Report on the Maryland Medical Assistance Program and Maryland Children's Health Program: Reimbursement Rates

September 2006

UMBC
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CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

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December 1, 2006

Re: Report on the Maryland Medical Assistance Program and Maryland Children's Health Program—Reimbursement Rates, September 2006

Dear interested party:

The Center for Health Program Development and Management at the University of Maryland, Baltimore County, conducted this study for the Maryland Department of Health and Mental Hygiene. The Center has a nationally recognized partnership with the Department to analyze issues and develop solutions for the Maryland Medicaid Program. The Department used this report to respond to a legislative study request.

We hope you find this report informative.

Sincerely,

Chuck Milligan
Executive Director

Report on the Maryland Medical Assistance Program and Maryland Children's Health Program – Reimbursement Rates
September 2006

I. Introduction

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

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

In addition, the Department has incorporated into this report information required by Chapter 280 (HB 627) from the 2005 session. Section 11 of this Act requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare those rates to the fee-for-service rates paid to similar providers for the same services under the Medical Assistance program and the rates paid to managed care organization providers for the same services. On or before January 1, the Department is to annually report this information and whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule.

The purpose of this report is to provide a status report on the progress that Maryland Medicaid has made in updating reimbursement rates, in keeping with the requirements of both SB 481 and HB 627.

II. Background

In September 2001, in response to Chapter 702 (HB 1071) of the 2001 session, the Department prepared the first annual report analyzing the physician fees that are paid by the Maryland Medicaid and Children's Health Programs. In 2002, SB 481 amended the prior year's legislation to require submission of this report on an ongoing annual basis. This is the sixth annual report.

The Department's first annual report showed that Maryland's Medicaid reimbursement rates in 2001 were, on average, about 36 percent of Medicare rates in 2001. The report also included the

results of a survey conducted by the American Academy of Pediatrics in 1998/1999 that showed that Maryland's physician reimbursement for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the legislature appropriated $50 million additional total funds ($25 million state funds) for increasing physician fees in the Medicaid program beginning July 2002. The increase was targeted to evaluation and management procedure codes largely used by primary care and specialty care physicians.

SB 836 from the General Assembly's 2005 session (Maryland Patients' Access to Quality Health Care Act of 2004 – Implementation and Corrective Provisions) alleviated the impact of recent increases in the cost of physicians' malpractice liability insurance in an effort to retain health care providers in the state. This bill created the "Maryland Health Care Provider Rate Stabilization Fund" to subsidize physicians for the cost of obtaining malpractice insurance. The main revenues of the Fund are from a tax imposed on managed care organizations (MCOs) and health maintenance organizations.

In addition to subsidizing physicians for the cost of obtaining malpractice liability insurance, SB 836 allocated funds to the Medical Assistance program to increase both fee-for-service physician fees and capitation payments to MCOs to enable these organizations to similarly raise their provider fees. The legislation allocated $15 million state funds ($30 million total funds) in FY 2006 to be used by the Department to increase both fee-for-service physician fees and to pay physicians in MCOs' networks "consistent with fee-for-service health care provider rates for procedures commonly performed by obstetricians/gynecologists, neurosurgeons, orthopedic surgeons and emergency medicine physicians." The legislation targeted the fee increase to these physician specialties because of the substantial rise in their malpractice insurance premiums. The bill also allocated additional funds each year to the Medical Assistance program for increasing and maintaining physician fee increases.

SB 836 also required the Department to consult with the MCOs, the Maryland Hospital Association, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatricians, and the Maryland Chapter of the American College of Emergency Room Physicians when determining the new payment rates. For FY 2007, the Department convened this workgroup (referred to as 'stakeholders' in this report) to determine the procedures that would be the target of fee increases in FY 2007.

In addition, SB 836 indicated that the Department shall submit its plan for Medicaid reimbursement rate increases to the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health and Government Operations Committee "prior to adopting the regulations implementing the increase." In accordance with this requirement, in May 2006, the Department submitted a report entitled "Report on Increasing Reimbursement Rates for Physicians participating in the Maryland Medical Assistance Program and Maryland Children's Health Program." The report described the Department's plan for increasing Medicaid physician fees for FY 2007.

III. FY 2007 Increase in Medicaid Physicians' Fees

The Department's analysis of claims and encounter data for Current Procedural Terminology (CPT) procedure codes used by different physician specialties indicates that in addition to using their own specialty procedure codes, physicians use procedure codes that are the domain of other specialists. For this reason, targeting fee increases to specific physician specialties, rather than procedures, may have limited usefulness.

