TRENDS

Changes In Medicaid Physician Fees, 1998–2003: Implications For Physician Participation

Despite recent gains, the relative attractiveness of Medicaid patients has not improved much over the longer term.

by Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols

ABSTRACT: After slow growth during much of the 1990s, Medicaid physician fees increased, on average, by 27.4 percent between 1998 and 2003. Primary care fees grew the most. States with the lowest relative fees in 1998 increased their fees the most, but almost no states changed their position relative to other states or Medicare. Physicians in states with the lowest Medicaid fees were less willing to accept most or all new Medicaid patients in both 1998 and 2003. However, large fee increases were associated with primary care physicians' greater willingness to accept new Medicaid patients.

During the mid-1990s, when states were dramatically expanding Medicaid patients' enrollment in managed care, Medicaid physician fees paid under the fee-for-service (FFS) part of the program grew very little. From 1993 to 1998 these fees grew only 5.6 percent, well below the 13 percent increase in prices over the same period.[1] Medicaid fees have never been generous compared with those of private payers or Medicare; as a result of their slow growth, by 1998 they had dropped to only 62 percent of Medicare fees, on average.[2] Although a large majority of physicians continued to see Medicaid patients, physicians typically have been less willing to take on new Medicaid patients than patients covered by other types of health insurance, and this did not change greatly between 1997 and 2001.[3]

State policymakers seemed to recognize Medicaid beneficiaries' potential access problems and raised Medicaid fees as state revenues grew during the prolonged economic expansion in the 1990s.[4] This was an important decision because FFS reimbursement continues to affect a majority of Medicaid enrollees despite large enrollment in Medicaid managed care. In 2001 more than 60 percent of all Medicaid enrollees remained in FFS or were in a primary care case management (PCCM) program.[5] Also, some of the highest users of medical care, such as elderly and disabled Medicaid beneficiaries, are often exempt from mandatory enrollment in managed care. As a result, almost 80 percent of Medicaid acute care spending remained in the FFS part of the program.[6] FFS physician reimbursement rates also have an important impact on what Medicaid health maintenance organizations (HMOs) pay physicians, because many states set capitation rates based on what they pay in the FFS part of the program.[7]

Stephen Zuckerman (szuckerm@ui.urban.org) is a principal research associate at the Urban Institute in Washington, D.C., where Joshua McFeeters is a research associate. Peter Cunningham is a senior health researcher at the Center for Studying Health System Change, also in Washington, and Len Nichols is the center's vice president.

DOI 10.1377/hlthaff.W4.374 ©2004 *Project HOPE–The People-to-People Health Foundation, Inc.*

Despite the continued importance of Medicaid physician fees, research on the impact of changes in Medicaid fees on beneficiaries' access to care is mixed. Some studies have shown that higher Medicaid physician fees increase physicians' participation in Medicaid, although not all studies concur.[8] In addition, higher fees lead more beneficiaries to receive care in doctors' offices rather than hospital-based settings, although fee levels do not seem to affect Medicaid recipients' number of medical visits.[9] Other studies find no major impact on the amount or type of access to care because of changes in Medicaid physician fees.[10] Despite the mixed evidence, when state budgets got tighter starting in 2001, policymakers turned to Medicaid—one of the biggest components of state budgets—for savings, and many of them reduced payment rates to physicians and other providers.[11]

This study uses data on Medicaid physician fees and Medicare fees from 1998 and 2003 to examine recent trends in Medicaid physician reimbursement. During this time span, states had two distinct periods with respect to their finances. Through the early part of 2001, states had plenty of funds available to expand Medicaid payments. Then state revenues dropped precipitously, and states were forced to make a wide variety of spending cutbacks. We also examine the association between Medicaid fee levels and changes in physicians' willingness to accept Medicaid patients, using data from a nationally representative survey of patient care physicians linked to the Medicaid fee data.

Study Data And Methods

■ **Data.** The Medicaid physician fee data used in this study were collected by a state survey fielded by the Urban Institute and the Center for Studying Health System Change (HSC). To maintain continuity with Urban Institute surveys from 1993 and 1998, states were asked to provide data on fees paid as of 1 January 2003 for the same set of services for which data had already been collected in the prior surveys. However, new physician services are introduced over time, and because the earlier Urban Institute surveys did not include all potentially important services, we augmented the list with twelve additional services that were included in a June 2001 study by the Lewin Group.[12] The survey covers three types of services: primary care, obstetrical care, and other services (including hospital visits, surgery, radiology, psychotherapy, and lab tests).

To combine data on individual fees from different states into the key analytic variables (discussed below), weights were constructed to reflect the relative importance of each service and each state. The weight for each service was defined as its share of Medicaid physician spending, computed from service-specific Medicaid spending data obtained from the Centers for Medicare and Medicaid Services (CMS).[13] The weight for each state was defined as the share of all beneficiaries enrolled in the state's program, derived from the Medicaid 2082 data system.

