	$41.00	$45.00	$38.99	$39.90
New Jersey[1]	NC	$16.00	$19.00	NC	$37.00
New Mexico	$129.65	$44.95	NC	$12.42	$62.39
New York	$81.00	$22.50	NP	NP	NP
North Carolina	$136.36	$47.98	NC	$10.14	$132.72
North Dakota	$122.40	$43.18	$18.36	$53.04	$53.04
Ohio	$96.06	$30.14	NC	$26.57	$42.51
Oklahoma	$94.74	$42.92	$56.61	MP	$91.95
Oregon	$164.30	$65.72	$89.00	$9.34	$94.46
Pennsylvania	NC	NC	NC	NC	$50.00
Rhode Island	NP	$15.60	NC	NC	NP
South Carolina	$94.05	$28.50	$44.83	$20.25	$40.55
South Dakota	$75.00	$22.10	$45.40	NL	NL
Texas[2]	$108.01	$42.50	NA	NA	NA
Utah[3]	$96.66	$323.01	$45.53	NC	NC
Vermont	$98.16	$47.66	$53.39	$49.98	$70.56
Virginia	$100.49	$35.30	NC	$9.53	$99.20
Washington	NA	$31.06	NC	NC	NC
West Virginia	NC	$38.22	NC	$33.37	$50.56
Wisconsin	$120.19	$31.68	$80.13	$80.13	$80.13
Wyoming	$128.97	$29.00	NC	$63.00	$106.92

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Allergy / Immunology

State*	95004 Percutaneous tests with allergenic extracts	95010 Percutaneous tests, sequential and incremental	95015 Intracutaneous tests, With biologicals	95024 Intracutaneous tests, with allergenic extracts	95115 Allergen immunotherapy, single injection	95117 Allergen immunotherapy, 2 or more injections
Alabama	$2.00	$10.00	$10.00	$4.00	$9.16	$11.62
Arizona	$4.06	$18.06	$11.48	$5.88	$14.69	$19.07
Arkansas	$2.00	$2.00	$2.00	$2.00	$4.00	$6.00
California	$1.90	$9.70	$10.30	$2.80	$4.90	NC
Colorado	$2.24	$6.22	$6.22	$3.42	$8.93	$12.35
Connecticut	$2.14	$9.42	$5.84	$3.14	$7.87	$10.25
Dist of Columbia	$2.22	$12.00	$10.77	$3.25	$8.35	$10.61
Florida	$2.29	$10.25	$6.48	$3.14	$8.58	$10.88
Georgia	$3.50	$13.31	$13.94	$5.11	$13.41	$17.25
Hawaii	$3.37	$12.30	$12.93	$4.63	$12.97	$16.72
Idaho	$3.12	$20.17	$18.22	$4.74	$12.43	$16.01
Illinois	$3.40	$13.20	$13.90	$5.00	$6.50	$8.30
Iowa	$3.37	$13.47	$14.10	$4.93	$12.99	$16.75
Kansas	$2.17	$5.36	$5.59	$3.24	$8.39	$10.74
Kentucky	$2.66	$6.12	$7.59	$4.00	$10.54	$13.37
Louisiana	$1.58	$1.98	$4.14	$2.93	$5.08	$8.46
Maine	$3.11	$2.74	$2.74	$2.74	$2.76	$4.01
Maryland	$0.35	$2.30	$2.30	$2.30	$6.50	$6.50
Massachusetts	$2.87	$7.35	$8.02	$4.33	$11.33	$14.61
Minnesota	$3.09	$6.79	$7.72	$4.63	$13.00	$16.45
Mississippi	$3.07	$14.57	$9.51	$4.47	$11.20	$14.57
Missouri	$1.00	$1.00	$1.40	$1.40	$3.75	$3.75
Montana	$2.89	$13.46	$8.73	$4.22	$10.51	$13.67
Nebraska	$2.81	$5.61	$6.42	$4.01	$4.88	$4.88
Nevada	$3.39	$19.39	$17.54	$4.92	$12.62	$16.00
New Hampshire	$1.63	$6.80	$3.85	$2.81	$7.00	$11.62
New Jersey[1]	$3.75	$20.00	$18.25	$5.50	$2.50	$2.50
New Mexico	$3.36	$13.36	$10.98	$4.93	$12.96	$16.71
New York	$0.50	$0.50	$0.75	$0.75	NP	NP
North Carolina	$3.56	$16.29	$10.29	$5.23	$13.45	$17.11
North Dakota	$3.06	$14.96	$9.52	$4.42	$12.24	$15.30
Ohio	$2.73	$8.37	$8.73	$3.89	$10.34	$14.85
Oklahoma	$2.40	$11.46	$7.34	$3.31	$9.14	$11.66
Oregon	$2.85	$15.57	$14.01	$4.15	$10.64	$13.49
Pennsylvania	$1.50	$4.00	$4.00	$5.00	$3.50	$7.00
Rhode Island	$0.96	$0.96	$0.96	$0.96	$8.40	$8.40
South Carolina	$1.91	$5.88	$5.71	$3.03	$9.45	$12.24
South Dakota	$2.51	$4.89	$5.69	$3.56	$4.10	$5.70
Texas[2]	$2.73	$10.09	$7.36	$4.09	$6.09	$9.14
Utah[3]	$2.63	$7.89	$8.37	$3.82	$10.04	$12.92
Vermont	$1.81	$11.41	$10.27	$2.75	$7.97	$9.54
Virginia	$2.83	$12.63	$7.99	$4.12	$10.31	$13.40
Washington	$2.49	$11.11	$7.03	$3.63	$9.07	$11.79
West Virginia	$2.70	$15.65	$14.14	$3.91	$10.53	$13.24
Wisconsin	$2.15	$6.91	$7.19	$4.60	$3.69	$4.90
Wyoming	$2.90	$20.07	$18.10	$4.35	$7.25	$14.50

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Cardiology

State*	**32020** Thoracostomy Tube	**92950** Cardio-pulmonary resuscitation	**93303** Transthoracic echocar-diography	**93307** Echocardiography, real-time with image documentation	**93320** Doppler echocar-diography
Alabama	$158.00	$145.00	$143.00	$133.00	$75.00
Arizona	$218.68	$187.47	$218.78	$199.80	$87.76
Arkansas	$241.00	$172.00	$238.10	$178.00	$129.00
California	$94.56	$115.00	$152.10	$150.10	$76.57
Colorado	$207.93	$84.00	$164.16	$132.72	$154.84
Connecticut	$134.10	$91.81	$114.30	$104.90	$46.06
Dist of Columbia	$130.00	$115.00	$125.00	$117.00	$51.00
Florida	$122.24	$105.07	$123.07	$112.07	$49.40
Georgia	$203.58	$189.40	$198.86	$185.42	$81.11
Hawaii	$180.76	$168.25	$187.44	$175.94	$77.00
Idaho	$196.21	$190.64	$185.98	$168.39	$73.86
Illinois	$224.70	$112.50	$98.10	$91.00	$39.80
Iowa	$210.97	$197.40	$197.61	$183.19	$79.99
Kansas	$150.00	$130.00	$200.00	$200.00	$88.09
Kentucky	$197.78	$176.52	$166.87	$157.16	$72.12
Louisiana	$93.00	$162.43	$169.21	$168.41	$93.58
Maine	$123.14	$100.21	$44.95	$25.39	$56.93
Maryland	$42.00	$32.00	$38.00	$34.00	$52.00
Massachusetts	$178.24	$148.83	$181.35	$178.52	$82.75
Minnesota	$355.35	$106.60	BR	$173.81	$76.16
Mississippi	$185.03	$161.23	$173.09	$156.69	$68.64
Missouri	$21.60	$60.00	$102.00	$110.00	$165.00
Montana	$168.35	$146.09	$160.76	$145.91	$63.95
Nebraska	$117.80	$148.37	$220.55	$236.59	$112.28
Nevada	$216.11	$176.00	$181.85	$165.85	$72.92
New Hampshire	$13.45	$107.00	$128.89	$121.89	$57.00
New Jersey[1]	$121.00	$37.00	$98.00	$60.00	$27.00
New Mexico	$208.48	$182.82	$196.39	$185.55	$81.39
New York	$20.00	$6.50	$90.00	$90.00	$87.00
North Carolina	$197.57	$282.31	$197.56	$179.32	$78.63
North Dakota	$180.54	$157.08	$182.00	$160.14	$70.38
Ohio	$174.09	$156.12	$162.25	$151.53	$66.43
Oklahoma	$138.00	MP	$134.31	$121.62	$53.36
Oregon	$363.00	$130.30	$152.10	$138.60	$60.72
Pennsylvania	$211.00	NA	NA	$158.00	$76.50
Rhode Island	$126.00	$129.60	NP	$48.00	$48.00
South Carolina	$262.12	$141.16	$137.77	$129.40	$62.59
South Dakota	$252.00	$195.90	NL	$194.78	$94.60
Texas[2]	$214.93	$147.02	$172.93	$161.20	$82.37
Utah[3]	$163.89	$142.38	$100.72	$100.72	$44.74
Vermont	$49.99	$86.53	$161.70	$173.46	$82.32
Virginia	$150.73	$129.35	$152.80	$139.65	$61.32
Washington	$131.26	$113.12	$134.43	$122.87	$53.95
West Virginia	$166.75	$143.87	$157.72	$142.97	$62.60
Wisconsin	$284.86	$117.79	$219.43	$119.52	$55.45
Wyoming	$191.48	$184.24	$126.67	$126.67	$77.22

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	Cardiology			*Critical Care*	
State*	**93501** Right heart catheterization	**93510** Left heart catheterization	**31500** Intubation, endotracheal	**36555** Insertion of non-tunneled center venous catherther; < 5 yrs	**36568** Insertion of peripherally inserted CVC; under 5 years
Alabama	$498.00	$894.00	$104.00	$211.00	$240.69
Arizona	$824.53	$1,699.51	$114.41	$327.71	$379.30
Arkansas	$294.00	$356.00	$69.00	$333.40	$290.69
California	$70.05	$70.05	$59.20	NA	NA
Colorado	$604.74	$1,236.34	$46.80	$89.59	$65.86
Connecticut	$433.90	$898.58	$69.78	$213.53	$250.75
Dist of Columbia	$477.00	$941.00	$66.00	$71.02	$210.73
Florida	$91.26	$141.70	$64.05	$186.70	$217.68
Georgia	$756.79	$1,489.41	$106.50	$292.33	$341.47
Hawaii	$719.33	$1,428.00	$93.64	$61.36	$74.05
Idaho	$687.78	$1,391.39	$107.99	$286.82	$331.52
Illinois	$371.00	$727.50	$55.50	NP	NP
Iowa	$743.12	$1,456.48	$111.38	$271.89	$71.64
Kansas	$743.23	$1,431.45	$76.92	$390.72	$214.56
Kentucky	$654.96	$1,223.29	$102.35	$102.82	$216.32
Louisiana	$481.92	$974.43	$55.46	NC	NC
Maine	$128.70	$423.91	$38.02	$60.30	$44.13
Maryland	$144.00	$80.00	$31.00	$129.46	$151.21
Massachusetts	$888.43	$1,403.94	$88.87	$251.97	$298.82
Minnesota	$463.50	$463.50	$100.42	BR	BR
Mississippi	$642.11	$1,314.18	$98.30	$264.11	$300.17
Missouri	$165.00	$165.00	$9.20	$31.72	$36.55
Montana	$599.04	$1,228.67	$89.10	$244.10	$279.00
Nebraska	$842.10	$1,644.10	$70.68	$61.26	$47.12
Nevada	$682.46	$1,388.65	$117.28	$141.30	$103.86
New Hampshire	$175.00	$900.00	$70.00	$18.70	$60.78
New Jersey[1]	$630.00	$1,045.00	$42.00	$172.00	$132.00
New Mexico	$740.10	$1,451.52	$109.91	$288.89	$311.20
New York	$140.00	$80.00	$20.00	$160.00	$112.00
North Carolina	$738.87	$1,518.20	$106.58	$290.74	$322.66
North Dakota	$659.60	$1,355.92	$95.54	$271.66	$308.52
Ohio	$610.34	$1,175.83	$90.13	$225.03	$261.13
Oklahoma	$499.59	$1,025.61	$73.45	$208.16	$240.23
Oregon	$572.50	$1,167	$81.74	$231.50	$269.90
Pennsylvania	$140.00	$187.50	$72.00	NA	NA
Rhode Island	$210.00	$235.20	$42.00	NP	NP
South Carolina	$538.85	$1,027.53	$78.71	$88.38	$184.23
South Dakota	$692.83	$1,293.81	$78.80	NL	NL
Texas[2]	$200.21	$247.67	$103.65	NA	NA
Utah[3]	$438.57	$958.74	$84.70	$222.11	$258.12
Vermont	$183.68	$424.02	$56.17	$42.35	$91.22
Virginia	$576.40	$1,189.13	$78.85	$229.06	$265.91
Washington	$506.22	$1,044.63	$68.92	$202.22	$235.09
West Virginia	$590.26	$1,199.18	$90.30	$240.80	$274.51
Wisconsin	$297.28	$410.98	$106.91	$314.97	$362.55
Wyoming	$145.42	$209.57	$104.29	NC	NC

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	Critical Care		*Emergency Care*			
	36600	**36620**	**99291**	**99292**	**10120**	**12015**
State*	Arterial puncture, diagnostic	Arterial line placement	Critical care, first hour	Critical care, additional 30 minutes	Simple surgical removal of foreign body	Simple surgical repair of facial wounds (76 - 125 cm)
Alabama	$21.00	$53.00	$126.00	$63.00	$58.00	$142.00
Arizona	$30.29	$54.55	$241.34	$107.51	$103.75	$247.39
Arkansas	$39.00	$125.00	$152.00	$76.00	$57.00	$106.00
California	$12.66	$42.07	$121.60	$58.90	$51.75	$112.81
Colorado	$6.69	$40.12	$149.32	$71.90	$26.74	$80.23
Connecticut	$19.53	$33.28	$121.44	$53.43	$66.14	$156.89
Dist of Columbia	NC	$36.00	$108.78	$55.91	$55.93	$132.58
Florida	$17.36	$30.34	$136.46	$60.27	$58.81	$140.02
Georgia	$21.78	$53.60	$163.48	$81.55	$76.56	$187.79
Hawaii	$15.16	$47.24	$144.68	$71.82	$49.27	$138.00
Idaho	$25.74	$50.10	$199.77	$102.30	$94.71	$227.88
Illinois	$16.65	$37.40	$84.90	$42.35	$39.05	$125.50
Iowa	$22.31	$56.01	$171.76	$85.64	$78.58	$193.20
Kansas	$10.50	$35.00	$176.54	$56.60	$50.00	$100.00
Kentucky	$17.39	$54.85	$147.84	$71.86	$48.47	$138.99
Louisiana	$14.81	$65.70	$150.30	$86.40	$14.81	$70.65
Maine	$22.50	$54.00	$128.67	$63.63	$15.75	$45.00
Maryland	$24.00	$21.00	$173.32	$90.05	$15.00	$50.00
Massachusetts	$20.69	$46.24	$118.91	$57.68	$72.11	$175.75
Minnesota	$36.30	$98.88	$123.60	$62.83	$38.62	$135.18
Mississippi	$61.94	$47.16	$204.18	$92.01	$85.09	$204.23
Missouri	$2.10	$6.00	$150.00	$75.00	$13.20	$35.00
Montana	$22.79	$42.67	$186.02	$83.56	$78.20	$187.31
Nebraska	$18.85	$51.83	$168.42	$84.21	$54.76	$108.38
Nevada	$15.92	$53.93	$180.93	$93.85	$62.26	$175.93
New Hampshire	$13.45	$90.00	$72.00	$36.00	$12.50	$45.00
New Jersey[1]	$8.00	$20.00	$66.20	$33.10	$18.00	$46.00
New Mexico	$22.07	$53.35	$169.28	$84.41	$77.74	$191.09
New York	$7.50	$7.50	$25.00	$12.50	$8.00	$20.00
North Carolina	$28.30	$50.91	$234.08	$104.28	$118.95	$226.00
North Dakota	$25.50	$45.56	$202.98	$90.10	$86.02	$205.36
Ohio	$19.93	$48.27	$95.19	$46.32	$50.40	$135.24
Oklahoma	$19.53	$35.09	$201.59	$89.69	$65.78	$157.25
Oregon	$19.46	$37.63	$148.20	$76.03	$74.22	$176.70
Pennsylvania	$13.00	$58.00	$151.63	$74.40	$30.50	$61.50
Rhode Island	$11.95	$33.60	$29.72	$17.00	$25.20	$42.00
South Carolina	$14.13	$46.27	$214.00	$107.00	$45.37	$106.33
South Dakota	$28.40	$80.60	$150.06	$77.10	$34.00	$125.95
Texas[2]	$17.46	$55.92	$112.10	$54.28	$49.10	$140.47
Utah[3]	$15.31	$45.45	$134.23	$65.31	$48.56	$127.76
Vermont	$13.58	$36.42	$98.59	$50.91	$27.28	$66.78
Virginia	$21.13	$37.62	$167.48	$74.47	$72.15	$171.86
Washington	$18.59	$32.87	$147.36	$65.52	$63.75	$150.76
West Virginia	$19.86	$41.53	$161.63	$82.47	$78.26	$188.72
Wisconsin	$24.02	$64.04	$88.09	$44.04	$41.22	$135.12
Wyoming	$25.33	$68.61	$189.83	$98.37	$91.35	$224.05

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	Consultations		*Pathology and Lab*		
State*	**36400** Venipuncture necessitating physician skill; < 3 years	**36410** Venipuncture necessitating physician skill; >= 3 yrs	**36415** Routine venipuncture	**36416** Finger, heel, ear stick	**62270** Lumbar puncture, diagnostic
Alabama	$13.00	$14.00	$2.00	$1.60	$79.00
Arizona	$25.18	$18.08	$3.00	BR	$157.51
Arkansas	$12.00	$18.00	$3.00	NC	$99.00
California	$16.75	NC	NC	NC	NC
Colorado	$13.37	$6.69	$3.00	$3.00	$33.43
Connecticut	$15.96	$11.70	$2.42	MP	$103.32
Dist of Columbia	$25.53	$11.52	$1.00	NC	$99.73
Florida	$30.16	$5.72	NC	NC	$88.96
Georgia	$17.10	$16.80	NC	NC	$107.29
Hawaii	$6.80	$7.48	$3.00	NC	$51.03
Idaho	$37.15	$22.87	$3.07	$3.07	$174.22
Illinois	$16.65	$16.65	MP	MP	$53.70
Iowa	$17.24	$17.00	$3.08	$3.08	$108.08
Kansas	$12.92	$13.00	$3.00	NA	$59.14
Kentucky	$6.73	$11.67	$8.45	$3.27	$53.66
Louisiana	$14.81	$7.99	$2.65	$2.65	$119.29
Maine	$27.00	$27.00	$2.70	$2.70	$44.10
Maryland	$15.00	$14.00	$1.50	$1.50	$18.00
Massachusetts	$11.83	$16.24	NC	NC	$81.56
Minnesota	$27.41	$20.46	$3.00	BR	$75.89
Mississippi	$21.18	$14.74	NC	NC	$126.37
Missouri	$2.40	$6.36	CP	NC	$19.20
Montana	$19.33	$13.58	$3.00	BO	$116.98
Nebraska	$18.85	$14.14	$3.67	NC	$94.24
Nevada	$18.10	$8.68	$3.98	$4.34	$61.90
New Hampshire	$10.00	$10.00	NC	NC	$37.00
New Jersey[1]	$13.00	$18.00	$1.80	$1.80	$18.00
New Mexico	$17.10	$16.84	$12.63	NC	$107.20
New York	$8.00	NP	NP	NP	$18.00
North Carolina	$23.70	$16.37	$3.00	NC	$142.10
North Dakota	$21.08	$15.30	$3.06	$6.80	$129.20
Ohio	$33.80	$15.33	$3.63	$3.63	$130.83
Oklahoma	$16.36	$11.76	$2.85	MP	$99.13
Oregon	$33.22	$15.05	$3.24	$3.00	$271.00
Pennsylvania	NA	NA	NA	NA	$42.00
Rhode Island	$5.40	$49.75	$1.92	NC	$25.20
South Carolina	$10.74	$11.66	$3.00	$3.00	$45.00
South Dakota	NL	$23.20	$4.60	NL	$78.80
Texas[2]	$7.91	$12.00	NA	NA	$54.28
Utah[3]	$9.32	$11.24	$3.02	NC	$46.17
Vermont	$13.58	$21.23	$8.00	$4.00	$69.00
Virginia	$17.52	$12.63	$3.00	$1.00	$110.28
Washington	$15.42	$11.11	$2.45	$2.45	$97.48
West Virginia	$33.71	$15.35	NC	NC	$131.53
Wisconsin	$33.87	$10.01	NC	NC	$58.70
Wyoming	$36.52	$22.70	$3.00	$3.00	$173.38