The Department initially developed and evaluated five different options for targeting the fee increase in FY 2007 to procedures used by various specialties. The five options considered were:

1. Increase fees for anesthesia procedures to 100 percent of Medicare fees.

2. Allocate available funds to increase fees for all surgery procedures. Implementing this option would have raised Medicaid fees for surgery procedures with the lowest fees to 57 percent of Medicare fees.

3. Allocate available funds to all procedures with the lowest fees (excluding procedures commonly performed by obstetricians/gynecologists, neurosurgeons, orthopedic surgeons, and emergency medicine physicians [four specialties] whose fees were raised in FY 2006). Because there are many procedures with low Medicaid fees compared to Medicare fees, implementing this option would have raised the fees for procedures with the lowest fees to only 39 percent of Medicare fees.

4. Increase fees for the following 12 specialties that the MCOs are required to include in their networks: allergy, cardiology, dermatology, endocrinology, otolaryngology, gastroenterology, infectious disease, nephrology, neurology, ophthalmology, pulmonology, and urology. Because many procedures are used by these specialty physicians, implementing this option would have raised the lowest fees for these procedures to only 45 percent of Medicare fees.

5. Allocate available funds to procedures with malpractice cost components that are greater than $10.00. The malpractice cost components for these procedures were determined based on Centers for Medicare and Medicaid Services estimates of this component of Medicare fees. Implementing this option would have raised the fees for procedures with malpractice cost components greater than $10.00 to about 64 percent of Medicare fees.

The Department presented the five options described above in the stakeholders meetings that were held in February 2006. The stakeholders were in favor of increasing fees for anesthesia and surgery procedures (options 1 and 2 above). However, option 2 would increase fees for all surgery procedures to only 57 percent of Medicare fees. Therefore, the stakeholders recommended targeting the fee increase to a more limited set of procedures that are mainly used for general surgery (10000-19396), digestive surgery/gastroenterology (40490-49999), ENT (ear/nose/throat)/otorhinolaryngology (69000-69990, 92502-92625), allergy/immunology (95004-95199), and dermatology (96900-96999). The stakeholders agreed that there is a need to

increase reimbursement rates for these procedures in order to recruit and train new surgeons that would specialize in these fields. Some of the stakeholders also requested fee increases for radiation oncology procedures (77261-77799).

In addition, the stakeholders recommended that the Department allocate any remaining funds to evaluation and management procedures that are used by both primary care physicians and specialists, so that almost all physicians receive some increase in their reimbursement rates.

For the FY 2007 fee increase, the total state and federal matching funds available for the physician fee increase were $25.2 million. The remaining allocated funds are used to maintain the payment for the four specialties whose fees were increased in FY 2006. Table 1 shows the Department's allocation of FY 2007 fee increase funds among anesthesia, surgery, ENT, and evaluation and management procedures.

Table 1. Allocation of FY 2007 Fee Increase Funds

	Total Cost of Fee Increase (Million $)	**Percent of Medicare**
Anesthesia Procedures	$6.66	100%
Procedures including: Integumentary, Digestive Surgery, Radiation Oncology, Allergy/Immunology, and Dermatology	$10.92	80%
ENT Procedures	$2.44	100%
Evaluation & Management Procedures	$5.18	78%
Total Costs of Fee Increase For All Procedures Above	**$25.20**	

IV. Comparisons of Maryland Fees with Medicare and Other States' Fees

A. Medicare Fees as a Benchmark

The Department has used the Medicare physician payment methodology as a benchmark for increasing Medicaid fees. A summary of the methodology to determine the new Medicaid physicians' fees is presented in Appendix 1. Medicare fees are based on the Resource-Based Relative Value Scale (RBRVS) methodology. This methodology relates payments to the resources and skills that physicians use to provide services. Three types of resources determine the relative weight of each procedure: physician work, practice expense, and malpractice expense. A geographic cost index and a conversion factor are used to convert the weights to fees.

Medicare reimbursement rates are adjusted annually according to a complex formula designed to control overall spending while accounting for factors that affect the cost of providing care. This caused an overall decrease in Medicare rates in 2002. However, following federal legislative mandates, Medicare physician fees were increased by 1.6 percent in 2003, by 1.5 percent in 2004, and by 1.5 percent in 2005. Following a similar legislative mandate, Medicare fees were held constant at the 2005 level in 2006[1].

In addition, Medicare fees are adjusted depending on where a procedure is performed. Medicare payments for some procedures are lower if they are performed in hospitals or skilled nursing facilities rather than in offices or other places. A more detailed description of Medicare fees is included in Appendix 2.