The fee surveys were sent to the forty-nine states and the District of Columbia that have an FFS component in their Medicaid programs. (Only Tennessee does not.) All of the jurisdictions either answered the survey directly or provided access to a physician fee schedule. The survey results were examined for any fees that rose or fell by a large amount between 1998 and 2003 and for any fees that were unusually high or low compared with the national average for that service. Most of this verification work was done with physician fee schedules found on the Internet or provided along with the survey. A few telephone calls were made to state Medicaid agencies when information was not otherwise available.

As a part of the survey, states were asked if physician fees were adjusted for specific providers or services to meet policy objectives. Sixteen states (Alabama, Arkansas, Connecticut, Florida, Illinois, Kansas, Louisiana, Minnesota, Missouri, Montana, New Jersey, New York, Pennsylvania, Utah, Washington, and Wisconsin) reported that they adjusted rates for specific preventive or obstetric services, or for providers most likely to provide these services. Three states (Alabama, Utah, and Wisconsin) reported using different fees to reim-

burse providers in rural areas at a higher rate. If a state had multiple fees for the same service, a simple average was taken to obtain a single fee for each state.

Exhibit 1 shows the 2003 national means for each service surveyed in either 1998 or 2003. The national mean is a weighted average, where the weights used are the number of Medicaid enrollees in each state in 2000 (the most recent year for which enrollee data were

EXHIBIT 1
Medicaid Fees For Surveyed Services, Selected States, 2003

Category/procedure	Percent of spending for surveyed procedures[a]	2000 mean fee ($)	Coefficient of variation (%)
Primary care			
Office visit, new patient, 30 minutes	2.7	54.87	30.05
Office visit, new patient, 45 minutes[b]	2.3	73.10	35.61
Office visit, established patient, 15 minutes	25.0	31.46	23.85
Office visit, established patient, 25 minutes	9.4	45.89	29.26
Emergency department visit[b]	7.9	40.03	30.77
Office visit, new patient, 60 minutes	1.3	91.10	36.42
Electrocardiogram	0.5	21.26	26.28
Echocardiography, transthoracic[b]	1.4	131.34	35.12
Nerve conduction, amplitude and latency/velocity study[b]	0.3	24.53	30.57
Ophthalmological services, new patient[b]	1.1	58.92	41.09
Ophthalmological services, established patient[b]	0.8	46.67	33.33
Obstetric care			
Total obstetric care, vaginal delivery[b]	8.4	1,172.75	26.40
Vaginal delivery only, no postpartum care[b]	4.7	688.65	24.13
Vaginal delivery and postpartum care	6.6	776.45	22.58
Cesarean delivery and no postpartum care[b]	1.7	766.66	22.52
Cesarean delivery and postpartum care	2.0	890.07	27.07
Total obstetric care, cesarean delivery[b]	2.8	1,312.61	26.03
Other services			
Hospital visits			
Initial hospital care, new or established patient, 50 minutes	1.3	67.26	38.12
Hospital visit, new patient, 45 minutes[b]	4.4	34.04	33.55
Initial inpatient consultation, 80 minutes	1.1	82.67	37.14
Surgery			
Upper gastrointestinal endoscopy	0.4	197.93	31.06
Upper gastrointestinal endoscopy with biopsy[b]	1.1	218.01	31.58
Dilation and curettage	0.2	187.54	25.51
Total hysterectomy	0.3	663.19	31.33
Cataract removal with lens implant	1.5	743.59	38.02
Radiology			
Computerized axial tomography scan, head or brain	1.9	174.81	25.43
X-ray, chest, two views	3.0	25.36	26.50
Echography, pregnant uterus	3.7	92.35	27.75
Lab tests			
Urinalysis, routine	0.4	3.95	17.62
Culture, bacterial, screening only	0.4	7.38	19.79
Surgical pathology	1.4	51.44	38.57
Psychotherapy			
Individual psychotherapy, 20–30 minutes[b]	0.0	47.89	33.43
Individual psychotherapy, 45–50 minutes[b]	0.0	68.30	28.32

SOURCE: Urban Institute/Health System Change 2003 Medicaid Physician Fee Survey.

[a] See Note 13 in the text.

[b] Fees for these services were not available in 1998 and were excluded from the fee change index. Service weights were adjusted accordingly in the index.

available). The coefficient of variation (the ratio of the weighted standard deviation to the weighted mean) shows that fees vary considerably across states but that this variation is slightly lower than the variation observed in 1998.[14] Finally, the exhibit also shows the percentage of spending for the procedures surveyed. These percentages are used to weight services when multiple services are analyzed in an index.