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Emergency Care

State*	99141 Conscious sedation; IV/IM/inhalation	99142 Conscious sedation; oral/rectal/intranasal	99282 ED visit, low complexity	99283 ED visit, moderate complexity	99284 ED visit, Detailed
Alabama	NC	NC	$21.00	$42.00	$65.00
Arizona	$102.02	$60.18	$27.64	$61.69	$95.67
Arkansas	NC	NC	$35.00	$49.00	$65.00
California	$84.28	$75.34	$24.38	$44.60	$68.35
Colorado	$46.06	$43.99	$26.07	$47.74	$73.02
Connecticut	$46.29	$29.25	$13.54	$30.12	$46.74
Dist of Columbia	$100.00	OM	$17.42	$30.86	$48.17
Florida	$58.60	$34.33	$22.92	$42.24	$64.68
Georgia	NC	NC	$27.00	$54.80	$84.21
Hawaii	NC	NC	$23.95	$48.05	$73.66
Idaho	$40.02	$30.25	$24.98	$55.94	$87.43
Illinois	$76.70	$76.70	$24.20	$32.20	$44.00
Iowa	NA	NA	$28.18	$57.50	$88.53
Kansas	NA	NA	$28.89	$55.23	$85.06
Kentucky	$58.97	$29.89	$24.71	$45.51	$69.53
Louisiana	$45.00	$45.00	$19.80	$39.65	$61.89
Maine	NC	NC	$19.42	$25.73	$34.41
Maryland	$20.00	$13.00	$21.33	$47.78	$74.44
Massachusetts	NC	NC	$22.29	$42.93	$66.98
Minnesota	BR	BR	$35.53	$43.07	$58.62
Mississippi	NC	NC	$23.71	$52.91	$82.28
Missouri	NC	NC	$19.00	$23.00	$24.00
Montana	BO	BO	$21.50	$47.97	$74.55
Nebraska	$52.13	$40.10	$31.32	$46.98	$55.68
Nevada	$94.16	$59.39	$22.27	$51.69	$80.31
New Hampshire	$225.80	NC	$22.00	$36.00	$54.00
New Jersey[1]	NC	$23.50	$23.50	$23.50	$32.36
New Mexico	NC	NC	$26.92	$56.71	$87.28
New York	$5.00	$5.00	$17.00	$17.00	$17.00
North Carolina	NC	NC	$25.39	$57.04	$89.08
North Dakota	$85.34	$50.32	$23.12	$51.00	$79.90
Ohio	NC	NC	$18.12	$34.55	$53.21
Oklahoma	$65.41	$38.50	$25.00	$25.00	$25.00
Oregon	$77.59	$48.79	$18.94	$42.56	$66.43
Pennsylvania	NA	NA	$35.00	$35.00	$50.00
Rhode Island	NC	NC	$17.91	$38.00	$59.20
South Carolina	$85.00	$85.00	$35.00	$71.00	$110.00
South Dakota	NL	NL	$34.79	$47.40	$71.90
Texas[2]	NA	NA	$35.73	$48.28	$70.64
Utah[3]	$44.98	$35.41	$22.25	$42.11	$64.60
Vermont	NL	NL	$26.84	$36.07	$50.91
Virginia	$71.37	$42.00	$19.07	$42.51	$65.96
Washington	BO	BO	$16.55	$37.18	$57.58
West Virginia	NC	NC	$20.46	$47.25	$73.44
Wisconsin	NC	NC	$30.30	$40.54	$92.11
Wyoming	$97.38	NC	$49.90	$53.96	$84.22

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	Gastrointestinal		*Ophthalmology*		
State*	**43239** Upper gastrointestinal endoscopy with biopsy	**44389** Colonoscopy with biopsy	**45331** Sigmoidoscopy With Biopsy	**67311** Strabismus surgery, horizontal	**67314** Strabismus surgery, vertical
Alabama	$201.00	$245.00	$76.00	$426.00	$475.00
Arizona	$317.84	$362.81	$152.46	$495.78	$560.16
Arkansas	$373.00	$244.00	$119.00	$607.00	$404.00
California	$234.18	NC	$72.23	$56.04	$56.04
Colorado	$20.06	$10.03	$16.72	$468.02	$501.45
Connecticut	$206.59	$236.03	$99.75	$315.62	$256.68
Dist of Columbia	$182.49	$209.98	$68.56	$273.00	$308.00
Florida	$181.89	$207.63	$87.91	$280.89	$317.73
Georgia	$210.98	$257.56	$102.19	$442.17	$493.57
Hawaii	$138.60	$163.35	$65.59	$217.62	$245.40
Idaho	$325.81	$362.83	$119.71	$448.43	$448.43
Illinois	$249.70	$192.85	$142.70	$511.90	$511.90
Iowa	$214.79	$261.60	$103.83	$454.25	$507.41
Kansas	$220.00	$185.50	$106.88	$250.00	$266.91
Kentucky	$179.22	$210.07	$83.80	$412.47	$467.63
Louisiana	$177.66	$266.72	$70.55	$514.99	$517.50
Maine	$166.95	$182.00	$61.06	$357.22	$384.55
Maryland	$234.00	$158.00	$128.00	$281.00	$281.00
Massachusetts	$219.23	$247.11	$100.01	$391.75	$443.83
Minnesota	$325.99	$280.16	$122.82	$596.37	BR
Mississippi	$257.67	$293.27	$122.51	$412.02	$465.63
Missouri	$88.00	$120.00	$148.00	$199.20	$224.00
Montana	$237.78	$270.84	$113.33	$377.37	$426.45
Nebraska	$202.62	$230.89	$84.82	$918.84	$918.84
Nevada	$158.19	$179.91	$65.16	$493.04	$547.70
New Hampshire	$126.00	$225.80	$225.80	$335.00	$432.00
New Jersey[1]	$163.00	$114.00	$54.00	$272.00	$262.80
New Mexico	$225.28	$259.08	$102.83	$449.05	$501.54
New York	$100.00	$160.00	$320.00	$240.00	$240.00
North Carolina	$298.55	$339.37	$145.72	$448.06	$497.50
North Dakota	$265.20	$302.26	$127.84	$414.46	$65.50
Ohio	$172.53	$198.19	$88.43	$370.61	$416.99
Oklahoma	$203.71	$231.89	$97.91	$319.21	$361.11
Oregon	$363.00	$273.80	$271.00	$417.00	$513.00
Pennsylvania	$211.50	$300.00	$85.00	$483.50	$483.50
Rhode Island	$184.80	$101.76	NP	NP	$369.60
South Carolina	$152.44	$244.62	$132.14	$422.84	$471.98
South Dakota	$62.08	$357.95	$89.38	$640.65	$694.04
Texas[2]	$207.84	$226.39	$90.28	$685.13	$735.88
Utah[3]	$164.38	$188.54	$89.96	$352.68	$396.70
Vermont	$173.80	$163.93	$60.73	$490.76	$501.05
Virginia	$222.11	$253.54	$106.67	$354.01	$389.85
Washington	$196.10	$223.75	$94.31	$304.00	$343.45
West Virginia	$246.51	$282.94	$93.00	$360.89	$402.13
Wisconsin	$481.90	$352.11	$106.45	$797.91	$797.46
Wyoming	$322.42	$359.60	$118.44	$935.55	$485.60

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	Ophthalmology		*Otolaryngology*	
State*	**68810** Nasolacrimal Probing	**42820** Tonsillectomy adenoidectomy, under 12 years	**42821** Tonsillectomy /adenoidectomy, over 12 years	**69436** Tympanostomy and tubes
Alabama	$152.00	$225.00	$248.00	$110.00
Arizona	$159.73	$286.16	$308.83	$161.17
Arkansas	$69.50	$343.00	$422.00	$211.00
California	$56.04	$168.65	$202.53	$56.04
Colorado	$52.15	$183.87	$200.58	$133.72
Connecticut	$102.41	$180.84	$195.02	$102.68
Dist of Columbia	$85.92	$164.49	$171.14	$81.00
Florida	$90.63	$162.01	$174.77	$91.26
Georgia	$209.01	$240.77	$271.07	$130.29
Hawaii	$158.37	$217.62	$245.40	$158.37
Idaho	$149.78	$275.04	$298.03	$139.00
Illinois	$103.50	$194.20	$202.50	$80.50
Iowa	$210.58	$247.71	$278.39	$133.50
Kansas	$20.00	$125.00	$150.00	$130.00
Kentucky	$51.50	$197.61	$236.90	$118.77
Louisiana	$60.25	$425.25	$425.25	$189.00
Maine	$22.50	$156.00	$189.00	$110.20
Maryland	$14.00	$86.00	$96.00	$83.00
Massachusetts	$100.81	$225.09	$243.53	$116.55
Minnesota	BR	$352.26	$374.66	$193.12
Mississippi	$131.62	$237.22	$256.40	$132.59
Missouri	$24.00	$154.00	$172.00	$141.00
Montana	$120.86	$217.30	$234.77	$121.73
Nebraska	$94.24	$310.99	$339.26	$188.48
Nevada	$106.79	$305.52	$330.86	$154.57
New Hampshire	$225.80	$351.00	$495.00	$351.00
New Jersey[1]	$20.00	$79.00	$103.00	$54.00
New Mexico	$152.25	$244.91	$275.33	$153.48
New York	$12.00	$60.00	$80.00	$100.00
North Carolina	$192.83	$257.12	$278.21	$151.21
North Dakota	$238.00	$238.00	$257.04	$133.62
Ohio	$51.58	$185.55	$225.21	$108.17
Oklahoma	$102.45	$182.41	$197.05	$102.43
Oregon	$314.00	$585.00	$585.00	$417.00
Pennsylvania	NA	$184.00	$199.00	$98.50
Rhode Island	NP	$117.60	$151.20	$84.00
South Carolina	$49.77	$187.32	$223.64	$112.10
South Dakota	NL	$274.10	$299.30	$176.40
Texas[2]	$50.46	$202.66	$244.12	$122.74
Utah[3]	$92.83	$175.62	$213.43	$102.64
Vermont	$48.87	$208.19	$194.30	$133.56
Virginia	$111.31	$198.66	$214.38	$112.08
Washington	$98.16	$174.33	$188.16	$98.39
West Virginia	$119.49	$233.27	$244.71	$114.38
Wisconsin	$81.23	$265.50	$265.52	$212.13
Wyoming	$146.73	$396.05	$430.35	$268.19

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Neonatal and Pediatric Critical Care

State*	36510 Umbilical vein catheterization	36660 Umbilical artery catheterization	99293 Initial pediatric critical care	99294 Subsequent pediatric critical care	99295 Initial neonatal critical care
Alabama	$46.00	$58.00	$189.00	$126.00	$189.00
Arizona	$180.12	$72.41	$811.96	$400.65	$920.26
Arkansas	$89.00	$129.00	$618.09	$305.79	$648.05
California	$25.69	$31.65	$495.82	$245.03	NC
Colorado	$25.07	$67.19	$556.14	$275.60	$511.00
Connecticut	$118.80	$44.48	$400.12	$198.02	$453.39
Dist of Columbia	$36.00	$36.52	NC	$204.94	$466.86
Florida	$103.82	$40.39	$455.24	$224.58	$515.95
Georgia	$48.22	$61.41	$690.72	$342.03	$683.12
Hawaii	$42.29	$53.88	$144.08	$144.08	$300.00
Idaho	$63.61	$63.58	$715.10	$355.59	$728.77
Illinois	$25.20	$37.40	$497.21	$245.39	$416.90
Iowa	$50.60	$64.59	$720.90	$360.41	$720.90
Kansas	$36.00	$60.71	$461.58	$228.85	$484.19
Kentucky	$610.50	$55.20	$610.50	$302.26	$644.30
Louisiana	$28.52	$46.11	$761.54	$376.19	$496.85
Maine	$59.40	$90.00	$354.75	$176.07	$34.07
Maryland	$14.00	$24.00	$616.80	$305.60	$621.42
Massachusetts	$44.26	$48.42	$576.64	$286.11	$558.85
Minnesota	$85.74	$112.01	BR	BR	BR
Mississippi	$143.59	$61.94	$697.66	$345.50	$793.10
Missouri	$36.00	$38.40	$344.60	$170.73	$600.00
Montana	$133.18	$56.22	$632.61	$313.11	$718.61
Nebraska	$47.12	$65.97	$521.30	$260.65	$601.50
Nevada	$69.86	$68.78	$684.94	$338.16	$665.56
New Hampshire	$15.00	$25.00	$408.00	$198.00	$408.00
New Jersey[1]	$14.00	$30.00	$435.10	$198.50	$435.10
New Mexico	$49.90	$70.41	$673.82	$333.55	$753.52
New York	$16.00	$20.00	$206.00	$114.00	$233.00
North Carolina	$171.09	$68.28	$758.62	$377.96	$869.94
North Dakota	$150.28	$60.18	$681.36	$337.62	$774.18
Ohio	$132.46	$51.31	$258.13	$127.81	$271.81
Oklahoma	$115.29	$46.31	$676.37	$336.08	$769.37
Oregon	$48.53	$50.08	$566.50	$280.30	$640.20
Pennsylvania	$42.50	$49.50	$621.87	$308.34	$703.91
Rhode Island	$25.20	$50.40	NP	NP	NP
South Carolina	$35.12	$46.46	$555.76	$277.10	$630.40
South Dakota	$44.46	NL	NL	NL	$648.63
Texas[2]	$70.04	$78.55	NA	NA	$350.00
Utah[3]	$37.56	$48.33	$686.63	$340.93	$544.81
Vermont	$33.33	$47.03	$160.97	$80.48	$404.14
Virginia	$126.26	$49.99	$561.20	$277.25	$636.18
Washington	$111.76	$43.75	$491.94	$243.70	$588.14
West Virginia	$52.07	$55.08	$623.67	$306.71	$704.64
Wisconsin	$97.42	$186.79	MP	MP	$502.64
Wyoming	$61.85	$61.19	$70.00	$70.00	$900.00

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	Neonatal and Pediatr Critical Care	*Intensive Low Birth Weight Services*		*Plastic Surgery*	
State*	**99296** Subsequent neonatal critical care	**99298** Subsq intensive care, < 1500 gm present body weight	**99299** Subsq intensive care, 1500-2500 gm present body weight	**40700** Cleft lip Repair	**42200** Cleft palate repair
Alabama	$126.00	$133.00	$52.00	$548.00	$621.00
Arizona	$402.84	$141.52	$132.92	$869.65	$823.93
Arkansas	$304.20	$149.64	$101.36	$776.00	$1,188.00
California	NC	NC	NC	$674.61	$134.77
Colorado	$428.01	$100.66	$91.28	$534.31	$167.15
Connecticut	$199.21	$69.98	$65.97	$546.92	$517.10
Dist of Columbia	$206.00	NC	$68.13	$464.52	$416.84
Florida	$226.05	$79.33	$74.72	$491.04	$464.46
Georgia	$341.09	$118.51	$120.72	$721.51	$675.92
Hawaii	$100.00	$75.00	$75.00	$647.11	$605.76
Idaho	$372.45	$131.12	$117.13	$825.96	$762.78
Illinois	$206.90	$86.56	$81.22	$718.70	$718.70
Iowa	$360.41	$125.08	$125.08	$744.96	$697.30
Kansas	$240.26	$120.00	$120.00	$469.00	$402.00
Kentucky	$301.83	$109.15	$99.73	$611.31	$491.68
Louisiana	$279.52	$100.10	$124.33	$580.78	$889.06
Maine	$160.00	$50.00	$58.13	$331.20	$338.40
Maryland	$319.02	$113.50	$101.50	$348.00	$356.00
Massachusetts	OM	OM	OM	$669.22	$617.10
Minnesota	BR	BR	BR	$1,027.42	$1,011.20
Mississippi	$347.27	$121.59	$113.75	$724.82	$685.48
Missouri	$350.00	$68.00	$56.26	$280.00	$240.00
Montana	$314.71	$110.26	$103.28	$662.84	$627.07
Nebraska	$320.80	$137.94	$80.20	$753.92	$763.34
Nevada	$338.47	$119.10	$112.31	$915.13	$846.71
New Hampshire	$198.00	$83.19	$198.00	$400.00	$500.00
New Jersey[1]	$198.50	$66.20	$60.00	$302.00	$203.00
New Mexico	$393.40	$123.19	$110.21	$736.32	$689.37
New York	$115.00	$57.00	$54.00	$280.00	$240.00
North Carolina	$379.62	$133.67	$122.33	$783.70	$800.59
North Dakota	$339.66	$119.00	$111.86	$722.84	$682.38
Ohio	$139.55	$45.36	$45.25	$585.65	$516.28
Oklahoma	$338.14	$118.14	$110.92	$554.17	$522.59
Oregon	$281.30	$98.87	$92.90	$812.00	$599.70
Pennsylvania	$309.40	$108.56	$101.83	$568.50	$531.00
Rhode Island	NP	NC	NP	$369.60	NP
South Carolina	$282.00	$95.99	$91.16	$576.22	$532.96
South Dakota	$350.21	NL	NL	$1,200.00	$1,200.00
Texas[2]	$225.00	$125.00	NA	$828.72	$1,015.00
Utah[3]	$280.18	$95.46	$112.60	$552.95	$504.13
Vermont	$205.08	$63.72	$63.54	$534.38	$540.43
Virginia	$278.79	$97.91	$91.99	$602.94	$570.99
Washington	$245.06	$85.92	$80.71	$528.44	$499.87
West Virginia	$307.62	$107.75	$101.13	$673.03	$646.84
Wisconsin	$351.86	MP	MP	$1,044.21	$895.03
Wyoming	$600.00	$400.00	$70.00	$809.34	$748.48

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Pulmonology

State*	31622 Bronchoscopy	32000 Thoracentesis	94010 Spirometry, Including graphic record	94640 Inhalation treatment	94664 Demonstration/ evaluation
Alabama	$147.00	$87.00	$24.00	$12.00	$12.00
Arizona	$262.99	$175.05	$32.03	$12.50	$13.31
Arkansas	$257.00	$109.00	$36.00	$9.00	$9.00
California	$164.93	$82.65	$24.60	$11.70	$8.60
Colorado	$40.12	$30.80	$12.60	$23.80	$13.44
Connecticut	$169.57	$114.00	$16.83	$6.67	$7.00
Dist of Columbia	$124.61	$93.71	$21.75	$14.73	$11.19
Florida	$149.24	$99.21	$18.62	$7.11	$7.74
Georgia	$196.25	$116.74	$25.73	$17.25	$16.90
Hawaii	$142.83	$57.25	$24.25	$16.72	$16.34
Idaho	$221.58	$157.02	$33.32	$24.49	$17.82
Illinois	$235.20	$71.40	$37.40	$14.50	$15.20
Iowa	$200.95	$119.16	$25.58	$16.75	$16.35
Kansas	$245.16	$51.67	$29.82	$10.00	$17.14
Kentucky	$186.18	$71.27	$24.44	$11.19	$14.38
Louisiana	$149.54	$59.30	$43.99	$17.85	$17.85
Maine	$102.90	$34.51	$28.44	$15.52	$5.77
Maryland	$113.00	$17.00	$13.00	$5.00	$6.00
Massachusetts	$183.51	$103.08	$29.26	$17.19	$16.31
Minnesota	$355.35	$100.42	$23.26	$15.02	$18.78
Mississippi	$214.99	$141.80	$25.32	$9.50	$10.01
Missouri	$84.80	$25.60	$15.00	$11.00	$27.00
Montana	$197.85	$130.89	$23.52	$8.94	$9.42
Nebraska	$221.46	$94.24	$42.11	$18.05	$34.09
Nevada	$152.40	$78.19	$32.62	$24.31	$18.15
New Hampshire	$225.00	$225.00	$18.00	$10.00	$6.00
New Jersey[1]	$113.00	$18.00	$18.00	NC	NC
New Mexico	$198.37	$117.90	$29.87	$11.42	$12.09
New York	$40.00	$12.00	$15.00	$3.00	$3.00
North Carolina	$292.85	$159.09	$29.12	$10.45	$11.25
North Dakota	$218.62	$144.84	$26.86	$9.86	$10.88
Ohio	$157.12	$124.82	$21.89	$10.89	$14.11
Oklahoma	$167.79	$111.21	$20.42	$7.54	$7.99
Oregon	$271.00	$271.00	$28.03	$18.68	$14.27
Pennsylvania	$166.00	$67.00	$15.00	NC	$15.02
Rhode Island	$117.60	$25.20	$18.00	$6.00	$10.80
South Carolina	$154.40	$171.92	$20.19	$8.92	$12.53
South Dakota	$234.08	$94.80	$31.75	$15.00	$12.60
Texas[2]	$192.57	NC	$25.37	$12.00	NA
Utah[3]	$149.30	$76.56	$10.76	$10.53	$13.64
Vermont	$156.28	$467.60	$32.34	$11.25	$19.32
Virginia	$183.46	$122.39	$22.42	$8.76	$9.28
Washington	$161.86	$108.14	$19.72	$7.71	$8.16
West Virginia	$173.97	$126.72	$28.29	NC	$14.44
Wisconsin	$332.74	$89.65	$41.46	$15.72	$16.82
Wyoming	$293.14	$154.96	$10.99	$17.40	$18.42