Anesthesia procedures and payments are a distinct exception to the RBRVS system. Prior to December 1, 2003, the Medicaid program reimbursed anesthesia services based on a percentage of the surgical fee. The Medicaid program in general did not use the anesthesia CPT procedure codes, but rather the surgical CPT codes with a modifier.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that national standard code sets be used. Payment for anesthesia services could no longer be linked to surgical procedures. In late 2003, the Medicaid program complied with the federal standards. Since that time, all anesthesia services have been identified based on the anesthesia CPT procedure codes. Appendix 2 describes the Medicare anesthesia payment methodology.

B. Maryland Medicaid Fees Compared to Medicare Fees

After the July 2005 increase in Medicaid fees, Maryland Medicaid's overall physician reimbursement rates were, on average, about 68 percent of 2005 Medicare rates. The increase of Medicaid fees for targeted procedures in July 2006 raised the overall average of Medicaid fees to 73 percent of Medicare fees in 2006.

However, there is a wide variation in the fees for individual procedures compared to Medicare fees. Fees for about 3,000 procedures are below the 73 percent average. For instance, for about 2,600 procedures, the Maryland Medicaid fee is less than 50 percent of the 2006 Medicare fees. Furthermore, within those 2,600 procedures, fees for about 800 procedures are still lower than 20 percent of Medicare fees.

Table 2 presents Medicaid fees as a percentage of Medicare 2006 fees for all procedures, grouped by specialty. It shows these percentages before and after the FY 2006 and FY 2007 fee increases. Procedure groups that had a fee increase in FY 2006 or FY 2007 are shown in bold letters.

Table 2. Procedure Group Fees as Percent of Medicare 2006 Fees

Specialty Groups	CPT Codes	Percent of Medicare Before Fee Increase	Current Percent of Medicare
Anesthesia	**00100-01999**	**48.0%**	**100.0%**
Integumentary	**10000-19396**	**21.4%**	**80.0%**
Orthopedic	**20000-29999**	**29.1%**	**99.0%**
Respiratory	30000-32999	33.5%	33.5%
Cardiovascular	33010-37790	27.6%	27.6%
Lymphatic	38100-38794	36.9%	36.9%
Mediastinum	39000-39561	34.0%	34.0%
Digestive	**40490-49999**	**42.9%**	**80.0%**
Urinary/ Male Genital	50010-55999	19.0%	19.0%
Gynecology/Obstetric	**56405-59899**	**49.7%**	**99.0%**
Endocrine System	60000-60699, 95250	38.2%	38.2%
Neurosurgery	**61000-64999**	**31.4%**	**99.0%**
Eye	65091-68850	53.8%	53.8%
Ear Surgery	**69000-69990**	**36.9%**	**100.0%**
Radiation Oncology	**77261-77799**	**23.0%**	**80.0%**
Radiology, Exclude Radiation Oncology	70010-79900	41.4%	41.4%
Laboratory	80048- 89330	64.6%	64.6%
Psychiatry	90801-90911	35.3%	35.3%
Dialysis	90918-90999	17.9%	17.9%
Gastroenterology	91000-91299	25.3%	25.3%
Ophthalmology	92002-92499	19.8%	19.8%
ENT (Otorhinolaryngology)	**92502-92625**	**22.6%**	**100.0%**
Cardiovascular	92950-93798	21.1%	21.1%
Non-Invasive Vascular Tests	93875-93990	8.6%	8.6%
Pulmonary	94010-94799	43.2%	43.2%
Allergy/Immunology	**95004-95199**	**32.0%**	**80.0%**
Neurology/Neuromuscular	95805-96004	18.4%	18.4%
CNS/Health/Behavior Assessment	96100-96155	59.3%	59.3%
Chemotherapy Administration	96400-96599	9.1%	9.1%
Special Dermatological Procedures	**96900-96999**	**22.6%**	**80.0%**
Physical Medicine/Rehab	97001-97799	41.5%	41.5%
Nutrition Therapy	97802-97804	0.0%	0.0%
Osteo/Chiropractic & Other Medicine	97810-99195	8.9%	8.9%
Evaluation & Management (Except Emergency)	**99201-99499**	**75.2%**	**77.9%**
Emergency Department Visits	**99281-99285**	**74.7%**	**99.0%**

C. Maryland Fees Compared to Other States' Medicaid Fees

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

The American Academy of Pediatrics conducted a survey of Medicaid reimbursement rates across the country in 2001 [2]. Based on the 2001 survey data and Maryland's July 2002 fees for evaluation and management procedures, Maryland's rank was 13 (ranked highest to lowest). Ranks of neighboring states were: Delaware: 6, Pennsylvania: 46, Virginia: 15, West Virginia: 11, and Washington, DC: 47.