■ **Methods.** The analyses we conducted were based on three indexes of Medicaid fees. First, we created a Medicaid fee index that measures each state's fee relative to national average Medicaid fees. This index is the weighted sum of the ratios of each state's fee for a given service to the national average, using 2000 expenditure weights. The national average for each service was computed as the weighted average fee, where the weights are equal to Medicaid enrollment in each state.

The second index captures differences between Medicaid and Medicare fees in 2003. This index provides some context for how Medicaid fees compare with those of the other major public payer to provide a sense of the attractiveness of Medicaid fees to providers. Medicare fees were calculated by obtaining the relative value units (RVUs), conversion factor, and geographic adjusters from the 31 December 2002 *Federal Register* and using the 2003 Clinical Diagnostic Fee Schedule.[15] The ratio of each service's Medicaid fee to its Medicare fee was computed by state. Again, these fee ratios were combined into a single index (and subindexes by type of service) as the weighted sum of the ratios, using the same expenditure weights as in the other indexes.

Third, we derived a Medicaid fee change index to capture fee change between 1998 and 2003. This index is the weighted sum of the ratios of each service's fee in 2003 to that same service's fee in 1998, using the 2000 expenditure weights as in the Medicaid fee index. Because we had data on fewer services and states in 1998 than in 2003, the fee change index was based on a subset of the services and states used in the fee index. In 1998, fee data were not available from Arkansas, Delaware, Mississippi, Montana, Nebraska, Pennsylvania, or Wyoming. For simplicity, the values of the Medicaid fee change index are expressed as the cumulative percentage change in Medicaid fees between 1998 and 2003. For all three indexes, we computed an overall index and subindexes by type of service (primary care, obstetric care, and other services).

To examine the association between state Medicaid fee levels and physicians' participation in Medicaid, data on 1998 Medicaid-to-Medicare fee indexes are linked to the Community Tracking Study (CTS) physician survey, a nationally representative survey of patient care physicians conducted in 1996–97, 1998–99, and 2000–01.[16] We compared physicians in states with low Medicaid fees relative to Medicare with physicians in states with moderate and high Medicaid fees, with respect to the percentage accepting most or all new Medicaid patients (a commonly used indicator of whether physicians' practices are open or closed to Medicaid patients). We examined differences in acceptance of new patients across groups of states with varying fee levels, as well as changes between 1997 and 2001 in the percentage of physicians accepting new Medicaid patients within each of the fee groupings.[17] We provide separate estimates for all patient care physicians, primary care physicians, and specialists.

Results

■ **Medicaid fees in 2003.** Exhibit 2 contains the Medicaid fee index for 2003. Average Medicaid physician fees ranged from 56 percent of the national average in New Jersey to 228 percent in Alaska.[18] Ten states (Alaska, Arizona, Connecticut, Delaware, Iowa, Massachusetts, Nevada, New Mexico, North Carolina, and Wyoming) had average Medicaid fees that were more than 125 percent of the national average. For these states, physician fees for all three types of services are higher than the national average. However, most of these states reimburse primary care services more generously relative to the national average than either obstetrical or other services. This higher level of reimbursement may repre-