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	Radiology		*Surgery*		
	71010 Frontal chest x-ray	**28262** Extensive Clubfoot release	**44950** Appendectomy	**49500** Bilateral inguinal hernia, 6 months to under 5 years	**49505** Bilateral inguinal hernia, 5 years or over
State*					
Alabama	$20.00	$828.00	$405.00	$285.00	$356.00
Arizona	$27.30	$1,222.28	$574.98	$341.64	$464.85
Arkansas	$26.00	$792.00	$488.00	$492.00	$531.00
California	$17.30	$649.29	$400.59	$260.61	$344.01
Colorado	$13.44	$702.03	$334.30	$234.01	$284.16
Connecticut	$15.80	$765.47	$354.39	$212.50	$288.48
Dist of Columbia	$15.00	$685.50	$292.17	$199.00	$243.57
Florida	$15.48	$688.22	$527.99	$335.13	$417.24
Georgia	$8.15	$974.90	$458.73	$294.45	$363.81
Hawaii	$22.95	$857.87	$408.32	$266.17	$320.63
Idaho	$23.06	$1,113.44	$544.41	$316.51	$431.15
Illinois	$17.00	$524.40	$374.55	$362.00	$387.05
Iowa	$24.36	$1,000.55	$474.30	$301.94	$374.93
Kansas	$23.85	$472.99	$268.00	$250.00	$250.00
Kentucky	$20.47	$712.14	$333.52	$286.06	$324.86
Louisiana	$17.85	$907.28	$343.81	$369.86	$331.88
Maine	$170.50	$525.00	$297.19	$223.10	$293.89
Maryland	$9.50	$320.00	$206.00	$175.00	$170.00
Massachusetts	$20.33	$914.26	$431.47	$283.51	$343.66
Minnesota	$29.35	$1,070.68	$610.27	$483.81	$602.55
Mississippi	$21.71	$1,001.58	$484.77	$286.27	$390.02
Missouri	$11.00	$397.60	$200.80	$176.00	$176.00
Montana	$20.14	$919.53	$441.56	$261.29	$355.81
Nebraska	$44.64	$942.40	$612.56	$490.05	$523.03
Nevada	$27.15	$1,240.57	$602.00	$350.41	$460.10
New Hampshire	$10.00	$300.00	$284.00	$432.00	$432.00
New Jersey[1]	$10.00	$212.00	$211.00	$182.00	$182.00
New Mexico	$24.20	$989.91	$468.89	$327.31	$447.32
New York	$10.00	$120.00	$160.00	$140.00	$140.00
North Carolina	NP	$1079.60	$533.15	$316.86	$421.08
North Dakota	$22.44	$998.58	$475.32	$283.22	$385.22
Ohio	$20.72	$739.10	$353.21	$257.64	$298.75
Oklahoma	$17.01	$758.30	$363.48	$216.81	$294.64
Oregon	$19.20	$917.60	$399.10	$513.00	$513.00
Pennsylvania	$19.00	$569.50	$301.50	$318.50	$317.50
Rhode Island	$14.10	$1,219.51	NP	NP	NP
South Carolina	$16.93	$671.59	$609.68	$369.11	$479.57
South Dakota	$24.40	$810.34	$529.20	$413.30	NL
Texas[2]	$21.55	$117.56	$343.68	$52.78	$295.13
Utah[3]	$11.04	$698.66	$350.05	$243.33	$281.38
Vermont	$22.82	$668.07	$374.41	$267.13	$297.15
Virginia	$19.07	$845.40	$396.80	$236.28	$321.31
Washington	$16.78	$736.09	$345.94	$206.52	$280.62
West Virginia	$19.86	$993.30	$441.26	$262.77	$361.20
Wisconsin	$27.71	$895.03	$533.73	$465.66	$465.66
Wyoming	$11.03	$1,109.06	$623.70	$309.92	$530.15

Note: Where multiple rates are reported by the state, the highest non-facility rate is presented in this report unless noted otherwise. * Tennessee does not have a fee-for-service Medicaid program. Alaska, Delaware, Indiana and Michigan have not provided payment rates to date. ** except EPSDT providers. [1] NJ offers enhanced payment (shown in Table) for specialists only. Payment rates for non-specialists are generally 10-15% less. [2] TX pays high volume providers 1.9% over regular rates; high-volume specialists are paid 6.1% higher. [3] Utah pays enhanced rates (112% of shown rates) for rural providers.

Urology and Dialysis

State*	**50200** Renal biopsy	**90918** ESRD (end stage renal disease) services, under 2 years	**90919** ESRD services, 2 through 11 years	**90920** ESRD services, 12 through 19 years	**90945** Peritoneal dialysis
Alabama	$135.00	$375(monthly)	$316(monthly)	$258(monthly)	$97.09
Arizona	$136.31	$699.36	$478.91	$419.56	$75.39
Arkansas	$191.00	NC	NC	NC	$74.00
California	$70.74	$280.20	$269.10	$269.10	$72.16
Colorado	$133.72	$156.60	$156.60	$156.60	$22.82
Connecticut	$84.43	NC	NC	NC	$68.18
Dist of Columbia	$103.00	$367.74	$248.24	$218.54	$90.49
Florida	$163.86	$425.63	$354.43	$283.43	$42.27
Georgia	$144.45	NC	NC	NC	NC
Hawaii	$129.47	$424.09	$338.03	$294.07	$63.76
Idaho	$126.90	$582.83	$455.36	$392.71	$75.20
Illinois	$112.40	$252.35	$213.65	$213.65	$36.50
Iowa	$149.72	$509.84	$403.54	$349.75	$73.58
Kansas	$84.55	$234.63	$200.00	$200.00	$78.59
Kentucky	NP	$390.20	$312.74	$275.47	$73.57
Louisiana	$142.25	$143.10	$143.10	$143.10	$83.79
Maine	$52.20	$170.40	$170.40	$170.40	$66.57
Maryland	$57.00	NC	NC	NC	$15.00
Massachusetts	$137.06	$445.64	$354.85	$308.30	$67.15
Minnesota	$266.51	$483.89	$388.54	$342.68	$115.87
Mississippi	$117.22	$571.45	$392.60	$343.86	$63.96
Missouri	$32.00	$60.00	$60.00	$60.00	$14.00
Montana	$106.38	$538.46	$371.32	$324.74	$58.23
Nebraska	$131.94	$641.60	$481.20	$401.00	$647.49
Nevada	$137.19	$533.55	$417.86	$360.32	$69.54
New Hampshire	$225.80	$160.00	$160.00	$160.00	$30.00
New Jersey[1]	$30.00	$160.00	$160.00	$160.00	$30.00
New Mexico	$133.13	$502.33	$397.77	$344.90	$72.69
New York	$20.00	$52.00	$2.00	$52.00	$75.00
North Carolina	$141.33	$613.56	$446.99	$391.56	$69.98
North Dakota	$114.92	NC	NC	$354.96	$62.90
Ohio	$131.02	$315.02	$250.93	$219.52	$57.48
Oklahoma	$88.61	$456.84	$312.88	$274.41	$48.69
Oregon	$271.00	$494.10	$336.30	$295.30	$52.94
Pennsylvania	$138.00	NC	NC	NC	NC
Rhode Island	$42.00	$117.00	$117.00	$117.00	$38.60
South Carolina	$177.84	$203.77	$170.83	$469.94	$100.98
South Dakota	$182.11	NL	NL	NL	$75.30
Texas[2]	$157.11	$329.77	$257.76	$223.12	$62.46
Utah[3]	$125.13	$340.71	$271.81	$238.06	$60.53
Vermont	$133.56	$242.93	$242.93	$242.93	$42.46
Virginia	$94.56	$487.97	NC	$291.65	$52.31
Washington	$82.97	$428.24	$292.22	$256.40	$46.02
West Virginia	$104.74	$529.45	$364.21	$318.75	$56.88
Wisconsin	$184.88	MP	MP	MP	MP
Wyoming	$122.06	$559.63	$437.90	$377.69	$72.71

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Dental Services

State*	D0120 Periodic Exam	D1120 Prophylaxis, Child	D1203 Topical fluoride treatment, child	D2150 Amalgam – two surfaces, primary or permanent	D2330 Resin-based composite – one surface anterior
Alabama	$18.00	$28.00	$15.00	$60.00	$59.00
Arizona	$27.02	$42.49	$19.84	$24.52	$70.06
Arkansas	$22.80	$23.75	NP	$51.30	$48.45
California	$15.00	$30.00	NC	$48.00	$55.00
Colorado	$17.00	$26.00	$13.00	$55.00	$56.00
Connecticut	$18.08	$21.70	$15.15	$37.64	$34.10
Dist of Columbia	$20.00	$22.50	$20.00	$42.50	$50.00
Florida	$15.00	$14.00	$11.00	$41.00	$34.00
Georgia	$22.77	$32.08	$17.59	$69.34	$71.41
Hawaii	$29.12	$26.00	$4.16	$40.40	$34.36
Idaho	$17.00	$28.00	$13.00	$55.00	$50.00
Illinois	$16.20	$25.40	$14.85	$48.15	$34.60
Iowa	$15.52	$23.28	$13.58	$55.29	$49.47
Kansas	$21.00	$30.00	$17.00	$64.00	$66.00
Kentucky	NC	NC	NC	$50.00	$44.00
Louisiana	$18.00	$12.00	$11.00	$50.00	$45.00
Maine	$13.00	$30.00	$12.00	$48.00	$68.00
Maryland	$15.00	$24.00	$14.00	$88.00	$84.00
Massachusetts	$21.00	$33.00	$21.00	$80.00	$60.00
Minnesota	$17.10	$25.67	$19.60	$58.31	$51.38
Mississippi	NC	$34.54	NC	$41.57	$41.57
Missouri	$24.00	$18.50	$10.00	$36.00	$36.00
Montana	$18.56	$26.52	$13.26	$58.34	$53.04
Nebraska	$16.00	$31.00	$7.50	$58.00	$55.00
Nevada	$33.24	$57.28	$18.39	$86.04	$56.38
New Hampshire	$28.00	$38.00	$18.00	$104.00	$82.00
New Jersey[1]	$15.00	$14.00	$10.00	$38.00	$35.50
New Mexico	$19.70	$27.58	$15.76	$64.02	$61.07
New York	$29.00	$43.00	$14.00	$84.00	$58.00
North Carolina	$23.07	NP	$15.44	NP	NP
North Dakota	$19.70	$25.55	$17.05	$62.30	NC
Ohio	$17.08	$20.00	$15.00	$54.00	$51.21
Oklahoma	$52.25	$26.37	$8.24	$79.10	$56.16
Oregon	$23.23	$28.06	$12.73	$45.74	$38.56
Pennsylvania	$20.00	$22.00	$17.00	$50.00	$45.00
Rhode Island	$20.00	NP	$27.00	$64.00	$52.50
South Carolina	$22.00	$31.00	$17.00	$75.00	$69.00
South Dakota	$20.11	$24.65	$15.90	$62.46	$56.78
Texas[2]	$14.72	$18.75	$7.50	$43.73	$39.67
Utah[3]	$11.67	$20.00	NC	$35.83	$26.67
Vermont	$18.00	$29.00	$15.00	$67.00	$65.00
Virginia	$13.16	$27.32	$16.94	$57.48	$56.46
Washington	$22.00	$23.23	$13.39	$62.62	$60.00
West Virginia	$20.00	$30.00	$15.00	$72.00	$68.00
Wisconsin	$15.76	$21.60	$12.76	$44.55	$40.91
Wyoming	$25.00	$25.00	$17.00	$78.00	$75.00

Note: Where multiple rates are reported by the state, the highest non-facility rate is presented in this report unless noted otherwise. * Tennessee does not have a fee-for-service Medicaid program. Alaska, Delaware, Indiana and Michigan have not provided payment rates to date. ** except EPSDT providers. [1] NJ offers enhanced payment (shown in Table) for specialists only. Payment rates for non-specialists are generally 10-15% less. [2] TX pays high volume providers 1.9% over regular rates; high-volume specialists are paid 6.1% higher. [3] Utah pays enhanced rates (112% of shown rates) for rural providers.

Dental Services

State*	D1351 Sealant, per tooth	D2930 Stainless steel crown on a primary tooth	D3220 Pulpotomy	D7140 Extraction
Alabama	$26.00	$73.00	$49.00	$53.00
Arizona	$66.47	$118.87	$80.76	$78.26
Arkansas	$19.00	$91.20	$45.60	$41.80
California	$22.00	$75.00	$71.00	$45.00
Colorado	$18.00	$95.00	$60.00	$50.00
Connecticut	$17.75	$85.01	$45.46	$33.12
Dist of Columbia	$15.00	$58.50	$50.00	$21.00
Florida	$13.00	$68.00	$50.00	$27.00
Georgia	$27.94	$143.86	$90.04	$64.17
Hawaii	$24.32	$74.36	$67.60	$46.80
Idaho	$20.00	$85.00	$50.00	$43.00
Illinois	$14.10	$73.40	$52.70	$391.20
Iowa	$19.40	$97.00	$56.26	$48.50
Kansas	$24.92	$60.00	$60.00	$42.50
Kentucky	$15.00	$92.00	$52.00	$38.00
Louisiana	$17.00	$88.00	$40.00	$38.00
Maine	$16.00	$120.00	$50.00	$67.00
Maryland	$9.00	$154.00	$60.00	$42.00
Massachusetts	$28.00	$131.00	$48.00	NC
Minnesota	$24.22	$107.11	$57.12	$62.58
Mississippi	$22.26	$78.99	$27.01	$41.25
Missouri	$19.00	$66.00	$41.50	$33.50
Montana	$21.22	$106.08	$79.56	$58.34
Nebraska	$20.00	$110.00	$70.00	$42.00
Nevada	$23.58	$92.25	$61.50	$45.10
New Hampshire	$30.00	$200.00	$87.00	$82.00
New Jersey[1]	$10.00	$76.00	$28.00	$32.00
New Mexico	$19.70	$102.44	$69.94	$58.12
New York	$43.00	$116.00	$87.00	$45.00
North Carolina	NP	NP	NP	NP
North Dakota	$20.25	$97.90	$63.80	$52.15
Ohio	$22.00	$101.92	$63.74	$52.45
Oklahoma	$19.78	$118.66	$59.33	$52.74
Oregon	$18.96	$71.79	$48.33	$75.19
Pennsylvania	$25.00	$90.00	$50.00	$45.00
Rhode Island	$27.00	$125.00	$85.00	$45.00
South Carolina	$27.00	$139.00	$87.00	$62.00
South Dakota	$20.67	$99.48	$49.29	$47.70
Texas[2]	$18.44	$78.03	$43.03	$33.52
Utah[3]	$12.50	$62.50	$19.16	$35.00
Vermont	$28.00	$116.00	$75.00	$80.00
Virginia	$26.31	$111.60	$67.80	$47.56
Washington	$22.22	$90.00	$44.44	$58.26
West Virginia	$24.00	$120.00	$42.00	$44.00
Wisconsin	$16.99	$95.28	$47.58	$41.81
Wyoming	$19.00	$99.00	$54.00	$68.00

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Source: http://www.aap.org/research/medreimPDF0405/45_states_and_DC.pdf.

Appendix E

Medicaid Reimbursement Survey, 2004/05

Hawaii

Contact Suk-fong Tang, PhD, Department of Practice, with comments about the report; contact Dan Walter, Division of State Government Affairs, for Medicaid questions and advocacy advice.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

AAP Medicaid Reimbursement Survey: Hawaii

2004/05 Medicaid Payments for Commonly Used Pediatric CPT™ Codes

Preventive Medicine Services	**Medicaid**	**Medicare**	**%Medicare**
99381 - New Patient, under 1 year	$95.00	$108.91	87%
99382 - New Patient, 1 through 4 years	$95.00	$116.93	81%
99383 - New Patient, 5 through 11 years	$95.00	$114.42	83%
99384 - New Patient, 12 through 17 years	$95.00	$124.01	77%
99385 - New Patient, 18 through 39 years	$95.00	$124.01	77%
99391 - Established Patient, under 1 year	$95.00	$82.11	116%
99392 - Established Patient, 1 through 4 years	$95.00	$91.70	104%
99393 - Established Patient, 5 through 11 years	$95.00	$90.44	105%
99394 - Established Patient, 12 through 17 years	$95.00	$99.73	95%
99395 - Established Patient, 18 through 39 years	$95.00	$100.99	94%
99401 - Individual Counseling, 15 min	BO	$46.99	_
99402 - Individual Counseling, 30 min	BO	$73.71	_
Office and Other Outpatient Services			
99201 - New Patient, office visit	$95.00	$38.40	247%
99202 - New Patient, expanded office visit	$95.00	$67.84	140%
99203 - New Patient, low complexity	$95.00	$100.51	95%
99204 - New Patient, moderate complexity	$95.00	$141.71	67%
99205 - New Patient, high complexity	$95.00	$179.50	53%
99211 - Established Patient, office visit	$95.00	$23.02	413%
99212 - Established Patient, expanded office visit	$95.00	$40.07	237%
99213 - Established Patient, low complexity	$95.00	$55.61	171%
99214 - Established Patient, moderate complexity	$95.00	$86.66	110%
99215 - Established Patient, high complexity	$95.00	$124.76	76%
92551 - Screening test, hearing evaluation	$10.13	NIS	NIS
92567 - Tympanometry, hearing evaluation	$17.78	$23.65	75%
99173 - Screening test, visual acuity	BO	NIS	NIS

Source: 2004/05 AAP Medicaid Reimbursement Surveys, American Academy of Pediatrics.
Abbreviations used in this report: **MP**: Manually priced, i.e., Carrier will establish payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report. **BR**: By report , i.e., Carrier will establish payment amounts for these services on a case-by-case basis following review of documentation, such as an operative report. **BO**: Bundled with other services, i.e., Payment for covered services is always bundled into payment for other services not specified. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. **OM**: Other method(s). **NC:** Not covered. **NA**: Not applicable. **NP**: Information not provided by state. **NL**: Information not provided by state, nor found on Medicaid fee schedule posted on state's web site. **NIS**: RVUs for code not included in RBRVS schedule. **LFS**: National limit amount per Clinical and Diagnostic Lab Fee Schedule.

Notes: (1) FFS payment (rates included in this report) may not apply to some or all services used by children in capitated plans. According to FFY2002 MSIS reports published by CMS, 96% of Hawaii children (under age 19) enrolled in Medicaid were in capitated plans. (2) Unless otherwise noted, the highest non-facility Medicaid payment rate is presented in this report when multiple rates are used by the state. (3) Medicare rates are GPCI-adjusted for geographic variation in medical care cost. Medicare rates may vary by region in states with multiple Medicare carriers.

Newborn Care	**Medicaid**	**Medicare**	**%Medicare**
99431 - Initial newborn care	$95.00	$61.16	155%
99433 - Subsequent newborn care	$95.00	$32.15	295%
99435 - Admit and discharge on same day	$95.00	$78.82	121%
99436 - Physician attendance at delivery	$45.00	$77.14	58%
99440 - Newborn resuscitation	$45.00	$152.81	29%
54150 - Circumcision; newborn	$84.95	$114.69	74%
Immunizations: ***Does Hawaii provide vaccines through a universal immunization program? Yes***			
90471 - One immunization administration	$4.00	$9.12	44%
90472 - Each additional immunization administration	$4.00	$6.18	65%
90473 - One immunization administration, oral or intranasal	$4.00	Medicare reimburses for vaccine products using 106% of the product's average sale price (ASP)	
90645-8 - Hemophilus Influenza B	$4.00		
90657 - Influenza virus (6-35 months)	$4.00		
90658 - Influenza virus (3+ years)	$4.00		
90660 - Influenza virus, intranasal use	$4.00		
90669 - Pneumococcal conjugate vaccine	$4.00		
90700 - DTaP (< 7 years)	$4.00		
90701 - DTP	$4.00		
90702 - DT (< 7 years)	$4.00		
90707 - Measles, mumps, rubella	$4.00		
90713 - IPV	$4.00		
90716 - Varicella	$4.00		
90718 - Td (>= 7 years)	$4.00		
90721 - DTaP, HIB	$4.00		
90744 - Hepatitis B, (pediatric/adolescent age)	$4.00		
Evaluation and Management			
99217 - Observation care discharge, day management	$50.53	$71.86	70%
99218 - Initial observation care, low severity	$53.33	$67.67	79%
99219 - Initial observation care, intermediate severity	$87.31	$113.17	77%
99220 - Initial observation care, high severity	$116.67	$158.83	73%
99354 - Prolonged service, outpatient, 1st hour, face-to-face	MP	$99.70	_
99355 - Same as 99354, each additional 30 min	MP	$98.86	_
99356 - Prolonged service, inpatient, 1st hour, face-to-face	MP	$92.00	_
99357 - Same as 99356, each additional 30 min	MP	$92.42	_

Source: 2004/05 AAP Medicaid Reimbursement Surveys, American Academy of Pediatrics. Abbreviations: VFC: Vaccine for Children program. SSV: State-supplied vaccine. MNVP: Minnesota's Vaccine Program. VAFAC: Vaccine Assurance for All Children Program of South Carolina.