For this report, we conducted a new survey of the neighboring states of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, DC. Although Virginia did not participate in our survey, we obtained their latest physician fee schedules from their websites. We collected each state's current Medicaid fees for approximately 110 high-volume procedures. The procedures consist of a sample of procedures from the list of procedures that had a fee increase in July 2006. In the following tables 3 through 8, fees for procedures are rounded to the nearest dollar amount.

Table 3 compares Maryland's old and new Medicaid fees for high volume evaluation and management procedures with neighboring states' Medicaid fees and with the corresponding Medicare fees.

Table 3 - Fees for High-Volume Evaluation and Management Procedures

CPT Code	Procedure Description	MD-Old [1]	DC	DE	PA	VA	W VA	MD-New[2]	Medi-care[3]
99201	Office/outpatient visit; new Minimal	$29	$25	$35	$20	$26	$26	$30	$39
99202	Office/outpatient visit; new Moderate	$51	$33	$63	$23	$46	$47	$53	$69
99203	Office/outpatient visit; new Extended	$77	$49	$93	$25	$69	$70	$79	$102
99204	Office/outpatient visit; new Comprehensive	$109	$69	$132	$27	$97	$100	$112	$144
99205	Office/outpatient visit; new Complicated	$139	$88	$167	$36	$123	$128	$142	$183
99211	Office/outpatient visit; established Minimal	$17	$15	$21	$20	$15	$14	$18	$23
99212	Office/outpatient visit; established Moderate	$30	$19	$37	$26	$27	$27	$32	$41
99213	Office/outpatient visit; established Extended	$42	$27	$51	$27	$37	$37	$43	$56
99214	Office/outpatient visit; established Comprehensive	$66	$42	$79	$29	$58	$59	$68	$87
99215	Office/outpatient visit; established Complicated	$97	$62	$115	$36	$85	$87	$98	$126
99222	Initial hospital care, comprehensive 50 minutes	$89	$56	$108	$30	$80	$85	$91	$117
99223	Initial hospital care, comprehensive 70 minutes	$124	$78	$151	$42	$111	$118	$127	$163
99231	Subsequent hospital care, 15 minutes	$27	$17	$33	$17	$24	$25	$28	$35
99232	Subsequent hospital care, 25 minutes	$44	$28	$53	$17	$39	$42	$45	$58
99233	Subsequent hospital care, 35 minutes	$63	$40	$76	$17	$56	$59	$64	$82
99238	Hospital discharge day management < 30 minutes	$55	$0	$68	$17	$50	$53	$57	$74
99241	Office consultation Minimal	$39	$32	$48	$30	$36	$36	$41	$53
99242	Office consultation Moderate	$73	$46	$88	$30	$65	$67	$75	$97
99243	Office consultation Extended	$97	$61	$118	$30	$87	$90	$100	$129
99244	Office consultation Comprehensive	$137	$87	$166	$49	$123	$127	$141	$182
99245	Office consultation Complex	$178	$113	$215	$49	$159	$165	$183	$234
99254	Initial inpatient consult, 80 minutes	$113	$71	$136	$49	$101	$107	$115	$147
99381	Preventive visit, new patient, infant	$83	$80	$100	$20	$73	$73	$86	$110
99391	Preventive visit, established patient, infant	$63	$30	$76	$20	$56	$56	$65	$83
99392	Preventive visit, established patient, age 1-4	$70	$30	$85	$20	$62	$63	$73	$93
99393	Preventive visit, established patient, age 5-11	$69	$30	$84	$20	$62	$62	$72	$92
99394	Preventive visit, established patient, age 12-17	$77	$45	$93	$20	$68	$69	$79	$101
99395	Preventive visit, established patient, age 18-39	$78	$45	$94	$20	$69	$70	$80	$103
99431	Initial care, normal newborn	$47	$75	$58	$42	$43	$46	$49	$63
	Average % of Medicare Fees in Maryland		**49%**	**91%**	**33%**	**67%**	**69%**	**78%**	

1- MD-Old in all relevant tables refers to Maryland Medicaid fees prior to the July 2006 fee increase.
2- MD-New in all relevant tables refers to Maryland Medicaid fees after the July 2006 fee increase.
3- Medicare Fee schedule for 2006 in all relevant tables.