EXHIBIT 2
Medicaid Fee Indexes And Medicaid-To-Medicare Fee Indexes, 2003

	2003 Medicaid fee indexes				2003 Medicaid-to-Medicare fee indexes			
State	Overall	Primary care	Obstetric care	Other services	Overall	Primary care	Obstetric care	Other services
US	1.00	1.00	1.00	1.00	0.69	0.62	0.84	0.73
AL	1.21	1.23	1.35	0.97	0.90	0.82	1.19	0.75
AK	2.28	2.50	1.90	2.19	1.37	1.38	1.38	1.36
AZ	1.55	1.63	1.44	1.49	1.06	1.01	1.17	1.05
AR	1.24	1.37	0.83	1.39	0.95	0.96	0.78	1.15
CA	0.91	0.87	0.83	1.09	0.59	0.51	0.65	0.74
CO	1.06	1.08	1.03	1.04	0.74	0.68	0.86	0.75
CT	1.30	1.33	1.53	0.96	0.83	0.74	1.16	0.62
DE	1.49	1.64	1.09	1.41	1.01	1.00	1.02	1.00
DC	0.78	0.62	1.24	0.63	0.52	0.35	0.94	0.41
FL	0.95	0.96	1.04	0.83	0.65	0.60	0.82	0.58
GA	1.13	1.05	1.18	1.24	0.81	0.68	1.00	0.91
HI	1.14	1.21	0.99	1.13	0.74	0.71	0.79	0.76
ID	1.22	1.31	1.08	1.18	0.92	0.89	0.99	0.93
IL	0.92	0.89	1.03	0.93	0.63	0.54	0.84	0.68
IN	0.92	0.91	0.84	1.02	0.68	0.60	0.77	0.79
IA	1.30	1.39	1.12	1.28	0.97	0.94	1.01	1.00
KS	1.00	0.93	1.05	1.10	0.75	0.63	0.92	0.86
KY	1.01	0.94	1.20	1.07	0.76	0.63	1.11	0.83
LA	1.04	1.05	1.05	0.97	0.73	0.70	0.89	0.75
ME	0.89	0.84	0.96	0.93	0.65	0.54	0.84	0.71
MD	1.21	1.28	1.20	1.05	0.80	0.76	1.03	0.72
MA	1.25	1.28	1.28	1.16	0.80	0.72	0.98	0.75
MI	0.96	1.06	0.82	0.89	0.62	0.63	0.60	0.60
MN	1.09	1.00	0.94	1.47	0.79	0.64	0.82	1.14
MS	1.19	1.32	0.75	1.23	0.91	0.90	0.85	0.99
MO	0.76	0.75	0.83	0.71	0.56	0.50	0.71	0.56
MT	1.13	1.11	1.08	1.26	0.86	0.75	0.97	1.00
NE	1.22	1.13	1.01	1.70	0.95	0.78	0.94	1.41
NV	1.43	1.17	1.67	1.79	0.98	0.71	1.30	1.27
NH	1.03	1.09	1.15	0.77	0.72	0.67	0.96	0.54
NJ	0.56	0.61	0.41	0.65	0.35	0.34	0.31	0.43
NM	1.31	1.41	1.11	1.31	0.95	0.93	0.95	1.00
NY	0.70	0.71	0.88	0.46	0.45	0.40	0.65	0.31
NC	1.34	1.47	1.15	1.28	0.97	0.96	1.01	0.96
ND	1.23	1.33	0.97	1.16	0.91	0.90	0.94	0.91
OH	0.97	1.03	0.89	0.87	0.68	0.66	0.79	0.66
OK	0.95	1.00	0.88	0.93	0.72	0.67	0.81	0.73
OR	1.18	1.17	1.33	1.03	0.86	0.75	1.17	0.76
PA	0.74	0.67	1.04	0.80	0.52	0.43	0.90	0.61
RI	0.62	0.58	0.63	0.72	0.42	0.34	0.50	0.50
SC	1.17	1.12	1.62	0.97	0.89	0.75	1.60	0.76
SD	1.05	0.98	0.94	1.35	0.83	0.68	0.88	1.13
TX	0.99	0.96	0.93	1.09	0.69	0.62	0.82	0.82
UT	1.01	1.02	0.98	1.00	0.73	0.66	0.86	0.75
VT	1.12	1.00	1.30	1.22	0.83	0.64	1.14	0.93
VA	1.08	1.15	0.97	1.05	0.77	0.73	0.84	0.77
WA	1.24	1.27	1.46	0.90	0.87	0.79	1.22	0.64
WV	1.21	1.22	1.35	1.09	0.88	0.82	1.19	0.83
WI	1.19	1.13	1.20	1.35	0.87	0.73	1.01	1.05
WY	1.40	1.47	1.25	1.41	1.03	0.96	1.07	1.12

SOURCE: Urban Institute/Health System Change 2003 Medicaid Physician Fee Survey.
NOTE: “US” denotes national average.

sent an attempt to improve the availability of primary care for Medicaid recipients. Six states (District of Columbia, Missouri, New Jersey, New York, Pennsylvania, and Rhode Island) had average Medicaid fees that were less than 80 percent of the national average. Most of the subindexes for these states were much lower than the national average, especially for primary care and other services.

■ **Medicaid-to-Medicare fee comparison in 2003.** Exhibit 2 also shows the index of Medicaid to Medicare fees nationally and in individual states. Medicaid physician fees still lag well behind Medicare fees, but the gap narrowed slightly during 1998–2003. In 2003, Medicaid fees were 69 percent of Medicare fees, up from 62 percent in 1998 (1998 data are not shown). Medicare physician fees in 2003 were at about the same level as in 1998 (based on the fee schedule conversion factor).[19] Therefore, growth in Medicaid fees was much higher than growth in Medicare fees. The increase in Medicaid fees relative to Medicare fees resulted from changes in all types of services, but the extent of the changes varied. Medicaid fees increased to 62 percent of Medicare fees in 2003 for primary care services (up from 56 percent in 1998), to 73 percent of Medicare fees in 2003 for other services (up from 68 percent in 1998), and to 84 percent of Medicare fees in 2003 for obstetrical services (up from 82 percent in 1998).