Evaluation and Management, cont.	**Medicaid**	**Medicare**	**%Medicare**
99358 - Prolonged service, 1st hour, not face-to-face	MP	NIS	NIS
99359 - Same as 99358, each additional 30 min	MP	NIS	NIS
99361 - Team medical conference, 30 min	NC	NIS	NIS
99362 - Team medical conference, 60 min	NC	NIS	NIS
99371 - Telephone call, simple or brief	NC	NIS	NIS
99372 - Telephone call, intermediate	NC	NIS	NIS
99373 - Telephone call - complex or lengthy	NC	NIS	NIS
99374 - Supervision of patient under home health agency care(15-29 min)	NC	$71.97	_
99375 - Same as 99374, 30 min or more	NC	$131.92	_
Hospital Care			
99221 - Initial hosptialization, per day, low complexity	$53.33	$68.51	78%
99222 - Initial hosptialization, per day, moderate complexity	$87.63	$114.01	77%
99223 - Initial hosptialization, per day, high complexity	$116.67	$158.95	73%
99231 - Subsequent hosptialization, per day, low complexity	$27.32	$34.16	80%
99232 - Subsequent hosptialization, per day,moderate complexity	$42.31	$56.33	75%
99233 - Subsequent hosptialization, per day,high complexity	$56.39	$80.03	70%
99238 - Hospital discharge, day management, 30 min or under	$50.28	$71.98	70%
Consultations			
99241 - Office consultation, problem focused	$44.04	$52.70	84%
99242 - Office consultation, straightforward decision	$71.19	$95.59	74%
99243 - Office consultation, low complexity	$90.55	$126.22	72%
99244 - Office consultation, moderate complexity	$124.60	$178.01	70%
99245 - Office consultation, high complexity	$161.44	$229.59	70%
99254 - Initial inpatient consultation, moderate complexity	$108.71	$144.08	75%
99255 - Initial inpatient consultation, high complexity	$148.14	$198.05	75%
Pathology and Laboratory			
81000 - Urinalysis, non-automated with microscopy	$4.37	$4.43 (LFS)	99%of LFS
81002 - Urinalysis, non-automated without microscopy	$3.54	$3.57 (LFS)	99%of LFS
86580 - Tuberculosis, intradermal	$5.15	$11.52	45%
87081 - Throat culture	$9.16	$9.26 (LFS)	99%of LFS
87880 - Rapid Streptococcus screen	$16.58	$16.76 (LFS)	99%of LFS

Source: 2004/05 AAP Medicaid Reimbursement Surveys, American Academy of Pediatrics.

Mental Health	**Medicaid**	**Medicare**	**%Medicare**
90801 - Psychiatric diagnostic interview examination	$104.43	$155.78	67%
90804 - Individual psychotherapy, 20-30 min face-to-face	$46.62	$66.96	70%
90806 - Individual psychotherapy, 45-50 min face-to-face	$75.00	$100.35	75%
90808 - Individual psychotherapy, 75-80 min face-to-face	$110.09	$149.84	73%
90862 - Pharmacological management	$38.28	$52.87	72%
90887 - Interpretation or explanation of results	NC	$92.76	_
96110 - Developmental testing, limited	NC	$13.46	_
96111 - Developmental testing, extended	NC	$147.47	_
Specialty Care Codes			
Allergy/Immunology			
95004 - Percutaneous tests with allergenic extracts	$3.37	$4.50	75%
95010 - Percutaneous tests, sequential and incremental	$12.30	$19.75	62%
95015 - Intracutaneous tests, with biologicals	$12.93	$12.20	106%
95024 - Intracutaneous tests with allergenic extracts	$4.63	$6.60	70%
95115 - Allergenic immunotherapy, single injection	$12.97	$16.56	78%
95117 - Allergen immunotherapy, two or more injections	$16.72	$21.59	77%
Cardiology			
92950 - Cardiopulmonary resuscitation	$168.25	$190.26	88%
93303 - Transthoracic echocardiography	$187.44	$239.64	78%
93307 - Echocardiography, real-time with image documentation	$175.94	$220.11	80%
93320 - Doppler echocardiograph	$77.00	$96.63	80%
93501 - Right heart catheterization	$719.33	$910.61	79%
93510 - Left heart catheterization	$1,428.00	$1,887.33	76%
Critical Care / Neonatal and Pediatric Critical Care			
31500 - Intubuation, endotracheal	$93.64	$115.57	81%
31622 - Bronchoscopy	$142.83	$283.99	50%
32000 - Thoracentesis	$57.25	$191.30	30%
32020 - Thoracostomy tube	$180.76	$222.20	81%
36555 - Insertion of non-tunneled CVC~ ; <5 yrs old	$61.36	$358.27	17%
36568 - Insertion of peripherally inserted CVC~; <5 yrs old	$74.05	$421.81	18%
36600 - Arterial puncture, diagnostic	$15.16	$32.70	46%
36620 - Arterial line placement	$47.24	$55.15	86%
99291 - Critical care, first hour	$144.68	$252.37	57%
99292 - Critical care, additional 30 minutes	$71.82	$111.11	65%

Source: 2004/05 AAP Medicaid Reimbursement Surveys, American Academy of Pediatrics.

	Medicaid	Medicare	%Medicare
Critical Care/Neonatal and Pediatric Critical Care, contd.			
36510 - Umbilical vein catheterization	$42.29	$199.79	21%
36660 - Umbilical artery catheterization	$53.88	$73.79	73%
99293 - Inital pediatric critical care	$144.08	$830.43	17%
99294 - Subsequent pediatric critical care	$144.08	$411.37	35%
99295 - Inital neonatal critical care	$300.00	$941.08	32%
99296 - Subsequent neonatal critical care	$100.00	$413.88	24%
Emergency Care			
10120 - Simple surgical removal of foreign body	$49.27	$110.48	45%
12015 - Simple surgical repair of facial wound(7.6-12.5cm)	$138.00	$261.83	53%
36400 - Venipuncture necessitating physician skill, < 3 yrs, femoral or jugular vein	$6.80	$26.66	26%
36410 - Venipuncture necessitating physician skill, >= 3 years	$7.48	$19.62	38%
36415 - Routine venipuncture	$3.00	NIS	NIS
36416 - Finger, heel, ear stick	NC	NIS	NIS
62270 - Lumbar puncture, diagnostic	$51.03	$173.59	29%
99141 - Conscious sedation; IV/IM/inhalation	NC	BO	_
99142 - Conscious sedation; oral/rectal/intranasal	NC	BO	_
99282 - ED visit, low complexity	$23.95	$28.05	85%
99283 - ED visit, moderate complexity	$48.05	$62.36	77%
99284 - ED visit, detailed	$73.66	$96.80	76%
Gastrointestinal			
43239 - Upper gastrointestinal endoscopy with biopsy	$138.60	$346.52	40%
44389 - Colonoscopy with biopsy	$163.35	$395.94	41%
45331 - Sigmoidoscopy with biopsy	$65.59	$167.50	39%
Ophthalmology			
67311 - Strabismus surgery, horizontal	$217.62	$527.42	41%
67314 - Strabismus surgery, vertical	$245.40	$596.07	41%
68810 - Nasolacrimal probing	$158.37	$171.36	92%
Otolaryngology			
42820 - Tonsillectomy/adenoidectomy, under 12 years	$217.62	$301.61	72%
42821 - Tonsillectomy/adenoidectomy, 12 years or over	$245.40	$325.23	75%
69436 - Tympanostomy and tubes	$158.37	$171.53	92%
Intensive Low Birth Weight Services			
99298 - Subsq intensive care, <1500gm present body weight	$75.00	$145.37	52%
99299 - Subsq intensive care, 1500-2500gm present body weight	$75.00	$136.87	55%

Source: 2004/05 AAP Medicaid Reimbursement Surveys, American Academy of Pediatrics.

	Medicaid	Medicare	%Medicare
Plastic Surgery			
40700 - Cleft lip repair	$647.11	$910.07	71%
42200 - Cleft palate repair	$605.76	$861.12	70%
Pulmonology			
94010 - Spriometry, including graphic record	$24.25	$35.38	69%
94640 - Inhalation treatment	$16.72	$14.04	119%
94664 - Demonstration/evaluation	$16.34	$14.65	112%
Radiology			
71010 - Frontal chest x-ray	$22.95	$29.88	77%
Surgery			
28262 - Extensive clubfoot release	$857.87	$1,273.03	67%
44950 - Appendectomy	$408.32	$587.89	69%
49500 - Bilateral inguinal hernia, 6 mos to under 5 yrs	$266.17	$353.21	75%
49505 - Bilateral inguinal hernia, 5 years or over	$320.63	$479.25	67%
Urology and Dialysis			
50200 - Renal biopsy	$129.47	$140.24	92%
90918 - ESRD (end stage renal disease) services, < 2 years	$424.09	$735.71	58%
90919 - ESRD, 2 through 11 years	$338.03	$498.14	68%
90920 - ESRD, 12 through 19 years	$294.07	$437.98	67%
90945 - Peritoneal dialysis	$63.76	$78.69	81%
Dental Services			
D0120 - Periodic exam	$29.12		
D1120 – Prophylaxis, child	$26.00		
D1203 - Topical fluoride treatment, child	$4.16		
D2150 – Amalgam – two surfaces, primary or permanent	$40.40		
D2330 – Resin-based composite – one surface anterior	$34.36	NIS	
D1351 – Sealant, per tooth	$24.32		
D2930 - Stainless steel crown on a primary tooth	$74.36		
D3220 – Pulpotomy	$67.60		
D7140 – Extraction	$46.80		

Source: 2004/05 AAP Medicaid Reimbursement Surveys, American Academy of Pediatrics.

This report can be downloaded from the AAP website. (URL: http://www.aap.org/research/medreimintro.htm)

Appendix F

Table 29

MEDICAID EXPENDITURES AS A PERCENT OF TOTAL EXPENDITURES

Region/State	Fiscal 2003	Fiscal 2004	Fiscal 2005
NEW ENGLAND			
Connecticut	26.4 %	27.0 %	27.8 %
Maine	28.5	31.3	33.3
Massachusetts	20.8	22.6	23.2
New Hampshire	21.7	26.4	28.0
Rhode Island	26.2	24.9	24.0
Vermont	21.4	21.5	20.5
MID-ATLANTIC			
Delaware	15.5	15.6	15.4
Maryland	27.0	27.1	27.6
New Jersey	22.0	20.6	19.3
New York	28.4	28.3	29.2
Pennsylvania	29.8	31.3	32.1
GREAT LAKES			
Illinois	23.7	20.9	25.5
Indiana	20.5	20.0	21.5
Michigan	20.0	20.8	20.9
Ohio	23.1	25.9	23.1
Wisconsin	12.6	14.6	14.3
PLAINS			
Iowa	18.3	17.8	15.1
Kansas	17.6	17.0	18.8
Minnesota	20.1	22.0	20.1
Missouri	32.6	32.0	34.4
Nebraska	18.9	19.4	17.4
North Dakota	15.8	16.8	16.0
South Dakota	21.1	21.8	21.1
SOUTHEAST			
Alabama	23.6	23.5	20.8
Arkansas	19.5	19.8	19.0
Florida	24.0	25.2	24.5
Georgia	18.4	19.0	19.1
Kentucky	20.8	21.7	20.9
Louisiana	23.6	24.1	20.6
Mississippi	31.1	32.2	32.5
North Carolina	23.4	23.0	25.6
South Carolina	23.0	24.9	26.3
Tennessee	34.2	35.2	35.2
Virginia	13.5	13.6	13.6
West Virginia	11.0	12.0	12.3
SOUTHWEST			
Arizona	17.5	17.6	19.5
New Mexico	22.1	24.4	22.0
Oklahoma	18.4	19.7	19.1
Texas	24.7	24.3	23.4
ROCKY MOUNTAIN			
Colorado	17.3	19.9	20.8
Idaho	19.6	20.8	20.6
Montana	15.6	16.2	14.9
Utah	14.5	16.1	17.0
Wyoming	4.6	4.6	4.5
FAR WEST			
Alaska	12.7	12.8	10.0
California	19.2	18.8	20.2
Hawaii	10.7	10.8	10.0
Nevada	18.6	18.2	16.9
Oregon	17.7	15.9	16.4
Washington	22.2	19.9	20.2
ALL STATES	**22.0 %**	**22.3 %**	**22.5 %**

Source: National Association of State Budget Officers, 2004 State Expenditure Report

Source: National Association of State Budget Officers, 2004 State Expenditure Report, page 50.

Appendix G

statehealthfacts.org
Your source for state health data

State Medicaid Expenditures (in millions), SFY2004

Bar Graph | Table | Map

Rank by: General Funds View by: $

Rank		General Funds	Federal Funds	Other Funds	Total
	United States	$85,906	$154,585	$22,070	$262,561
1	California	$11,009	$15,459	$3,018[1]	$29,486
2	Ohio	$9,858[2]	$1,702	$934	$12,494
3	New York	$6,061[3]	$18,729	$2,772	$27,562
4	Texas	$5,811	$9,631	$0[4]	$15,442
5	Pennsylvania	$5,054	$8,441	$1,553	$15,048
6	Florida	$3,711	$8,330	$1,038[5]	$13,079
7	New Jersey	$3,556	$4,023	$50	$7,629
8	Illinois	$3,277	$5,539	$1,684	$10,500
9	Massachusetts	$2,908	$2,908	$0	$5,816
10	Connecticut	$2,849	$1,938[6]	$692	$5,479
11	Washington	$2,420	$2,750	$0	$5,170
12	Minnesota	$2,341	$2,831	$0	$5,172
13	Maryland	$2,142	$2,432	$0	$4,574
14	Tennessee	$2,108	$4,857	$666[7]	$7,631
15	North Carolina	$1,983	$5,163	$235	$7,381
16	Michigan	$1,960[8]	$4,803	$1,492	$8,255
17	Virginia	$1,812	$1,977	$37	$3,826
18	Georgia	$1,716	$3,669	$53	$5,438
19	Indiana	$1,488[9]	$2,808	$11	$4,307
20	Colorado	$1,127	$1,442	$148	$2,717
21	Missouri	$1,097	$3,691	$957	$5,745
22	Wisconsin	$778	$2,728	$1,291	$4,797
23	Kentucky	$740	$3,003	$377	$4,120
24	Oregon	$731	$1,731	$262	$2,724
25	Louisiana	$723	$3,614	$541	$4,878
26	Arizona	$674	$2,781	$359	$3,814
27	Oklahoma	$596	$1,852	$125	$2,573
28	Rhode Island	$592	$845	$0	$1,437

29	**Kansas**	$549	$1,103	$80	$1,732
30	**Maine**	$529	$1,454	$64	$2,047
31	**Nevada**	$524	$624	$86	$1,234
32	**South Carolina**	$487	$2,868	$602	$3,957
33	**Arkansas**	$459	$2,101	$150	$2,710
34	**Nebraska**	$457	$895	$25	$1,377
35	**New Mexico**	$418	$1,886	$34	$2,338
36	**New Hampshire**	$374	$599	$168	$1,141
37	**Delaware**	$346	$384	$0	$730
38	**Iowa**	$332	$1,509	$556	$2,397
39	**Alabama**	$326	$2,731	$716	$3,773
40	**Hawaii**	$322	$530	$8	$860
41	**Mississippi**	$258	$2,674	$541	$3,473
42	**Alaska**	$230	$669	$83	$982
43	**West Virginia**	$228	$1,554	$211	$1,993
44	**Idaho**	$225	$650	$77	$952
45	**Utah**	$192	$915	$163	$1,270
46	**South Dakota**	$169[10]	$410	$0	$579
47	**North Dakota**	$136	$356	$0	$492
48	**Montana**	$127	$493	$20	$640
49	**Vermont**	$60	$439	$191	$690
50	**Wyoming**	$36	$64	$0	$100
	District of Columbia	NA	NA	NA	NA

This table may be broken into the four Census regions as defined by the 2000 U.S. Census: 1) Northeast; 2) Midwest; 3) South; 4) West. **Show Census Regions**.

Notes: Data are for state fiscal year 2004 (SFY2004) and include the General Fund and Other State Fund expenditures.

In 46 states the fiscal year begins on July 1 and ends on June 30. The exceptions are as follows: in Alabama and Michigan the fiscal year begins on October 1; in Texas, the fiscal year begins on September 1; and in New York, the fiscal year begins on April 1. Additionally, the length of budget cycles vary among states, with more than half of the states budgeting annually and the remainder enacting biennial budgets.

The state and federal Medicaid spending data posted on statehealthfacts.org are for different years, come from different sources, and cannot be used to calculate Total Medicaid spending.

Definitions: SFY2004: state fiscal year 2004.
NA: Data not available.
General Fund: the predominant fund for financing a state's operations. Revenues are received from broad-based state taxes. There are differences in how specific functions are financed from state to state, however. General Funds include funds appropriated to the Medicaid agency and any other agency, which are used for direct Medicaid matching purposes under Title XIX.
Federal Funds: Funds received directly from the federal government.
Other State Fund: expenditures from revenue sources, which are restricted by law for particular governmental functions or activities. Other State Funds include funds and revenue sources used as Medicaid match, such as local funds and provider taxes, fees, donations, and assessments. These figures do not capture 100 percent of state provider taxes, fees, donations, assessments and local funds.

Sources: Table 28, Medicaid Expenditures, 2004 State Expenditure Report, National Association of State Budget Officers; available at http://www.nasbo.org/Publications/PDFs/2004ExpendReport.pdf.

Footnotes:

1. Other State Funds includes local government matching funds for Disproportionate Share Hospitals, Voluntary Governmental Transfers, Targeted Case Management, Local Education Agencies, Medi-Cal Administrative Activities, Los Angeles Co. Medicaid Demonstration Project, Hospital Outpatient Supplemental Payments, Teaching Hospitals, mental health services, and personal care services.

2. Ohio's federal funds are deposited to the state General Fund and shown as General Fund expenditures for Medicaid amount to $5,270.2 million in fiscal 2004.

3. New York Medicaid spending does not include administrative costs or local government shares.

4. Texas Medicaid expenditures are reported from the Medicaid History Report (11/2004), which does not distinguish other funds from state funds.

5. Spending in Florida includes provider assessments of $275 million, cigarette taxes of $109 million, tobacco settlement funds of $50 million, tobacco non-general funds transferred for matching funds of $71 million, other non-general funds transferred for matching funds of $2 million, state fraud recoupments of $22 million, and local county funds of $287 million.

6. Medicaid appropriations are "gross funded": federal funds are deposited directly to the State Treasury.

7. Tennessee's premium revenue totals $53 million, local fund from hospitals totals $248 million, nursing home tax totals $87 million, ICF/MR 6 percent gross receipts tax totals $15 million, intergovernmental transfers totals $57 million.

8. Public health and community and institutional care for mentally and developmentally disabled persons are partially reported in the Medicaid totals.

9. Indiana received $130.9 million from the Federal Jobs & Growth Relief Reconciliation Act of 2003 in fiscal 2004. This enhanced match understates General Fund expenditures and overstates Federal expenditures by $130.9 million for fiscal 2004.

10. The enhanced FMAP from the Federal Jobs & Growth Tax Reconciliation Act of 2003 resulted in a decrease in general fund expenditures of $16.3 million and an increase in federal fund expenditures by the same amount for fiscal 2004.