The last row of Table 3 shows the average of each state's fees for surveyed evaluation and management procedures as a percent of Medicare fees in Maryland. As these data indicate, Maryland Medicaid fees for evaluation and management procedures are lower than the Medicaid fees in Delaware, but are higher than the corresponding Medicaid fees in the other neighboring states. Average Medicare fees in Maryland are about equal to average Medicare fees in Virginia, but are about 3 percent higher than Medicare fees in Delaware, and about 8 percent higher than Medicare fees in West Virginia. Therefore, fees for evaluation and management procedures in Delaware are about 94 percent of Medicare fees in Delaware, and similarly, fees for evaluation

and management procedures in West Virginia are about 75 percent of Medicare fees in West Virginia.

Like Table 3, the following Tables 4 through 9 compare Maryland's old and new Medicaid fees for Integumentary, Digestive Surgery, ENT, Radiation Oncology, and Allergy/Immunology procedures with the corresponding Medicare and the neighboring states' Medicaid fees.

Table 4. Fees for Integumentary/General Surgery Procedures

CPT Code	Procedure Description	MD-Old	DC	DE	PA	VA	W VA	MD-New	Medicare
10060	Drainage of skin abscess, Simple	$15	$54	$91	$24	$64	$69	$80	$100
10061	Drainage of skin abscess, Complex	$50	$86	$162	$53	$114	$126	$142	$178
10120	Remove foreign body, simple	$15	$56	$128	$31	$90	$93	$114	$142
11040	Debride skin, partial thickness	$10	$21	$39	$22	$28	$30	$34	$43
11042	Debride skin and tissue	$75	$42	$81	$33	$57	$62	$75	$88
11043	Debride skin, tissue and muscle	$75	$121	$220	$33	$155	$166	$195	$244
11044	Debride tissue/muscle/bone	$125	$160	$288	$33	$203	$217	$255	$319
11100	Biopsy, skin, single lesion	$19	$41	$77	$35	$53	$55	$68	$85
11402	Excision, benign lesion, trunk, arms, legs, 1.1-2 cm	$26	$77	$141	$54	$99	$104	$125	$156
11721	Debride nail, 6 or more	$16	$21	$38	$20	$27	$29	$33	$42
11730	Removal of nail plate	$23	$39	$83	$26	$59	$64	$73	$91
11750	Removal of nail and nail matrix	$59	$78	$154	$100	$108	$117	$136	$170
12001	Repair superficial wound(s) < 2.6 cm	$11	$78	$140	$25	$98	$104	$123	$154
12002	Repair superficial wound(s) 2.6-7.5 cm	$24	$83	$148	$36	$104	$111	$131	$163
12011	Repair superficial wound(s)-other sites < 2.6 cm	$20	$83	$148	$32	$104	$110	$130	$163
12013	Repair superficial wound(s)-other sites 2.6 - 5 cm	$28	$91	$162	$48	$113	$121	$143	$178
12032	Layer closure of wound(s) 2.6-7.5 cm	$25	$110	$236	$33	$165	$172	$209	$262
12051	Layer closure of wound(s) 2.5 cm or less	$29	$113	$216	$32	$152	$160	$191	$239
15100	Skin split graft, trunk/arm/leg	$116	$424	$831	$298	$585	$627	$736	$919
16020	Dress/debride small burn(s)	$10	$39	$79	$20	$55	$58	$70	$87
17000	Destroy benign or premalignant lesion	$14	$33	$58	$20	$41	$42	$52	$65
17003	Destroy benign lesions, 2-14, each	$6	$5	$10	$47	$7	$7	$9	$11
17110	Destruct lesion, up to 14	$10	$48	$85	$49	$59	$60	$76	$94
17250	Chemical cautery of granulation tissue	$10	$35	$65	$26	$45	$46	$58	$72
19120	Removal of breast lesion or tumor	$103	$213	$392	$173	$276	$305	$343	$429
	Average % of Medicare Fees in Maryland		**48%**	**91%**	**45%**	**64%**	**68%**	**80%**	

N/C: Procedure is Not Covered.

The last row of Table 4 shows the average of each state's fees for surveyed integumentary procedures as a percent of Medicare fees in Maryland. The data indicate that Maryland Medicaid fees for integumentary procedures are lower than the corresponding Medicaid fees in Delaware, but higher than the corresponding Medicaid fees in the other neighboring states. The only exception is the Pennsylvania fee for procedure code 17003, which is more than four times the corresponding Medicare fee.

The data in Table 5 compare Maryland Medicaid fees for digestive surgery procedures with the corresponding Medicare and other states' Medicaid fees.