Of the forty-three states for which we had data in 1998 and 2003, thirty-two raised Medicaid fees to bring them closer to Medicare fees. The most extreme case was South Carolina, where average Medicaid fees rose from 39 percent below Medicare in 1998 to 11 percent below Medicare in 2003. However, only one state, Arizona, increased its Medicaid fees by enough to move from paying less than Medicare in 1998 (by about 6 percent) to paying more than Medicare in 2003 (by about 6 percent). The two largest Medicaid programs in terms of expenditures (New York and California) raised their Medicaid fees relative to Medicare by about ten percentage points, but they remain well below the national average; California's Medicaid fees were 59 percent of Medicare in 2003, while New York's were 45 percent of Medicare.

Among the thirty-two states in which overall Medicaid fees increased relative to Medicare, the increases were not observed across all types of services. In fact, only nine of these states reported increases in Medicaid fees relative to Medicare in all three service categories. However, twenty-seven states experienced increased or steady relative fees for primary care.

■ **Changes in Medicaid physician fees, 1998–2003.** Between 1998 and 2003, Medicaid physician fees for all surveyed services increased 27.4 percent, for an average annual rate of increase of 5 percent (Exhibit 3).[20] Over the same period, the Consumer Price Index (CPI) rose 13.5 percent, for an average annual rate of increase of 2.6 percent.[21] In real terms, Medicaid physician fees increased approximately 14 percent during the study period. Exhibit 3 also shows Medicaid fee changes for individual states. Thirty-six states raised their physician fees, seven states left their fees essentially unchanged, and the District of Columbia had a 2 percent decline. Thirty states raised their fees at or above the rate of inflation, including ten states (Connecticut, Hawaii, Illinois, Iowa, Maryland, Michigan, New York, Oklahoma, Oregon, and South Carolina) that raised physician fees by more than 35 percent.

Most of the increases in overall physician fees were caused by large increases in fees for primary care services. On average, such fees rose 41.2 percent between 1998 and 2003. Physician fees for obstetrical services and other services increased by 10.2 percent and 11.1 percent, respectively, slightly lower than price increases during that time period. There was considerable variation in changes to primary care fees across states. Seven states (District of Columbia, Georgia, Indiana, Kentucky, Maine, Rhode Island, and South Dakota) left primary care fees almost unchanged, while two states (Iowa and New York) raised them by more than 100 percent.

Further analysis of the data suggests that states may have been raising fees during this period in reaction to low fees in 1998. When states are grouped according to their relative

EXHIBIT 3
Cumulative Percentage Change In Medicaid Fees, By Type Of Service, 1998–2003

State	All services	Primary care	Obstetric care	Other services
US	27.4%	41.2%	10.2%	11.1%
AL	23.8	31.2	15.2	16.3
AK	21.8	44.5	−1.9	−4.7
AZ	22.3	37.0	0.0	14.1
CA	29.1	40.6	18.7	13.6
CO	5.8	8.3	0.0	7.1
CT	49.3	83.6	4.9	19.7
DC	−2.4	−0.1	0.0	−11.2
FL	13.0	17.6	6.1	5.4
GA	0.0	−2.1	1.9	3.1
HI	38.5	36.3	77.9	−6.4
ID	16.4	30.2	3.8	−2.1
IL	37.6	59.2	−5.5	7.0
IN	−0.1	0.0	0.0	−0.2
IA	58.4	105.5	2.3	11.7
KS	20.6	30.7	0.0	21.4
KY	0.0	0.0	0.0	0.0
LA	31.3	48.6	0.0	4.2
ME	0.0	0.0	0.0	0.0
MD	46.2	54.5	0.0	51.1
MA	30.8	21.5	39.0	44.1
MI	34.7	50.8	15.1	4.9
MN	5.3	4.5	3.0	10.4
MO	25.4	47.8	0.0	1.4
NV	11.7	2.5	33.4	7.2
NH	16.4	34.6	0.0	−8.2
NJ	22.7	41.2	0.0	5.1
NM	28.3	39.5	19.9	11.0
NY	74.4	135.9	2.6	11.4
NC	25.1	40.9	6.5	9.1
ND	15.8	28.9	−9.7	−2.9
OH	17.1	24.3	6.0	5.2
OK	39.2	60.7	2.3	31.5
OR	41.9	51.2	53.2	4.3
RI	−0.3	−0.4	0.0	−0.3
SC	55.1	65.9	71.4	19.0
SD	0.3	0.2	0.0	1.0
TX	5.1	2.9	2.0	12.5
UT	24.9	26.7	10.5	38.6
VT	24.7	26.1	23.4	22.9
VA	8.3	17.2	−1.0	−2.3
WA	14.2	20.6	8.8	5.0
WV	16.6	28.7	−7.9	−0.3
WI	17.1	20.4	13.1	13.6

SOURCE: Urban Institute/Health System Change 2003 Medicaid Physician Fee Survey.
NOTE: “US” denotes national average.