Appendix H

statehealthfacts.org
Your source for state health data

Medicaid Payments per Enrollee, FY2003

Bar Graph | Table | Map

Rank by: State name (alphabetical) View by: $

United States	USD
Children	$1,467
Adults	$1,872
Elderly	$10,799
Blind and Disabled	$12,265
Total	$4,072

46: Alabama	USD	$0 - $24,888
Children	$1,595	
Adults	$989	
Elderly	$7,485	
Blind and Disabled	$5,623	
Total	$3,119	

4: Alaska	USD	$0 - $24,888
Children	$3,504	
Adults	$4,443	
Elderly	$17,921	
Blind and Disabled	$23,402	
Total	$6,512	

50: Arizona	USD	$0 - $24,888
Children	$1,443	
Adults	$1,293	
Elderly	$7,531	
Blind and Disabled	$10,924	
Total	$2,525	

44: Arkansas	USD	$0 - $24,888
Children	$1,396	
Adults	$879	

Elderly	$9,919
Blind and Disabled	$8,420
Total	$3,215

51: California	**USD**	**$0 - $24,888**
Children	$1,210	
Adults	$813	
Elderly	$8,016	
Blind and Disabled	$11,475	
Total	$2,520	

19: Colorado	**USD**	**$0 - $24,888**
Children	$1,603	
Adults	$2,447	
Elderly	$12,290	
Blind and Disabled	$13,932	
Total	$4,595	

3: Connecticut	**USD**	**$0 - $24,888**
Children	$1,920	
Adults	$2,281	
Elderly	$20,158	
Blind and Disabled	$21,050	
Total	$6,657	

17: Delaware	**USD**	**$0 - $24,888**
Children	$1,887	
Adults	$2,661	
Elderly	$14,524	
Blind and Disabled	$15,535	
Total	$4,738	

2: District of Columbia	**USD**	**$0 - $24,888**
Children	$2,775 [1]	
Adults	$3,255 [1]	
Elderly	$18,038 [1]	
Blind and Disabled	$19,176 [1]	
Total	$7,020 [1]	

34: Florida	**USD**	**$0 - $24,888**
Children	$1,160	

Adults	$1,696
Elderly	$8,986
Blind and Disabled	$9,938
Total	$3,621

47: Georgia	**USD**	**$0 - $24,888**
Children	$1,302	
Adults	$2,606	
Elderly	$7,336	
Blind and Disabled	$7,421	
Total	$3,061	

38: Hawaii	**USD**	**$0 - $24,888**
Children	$1,413	
Adults	$2,163	
Elderly	$10,102	
Blind and Disabled	$9,835	
Total	$3,462	

28: Idaho	**USD**	**$0 - $24,888**
Children	$1,220	
Adults	$2,698	
Elderly	$14,368	
Blind and Disabled	$14,759	
Total	$4,119	

35: Illinois	**USD**	**$0 - $24,888**
Children	$1,372[2]	
Adults	$2,359[2]	
Elderly	$4,749[2]	
Blind and Disabled	$13,077[2]	
Total	$3,552[2]	

29: Indiana	**USD**	**$0 - $24,888**
Children	$1,402	
Adults	$2,206	
Elderly	$12,360	
Blind and Disabled	$12,843	
Total	$4,087	

15: Iowa	**USD**	**$0 - $24,888**
Children	$1,540	

Adults	$2,358
Elderly	$13,351
Blind and Disabled	$14,611
Total	$5,169

16: Kansas	**USD**	**$0 - $24,888**
Children	$1,499	
Adults	$2,058	
Elderly	$14,027	
Blind and Disabled	$13,823	
Total	$4,856	

24: Kentucky	**USD**	**$0 - $24,888**
Children	$1,844	
Adults	$2,651	
Elderly	$9,526	
Blind and Disabled	$7,878	
Total	$4,339	

43: Louisiana	**USD**	**$0 - $24,888**
Children	$912	
Adults	$2,572	
Elderly	$7,671	
Blind and Disabled	$9,100	
Total	$3,236	

11: Maine	**USD**	**$0 - $24,888**
Children	$3,961	
Adults	$3,606	
Elderly	$5,054	
Blind and Disabled	$9,155	
Total	$5,445	

9: Maryland	**USD**	**$0 - $24,888**
Children	$2,327[3]	
Adults	$3,984[3]	
Elderly	$14,345[3]	
Blind and Disabled	$17,053[3]	
Total	$5,870[3]	

12: Massachusetts	**USD**	**$0 - $24,888**

Children	$1,593
Adults	$1,637
Elderly	$14,052
Blind and Disabled	$13,012
Total	$5,312

33: Michigan	**USD**	**$0 - $24,888**
Children	$1,033	
Adults	$1,993	
Elderly	$11,601	
Blind and Disabled	$10,446	
Total	$3,741	

5: Minnesota	**USD**	**$0 - $24,888**
Children	$2,254	
Adults	$2,440	
Elderly	$13,977	
Blind and Disabled	$21,583	
Total	$6,376	

36: Mississippi	**USD**	**$0 - $24,888**
Children	$1,225	
Adults	$2,664	
Elderly	$8,142	
Blind and Disabled	$7,132	
Total	$3,495	

32: Missouri	**USD**	**$0 - $24,888**
Children	$1,552	
Adults	$1,794	
Elderly	$11,386	
Blind and Disabled	$10,676	
Total	$3,784	

18: Montana	**USD**	**$0 - $24,888**
Children	$1,888	
Adults	$2,858	
Elderly	$13,591	
Blind and Disabled	$10,942	
Total	$4,664	

	USD	**$0 - $24,888**

23: Nebraska		
Children	$1,768	
Adults	$2,222	
Elderly	$15,166	
Blind and Disabled	$13,382	
Total	$4,344	

37: Nevada	**USD**	**$0 - $24,888**
Children	$1,409	
Adults	$2,059	
Elderly	$7,336	
Blind and Disabled	$11,033	
Total	$3,491	

8: New Hampshire	**USD**	**$0 - $24,888**
Children	$2,292	
Adults	$2,606	
Elderly	$17,442	
Blind and Disabled	$17,338	
Total	$6,039	

7: New Jersey	**USD**	**$0 - $24,888**
Children	$1,749	
Adults	$2,345	
Elderly	$14,893	
Blind and Disabled	$16,456	
Total	$6,091	

31: New Mexico	**USD**	**$0 - $24,888**
Children	$1,907	
Adults	$2,176	
Elderly	$11,701	
Blind and Disabled	$14,180	
Total	$3,818	

1: New York	**USD**	**$0 - $24,888**
Children	$1,885	
Adults	$3,418	
Elderly	$21,903	
Blind and Disabled	$24,888	
Total	$7,583	

20: North Carolina	USD	$0 - $24,888
Children	$1,540	
Adults	$2,884	
Elderly	$9,478	
Blind and Disabled	$11,558	
Total	$4,463	

10: North Dakota	USD	$0 - $24,888
Children	$1,537	
Adults	$1,879	
Elderly	$16,966	
Blind and Disabled	$17,195	
Total	$5,702	

14: Ohio	USD	$0 - $24,888
Children	$1,357	
Adults	$2,364	
Elderly	$19,843	
Blind and Disabled	$14,873	
Total	$5,265	

45: Oklahoma	USD	$0 - $24,888
Children	$1,319	
Adults	$1,608	
Elderly	$8,847	
Blind and Disabled	$9,808	
Total	$3,171	

40: Oregon	USD	$0 - $24,888
Children	$1,598	
Adults	$1,823	
Elderly	$9,689	
Blind and Disabled	$10,196	
Total	$3,345	

13: Pennsylvania	USD	$0 - $24,888
Children	$1,780	
Adults	$2,491	
Elderly	$14,452	
Blind and Disabled	$9,756	
Total	$5,268	

6: Rhode Island	USD	$0 - $24,888
Children	$2,175	
Adults	$2,301	
Elderly	$16,045	
Blind and Disabled	$16,262	
Total	$6,308	

48: South Carolina	USD	$0 - $24,888
Children	$1,421[4]	
Adults	$1,538[4]	
Elderly	$4,901[4]	
Blind and Disabled	$9,352[4]	
Total	$2,974[4]	

22: South Dakota	USD	$0 - $24,888
Children	$1,688	
Adults	$2,601	
Elderly	$12,259	
Blind and Disabled	$14,014	
Total	$4,451	

41: Tennessee	USD	$0 - $24,888
Children	$1,163[5]	
Adults	$2,658[5]	
Elderly	$7,307[5]	
Blind and Disabled	$7,361[5]	
Total	$3,283[5]	

39: Texas	USD	$0 - $24,888
Children	$1,478	
Adults	$2,419	
Elderly	$7,842	
Blind and Disabled	$10,599	
Total	$3,371	

42: Utah	USD	$0 - $24,888
Children	$1,591	
Adults	$1,413	
Elderly	$10,295	
Blind and Disabled	$13,983	
Total	$3,268	

30: Vermont	**USD**	**$0 - $24,888**
Children	$2,095	
Adults	$1,713	
Elderly	$7,849	
Blind and Disabled	$12,970	
Total	$3,977	

26: Virginia	**USD**	**$0 - $24,888**
Children	$1,393	
Adults	$2,354	
Elderly	$9,065	
Blind and Disabled	$10,585	
Total	$4,241	

49: Washington	**USD**	**$0 - $24,888**
Children	$1,050	
Adults	$1,880	
Elderly	$9,347	
Blind and Disabled	$8,223	
Total	$2,793	

21: West Virginia	**USD**	**$0 - $24,888**
Children	$1,545	
Adults	$2,166	
Elderly	$13,001	
Blind and Disabled	$8,480	
Total	$4,456	

25: Wisconsin	**USD**	**$0 - $24,888**
Children	$1,076	
Adults	$2,012	
Elderly	$9,272	
Blind and Disabled	$12,922	
Total	$4,317	

27: Wyoming	**USD**	**$0 - $24,888**
Children	$1,517	
Adults	$2,476	
Elderly	$13,118	
Blind and Disabled	$16,377	

Total	$4,220

Notes: Spending includes both state and federal payments to Medicaid. These figures represent the average (mean) level of payments across all Medicaid enrollees. Spending per enrollee does not include disproportionate share hospital payments (DSH).

Some enrollees are only eligible for a limited set of benefits. A small fraction of elderly and disabled enrollees in every state qualify only for assistance with their Medicare premiums and coinsurance. In 2003, a few states also had waivers that allowed them to enroll relatively large numbers of people in Medicaid-funded programs for family planning-related services or prescription drug coverage.

Definitions: Enrollees: Individuals who participate in Medicaid for any length of time during the federal fiscal year. They may not actually use any services during this period, but they are reported as enrolled in the program and are eligible to receive services in at least one month. Enrollees are presumed to be unduplicated (each person is only counted once), though limited duplication may occur.

Sources: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006.

Footnotes:

1. In the District of Columbia, payments per enrollee appear to have increased significantly. This may be related to possible over-reporting in FY2002, when MSIS data for the District showed much higher enrollment numbers than were listed on the CMS Datamart. Therefore the 2002 payments per enrollee were most likely lower than they should have been, resulting in a larger increase between FY2002 and FY2003.

2. In Illinois, payments per elderly enrollee decreased a great deal. This is most likely attributable to the addition of pharmacy benefit-only enrollees through the state's Senior Care program.

3. Total expenditures in Maryland in the 2003 MSIS are overstated by $466.8 million and appear misallocated between services because the state submitted expenditures linked to encounter data in error. 2003 Maryland data have been replaced with 2002 data.

4. In South Carolina, payments per elderly enrollee decreased significantly. This is most likely attributable to the addition of pharmacy benefit-only enrollees through the state's new SilveRxCard program.

5. In Tennessee, overall payments per enrollee increased significantly. This may be related to the state's July 2002 conversion of its managed care system into a new system in which its HMOs were no longer bearing risk. Instead, the state paid them a capitated fee to process fee-for-service (FFS) claims for their enrollees from a network of providers.

Hawaii Health Information Corporation

Medicaid Charge, Cost and Payment Data for Private Acute Hospitals

Part 1: Calculated from DataBank, HHIC's financial database

Peer Group	Medicaid Inpatient Charges	Medicaid Outpatient Charges	Total Medicaid Charges	Medicaid Costs	Medicaid Payment	Payment Shortfall from Charges	Payment Shortfall from Cost	Payment Percent of Cost
HI PRIVATE ACUTE: July 1, 2003-June 30, 2004, 10 hos.	$309,617,109	$110,324,380	$419,941,489	$194,799,365	$147,630,432	$272,311,057	$47,168,933	75.79%
HI PRIVATE ACUTE: July 1, 2004-June 30, 2005, 10 hos.	$353,871,631	$132,513,025	$486,384,656	$213,067,032	$158,043,214	$328,341,442	$55,023,818	74.18%
HI PRIVATE ACUTE: July 1, 2005-June 30, 2006, 11 hos.	$342,351,801	$148,079,457	$490,431,258	$215,440,263	$164,798,837	$325,632,421	$50,641,426	76.49%
HI PRIVATE ACUTE: July 1, 2006-September 30, 2006, 5 hos.	$35,119,801	$17,657,940	$52,777,741	$24,444,237	$14,158,395	$38,619,346	$10,285,842	57.92%

Nov. 02, 2006

Part II. Estimates derived from HHIC's discharge and emergency department databases for those hospitals not yet reporting to DataBank

FYE 2006 Hospitals not included:	Medicaid Inpatient Charges	Medicaid Emergency Department Charges	Medicaid Total Charges	Costs as Percent of Charges	Estimated Costs	Payment Percent of Costs	Estimated Medicaid Payment	Estimated Payment Shortfall from Cost
Castle Medical Center	$ 24,842,970	$ 6,168,026	$ 31,010,996	43.93%	$ 13,622,739	76.49%	$ 10,420,038	$ 3,202,706
Kahuku Hospital	$ 421,800	Did Not Report	$ 421,800	43.93%	$ 185,297	76.49%	$ 141,738	$ 43,563
Kaiser Moanalua Medical Center	$ 14,939,365	$ 2,076,178	$ 17,015,543	43.93%	$ 7,474,928	76.49%	$ 5,717,572	$ 1,757,356
Wahiawa Hospital	$ 5,469,150	$ 2,847,670	$ 8,316,820	43.93%	$ 3,653,579	76.49%	$ 2,794,623	$ 858,956
								$ 5,862,581

Part II Methodology

1. The discharge and emergency department databases include total charges and the principal source of payment for each case (e.g., discharge or visit).
2. Medicaid inpatient and emergency department charges were totaled for the period 7/1/05-6/30/06. Note that for emergency department visits, data were only available for the first 6 months of the fiscal year. **THEREFORE**, the total charges were doubled to approximate a full year. For the previous six years, the first two quarters averaged 47% of the total charges for the year--the approach taken here is conservative.
3. Costs as a percent of charges, calculated for the 11 private acute hospitals in DataBank at 43.93%, was applied to medicaid total charges to derive estimated costs.
4. Payment as a percent of costs, calculated for the 11 private acute hospitals in DataBank at 76.49%, was applied to estimated costs to derived estimated medicaid payment.
5. The estimated medicaid payment was subtracted from estimated costs to provide estimated shortfall from cost.

Part III. Total Payment Shortfall from Costs

As Calculated from HHIC's financial database for 11 private acute care hospitals for FYE 2006:	$50,641,426	**Hospitals included**: Kapiolani Medical Center for Women and Children, Kapiolani Medical Center at Pali Momi, Kuakini Medical Center, Molokai Hospital, North Hawaii Community Hospital, The Queen's Medical Center, Rehabilitation Hospital of the Pacific, St. Francis Medical Center-Liliha, St. Francis Medical Center West, Straub Hospital, Wilcox Hospital.
As calculated from HHIC's discharge and emergency department databases for 4 hospitals not yet included in financial database for FYE 2006:	$ 5,862,581	**Hospitals included:** Castle Medical Center, Kahuku Hospital, Kaiser Moanalua Medical Center, Wahiawa Hospital.
Total Payment Shortfall from Costs for Private Acute Care Hospitals, FYE 2006	**$56,504,007**	

Appendix I

Health Policy Tracking Service
A Service of Thomson West
Issue Brief
Oct. 2, 2006

Medicaid Reimbursement

Authored by Patrick Johnson, Senior Health Policy Analyst

BACKGROUND

State Medicaid agencies recognize that reimbursement rates for healthcare providers — both individuals and facilities — whether traditional fee-for-service rates or capitation rates for managed care providers, must be sufficient to ensure that Medicaid programs have enough providers to deliver care. However, states often attempt to save money by lowering payments to providers who deliver healthcare services to Medicaid beneficiaries. This cost crunch has resulted in provider payment rates that often are substantially below market rates. State legislatures, program administrators and providers have sought to find the proper balance between adequate levels of reimbursement and cost control measures. However, dissatisfaction with low reimbursement levels has caused some providers to cease participating in the Medicaid program. This attrition has a detrimental affect on Medicaid recipients' access to health services. States have become aware of the problem and have tried to revise their rates to find the elusive balance between adequate reimbursement and fiscal control.

WHAT HAVE STATES DONE?

The struggle to find a proper balance between adequate reimbursement rates and cost control measures was certainly evident during the states' fiscal crises between 2001 and 2004. Yet, no definitive trend of either lowering or raising reimbursement rates emerged. During the legislative sessions of 2002 and 2003, 47 states enacted legislation concerning provider reimbursement. Forty-one states reduced or froze provider reimbursement rates, and 34 states increased reimbursement rates. Twenty-nine of these states decreased some rates but increased others.

In 2004, 27 states enacted legislation affecting reimbursement for medical assistance providers. The number of states that increased reimbursement levels was slightly higher than those that decreased rates — 18 states increased provider rates, while 11 reduced them. And, as usual, many states, in addition to increasing or decreasing reimbursement levels, "clarified" existing rates.

In 2005, however, the pendulum began to swing toward increasing reimbursement rates. With the recovery of the national economy and revenue beginning to fill state treasuries, provider groups in states such as **California**, **Connecticut**, **Georgia**, **New Hampshire**, **Ohio** and **Pennsylvania** pressured their state legislatures to increase the rates and timeliness of Medicaid reimbursements. The combination of provider group advocacy and increased revenues led legislatures in 30 states to enact measures dealing with Medicaid provider reimbursement. While four states — **Connecticut**, **Michigan**, **Vermont** and **Wisconsin** — decreased some provider rates, and three states — **New Hampshire**, **North Carolina** and **Ohio** — froze

some provider reimbursement rates, 19 states increased provider reimbursement rates. The 19 states that increased rates are **Arizona**, **Arkansas**, **Florida**, **Illinois**, **Iowa**, **Kentucky**, **Louisiana**, **Maine**, **Maryland**, **Massachusetts**, **Mississippi**, **Missouri**, **New Hampshire**, **North Carolina**, **Oklahoma**, **Tennessee**, **Utah**, **Virginia** and **Washington.**

See Table 1 below for a summary of enacted legislation regarding reimbursement rates in the 2004 and 2005 legislative sessions.

Table 1

2004 and 2005 Legislative Activity Regarding Reimbursement Rates
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

Year	Decreased or Froze Reimbursement Rates	Increased Reimbursement Rates
2004	AZ, CA, CO, CT, FL, GA, IL, ME, MD, MT, VA	AZ, CA, CO, FL, GA, IL, IA, KY, MD, MA, MI, MS, NJ, SC, UT, VA, WA, WY
2005	CT, MI, NH, NC, OH, VT, WI	AZ, AR, FL, IL, IA, KY, LA, ME, MD, MA, MS, MO, NH, NC, OK, TN, UT, VA, WA

2006 STATE ACTIVITY

State Fiscal Conditions
States have recovered from the budget crises that tied legislators' hands during the previous five years. In fact, the National Conference of State Legislatures reported in April that fiscal offices in 42 states expect to end the 2006 fiscal year with a collective $28.9 billion surplus. In addition, 41 states revised their revenue forecasts since the start of the 2006 fiscal year, with collections exceeding expectations in 18, on target in another 18, and below forecasted levels in only one. As a result, in 2006, state legislatures are continuing the trend started in 2005 — increasing provider reimbursement rates.[1]

Provider Advocacy
As in 2005, provider groups are drawing attention to reimbursement rates they consider to be less than adequate. For example, in **Michigan**, the Legislature restored dental coverage to 600,000 Medicaid beneficiaries last October, but the number of Michigan dentists accepting Medicaid patients has decreased by 39 percent, from 1,578 in 2000 to 961 in 2005, according to the state Department of Community Health. Currently, only 15 percent of the state's 6,500 dentists accept Medicaid, citing low reimbursement rates as the major reason for their not participating in the program. Dentists in Michigan say the rates are well below what it costs them to perform their services. They also claim that the reimbursement process can be a major hassle, as they often have to submit claims multiple times.[2]

[1] National Conference of State Legislatures, State Budget Update: March 2006 (April 2006).
[2] Associated Press, *Dental Care Eludes Medicaid Patients*, THE GRAND RAPIDS PRESS, March 13, 2006. 2006 WLNR 425465

In addition to Michigan, provider groups in **Arkansas, Maine** and **West Virginia** advocated for increased rates or more timely payments in 2006.

Arkansas Hospital Association officials testified that the state's hospitals lost $64 million in 2004 because reimbursement rates have not increased in 10 years. In January, the state Department of Health and Human Services came to an agreement with the Arkansas State Dental Association on new rates that will nearly double state payments to dentists for Medicaid services. The new rate is pending approval by the federal government and would be retroactive to Feb. 1. Dental rates have not been increased since 1997, and as a result, only about 150 of the 1,200 Arkansas dentists accept Medicaid patients.[3]

Earlier this year **Maine** hospitals estimated they were owed $360 million in overdue Medicaid payments and expected that figure to double by July. The debt includes federal and state payments and dates back to patients treated in 2003. The state's share of the estimated $360 million debt is $110 million. Hospital officials want the state to pay the back settlements owed for patients already treated as well as to increase the reimbursement rate to reflect the increase in services provided due to expansions in Medicaid.[4]

Healthcare providers in **West Virginia** state that Medicaid owes them a considerable amount in unpaid claims. As a result, some providers have reduced their office hours and others no longer accept Medicaid patients. The lack of timely payments stems from problems within the Unisys Corp. system, the state's fiscal Medicaid agent. Providers are concerned that if the claims process does not improve soon, fewer providers will accept Medicaid patients and more residents will turn to more costly emergency room care.[5]

Enacted Legislation

Recognizing the need for competitive provider reimbursement rates, numerous state legislatures are acting on measures to increase Medicaid provider reimbursement. Thus far in 2006, 15 states — **California**, **Louisiana**, **Maine**, **Maryland**, **Massachusetts**, **Michigan**, **Mississippi**, **New Hampshire**, **New Mexico**, **Oklahoma**, **Utah**, **Vermont**, **Washington**, **Wisconsin** and **Wyoming** — have passed legislation to increase the rates for such providers and services as long-term care providers, hospitals, physicians, personal care services, dental services, mental health services and wheelchair van services. Table 2 shows the states that have increased rates for particular providers.

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[3] Seth Blomeley, *Hospitals seek bigger payback from Medicaid*, ARKANSAS DEMOCRAT GAZETTE, Feb. 24, 2006.

[4] A.J. Higgins, *Budget Deal Eludes Democrats, GOP*, BANGOR DAILY NEWS, March 21, 2006. 2006 WLNR 4727425

[5] Fred Pace, *Providers: Medicaid payment situation still bleak in W.Va*, THE REGISTER-HERALD, Feb. 19, 2006.

Table 2

2006 Legislative Activity: Increased Reimbursement Rates Source: Health Policy Tracking Service, a service of Thomson West, October 2006						
LTC	**Physicians**	**Hospitals**	**Personal Care**	**Dental**	**Others**	**Studies**
OK VA WA WI WY	MD MI NM OK VA WY	CO LA MA OK VT	ME MD MI NH	MS NM VT	CA ME MA MS UT VA WA	CA ME MD MN

Long-Term Care Providers

Washington's FY 2006 supplemental budget, 2005 WA S.B. 6386 (NS), contains numerous provisions that enhance reimbursement rates for long-term care providers. Specifically, the supplemental budget provides funds to perform the following tasks:

- Increase home care agency payment rates to cover the cost of all hourly wage, vacation and seniority wage increases that have been funded on behalf of individual providers of homecare services
- Boost vendor rates by 1 percent for boarding home payment rates and adult family home payment rates, effective July 1, 2006
- Increase payment rates for adult day health services by 14 percent
- Boost the payment rate for supported living providers to 15 cents per hour for King County and 12 cents per hour for all other counties, with appropriate benchmark adjustments to the administrative portion of the rate
- Provide capital add-on rates to assisted living facilities that have a minimum Medicaid occupancy percentage of 60 percent or greater (Managed care clients will be included in the calculation of Medicaid occupancy.)
- Provide one-time funding in FY 2006 for payments to any assisted living facility licensed Jan. 25, 2002, that serves 20 or more clients participating in the program for all-inclusive care
- Increase nursing home payment rates by an average of 6 percent next year

Washington lawmakers also approved another bill, 2005 WA H.B. 2716 (NS), which modifies provisions relating to nursing facility Medicaid payment systems by recalculating the direct care and operations component rate allocations based upon calendar year 2003 cost reports. The newly enacted law removes the minimum occupancy standards for direct care component rate allocations. In addition, the law modifies the direct care case-mix corridor by eliminating the corridor floor and increasing the corridor ceiling to 112 percent of the peer group median.