Table 5. Fees for Digestive Surgery Procedures

CPT Code	Procedure Description	MD-Old	DC	DE	PA	VA	W VA	MD-New	Medi-care
42820	Remove tonsils and adenoids, under age 12	$86	$164	$273	$184	$191	$208	$239	$299
42821	Remove tonsils and adenoids	$96	$171	$295	$199	$208	$226	$259	$324
42826	Removal of tonsils, age 12 or over	$96	$144	$243	$199	$170	$184	$213	$266
42830	Removal of adenoids, under age 12	$62	$100	$194	$134	$136	$146	$171	$213
43235	Upper GI endoscopy, diagnosis	$209	$167	$283	$180	$198	$203	$252	$315
43239	Upper GI endoscopy, biopsy	$234	$182	$321	$212	$225	$232	$286	$358
43246	Upper GI endoscopy, place gastrostomy tube	$234	$181	$230	$315	$162	$183	$234	$249
43760	Change gastrostomy tube	$12	$51	$119	N/C	$84	$86	$106	$133
44950	Appendectomy	$206	$292	$563	$302	$398	$457	$488	$610
44970	Laparoscopy, appendectomy	$225	$274	$502	$444	$355	$405	$436	$545
45330	Diagnostic sigmoidoscopy	$91	$56	$121	$65	$85	$86	$108	$135
45378	Diagnostic colonoscopy	$209	$237	$369	$181	$259	$270	$328	$410
45380	Colonoscopy and biopsy	$246	$260	$436	$257	$306	$319	$387	$484
45384	Colonoscopy, with lesion/tumor removal	$246	$278	$433	$417	$303	$319	$383	$479
45385	Lesion/tumor removal colonoscopy by Snare technique	$304	$293	$493	$351	$345	$363	$437	$546
47000	Needle biopsy of liver	$31	$206	$186	$95	$130	$135	$165	$206
47562	Laparoscopic cholecystectomy	$250	$364	$632	$589	$447	$511	$548	$685
49000	Exploration of abdomen / exploratory laparatomy	$231	$364	$669	$333	$473	$541	$581	$727
49080	Puncture, peritoneal cavity, initial, diagnostic or therapeutic	$18	$117	$198	$67	$138	$139	$177	$222
49320	Diagnostic laparoscopy separate procedure	$122	$182	$302	$293	$214	$242	$263	$329
49500	Repair inguinal hernia, initial, reducible, age 6 mo to <5 yrs	$175	$199	$336	$319	$273	$268	$292	$365
49505	Repair inguinal hernia, initial reducible, >5 yr	$170	$244	$446	$318	$315	$360	$387	$484
49560	Repair ventral hernia, initial reducible	$246	$353	$657	$372	$465	$532	$570	$712
49580	Repair umbilical hernia, reducible, < 5 yr	$170	$156	$260	$308	$185	$207	$228	$285
49585	Repair umbilical hernia, reducible, > 5 yr	$195	$207	$373	$355	$264	$299	$324	$406
	Average % of Medicare Fees in Maryland		**54%**	**91%**	**65%**	**64%**	**70%**	**81%**	

N/C: Procedure is Not Covered.

The last row of Table 5 shows the average of each state's fees for surveyed digestive surgery procedures as a percent of Medicare fees in Maryland. The data indicate that Maryland Medicaid fees for digestive surgery procedures are lower than the corresponding Medicaid fees in Delaware, while they are mostly higher than the corresponding Medicaid fees in the other neighboring states. Pennsylvania's Medicaid fees for procedure codes 43246, 44970, 45384, 47562, 49320, 49500, 49580, and 49585 are still higher than Maryland Medicaid fees. For two of these procedures, Pennsylvania's fees are higher than the corresponding Medicare fees. Washington, DC's fee for procedure code 47000 is equal to the Medicare fee in Maryland and is highest in the region.

The data in Table 6 show Maryland Medicaid fees for Ear Surgery and Otorhinolaryngology (Ear, Nose, Throat) procedures and the corresponding Medicare and other states' Medicaid fees.