Medicaid fees in 1998, the seven states with the lowest fees—as a group, 22 percent below the national average—increased their fees by 39 percent between 1998 and 2003 (data not shown).[22] In contrast, all other states raised their Medicaid fees by only about 18 percent. Despite the fact that this latter group raised fees by more than inflation, the group with lowest fees initially increased their fees by a far greater amount.

Although the fee changes in the seven states with the lowest average Medicaid fees in 1998 were far greater than those in other states, this did not result in reports of above-average Medicaid fees in these states in 2003. In this group, New York had the largest increase in relative Medicaid fees: from 61 percent of the national average in 1998 to 70 percent in 2003. Across all states, only one state, South Carolina, moved from having below-average Medicaid fees to having fees well above average between 1998 and 2003. This was the result of large increases in both primary care and obstetrical fees. Five states (Florida, Indiana, Kentucky, Maine, and Ohio) kept fees unchanged or raised them less than the national average rate, and, as a result, their Medicaid fees fell from above to below average.

■ **Changes in access to physicians for Medicaid beneficiaries.** The primary concern about low Medicaid fees relative to those of other payers is that they may discourage physicians from accepting Medicaid patients, thereby reducing access to care for enrollees. Surveys of physicians have shown that although a majority of physicians accept Medicaid patients, fewer physicians nationally accept new Medicaid patients than accept other types of insured patients.[23] In addition, findings from the CTS physician survey show that acceptance of new Medicaid patients is higher in states that have higher Medicaid fees relative to Medicare than in states with lower Medicaid fees (Exhibit 4).[24] Among all patient care physicians in 2001, 52 percent in low-fee states were accepting new Medicaid patients, compared with 68 percent in high-fee states.

The results in Exhibit 4 also suggest that the more recent fee increases did not increase physicians' participation in Medicaid nationally, although participation did increase for primary care physicians in states with the largest fee increases. Nationally, the percentage of all patient care physicians who reported ac-

EXHIBIT 4
Physicians' Acceptance Of Medicaid Patients And Medicaid-To-Medicare Fee Levels

		1998 Medicaid-to-Medicare fee index		
	U.S.	Low-fee states	Moderate-fee states	High-fee states
Average 1998 Medicaid-to-Medicare fee index	0.62	0.49	0.71	0.86
Average 1998–2003 Medicaid fee change index	1.27	1.36	1.19	1.16
Percent of physicians accepting most or all new Medicaid patients				
All patient care physicians				
1997	61%	50%	67%[a]	69%[a,b]
2001	62	52	67[a]	68[a]
Primary care physicians				
1997	53	43	58[a]	61[a,b]
2001	54	47[c]	58[a]	58[a]
Specialists				
1997	66	54	73[a]	75[a]
2001	67	55	74[a]	75[a]

SOURCES: Community Tracking Study physician survey, 1997 and 2001; and Urban Institute/Health System Change 2003 Medicaid Physician Fee Survey.
[a] Difference with low-fee states is statistically significant at .05 level.
[b] Difference with moderate-fee states is statistically significant at .05 level.
[c] Difference between 2001 and 1997 is statistically significant at .05 level.

cepting all or most new Medicaid patients did not change significantly between 1997 and 2001 (about 61–62 percent; see Exhibit 4).[25]

However, acceptance of new patients did increase among primary care physicians in states that had the lowest 1998 Medicaid-to-Medicare fee ratios, which is consistent with the fact that fee increases were generally greatest for these physicians. The percentage of primary care physicians accepting most or all new Medicaid patients rose from 43 percent in 1997 to 47 percent in 2001. Acceptance of new patients did not change significantly among primary care physicians in states with moderate or high fee levels in 1998 (where fee increases were much smaller), nor among specialists in any of the fee groups. But just as fee increases in states with the lowest fee levels still left these states with below-average Medicaid fees by 2003, physicians' acceptance of new patients in states with low 1998 fees is still well below that of physicians in states with higher fee levels.