Oklahoma lawmakers, through one of the fiscal year 2007 appropriation acts, 2005 OK S.B. 80XX (NS), allocated $22 million to fully implement a 13.2 percent increase in nursing reimbursement rates and a 10 percent rate increase for ICF/MR facilities.

Virginia included a provision in 2006 VA H.B. 5002 (NS), the FY 2006-2008 "Biennial Budget Act," that allocates funds to increase reimbursement rates for skilled nursing services provided through the Medicaid technology assisted home- and community-based waiver program and the HIV/AIDS Home and Community-based Care Waiver program by 5 percent, effective July 1, 2006.

Wisconsin approved a new aid package to grant more state and federal money for Medicaid patients in nursing homes. The enacted bill, 2005 WI H.B. 981 (NS), gives nursing homes a 2.8 percent annual increase in Medicaid reimbursement rates, which Gov. Jim Doyle (D) vetoed last year. The measure, signed into law in late March, provides state nursing homes with an additional $3 million ($1.29 million in state funds and $1.8 million in federal aid) by June 30. In fiscal year 2007, nursing homes would get an additional $23.8 million ($10.1 million from the state and $13.7 million in federal funding).

Wyoming's budget act, 2006 WY H.B. 1 (NS), allocates approximately $435,000 in state funds and $486,000 in federal funds to increase payments under the Medicaid assisted living waiver program to a range of $42 to $50 per day.

In addition, a **Kentucky** measure, 2006 KY S.J.R. 176 (NS), directs the Cabinet for Health and Family Services to apply to participate in any pay-for-performance demonstrations solicited by the federal Centers for Medicare and Medicaid Services (CMS) to improve the quality of long-term care. It encourages the cabinet to explore opportunities to participate in federal Medicaid pay-for-performance demonstrations that would provide financial incentives to nursing facilities for improvements in outcomes of care.

Physicians

Maryland's FY 2007 budget act, 2006 MD S.B. 110 (NS), includes $30 million for rate enhancements for physicians.

Michigan's main budget act, 2005 MI S.B. 1083 (NS), appropriates approximately $16.6 million from funds dedicated for physician services and health plan services, to increase Medicaid reimbursement rates for physician well child procedure codes and primary care procedure codes. The increased reimbursement rates will be implemented Oct. 1, 2006 and will not exceed the comparable Medicare payment rate for the same services.

New Mexico's FY 2007 "General Appropriations Act," 2006 NM H.B. 2 (NS), allocates $9.45 million to increase Medicaid payments to physicians.

One of **Oklahoma's** appropriation acts, 2005 OK S.B. 80XX (NS), includes $13 million to increase hospital and physician rates for six months — funds that will allow hospitals to be reimbursed at their upper payment limit (UPL).

Virginia's biennial budget bill, 2006 VA H.B. 5002 (NS), authorizes the Department of Medical Assistance Services to increase payments to physicians who are faculty affiliated with Type I hospitals or related universities. The amount of the total payment will be up to the upper payment limit for these services as permitted by federal Medicaid law and regulation.

Wyoming lawmakers passed a measure, 2006 WY H.B. 80 (NS), that provides for increased reimbursement for obstetric services. The bill establishes an increased

reimbursement rate for obstetric services at 90 percent of the statewide average of the physician's specialty for the service as of July 1, 2006, not to exceed 100 percent of the provider's usual and customary charge for the service. The rate increase will occur from July 1, 2006, through June 30, 2008. In addition, the Department of Health is required to report to the Joint Labor, Health and Social Services Interim Committee by Oct. 31, 2007, with respect to the additional costs incurred as a result of the increased reimbursement rate.

Hospitals

A **Colorado** law, 2006 CO S.B. 145 (NS), allows local governments to charge hospitals and home healthcare agencies a fee to obtain matching funds from the federal government for Medicaid costs that are not reimbursed. That money would then be returned to the facilities, with hospitals standing to receive approximately $50 million in additional Medicaid payments.

A **Louisiana** budget act, 2006 LA H.B. 1 (NS), appropriates $38 million to the Payments to Private Providers Program for an increase in Medicaid reimbursement rates for hospital inpatient and outpatient services.

The **Massachusetts** healthcare reform bill, 2005 MA H.B. 4850 (NS), authorizes $90 million in rate relief for hospitals for fiscal years 2007, 2008 and 2009. The bill also establishes, for the first time, a process of tying rate increases to specific performance goals related to quality, efficiency, the reduction of racial and ethnic disparities and improved outcomes for patients.

Vermont's healthcare reform bill, 2005 VT H.B. 861 (NS), allows an increase in Medicaid reimbursement to hospitals effective Jan. 1, 2007. In fiscal year 2008 and thereafter, the office will increase Medicaid reimbursement rates annually on July 1 until the federal upper limit is reached.

Personal Care Services

Maine passed a measure, 2005 ME S.R. 769 (NS), that directs the commissioner of health and human services to adopt rules governing MaineCare physical disabilities waivers and the consumer-directed attendant services programs to increase the rate of reimbursement for providers of consumer-directed personal care assistance services from $7.71 per hour to $10 per hour.

Maryland's budget act, 2006 MD S.B. 110 (NS), includes $2 million to increase rates for personal care providers.

Michigan's budget act, 2005 MI S.B. 1083 (NS), states that, beginning Oct. 1, 2006, the Department of Community Health will increase the monthly Medicaid personal care supplement by $10 to adult foster care facilities and homes for the aged providing personal care services to Medicaid beneficiaries.

New Hampshire enacted a law, 2005 NH H.B. 1611 (NS), authorizing the Department of Health and Human Services to reimburse a parent who provides personal care to a minor child with special healthcare needs residing at home under certain circumstances. Such reimbursement will occur only when the department determines that the needs of the child, the unavailability of appropriate providers or suitable alternative care services and cost efficiencies make utilization of a parent for the provision of such services necessary and appropriate. Reimbursement shall be limited to care that is medically necessary due to specific health needs and shall not

be made for care generally expected and provided by parents to a child of similar age and developmental stage.

Dental Services

Mississippi's "FY 2007 Appropriations Act for the Division of Medicaid," 2006 MS H.B. 1563 (NS), allocates $1.5 million to increase reimbursement rates for dental providers.

New Mexico's "FY 2007 General Appropriations Act," 2006 NM H.B. 2 (NS), allocates $950,000 to increase Medicaid payments for dental services.

Vermont's healthcare reform bill, 2005 VT H.B. 861 (NS), increases dental reimbursement by restoring the reductions in adult dental rates that were effective Feb. 1, 2006, and by splitting the remaining amount approximately in half to increase rates for dental services and to increase the dental cap for adults in such a manner as to offset any loss in benefit level due to the rate increases.

Other Providers

A **California** budget act, 2005 CA A.B. 1801 (NS), appropriates $9.35 million for Medi-Cal managed care rate increases for plans that are experiencing financial hardship, as determined by the Department of Health Services and approved by the Department of Finance. Rate increases may be retroactive to the beginning of a plan's 2006-07 rate year.

Maine lawmakers passed a measure, 2005 ME H.B. 1355 (NS), which provides a FY 2006-07 General Fund appropriation of $1.26 million for the Department of Health and Human Services to increase MaineCare reimbursement rates for wheelchair van services. While the bill specifies that the rates should be set so that providers are not providing services at a loss, it does not otherwise specify the amount of the rate increase to be funded by this appropriation.

Massachusetts, through its healthcare reform bill, 2005 MA H.B. 4850 (NS), authorized continued payments of supplemental funding to Medicaid Managed Care Organizations operated by Cambridge Health Alliance and Boston Medical Center.

Mississippi's "FY 2007 Appropriations Act for the Department of Health," 2006 MS H.B. 1564 (NS), contains a provision allowing the Department of Health to transfer a portion of Trauma Care System funds to the Division of Medicaid for the development and implementation of an enhanced reimbursement fee program related to trauma care and services, used to match federal funds, under a cooperative agreement between the State Department of Health and the Division of Medicaid.

Washington's 2006 supplemental budget, 2005 WA S.B. 6386 (NS), provides funds to improve the quality and availability of community mental health services and to assure more equitable access to such services statewide. In FY 2007, non-Medicaid funds are to be distributed proportionally to total population in each Regional Support Network (RSN) region. Medicaid payment rates will be increased to the statewide average for those RSNs whose rates would otherwise be below that level and by 3.5 percent for those RSNs whose rates are above the current average. Additional state funds are provided to assure that no RSN receives less total funding next year. Statewide, RSN funding will be increased by $34.6 million, or 9.1 percent, in FY 2007.

Utah's appropriation act, 2006 UT H.B. 1 (NS), allocates $34.5 million to increase FY 2007 reimbursement rates by an average of 2.5 percent to selected providers of Medicaid services.

Virginia's biennial budget bill, 2006 VA H.B. 5002 (NS), provides funds to increase the following provider reimbursement rates:

- Adult day healthcare reimbursement rates provided under Medicaid home- and community-based waiver programs by 5 percent
- Personal care reimbursement rates provided under community-based Medicaid waiver programs by 3 percent, effective July 1, 2007
- Providers delivering unique services provided through the Mental Retardation, Individual and Family Developmental Disabilities Support or Day Support Home and Community-based Waiver Programs (but not provided in other waiver programs) by 5 percent
- Providers of congregate residential group home services for individuals in the Mental Retardation Home and Community-based Waiver Program by 10 percent (This increase does not apply to personal care and related services, nursing services or services that are either fixed price or determined through individual consideration.)

Reimbursement Studies

Outside of legislation that has increased provider rates, four states — **California**, **Maine**, **Maryland** and **Minnesota** — commissioned studies of their states' reimbursement rates and payment schedules.

One of **California's** budget acts, 2005 CA A.B. 1801 (NS), appropriates up to $600,000 to be used to conduct a study of the pharmacy reimbursement rates and fees provided under the Medi-Cal program, including the cost of providing prescription drugs and services. This study will take into account the revised payments for Medicaid drug ingredient costs mandated by the 2005 federal "Deficit Reduction Act." Due to the Jan. 1, 2007, timeline for changes contained in the federal law, this study will be conducted in an expedited manner to the extent feasible for a quality work product. The department will provide the results of the study to the Legislature on or before Dec. 1, 2006.

Maine enacted legislation, 2005 ME S.R. 735 (NS), requiring the Department of Health and Human Services to study potential options and their costs for increasing wages and providing health coverage for direct care workers in state-funded and MaineCare-funded long-term care programs. The Department of Health and Human Services, in conjunction with the Department of Labor, will conduct a study of direct care workers in state-funded and MaineCare-funded programs to perform the following tasks:

- Examine the wage, benefit and reimbursement structures for direct care workers in all long-term care settings including but not limited to nursing facilities, residential care facilities, mental retardation waiver homes and home care
- Determine the cost of a wage floor of $8.50 per hour and the cost of a wage floor of $10 per hour for entry-level direct care workers, including certified nursing assistants, personal support specialists, home health aides, homemakers and direct support professionals (The study must include

determination of the cost of proportional increases in current wage scales for more experienced workers and employer-related costs such as FICA.)
- Develop options to extend MaineCare or other health insurance coverage for direct care workers
- Evaluate the need for a direct care worker registry, including desired objectives of such a registry and a cost estimate

The department will invite interested parties involved in long-term care or home healthcare, including direct support and personal assistance workers from all settings to participate during the course of study. It will submit its report, including any necessary implementing legislation, to the joint standing committee of the Legislature with jurisdiction over health and human services matters no later than Jan. 1, 2007.

Maine also passed another measure, 2005 ME S.B. 674 (NS), directing the MaineCare Advisory Committee to review and monitor changes in the federal Medicaid program and implementation of the provisions of the federal "Deficit Reduction Act of 2005," PL 109-171, 2005 FD S.B. 1932 (NS). The MaineCare Advisory Committee will report to the Joint Standing Committee on Health and Human Services the results of its review and any recommendations the committee has for legislation or rulemaking by the Department of Health and Human Services in an initial report by Sept. 1, 2006, and a final report by Jan. 1, 2007. The report must identify strategies that ensure the sustainability of the MaineCare program while protecting the health and welfare of MaineCare beneficiaries and the viability of Maine's healthcare provider safety net.

Maryland passed legislation, 2006 MD H.B. 771 (NS), requiring the Department of Health and Mental Hygiene (DHMH) to conduct a study of the adequacy of rates paid to therapeutic behavioral services providers and submit a report to the governor and specified standing committees of the General Assembly on or before Jan. 1, 2007. The study must assess the impact of the current rates on participation of existing and potential therapeutic behavioral services providers in Medicaid, the ability of providers to recruit and retain staff, the ability of DHMH to promptly refer a child for receipt of therapeutic behavioral services and the ability of providers to deliver the requisite number of therapeutic behavioral service hours.

Minnesota enacted a measure, 2005 MN S.F. 367 (NS), requiring the medical director for medical assistance and the assistant commissioner for chemical and mental health services, in conjunction with the mental health licensing boards, to evaluate the requirements of licensed mental health practitioners to receive Medical Assistance (MA) reimbursement. The law states that the purpose of the study is to evaluate the qualifications of all licensed mental health practitioners and professionals and make recommendations regarding medical assistance reimbursement requirements and requires the study to be completed by Jan. 15, 2007. It also directs the commissioner of human services to encourage and assist providers to adopt and use electronic billing for state programs, including training, out of existing resources.

In a related note, **Louisiana** hospitals and healthcare providers are applying for reimbursement for the costs they incurred in providing services to uninsured hurricane evacuees. The money for the reimbursement will come from a special pool of $2 billion in federal funds allocated by Congress under the federal "Deficit Reduction Act." However, even when Louisiana receives the federal funding, which is

expected to be more than $100 million, providers will receive no more than 70 percent of the amount Medicaid would normally pay, according to Medicaid Director Jerry Phillips.

To be reimbursed, providers must have been enrolled in the Medicaid program as of Aug. 24, 2005. They will be reimbursed for care provided through Jan. 31, 2006, to evacuees of Hurricanes Katrina and Rita. Claims must have been filed by June 30, 2006, for each hurricane evacuee treated.

Pending Legislation

In addition to the enacted legislation described above, bills that are still moving through state legislatures that would affect Medicaid reimbursement rates can be found in Table 4 in the Appendix.

CONCLUSION

While state legislatures always strive to find a proper balance between adequate reimbursement rates and cost control measures, no definitive trend of either lowering or raising reimbursement rates emerged during the states' fiscal crises between 2001 and 2004. In 2005, however, with healthy state revenues, the pendulum began to swing toward increasing reimbursement rates. In 2006, legislators are again recognizing the need for competitive provider reimbursement rates, with 15 states acting on measures to increase Medicaid provider reimbursement.

Appendix

Table 3

Table 3 summarizes enacted 2006 legislation affecting Medicaid reimbursement.

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
AZ	2006 AZ SB 1137 (NS)	States that under a comprehensive care for the elderly program agreement the program contractor will make a prospective monthly payment to the comprehensive care for the elderly organization of a capitation rate for each Medicaid participant Specifies that the comprehensive care for the elderly organization must accept the capitation payment as payment in full for Medicaid participants and may not bill, charge, collect or receive any other form of payment from the program contractor, administration or from or on behalf of the comprehensive care for the elderly participant, except as follows: 1. Payment with respect to the share of cost and any amounts due under the post-eligibility treatment of income 2. Medicare payment received from CMS or from other payors 3. Adjustments related to enrollment and disenrollment of comprehensive care for the elderly participants in the comprehensive care for the elderly organization 4. A fee-for-service payment by the administration or CMS prior to the participant being capitated

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
CA	2005 CA A.B. 959 (NS)	(Existing law provides that a health facility is eligible to receive supplemental reimbursement under the Medi-Cal program if the facility provides services to Medi-Cal beneficiaries, is a distinct part of an acute care hospital providing skilled nursing services and is owned by any of certain local entities. Current law also provides for the payment of supplemental reimbursement to acute care hospitals owned by certain local entities, or by the University of California, that provide outpatient services to Medi-Cal beneficiaries.) Allows for the payment of supplemental reimbursement to a facility described above that is owned by the state. The bill expands for the department's rate year beginning Aug.1, 2006, and for subsequent rate years, this supplemental reimbursement provision to apply to a state veterans' home Commencing with the 2006-07 fiscal year, allows for the payment of supplemental reimbursement to publicly owned or operated health clinics that are enrolled as Medi-Cal providers Requires an eligible facility under these provisions, as a condition of receiving supplemental reimbursement, to enter into and maintain an agreement with the department for the purposes of implementing these provisions and reimbursing the department for the costs of administering them

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
CA	2005 CA A.B. 1801 (NS)	"The Budget Act of 2006" Appropriates up to $600,000 to be used to conduct a study of the pharmacy reimbursement rates and fees provided under the Medi-Cal program, including the cost of providing prescription drugs and services (This study will take into account the revised payments for Medicaid drug ingredient costs mandated by the 2005 federal "Deficit Reduction Act." Due to the Jan. 1, 2007, timeline for changes contained in the federal law, it is the intent of the Legislature that this study be conducted in an expedited manner to the extent feasible for a quality work product. The department will provide the results of the study to the Legislature on or before Dec. 1, 2006.) Directs the Department of Health Services to establish increases in maximum Drug Medi-Cal reimbursement rates during the 2006-07 fiscal year Appropriates $9.35 million for Medi-Cal managed care rate increases for plans that are experiencing financial hardship, as determined by the Department of Health Services and approved by he Department of Finance (Rate increases may be retroactive to the beginning of a plan's 2006-07 rate year.)