Table 6. Fees for ENT: Ear Surgery and Otorhinolaryngology Procedures

CPT Code	Procedure Description	MD-Old	DC	DE	PA	VA	W VA	MD-New	Medicare
69200	Clear outer ear canal without anesthesia	$18	$45	$117	$30	$82	$83	$132	$132
69205	Clear outer ear canal with general anesthesia	$44	$56	$97	$93	$68	$72	$107	$107
69210	Remove impacted ear wax	$18	$24	N/C	$20	$33	$35	$52	$52
69424	Remove ventilating tube, with general anesthesia	$12	$52	$113	$57	$79	$81	$127	$127
69436	Tympanostomy, Create eardrum opening, with anesthesia	$83	$81	$161	$99	$113	$121	$178	$178
69990	Microsurgery add-on, using microscope	$78	$111	$218	$220	$157	$185	$239	$239
92504	Ear microscopy examination	$7	$14	$25	N/C	$18	$17	$28	$28
92552	Pure tone audiometry, air	$5	$10	$17	$8	$12	$12	$20	$20
92556	Speech audiometry, complete	$9	$13	$23	$15	$16	$16	$26	$26
92557	Comprehensive hearing test	$18	$26	$48	$29	$33	$34	$54	$54
92567	Tympanometry	$5	$12	$21	$12	$15	$15	$24	$24
92568	Acoustic reflex threshold testing	$4	$8	$15	$10	$11	$11	$17	$17
92585	Auditor evoke potent, comprehensive	$19	$78	$99	$27	$70	$21	$111	$111
92587	Evoked auditory test, limited	$23	$32	$59	$49	$41	$5	$66	$66
	Average % of Medicare Fees in Maryland		**48%**	**89%**	**50%**	**63%**	**58%**	**100%**	

N/C: Procedure is Not Covered.

The last row of Table 6 shows the average of each state's fees for surveyed ENT procedures as a percent of Medicare fees in Maryland. New Maryland Medicaid fees for ENT procedures, which are set at 100 percent of Medicare fees in Maryland, are higher than the corresponding Medicaid fees in all of the neighboring states.

Table 7 compares Maryland Medicaid fees for Radiation Oncology procedures with the corresponding Medicare and other states' Medicaid fees.

Table 7. Fees for Radiation Oncology Procedures

CPT Code	Procedure Description	MD-Old	DC	DE	PA	VA	W VA	MD-New	Medicare
77263	Radiation therapy planning, complex	$71	$86	$160	$241	$112	$126	$138	$173
77290	Set radiation therapy field, complex	$54	$179	$328	$122	$230	$61	$295	$368
77300	Radiation therapy dose plan	$17	$45	$82	$37	$58	$24	$73	$92
77331	Special radiation dosimetry	$41	$34	$62	$122	$44	$34	$55	$68
77334	Radiation treatment aid(s), complex	$21	$101	$187	$92	$131	$48	$167	$209
77336	Radiation physics consult, per week	$25	$63	$115	$49	$80	$79	$104	$130
77413	Radiation treatment delivery 6-10 MeV	$42	$50	$90	$44	$63	$62	$82	$102
77414	Radiation treatment delivery 11-19 MeV	$42	$50	$90	$44	$63	$62	$82	$102
77417	Radiology port film(s)	$7	$13	$23	$18	$16	$16	$21	$26
77427	Radiation treatment management, 5 treatments	$59	$87	$165	$138	$116	$130	$142	$178
	Average % of Medicare Fees in Maryland		**49%**	**90%**	**70%**	**63%**	**50%**	**80%**	

The last row of Table 7 shows the average of each state's fees for surveyed radiation oncology procedures as a percent of Medicare fees in Maryland. As these data indicate, Maryland Medicaid fees for radiation oncology procedures are lower than the corresponding Medicaid fees in Delaware, but they are mostly higher than the corresponding Medicaid fees in the other

neighboring states. Pennsylvania's Medicaid fees for procedure codes 77263 and 77331 are higher than their corresponding Medicare fees and Maryland Medicaid fees.

Table 8 compares Maryland Medicaid fees for allergy, immunology, and dermatology procedures with corresponding Medicare and other states' Medicaid fees. Pennsylvania's average percent of Medicare fees shown in the last row is high (97 percent) because of the fee for procedure code 95165, which is five times the Medicare fee for this procedure.

Table 8. Fees for Allergy, Immunology, and Dermatology Procedures

CPT Code	Procedure Description	MD - Old	DC	DE	PA	VA	W VA	MD-New	Medi-care
95004	Percutaneous allergy skin tests	$0	$2	$4	$2	$3	$3	$4	$5
95024	Interacutaneous allergy test, drug/bug	$2	$3	$6	$5	$4	$4	$5	$7
95115	Immunotherapy, one injection, excluding allergenic extracts	$7	$8	N/C	$4	$10	$10	$14	$17
95117	Immunotherapy injections, >2, excluding allergenic extracts	$7	$11	N/C	$7	$13	$13	$17	$22
95165	Antigen therapy services	$3	$5	$9	$56	$7	$6	$8	$11
96900	Ultraviolet light therapy	$2	$10	$17	N/C	$12	$11	$15	$19
96910	Photochemotherapy with UV-B	$2	$33	$38	$20	$26	$26	$34	$43
96912	Photochemotherapy with UV-A	$17	$38	$48	$20	$33	$32	$43	$54
	Average % of Medicare Fees in Maryland		**56%**	**89%**	**97%**	**62%**	**59%**	**80%**	

N/C: Procedure is Not Covered.