Discussion And Policy Implications

The increase in Medicaid physician fees between 1998 and 2003 exceeded growth between 1993 and 1998. During the previous period, Medicaid fees fell relative to inflation. However, fee growth in the years covered by this study exceeded inflation by a factor of two. States were able to increase fees to the extent they did because of their strong fiscal situation at the end of the 1990s. This growth in Medicaid fees was skewed toward increasing payments for primary care services, possibly reflecting a growing concern for access to basic care for Medicaid beneficiaries.[26]

Medicaid fee changes over the longer period of ten years, 1993–2003, suggest that Medicaid fees have not grown by much more than the rate of inflation. In fact, after falling by 14 percent relative to Medicare between 1993 and 1998, the recent 11 percent relative increase in Medicaid fees leaves them in a somewhat worse position than they were in 1993. Therefore, despite the experience of the five years covered in this paper, it is hard to conclude that states have improved the relative attractiveness of Medicaid patients when viewed from a longer perspective. Despite some improvement among primary care physicians in states with the lowest fee levels, physicians continue to be paid less for Medicaid beneficiaries than for other groups of insured patients, and they are much less likely to accept new Medicaid patients than other insured patients.[27]

Fiscal good times have receded; during the past three years, states have faced serious budget choices. One of the primary causes of states' financial crises from 2001 to 2004 has been the continued growth in Medicaid spending combined with falling tax revenues. Between 2001 and 2002 state Medicaid spending grew by 11.6 percent, while state tax revenues declined by 4.7 percent.[28] A December 2003 report from the National Governors Association indicates that in the past three years every state has frozen or reduced provider reimbursement, although the size of these cuts seems to be small.[29]

The period 1998–2003 contained a prosperous episode in states' financial history. Early on, states had the resources to expand access to care for Medicaid recipients by increasing physician fees. States are now dealing with the worst financial crisis since the Great Depression and will not be in position to raise provider fees greatly, so access for Medicaid recipients may be at increasing risk.

This research was supported by the Robert Wood Johnson Foundation through its funding of the Urban Institute's Assessing the New Federalism project and of the Center for Studying Health System Change. The authors thank Jessica Buckpitt for helping them complete the Medicaid Fee Survey, John Holahan and Stephen Norton for their advice during the design and analysis phases, and Terry Lied and Brian Bruen for providing the data used as weights. The views presented here are those of the authors and do not represent the Urban Institute, its trustees, or funders, or the Center for Studying Health System Change.

NOTES

1. S. Norton and S. Zuckerman, "Trends in Medicaid Physician Fees, 1993–1998," *Health Affairs* 19, no. 4 (2000): 222–232. The Medicaid fee increase reported in that paper (4.6 percent) differs from the number reported here (5.6 percent) because we used weights for individual fees that reflected a more recent distribution of Medicaid services.
2. The Norton and Zuckerman paper reported that in 1998 Medicaid fees were 64 percent of Medicare fees. Ibid. Again, the difference is the result of using weights for individual fees that reflected a more recent distribution of services.
3. P. Cunningham, "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997–2001," Tracking Report no. 6, December 2002, www.hschange.org/CONTENT/505/505.pdf (10 May 2004).
4. J. Holahan, J.M. Wiener, and A.W. Lutzky, "Health Policy for Low-Income People: States' Responses to New Challenges," *Health Affairs,* 22 May 2002, content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.187 (10 May 2004).
5. These data are derived from J. Holahan and S. Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001: Results of a New National Survey," March 2003, www.urban.org/UploadedPDF/410660_MMCPaymentMethods.pdf (10 May 2004). Under primary care case management (PCCM) plans, providers are paid a monthly fee for overseeing the care received by individual Medicaid enrollees, but services are still paid for via fee-for-service (FFS).
6. Urban Institute analysis of 2000 data from the Medicaid Statistical Information System (MSIS).
7. When states moved from FFS Medicaid to managed care, they used their historical FFS rates to establish capitation rates for managed care plans. This provided states with a basis for setting capitation rates that could result in some savings. Over time, states have adjusted both sets of rates in tandem. Holahan and Suzuki, "Medicaid Managed Care Payment Methods."
8. See, for example, S. Berman et al., "Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients," *Pediatrics* 110, no. 2 (2002): 239–248; J. Mitchell, "Physician Participation in Medicaid Revisited," *Medical Care* 29, no. 7 (1991): 645–653; E.K. Adams, "Effect of Increased Medicaid Fees on Physician Participation and Enrollee Service Utilization in Tennessee, 1985–1988," *Inquiry* 31, no. 2 (1995): 173–187; A.F. Coburn, S.H. Long, and M.S. Marquis, "Effects of Changing Medicaid Fees on Physician Participation and Enrollee Access," *Inquiry* 36, no. 3 (1999): 265–279; and J. Perloff et al., "Medicaid Participation among Urban Primary Care Physicians," *Medical Care* 35, no. 2 (1997): 142–157.
9. J. Cohen and P. Cunningham, "Medicaid Physician Fee Levels and Children's Access to Care," *Health Affairs* 14, no. 1 (1995): 255–262; Adams, "Effect of Increased Medicaid Fees"; and Coburn et al., "Effects of Changing Medicaid Fees."
10. Coburn et al., "Effects of Changing Medicaid Fees"; and Perloff et al., "Medicaid Participation."
11. Holahan et al., "Health Policy for Low-Income People"; and V. Smith et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004, Results from a Fifty-State Survey,* September 2003, www.kff.org/medicaid/kcmu4137report.cfm (11 May 2004).
12. J. Menges et al., *Comparing Physician and Dentist Fees among Medicaid Programs,* June 2001, www.chcf.org/documents/policy/ComparingPhysicianAndDentistFees.pdf (11 May 2004).
13. Service-specific spending is based on the 2000 calendar year files and on aggregating spending for the specific services for the twenty states with the largest Medicaid spending.
14. Norton and Zuckerman, "Trends in Medicaid Physician Fees."
15. Relative value units (RVUs) were determined from the 2003 Clinical Diagnostic Fee Schedule by dividing the national limit fee for a given service by the 2003 Physician Conversion Factor for RVUs of $36.7856. A single Medicare physician fee for each state was obtained by an average weighted by population of Medicare physician fees from all regions of the state.
16. For more information on the CTS physician survey, see N. Diaz-Tena et al., "Community Tracking Study, Physician Survey Methodology Report 2000–01 (Round 3)," Technical Publication no. 38, 2003, www.hschange.org/CONTENT/570/570.pdf (11 May 2004).
17. Since fee changes reflect the period 1998–2003 and the most recent survey was completed in 2001, changes in physicians' participation may not fully reflect the impact of the fee changes. Also, these results are descriptive and do not account for other changes that may affect physicians' decisions to participate in Medicaid. Therefore, caution should be used in making firm causal associations with fee levels.
18. The coefficient of variation for the 2003 Medicaid fee index is 21 percent. The fact that the overall fee index has a coefficient of variation on the low side of those shown in Exhibit 1 for the individual fees suggests that some states are high for some fees but low for others.
19. The 1998 conversion factor ($36.69) can be found