Source: http://www.pcc.com/clients/aaprbrvsbrochure06.pdf

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
CA	2005 CA A.B. 1807 (NS)	(Existing law requires the department to establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined. Existing law requires that reimbursement for all durable medical equipment billed to the Medi-Cal program using codes with no specified maximum allowable rate be the lesser of certain amounts, including the manufacturer's suggested retail price, reduced by a percentage discount not to exceed 20 percent.) Bases the above amount, instead, on the manufacturer's suggested retail purchase price on June 1, 2006, and documented by a printed catalog or a hard copy of an electronic catalog page showing the price on that date, reduced by a percentage discount not to exceed 20 percent, or not to exceed 15 percent for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation professional Requires, commencing Jan. 1, 2007, that reimbursement for oxygen delivery systems and oxygen contents utilize certain national codes and be the lesser of specified amounts Directs the department, within a specified period, to review the utilization of those services and equipment resulting from these changes and to notify the Joint Legislative Budget Committee if it finds an increase in inappropriate use of those services or equipment (Existing law requires the Department of Health Services to establish a list of hearing aids and hearing aid accessories and determine the maximum allowable product cost for each hearing aid product provided under the Medi-Cal program and instructs that the list be published in provider bulletins.) Revises provisions governing maximum reimbursement rates for hearing aids and hearing aid accessories and authorizes the department to implement those provisions by provider manual or bulletin

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
CA	2005 CA A.B. 1807 (NS) (cont.)	(Existing law prohibits Medi-Cal reimbursement from being made for a service rendered by an adult day healthcare provider that does not have a license as an adult day healthcare center or that does not have currently effective Medi-Cal certification.) Requires that, notwithstanding this prohibition, Medi-Cal certification be granted as of the date of licensure with respect to, and reimbursement be made for, a service rendered on or after that date if the provider meets specified requirements
CA	2005 CA A.B. 2950 (NS)	(Existing law provides that a bill submitted by a medical provider for a service provided under the Medi-Cal program is required to be submitted not more than six months after the month in which the service is rendered, with specified exceptions. Current law also requires that reimbursement for an original claim, submitted for payment between six and 12 months after the month of service, and which does not meet an exception, be reduced by 25 percent to 50 percent, as specified.) Provides that the reductions in reimbursement specified under the above provisions do not apply with respect to certain Medi-Cal programs for which there is no state General Fund match

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
CA	2005 CA S.B. 912 (NS)	(Existing law requires the director of health services, until Jan. 1, 2007, to reduce by 5 percent Medi-Cal provider payments for Medi-Cal program services for dates of service on and after Jan. 1, 2004. However, current law makes this reduction inapplicable to Medi-Cal program services provided between Jan. 1, 2004, and Dec. 31, 2005. Existing law also requires the director to make reductions in other specified programs, including payments made to managed healthcare plans.) Eliminates the above reductions with respect to Medi-Cal program services for dates of service commencing 14 days after the effective date of the bill and ending Jan. 1, 2007, to the extent that federal financial participation is available for the increase provided for in these provisions Exempts from elimination the reduction in payments to managed healthcare plans States the intent of the Legislature that the department take all administrative steps necessary to implement expeditiously these provisions Appropriates $22.5 million from the General Fund and $25.8 million from the Federal Trust Fund to defray the cost of eliminating the Medi-Cal reductions described above

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
CO	2006 CO H.B. 1299 (NS)	Requires the State Medical Services Board to implement rules for the payment of disposable medical supplies and durable medical equipment Stipulates that rules must prohibit a provider from being reimbursed by Medicaid unless the provider meets the following requirements: ▪ Operates a physical location within the state or within 50 miles of the state border, unless the medical equipment cannot be purchased from a provider meeting this requirement ▪ Complies with all licensing, insurance and regulatory requirements ▪ Is responsible for the delivery and instruction for proper use of the equipment ▪ Provides repair, replacement and adjustment of the product as required by the board ▪ Contracts with a provider who meets the above criteria Provides that the provisions of this law will apply to fee-for-service and primary care physician program recipients
CO	2006 CO S.B. 145 (NS)	Allows local governments to charge hospitals and home healthcare agencies a fee to obtain matching funds from the federal government for unreimbursed Medicaid costs and stipulates that the money would then be returned to healthcare providers (This creative financing mechanism, which has been used by other states, would increase federal funds for Medicaid without increasing the share paid by the state.)
HI	2005 HI S.B. 2227 (NS)	Establishes conditions for reimbursement of telehealth services

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
HI	2005 HI S.B. 3270 (NS)	Would provide for reimbursement to federally qualified health centers (FQHCs) Would direct that reimbursement rates paid to FQHCs may be adjusted if costs exceed 1.75 percent for changes related to the intensity, duration or amount of service provided, facilities, regulatory requirements or other extraordinary circumstances Would require FQHCs to submit an adjusted cost report covering a period of the previous two years Would appropriate funds to the Department of Health for direct medical services for the uninsured
ID	2006 ID S.B. 1370 (NS)	Adds dentists to Idaho Code section 56-136, which provides for an annual adjustment for the rate of reimbursement paid to physicians for Medicaid-covered services
KY	2006 KY S.J.R. 176 (NS)	Directs the Cabinet for Health and Family Services to apply to participate in any pay-for-performance demonstrations solicited by CMS to improve the quality of long-term care Encourages the cabinet to explore opportunities to participate in federal Medicaid pay-for-performance demonstrations that would provide financial incentives to nursing facilities for improvements in outcomes of care
LA	2006 LA H.B. 1 (NS)	Appropriates $38 million to the Payments to Private Providers Program for an increase in Medicaid reimbursement rates for hospital inpatient and outpatient services
LA	2006 LA H.B. 1001 (NS)	Establishes the Care for Evacuated Patients Program States that medically necessary services rendered to medically indigent patients, or those insured by Medicaid, from the date of the admission necessitated by evacuation of the patient from a state hospital through the 60th day of such admission will be eligible for payment by the state Specifies that for patients who are medically indigent, the state will pay on a per service basis an amount not to exceed the Medicare DRG rate for each such service, and for patients who are insured by Medicaid, the state will pay on a per service basis the difference between the Medicaid rate and the Medicare DRG rate for each such service
LA	2006 LA S.B. 135 (NS)	Provides for direct reimbursement of healthcare services to Medicaid recipients by an advanced practice registered nurse

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
LA	2006 LA S.B. 246 (NS)	To ensure compliance with the "Rural Hospital Preservation Act," states that any Medicaid common payment methodology applicable to a rural hospital will maximize Medicaid reimbursement as required by R.S. 40:1300.144(A)(2)
LA	2006 LA S.B. 613 (NS)	States that no later than Oct. 1, 2006, (instead of July 1, 2002) the Department of Health will promulgate rules and regulations in accordance with the "Administrative Procedure Act" to provide for a case mix reimbursement system for nursing homes States that in the event the Department of Health and Hospitals is required to implement reductions in the nursing home program as a result of a budget shortfall, a budget reduction category will be created (This category will reduce the statewide average Medicaid rate, without changing the parameters established in this section, by reducing the reimbursement rate paid to each nursing home using an equal amount per patient per day. The direct care spending floor will be decreased 1 percentage point for each 30-cent reduction in the average Medicaid rate computed under this system not to be reduced to below 90 percent of the median.)

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
ME	2005 ME S.P. 674 (NS)	Gives the Department of Health and Human Services the authority to enact retroactive rules on an emergency basis to increase MaineCare provider reimbursements Directs the MaineCare Advisory Committee to review the report of the Blue Ribbon Commission on the Future of MaineCare with the goal of identifying initiatives for the continuing improvement of the MaineCare program in order to preserve the long-term capability of the state to provide high-quality healthcare services to MaineCare beneficiaries Requires the MaineCare Advisory Committee to review and monitor changes in the federal Medicaid program and implementation of the provisions of the federal "Deficit Reduction Act of 2005" Directs the MaineCare Advisory Committee to report to the Joint Standing Committee on Health and Human Services the results of its review and any recommendations the committee has for legislation or rulemaking by the Department of Health and Human Services in an initial report by Sept. 1, 2006, and a final report by Jan. 1, 2007 Requires the report to identify strategies that ensure the sustainability of the MaineCare program while protecting the health and welfare of MaineCare beneficiaries and the viability of Maine's healthcare provider safety net
ME	2005 ME H.P. 1355 (NS)	Provides a FY 2006-07 General Fund appropriation of $1.26 million for the Department of Health and Human Services to increase MaineCare reimbursement rates for wheelchair van services (While the bill specifies the rates should be set so that providers are not providing services at a loss, it does not otherwise specify the amount of the rate increase to be funded by this appropriation.)

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
ME	2005 ME S.R. 735 (NS)	Requires the Department of Health and Human Services to study potential options and their costs for increasing wages and providing health coverage for direct care workers in state-funded and MaineCare-funded long-term care programs Directs the Department of Health and Human Services in conjunction with the Department of Labor to conduct a study of direct care workers in state-funded and MaineCare-funded programs with the following objectives: ▪ Examine the wage, benefit and reimbursement structures for direct care workers in all long-term care settings including but not limited to nursing facilities, residential care facilities, mental retardation waiver homes and home care ▪ Determine the cost of a wage floor of $8.50 per hour and the cost of a wage floor of $10 per hour for entry-level direct care workers, including certified nursing assistants, personal support specialists, home health aides, homemakers and direct support professionals (The study must include determination of the cost of proportional increases in current wage scales for more experienced workers and employer-related costs such as FICA.) ▪ Develop options to extend MaineCare or other health insurance coverage for direct care workers ▪ Evaluate the need for a direct care worker registry including desired objectives of such a registry and a cost estimate Requires the department to invite interested parties involved in long-term care or home healthcare including direct support and personal assistance workers from all settings to participate during the course of study Directs the department to submit its report including any necessary implementing legislation to the joint standing committee of the Legislature with jurisdiction over health and human services matters no later than Jan. 1, 2007

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
ME	2005 ME S.R. 769 (NS)	Directs the commissioner of health and human services to adopt rules governing the MaineCare physical disabilities waiver and the consumer-directed attendant services programs to increase the rate of reimbursement for providers of consumer-directed personal care assistance services from $7.71 per hour to $10 per hour Requires the commissioner of labor to adopt rules governing the program of state-funded consumer-directed personal care assistance services to increase the rate of reimbursement for providers of consumer-directed personal care assistance services from $7.71 per hour to $10 per hour Directs the commissioner of health and human services and the commissioner of labor to initiate a competitive bidding process to solicit bids from prospective providers of consumer-directed personal care assistance services
ME	2005 ME H.P. 1397 (NS)	Directs the Department of Health and Human Services to amend its rules governing reimbursement under MaineCare to allow for reimbursement to outpatient clinical service providers who practice independently Specifies that for purposes of this law, “outpatient clinical service providers” includes, but is not limited to, licensed clinical social workers and licensed clinical professional counselors
MD	2006 MD S.B. 110 (NS)	FY 2007 budget act, includes rate enhancements for many provider groups including physicians ($30 million), private-duty nurses ($9 million) and personal care providers ($2 million)
MD	2006 MD H.B. 771 (NS)	Requires the Department of Health and Mental Hygiene (DHMH) to conduct a study of the adequacy of rates paid to therapeutic behavioral service providers and submit a report to the governor and specified standing committees of the General Assembly on or before Jan. 1, 2007 Specifies that the study must assess the impact of the current rates on participation of existing and potential therapeutic behavioral services providers in Medicaid, the ability of providers to recruit and retain staff, the ability of DHMH to promptly refer a child for receipt of therapeutic behavioral services and the ability of providers to deliver the requisite number of therapeutic behavioral service hours

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
MD	2006 MD S.B. 447 (NS)	Requires that, beginning in fiscal year 2008, the fees paid by the Department of Health and Mental Hygiene to a community developmental disabilities services provider or a community mental health services provider for offering developmental disabilities services or mental health services to eligible individuals be adjusted annually for inflation by the update factor recommended by the Community Services Reimbursement Rate Commission Prohibits the annual rate of change from exceeding 5 percent
MA	2005 MA H.B. 4850 (NS)	The Massachusetts healthcare reform bill, authorizes continued payments of supplemental funding to Medicaid Managed Care Organizations operated by Cambridge Health Alliance and Boston Medical Center Includes $90 million in rate relief for hospitals for fiscal years 2007, 2008 and 2009 (in response to concern that Medicaid has underpaid many of its providers in recent years) Establishes, for the first time, a process of tying rate increases to specific performance goals related to quality, efficiency, the reduction of racial and ethnic disparities and improved outcomes for patients Specifies that Medicaid rate increases in the law are made contingent upon providers meeting performance benchmarks, including in the area of reducing racial and ethnic disparities
MI	2005 MI S.B. 1083 (NS)	Appropriations act, states that Medicaid substance abuse treatment services will be managed by selected CMHSPs or specialty prepaid health plans pursuant to CMS' approval of Michigan's 1915(b) waiver request to implement a managed care plan for specialized substance abuse services Specifies that the selected CMHSPs or specialty prepaid health plans will receive a capitated payment on a per eligible per month basis to assure provision of medically necessary substance abuse services to all beneficiaries who require those services Stipulates that the selected CMHSPs or specialty prepaid health plans will be responsible for the reimbursement of claims for specialized substance abuse services States that the CMHSPs or specialty prepaid health plans that are not coordinating agencies may continue to contract with a coordinating agency and that any alternative arrangement

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
MI	2005 MI S.B. 1083 (NS) (cont.)	must be based on client service needs and have prior approval from the department Directs the department of community health to provide an administrative procedure for the review of cost report grievances by medical services providers with regard to reimbursement under the medical services program (Settlements of properly submitted cost reports will be paid no later than nine months from receipt of the final report.) Specifies that for care provided to medical services recipients with other third-party sources of payment, medical services reimbursement will not exceed, in combination with such other resources, including Medicare, those amounts established for medical services-only patients (The medical services payment rate shall be accepted as payment in full. Other than an approved medical services copayment, no portion of a provider's charge will be billed to the recipient or any person acting on behalf of the recipient. The department will require a nonenrolled provider to accept medical services payments as payment in full.) States that unless prohibited by federal or state law or regulation, the department will require enrolled Medicaid providers to submit their billings for services electronically Specifies that for ambulance services, the department will continue the 5 percent increase in payment rates for ambulance services implemented in fiscal year 2000-2001 and continue the ground mileage reimbursement rate per statute mile at $4.25 States that from the funds appropriated for physician services and health plan services, the department will continue the increase in Medicaid reimbursement rates for obstetrical services implemented in fiscal year 2005-2006 Specifies that from the funds appropriated for physician services and health plan services, $16.6 million of which $7.3 million is general fund/general purpose funds will be allocated to increase Medicaid reimbursement rates for physician well child procedure codes and primary care procedure codes Stipulates that the increased reimbursement rates will be implemented Oct. 1, 2006, and will not exceed the comparable Medicare payment rate for the same services

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
MI	2005 MI S.B. 1083 (NS) (cont.)	Directs Medicaid HMOs to provide for reimbursement of HMO-covered services delivered other than through the HMO's providers if medically necessary and approved by the HMO, immediately required, and that could not be reasonably obtained through the HMO's providers on a timely basis (Such services shall be considered approved if the HMO does not respond to a request for authorization within 24 hours of the request. Reimbursement will not exceed the Medicaid fee-for-service payment for those services.) States that reimbursement for medical services to screen and stabilize a Medicaid recipient, including stabilization of a psychiatric crisis, in a hospital emergency room will not be made contingent on obtaining prior authorization from the recipient's HMO (If the recipient is discharged from the emergency room, the hospital will notify the recipient's HMO within 24 hours of the diagnosis and treatment received. If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's HMO prior to admitting the recipient.) States that payment increases for enhanced wages and new or enhanced employee benefits provided in previous years through the Medicaid nursing home wage pass-through program will be continued in fiscal year 2006-2007 (The department will not implement any increase or decrease in the Medicaid nursing home wage pass-through program in fiscal year 2005-2006.) States that all nursing home rates, class I and class III, must have their respective fiscal year rate set 30 days prior to the beginning of their rate year (Rates may take into account the most recent cost report prepared and certified by the preparer, provider, corporate owner or representative as being true and accurate, and filed timely, within five months of the fiscal year end in accordance with Medicaid policy. If the audited version of the last report is available, it will be used. Any rate factors based on the filed cost report may be retroactively adjusted upon completion of the audit of that cost report.)

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
MI	2005 MI S.B. 1083 (NS) (cont.)	Directs the Department of Community Health to not impose a limit on per unit reimbursements to service providers that provide personal care or other services under the Medicaid home- and community-based services waiver program for the elderly and disabled (The department's per day per client reimbursement cap calculated in the aggregate for all services provided under the Medicaid home- and community-based services waiver is not a violation of this section.) Directs the Department of Community Health to create two pools for distribution of disproportionate share hospital funding (The first pool, totaling $45 million, will be distributed using the distribution methodology used in fiscal year 2003-2004. The second pool, totaling $5 million, will be distributed to unaffiliated hospitals and hospital systems that received less than $900,000 in disproportionate share hospital payments in fiscal year 2003-2004 based on a formula that is weighted proportional to the product of each eligible system's Medicaid revenue and each eligible system's Medicaid utilization. By Sept. 30, 2007, the department will report to the Senate and House Appropriations Subcommittees on Community Health and the Senate and House fiscal agencies on the new distribution of funding to each eligible hospital from the two pools.) States that, beginning Oct. 1, 2006, the Department of Community Health will increase the monthly Medicaid personal care supplement by $10 to adult foster care facilities and homes for the aged providing personal care services to Medicaid beneficiaries Stipulates that in order to be reimbursed for adult home help services provided to Medicaid recipients, the matching of adult home help providers with service recipients shall be coordinated by the local county department of human services

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
MN	2005 MN S.F. 367 (NS)	Requires the medical director for medical assistance and the assistant commissioner for chemical and mental health services in conjunction with the mental health licensing boards to evaluate the requirements of licensed mental health practitioners in order to receive medical assistance reimbursement States that the purpose of the study is to evaluate the qualifications of all licensed mental health practitioners and professionals and make recommendations regarding medical assistance reimbursement requirements Requires the study to be completed by Jan. 15, 2007 Directs the commissioner of human services to encourage and assist providers to adopt and use electronic billing for state programs including training out of existing resources
MS	2006 MS H.B. 1563 (NS)	"FY 2007 Appropriations Act for the Division of Medicaid," allocates $1.5 million to increase reimbursement rates for dental providers
MS	2006 MS H.B. 1564 (NS)	"FY 2007 Appropriations Act for the Department of Health," contains a provision allowing the Department of Health to transfer a portion of Trauma Care System funds to the Division of Medicaid for the development and implementation of an enhanced reimbursement fee program related to trauma care and services used to match federal funds under a cooperative agreement between the State Department of Health and the Division of Medicaid
MO	2006 MO S.B. 822 (NS)	Extends the sunset for the Medicaid managed care organization reimbursement allowance and the pharmacy tax from June 30, 2006, to June 30, 2007 Extends the sunset of the federal reimbursement allowance assessment and nursing facility reimbursement allowance from Sept. 30, 2006, to Sept. 30, 2007

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
NH	2005 NH H.B. 1611 (NS)	Authorizes Medicaid reimbursement for parents who provide personal care to a minor child with special healthcare needs living at home Stipulates that such reimbursement would occur only when the Department of Health and Human Services determines that the needs of the child, the unavailability of appropriate providers or suitable alternative care services and cost efficiencies make utilization of a parent for the provision of such services necessary and appropriate Directs that reimbursement would be limited to care that is medically necessary due to specific health needs and would not be made for care generally expected and provided by parents to a child of similar age and developmental stage
NH	2005 NH H.B. 1763 (NS)	Declares that the Committee to Study Medicaid Reimbursement Rates for Pharmacy Providers, established in 2005, is extended until Nov. 1, 2006, and adds new duties to the committee's study Directs the committee to examine rate changes in the price of drugs, which are usually changed on a daily basis; the electronic payment of pharmacy reimbursements for quicker turnaround on payments to pharmacies; the most-favored-nation issue; and a method to reimburse pharmacies for the co-payments that Medicaid clients do not pay
NH	2005 NH H.B. 1764 (NS)	Declares that the Committee to Study Medicaid Reimbursement Rates for Pharmacy Providers, established in 2005, is extended for the purpose of further developing the committee's response to issues identified in the committee's Nov. 1, 2005, report Specifies that the committee will report its findings and any recommendations for proposed legislation to the speaker of the House of Representatives, the president of the Senate, the House clerk, the Senate clerk, the governor and the State Library on or before Nov. 1, 2006

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
NH	2005 NH S.B. 296 (NS)	Permits the Department of Health and Human Services to waive or reduce the state's right to reimbursement for public assistance, including medical assistance, in certain cases Stipulates that the commissioner may waive or reduce the amount due the state for good cause upon written request from a recipient or recipient's attorney States that the acceptance of any waiver or the payment of any reduced amount due will create a rebuttable presumption that the apportionment was equitable in any action brought
NM	2006 NM H.B. 2 (NS)	"FY 2007 General Appropriations Act," allocates approximately $14 million to increase payment rates for physicians, dentists and other providers of medical assistance Provides $9.45 million to increase Medicaid payments to physicians, $950,000 to increase Medicaid payments for dental services and another $5.2 million to increase Medicaid rates to other providers States (for the portion of physician payment increases allocated to managed care organizations) that each managed care organization will provide a written report to the Human Services Department and the Legislative Finance Committee of its increased compensation to physicians Directs the department to establish rules to ensure full implementation of the physician payment increase, including rules providing that the department may pay physicians directly if a managed care organization does not increase its compensation to physicians as provided in the act
NY	2005 NY A.B. 8219 (NS)	Authorizes the commissioner of health to establish an all-inclusive program for children with life-limiting illnesses States that qualified agencies providing services to a child will be reimbursed under medical assistance under Article 5 of the social services law, at a per diem rate for each day the child is enrolled in a program (To ensure the alienability of needed services to these children, reimbursement will be provided only to those agencies having satisfied conditions of the department including satisfactory training in pediatric palliative care.)

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
NY	2005 NY S.B. 6457 (NS)	States that payment for emergency physician services provided to eligible persons by qualified emergency physicians in an emergency room or inpatient unit will be no less than $25 per visit Specifies that eligible persons will not include persons who receive items and services from the Medicaid managed care program
OK	2005 OK S.B. 80XX (NS)	One of the FY 2007 appropriation acts, allocates $22 million to fully implement a 13.2 percent increase in nursing reimbursement rates and a 10 percent rate increase for ICF/MR facilities Includes $13 million to increase hospital and physician rates for six months — these funds will allow hospitals to be reimbursed at their UPL
RI	2005 RI H.B. 7120 (NS)	FY 2007 appropriations act, directs the Department of Human Services to adopt and implement a methodology for determining a Medicaid per visit reimbursement for community health centers that is compliant with the prospective payment system provided for in the "Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2001"
TN	2005 TN H.B. 1554 (NS)	Revises the scope of the comptroller's annual actuarial study of the TennCare program to assure reasonable reimbursement for providers
TN	2005 TN S.B. 3914 (NS)	Directs the Office of Children's Care Coordination and the TennCare Bureau to coordinate in the development of such programs and directs the TennCare Bureau to make reasonable adjustments to reimbursement rates for prenatal, obstetric and related services in underserved areas as may be necessary to sustain the availability of such services
UT	2006 UT H.B. 1 (NS)	Allocates $34.5 million to increase FY 2007 reimbursement rates an average of 2.5 percent to selected providers of Medicaid services
UT	2006 UT H.B. 105 (NS)	Amends the "Pharmacy Practice Act," §58-17b-606**,** to permit the state's Medicaid program to reimburse for non-generic drugs when the brand name drug is cheaper to the state than the generic form of the drug

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
VA	2006 VA H.B. 5002 (NS)	FY 2006-2008 "Biennial Budget Act," directs the Office of Comprehensive Services to work with the State Executive Council and the Department of Medical Assistance Services to assist Community Policy and Management Teams in appropriately accessing a full array of Medicaid-funded services for Medicaid-eligible children and youth through the "Comprehensive Services Act for At-Risk Children and Youth," thereby increasing Medicaid reimbursement for treatment services and decreasing the number of denials for Medicaid services related to medical necessity and utilization review activities Directs the Department of Medical Assistance Services (DMAS) to reimburse school divisions who sign an agreement to provide administrative support to the Medicaid program and who provide documentation of administrative expenses related to the Medicaid program 50 percent of the Federal Financial Participation by the department Authorizes DMAS to amend the State Plan for Medical Assistance Services governing Medicaid reimbursement for nursing facilities effective July 1, 2006 (The provision to increase the ceilings by $3 per day will be deleted. In its place, the department shall amend the State Plan to eliminate administrator salary limits, medical director salary limits and management fee limits, except when the administrator, medical director or contracted management firm is a related party, and set the indirect care ceiling at 106.13 percent of the day weighted median of base year cost. In addition, $3 per resident day, adjusted for inflation from FY 2006, multiplied times Medicaid utilization and allocated proportionately between direct and indirect cost, will be added to facility specific cost per day used to set prospective rates to the extent those facility specific costs are from a cost reporting period that includes any days before July 1, 2005.