in *Federal Register* 62, no. 211 (31 October 1997), and the 2003 conversion factor ($36.20), in *Federal Register* 67, no. 251 (31 December 2002).

20. This 5 percent average annual rate of increase is higher than the increase in fees represented by the median state. The median state raised Medicaid fees by about 4 percent annually, still above the rate of inflation. The average fee increase is higher, because several large states (such as New York, California, Illinois, and Michigan) had fee growth that exceeded the median.
21. Bureau of Labor Statistics, Inflation and Consumer Spending, Inflation Calculator, data.bls.gov/cgi-bin/cpicalc.pl (11 December 2003).
22. California, Illinois, Michigan, Missouri, New Jersey, New York, and Rhode Island.
23. Cunningham, "Mounting Pressures"; and J.A. Schoenman and J. Feldman, *Results of the Medicare Payment Advisory Commission's 2002 Survey of Physicians*, December 2002, www.medpac.gov/publications/contractor_reports/Mar03_02PhysSurvRpt2.pdf (11 May 2004).
24. Some physicians might report accepting new patients when they actually see few or no Medicaid patients. However, it is unlikely that this would affect estimates of change in acceptance of new patients over time, which is this paper's main objective. Also, the overall percentage of physicians accepting most or all new Medicaid patients in 2001 (62 percent, as in Exhibit 4) is lower than that for Medicare and private insurance (85 percent and 80 percent, respectively; data not shown), which is consistent with both previous research and expectations based on the lower reimbursement levels in Medicaid relative to those of other payers. Other major physician surveys have also used the percentage of physicians accepting new Medicaid patients as a way to track changes in Medicaid access over time. For example, see Schoenman and Feldman, *Results of the Medicare Payment Advisory Commission's 2002 Survey.*
25. Medicaid patients' access to physicians might have declined if not for the overall increase in Medicaid fees. In other words, the increase in fees might have offset the effects of other factors that otherwise would have resulted in decreased access to physicians over the study period.
26. Medicaid payment rates also could have been raised because states recognized that more providers would need to participate if the expanded eligibility to public coverage offered through the State Children's Health Insurance Program (SCHIP) was to result in meaningful access to care. Although many states did not implement SCHIP as an expansion of Medicaid, most states set payment rates that were fairly similar in both programs. See I. Hill, "Charting New Courses for Children's Health Insurance," *Policy and Practice* 58, no. 4 (2000): 30–38.
27. Cunningham, "Mounting Pressures."
28. K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23, no. 1 (2004): 147–159; and U.S. Census Bureau, Governments Division, *State Government Tax Collections: 2001,* 23 April 2003, www.census.gov/govs/statetax/0100usstax.html (11 May 2004).
29. National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of States*, December 2003, www.nga.org/cda/files/FSS1203.pdf (25 May 2004); and J. Holahan et al., *State Responses to Budget Crisis in 2004: An Overview of Ten States,* January 2004, www.kff.org/medicaid/7002.cfm (11 May 2004).