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
VA	2006 VA H.B. 5002 (NS) cont.	DMAS will amend the State Plan for Medical Assistance Services governing Medicaid reimbursement for nursing facilities to set the direct care ceiling at 117 percent and the indirect care ceiling at 107 percent of the day-weighted median of base year cost, effective July 1, 2006) Authorizes DMAS to increase payments to physicians who are faculty affiliated with Type I hospitals or related universities (The amount of the total payment will be up to the upper payment limit for these services as permitted by federal Medicaid law and regulation.) Directs DMAS to increase the physician/practitioner reimbursement fees in the following manner: evaluation and management procedures, excluding hospital emergency department visits, provided to children under the age of 21 will be increased by 5 percent effective July 1, 2006, and by 5 percent effective July 1, 2007; reimbursement fees for obstetrical/gynecological services which were increased Sept. 1, 2004, shall not be increased; all other physician rates shall be increased 3 percent effective July 1, 2007 (The Department of Medical Assistance Services shall implement these reimbursement changes on July 1, 2006, or on the date of this enactment, whichever is later. The Department shall have authority to implement these reimbursement changes prior to the completion of any regulatory process undertaken in order to effect such change.) Directs DMAS to increase adult day healthcare reimbursement rates provided under Medicaid home- and community-based waiver programs by 5 percent effective Jan. 1, 2007 Authorizes DMAS to implement cost-based reimbursement for special education health services furnished by school division providers effective July 1, 2006 Directs DMAS to amend the State Plan of Medical Assistance Services governing Medicaid reimbursements for hospitals to set the adjustment factor for Type 2 hospitals equal to 78 percent, effective July 1, 2006 Provides funds to increase personal care reimbursement rates provided under community-based Medicaid waiver programs by 3 percent, effective July 1, 2007

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
VA	2006 VA H.B. 5002 (NS) cont.	Provides funds to increase reimbursement rates for skilled nursing services provided through the Medicaid technology assisted home- and community-based waiver program and the HIV/AIDS Home and Community-based Care Waiver program by 5 percent, effective July 1, 2006 Provides funds to increase reimbursement rates paid to providers delivering unique services provided through the Mental Retardation, Individual and Family Developmental Disabilities Support or Day Support Home and Community-based Waiver Programs (but not provided in other waiver programs) by 5 percent effective July 1, 2006 (Reimbursement rates paid to providers of congregate residential group home services for individuals in the Mental Retardation Home and Community-based Waiver Program shall be increased by 10 percent, effective July 1, 2006. The increase does not apply to personal care and related services, nursing services or services that are either fixed price or determined through individual consideration.)

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
VT	2005 VT H.B. 861 (NS)	Establishes a health insurance program called Catamount Health under which everyone who is currently uninsured will have access to — and will help pay for — a comprehensive package of benefits Directs that the benefits will be administered by a private, third-party entity and premiums will be based on income Stipulates that health benefits will include primary care, preventive and chronic care, acute episodic care and hospital services — similar to a point-of-service plan offered to state employees Directs the Office of Vermont Health Access (OHVA) to adjust Medicaid and the Vermont Health Access Plan reimbursement to reflect the following priorities in the following order: ▪ An increase in base rates for evaluation and management procedure codes to enhance payment to a level equivalent to the 2006 rates in the Medicare program ▪ Incentives and payment restructuring for healthcare professionals participating in the care coordination program ▪ An increase in base rates for current procedural terminology codes, which are significantly lower than the 2006 Medicare reimbursement levels, starting with the lowest first ▪ An increase in dental reimbursement by restoring the reductions in adult dental rates that were effective Feb. 1, 2006, and by splitting the remaining amount approximately in half to increase rates for dental services and to increase the dental cap for adults in such a manner as to offset any loss in benefit level due to the rate increases Requires OVHA to increase Medicaid reimbursements to hospitals effective Jan. 1, 2007 Specifies that in fiscal year 2008 and thereafter, the office will increase Medicaid reimbursement rates annually July 1 until the federal upper limit is reached and provides that in fiscal years subsequent to 2007, it is the intent of the General Assembly that Medicaid reimbursement increases to healthcare professionals and hospitals under Medicaid, the Vermont health access plan and Dr. Dynasaur should be tied to the standards and quality or performance measures developed under the Vermont Blueprint for Health strategic plan

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
WA	2005 WA H.B. 2716 (NS)	Modifies provisions relating to nursing facility Medicaid payment systems by recalculating the direct care and operations component rate allocations based upon calendar year 2003 cost reports Removes the minimum occupancy standards for direct care component rate allocations Modifies the direct care case-mix corridor by eliminating the corridor floor and increasing the corridor ceiling to 112 percent of the peer group median Effective July 1, 2006, sets variable return component rate allocations to each facility's June 30, 2006, variable return component allocation Defines vital local providers as those nursing facilities that have a home office in the state and have a sum of Medicaid days for all Washington facilities that was greater than 215,000 in 2003 Stipulates that vital local providers will receive the greater of either their June 30, 2006, direct care and operations component rate allocations or the rate allocations that they would qualify for under the standard payment system Makes a number of clarifying technical changes

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
WA	2005 WA S.B. 6286 (NS)	"2006 Supplemental Appropriations Act," contains numerous provisions providing funding for enhanced reimbursement rates including funds for the following activities: ▪ Increase home care agency payment rates to cover the cost of all hourly wage, vacation and seniority wage increases that have been funded on behalf of individual providers of homecare services ▪ Improve the quality and availability of community mental health services to assure more equitable access to such services statewide (In FY 2007, non-Medicaid funds are to be distributed proportionally to total population in each Regional Support Network (RSN) region. Medicaid payment rates are increased to the statewide average for those RSNs whose rates would otherwise be below that level and by 3.5 percent for those RSNs whose rates are above the current average. Additional state funds are provided to assure that no RSN receives less total funding next year. Statewide, RSN funding is increased by $34.6 million, or 9.1 percent, in FY 2007) ▪ Increase vendor rates by 1 percent for boarding home payment rates and adult family home payment rates, effective July 1, 2006 ▪ Increase payment rates for adult day health services by 14 percent ▪ Increase the payment rate for supported living providers to 15 cents per hour for King County and 12 cents per hour for all other counties, with appropriate benchmark adjustments to the administrative portion of the rate ▪ Provide capital add-on rates to assisted living facilities that have a minimum Medicaid occupancy percentage of 60 percent or greater (Managed care clients will be included in the calculation of Medicaid occupancy.) ▪ Provide one-time funding in FY 2006 for payments to any assisted living facility licensed Jan. 25, 2002, that serves 20 or more clients participating in the program for all-inclusive care ▪ Increase nursing home payment rates by an average of 6 percent next year

Medicaid Reimbursement Rates: 2006 Enacted Legislation
Source: Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Description
WV	2006 WV H.B. 4383 (NS)	Continues the pilot program offered through a community access program to coordinate healthcare provider reimbursements, to allow an opportunity for innovations in payment for healthcare services to be tested and, if successful, to be permanently implemented (The program is an effort by the federal government to encourage innovative integrated healthcare delivery systems to serve uninsured and underinsured persons with greater efficiency and improved quality of care and to further maximize reimbursements to healthcare providers that provide these services.)
WI	2005 WI H.B. 981 (NS)	Provides a 2.8 percent increase over the next two years in the Medicaid reimbursement rate for nursing home care, which represents $11.4 million in state funding and will bring the state an additional $15.4 million in federal funding
WY	2006 WY H.B. 1 (NS)	The state budget act, allocates approximately $435,000 in state funds and $486,000 in federal funds to increase payments under the Medicaid assisted living waiver program to a range of $42 to $50 per day Appropriates $1.35 million in state funds in FY 2007 to increase the daily rate for youth group home providers and non-Medicaid residential treatment centers and allocates $1.79 million in state funds and $1.95 million in federal funds for continuing a resource-based relative value system formula for determining the rate of Medicaid reimbursement for physicians
WY	2006 WY H.B. 80 (NS)	Appropriates $3.5 million from the General Fund and $3.8 million in federal funds for the period from July 1, 2006, to June 30, 2008, to increase reimbursement for obstetric services, including the delivery of a child and prenatal and postpartum care related to the delivery, to 90 percent of the statewide average of the physician's specialty for the services provided as of July 1, 2006, not to exceed 100 percent of the provider's usual and customary billed charges Directs the Department of Health to report to the Joint Appropriations Interim Committee on or before Oct. 31, 2007, the additional costs incurred by the increased reimbursement rate under this act and recommendations for modifications to the reimbursement rate for obstetric services

Table 4

Table 4 tracks 2006 legislation affecting Medicaid reimbursement that continues to move through the legislative process or died with adjournment.

Medicaid Reimbursement Rates: 2006 Pending Legislation
Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Status	Description
CA	2005 CA S.B. 676 (NS)	Passed Senate and House	Would require the Department of Health Services to ensure that Medi-Cal reimbursements for intravenous or infusion therapy are made in a manner consistent with the services provided to ensure that patients receiving these services continue to receive appropriate care and continuity of their drug regimen
CT	2006 CT S.B. 338 (NS)	Passed Senate	Would make changes to Medicaid reimbursements in school-based programs Would clarify that schools may be reimbursed through Medicaid for durable medical equipment provided to Medicaid clients who participate in the school-based child health program Would provide the commissioner of social services with prior authorization authority in the provision of medically necessary durable medical equipment Would delete the requirement that diagnostic and evaluation services be specified on the individualized education plan
FL	2006 FL S.B. 874 (NS)	Introduced; Died in Committee	Would have increased Medicaid reimbursement rates for air ambulance transportation to match Medicare rates
IL	2005 IL S.B. 2626 (NS)	Passed Senate	Would require the Department of Health and Family Services to reimburse a nursing home under the Medicaid program from the date a Medicaid recipient is transferred from a hospital to the nursing home, regardless of whether the nursing home has received the appropriate forms required under federal law in connection with the transfer by that date

Medicaid Reimbursement Rates: 2006 Pending Legislation
Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Status	Description
IA	2005 IA H.B. 788 (NS)	Introduced; No Action Taken; Died with adjournment	Would have established a quality assurance assessment not to exceed 6 percent of the total annual revenue of all licensed nursing facilities, in the aggregate, under the medical assistance program Would have stipulated that the maximum assessment be consistent with the guidelines established by CMS and the corresponding waiver of uniformity of the assessment granted by the federal government Would have provided for payment of the assessment by nursing facilities and for reimbursement of the nursing facilities by the Department of Human Services Would have provided for payment of an additional amount to nursing facilities beyond any reimbursement amounts Would have provided that the net revenue generated by imposition of the assessment is to be deposited in the Senior Living Trust Fund
KY	2006 KY H.B. 62 (NS)	Passed House	Would amend existing law to provide Medicaid reimbursement for tobacco dependency treatment interventions, including counseling and pharmacotherapies Would require the Department of Medical Services to submit a state plan amendment or waiver to CMS to charge nonsmokers a lower copayment for physician, nurse practitioner and physician assistant office visits Would permit Medicaid to pay incentives to physicians, nurse practitioners and physician assistants for recommending to Medicaid recipients who smoke that they should quit

Medicaid Reimbursement Rates: 2006 Pending Legislation
Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Status	Description
MD	2006 MD H.B. 1079 (NS)	Introduced; Died with adjournment	Would have required the Department of Health and Mental Hygiene to reimburse medically based child care centers that participate in the Maryland Medical Assistance Program for care provided to program recipients at a per diem rate of at least $140
MD	2006 MD H.B. 1340 (NS)	Introduced; Died with adjournment	Would have specified that the Medicaid reimbursement rate for medical day care must be adjusted annually by adjusting the per diem rate for the preceding fiscal year by the percentage of the annual increase or decrease in the *March Consumer Price Index for All Urban Consumers, Medical Care Component, Washington-Baltimore*, from the U.S. Department of Labor, Bureau of Labor Statistics
MD	2006 MD S.B. 579 (NS)	Passed Senate; Died with adjournment	Would have required that the reimbursement rates for medical day care be adjusted by a specified index annually Would apply to per diem rates for services provided on or after July 1, 2006
MD	2006 MD S.B. 644 (NS)	Passed Senate; Died with adjournment	Would have required the Department of Health and Mental Hygiene to reimburse medically based child care centers that participate in the Maryland Medical Assistance Program for care provided to program recipients at a per diem rate of at least $80
MN	2005 MN H.F. 3208 (NS)	Introduced	Would provide for an 8 percent increase in the reimbursement rate over the provider's current reimbursement rate of a day training and habilitation provider in Meeker County providing services to up to 110 individuals

Medicaid Reimbursement Rates: 2006 Pending Legislation
Health Policy Tracking Service, a service of Thomson West, October 2006

State	Bill No.	Status	Description
MO	2006 MO S.B. 971 (NS)	Introduced; Hearing Cancelled; Died with adjournment	Would have provided that personal care services be provided for persons residing in a level I or II residential care facility who are eligible for Medicaid coverage Would direct that such recipients will be assessed by the Department of Health and Senior Services to determine the amount of personal care services the residential care facility is authorized to be reimbursed for under federal Medicaid laws Would establish three categories of assistance representing various amounts of minutes for which an eligible recipient needs assistance — minimal, moderate and maximum Would call for a reimbursement rate for the residential care facility to be established based on the assessments made of the recipient by the department
NE	2005 NE L.B. 869 (NS)	Introduced; Indefinitely Postponed	Would require intermediate care facilities for the mentally retarded to be reimbursed under the medical assistance program in an amount sufficient to compensate such facilities for the reasonable and necessary costs of providing services to their residents Would direct that reimbursements would be increased annually by a percentage that is not less than the previous year's percentage increase in the skilled nursing facility market basket index update published by CMS
NM	2006 NM H.B. 561 (NS)	Passed Committee; Died on Calendar	Would have appropriated $355,000 from the General Fund to the Department of Health for expenditure in fiscal year 2007 to increase reimbursement rates for providers of non-Medicaid services to the developmentally disabled Would have directed that any unexpended or unencumbered balance remaining at the end of fiscal year 2007 would revert to the General Fund

Medicaid Reimbursement Rates: 2006 Pending Legislation
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State	Bill No.	Status	Description
NM	2006 NM H.B. 624 (NS)	Passed Committee; Died on Calendar	Would have appropriated $3.15 million from the General Fund to the Department of Health for expenditure in fiscal year 2007 to increase reimbursement rates for Medicaid to providers in the developmental disabilities waiver program
NM	2006 NM H.B. 704 (NS)	Passed Committee; Died on Calendar	Would have appropriated $3.2 million from the General Fund to the Human Services Department for expenditure in FY 2007 to provide monthly supplemental reimbursement to Medicaid-certified nursing facilities and intermediate care facilities for the mentally retarded to cover the cost of staffing recruitment, retention, wages and benefits and other operating expenses Would have stipulated that supplemental reimbursement amounts per facility would be based on a rate that is equivalent to 5 percent of the monthly Medicaid payment per facility Would have directed that any unexpended or unencumbered balance remaining at the end of fiscal year 2007 would revert to the General Fund
NM	2006 NM H.B. 779 (NS)	Passed Committee; Died on Calendar	Would have appropriated $3.2 million from the General Fund to the Human Services Department for expenditure in fiscal year 2007 as follows: ▪ $2.2 million to increase the Medicaid reimbursement rate for licensed nursing facilities and licensed intermediate care facilities for the mentally retarded ▪ $1 million to restore funding lost due to reductions in the Medicaid reimbursement rate made in fiscal years 2005 and 2006 to licensed nursing homes and licensed intermediate care facilities for the mentally retarded

Medicaid Reimbursement Rates: 2006 Pending Legislation
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State	Bill No.	Status	Description
NM	2006 NM S.B. 48 (NS)	Passed Committee; Died on Calendar	Would have appropriated $750,000 from the General Fund to the Medical Assistance Division of the Human Services Department for expenditure in FY 2007 to increase reimbursement for obstetrical services under Medicaid fee-for-service and managed care programs, including deliveries, to ensure access to these services and to offset the cost of medical malpractice insurance
NM	2006 NM S.B. 49 (NS)	Passed Committee; Died on Calendar	Would have appropriated $3.15 million from the General Fund to the Department of Health for expenditure in FY 2007 to increase Medicaid reimbursement rates for providers in the developmental disabilities waiver program
NM	2006 NM S.B. 480 (NS)	Passed Committee; Died on Calendar	Would have directed the Human Services Department to reimburse dentists, optometrists, podiatrists and psychologists for services rendered to Medicaid fee-for-service or managed care patients at the same level that Medicare Part B pays for services

Medicaid Reimbursement Rates: 2006 Pending Legislation
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State	Bill No.	Status	Description
NM	2006 NM S.B. 663 (NS)	Passed Committee; Died on Calendar	Would have appropriated $3.2 million from the General Fund to the Human Services Department for expenditure in fiscal year 2007 as follows: ▪ $2.2 million to increase the Medicaid reimbursement rate for licensed nursing facilities and licensed intermediate care facilities for the mentally retarded ▪ $1 million to restore funding lost due to reductions in the Medicaid reimbursement rate made in fiscal years 2005 and 2006 to licensed nursing homes and licensed intermediate care facilities for the mentally retarded Would have stipulated that on July 1, 2006, and on July 1 of each subsequent year, the department would adjust for inflation Medicaid rates paid to nursing facilities Would have directed that on Sept. 1, 2006, and on Sept. 1 of each subsequent year, the department would adjust for inflation Medicaid rates paid to intermediate care facilities for the mentally retarded Would have stipulated that the new provider rates each year would equal the previous year's rate plus the current market basket index inflation adjustment as determined by CMS
NM	2006 NM S.B. 734 (NS)	Passed Committee; Died on Calendar	Would have appropriated $10 million from the General Fund to the Human Services Department for expenditure in fiscal year 2007 to increase the Medicaid reimbursement rate for nursing facilities and intermediate care facilities for the mentally retarded to maintain competitive wages, adequate staffing and local minimum wage requirements Would have directed that any unexpended or unencumbered balance remaining at the end of fiscal year 2007 will revert to the General Fund

Medicaid Reimbursement Rates: 2006 Pending Legislation
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State	Bill No.	Status	Description
NY	2005 NY S.B. 3438 (NS)	Introduced	Would extend until March 31, 2007, the application of certain provisions of the public health law adjusting state medical reimbursement payments to healthcare providers who offer care to recipients of public assistance
NY	2005 NY A.B. 1997 (NS)	Introduced	Would increase state reimbursement for care, treatment, maintenance and nursing services in nursing homes in certain eligible social services districts
RI	2005 RI S.B. 2340 (NS)	Introduced; Held for further study	Would increase the rate paid by the state to dentists, dental hygienists and dental assistants who provide dental services to Medicaid-eligible residents of nursing facilities Would stipulate that the rates to be paid each year by the state to such dentists, dental hygienists and dental assistants will be equal to or greater than 125 percent of the median of the rates paid to dentists, dental hygienists and dental assistants for similar services by Blue Cross Blue Shield of Rhode Island, Delta Dental and the rates reported by the American Dental Association (or any successor organization) fee schedule survey for New England for the corresponding year Would require the Department of Human Services to utilize incentive programs and encourage private practice dentists participating in Medicaid to accept and treat nursing facility residents as patients
UT	2006 UT H.B. 24 (NS)	Passed House and Senate; Sent to Governor	Would establish a statutory requirement, within appropriations from the Legislature, to reimburse dentists providing children's Medicaid dental services at 75 percent of the mountain region fee schedule for dental services Would appropriate $2.7 million on an ongoing basis to raise the reimbursement rate for children's dental services for fiscal year 2006-2007
VT	2005 VT S.B. 295 (NS)	Introduced	Would increase Medicaid reimbursement rates for nursing homes

Medicaid Reimbursement Rates: 2006 Pending Legislation
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State	Bill No.	Status	Description
VA	2006 VA H.B. 426 (NS)	Introduced; Died with adjournment	Would have required children's residential facilities to be Medicaid providers in order to be eligible for reimbursement Would have allowed the director of the Department of Medical Assistance Services to enroll out-of-state residential facilities to be Medicaid providers if they are providing services to children
WI	2005 WI S.B. 532 (NS)	Introduced; Failed to Pass	Would have increased the appropriation of general purpose revenues for medical assistance by $10.12 million for fiscal year 2007, as a rate reimbursement increase for care provided to assistance recipients by nursing homes Would have increased the appropriation of general purpose revenues for medical assistance by $1.29 million for fiscal year 2006 to provide a one-time supplement to nursing home reimbursement Would have required this supplement to be based on each nursing home's proportionate share of numbers of medical assistance recipient patient days in fiscal year 2005