V. Trauma Center Payment Issues

During the 2003 legislative session, the General Assembly passed and the Governor signed into law SB 479, which created a Trauma and Emergency Medical Fund that is financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the Fund. Based on the legislation, Maryland Medicaid is required to pay physicians 100 percent of the Medicare rate (the Baltimore facility Medicare rate) when they provide trauma care to Medicaid's fee-for-service and HealthChoice program enrollees. The enhanced Medicaid fee only applies to services rendered in a Maryland Institute for Emergency Medical Services Systems (MIEMSS)-designated trauma center for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fee was limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. The passage of HB 1164 during the 2006 legislative session extends the enhanced rate to any physician, beginning July 1, 2006. MHCC and HSCRC fully cover the additional outlay of general funds that the Maryland Medicaid program incurs due to enhanced trauma fees (relevant percent of the difference between 100 percent of Medicare rates and Medicaid's current rates). MHCC pays physicians directly for uncompensated care and on-call services.

VI. Reimbursement for Oral Health Services

Historically, the Maryland Medicaid program has had low dental fees. Unlike physician services, there is no federal public program (such as Medicare) that could serve as a benchmark for oral

health service fees. In addition, there are no published data available on average payment levels by private payers for dental services. However, the American Dental Association (ADA) publishes a survey reporting the national and regional average charges for nearly 165 most commonly used dental procedures, offering data for comparisons.

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

In compliance with the budgetary language, effective March 1, 2004, MCOs were required to reimburse their contracted providers at the ADA 50th percentile levels as of 2001 for 12 restorative procedure codes. At the same time, Medicaid increased fee-for-service rates to the ADA 50th percentile levels as of 2001 for the same restorative procedures.

Table 9 shows Maryland's progress in improving reimbursement to dentists for some of the more common services. On average, Medicaid tripled reimbursement rates for dentists in July 2000, and then increased reimbursement for 12 restorative procedures in 2004. The last column shows the average fee charged by dentists in 2005 in the South Atlantic Region [3]. It is important to note, however, that the South Atlantic average is based on the fees charged by dentists for the service performed, which does not equate to the average payment received as reimbursement from insurance companies or private pay patients.

Table 9. Oral Health Reimbursement Schedule - Selected Procedures

CDT-3	CDT-2	Description	MA Fee before 7/1/00 rate increase	MA Fee after 7/1/00 rate increase	MA Fee after 3/1/04 restorative rate increase	South Atlantic 50th Percentile of Charges
D0120	00120	Periodic oral evaluation	$5	$15	$15	$36
D0220	00220	Intraoral periapical first film	$3	$9	$9	$18
D0272	00272	Bitewings-two films	$3	$15	$15	$30
D0330	00330	Panoramic film	$21	$42	$42	$83
D1110	01110	Prophylaxis-adult	$12	$36	$36	$72
D1120	01120	Prophylaxis-child	$8	$24	$24	$50
D1201	01201	Topical application of fluoride with prophylaxis	$17	$35	$35	$64
D1203	01203	Topical application of fluoride - no prophylaxis	$17	$14	$14	$29
D1351	01351	Sealant-per tooth	$3	$9	$9	$40
D1510	01510	Space maintainer – fixed – unilateral	$42	$84	$84	$225
D1515	01515	Space maintainer – fixed – bilateral	$48	$144	$144	$300
D2140	*02140*	*Amalgam – one surface, Primary or permanent*	$13	$37	*$70*	$85
D2150	*02150*	*Amalgam - two surfaces, Primary or permanent*	$19	$45	*$88*	$110
D2330	*02330*	*Resin – one surface – anterior*	$13	$39	*$84*	$100
D2331	*02331*	*Resin – two surfaces – anterior*	$19	$48	*$102*	$130
D2332	*02332*	*Resin – three surfaces – anterior*	$22	$56	*$125*	$160
D2930	*02930*	*Prefabricated stainless steel crown - primary*	$27	$75	*$154*	$183
D3220	03220	Therapeutic pulpotomy	$16	$60	$60	$129
D9230	09230	Analgesia	$6	$18	$18	$34

Note: The South Atlantic 50th percentile of charges is based on data from the 2005 American Dental Association survey. The procedures identified in italics are among the 12 restorative procedures targeted for the 2004 restorative fee increase.

VII. Physician Participation in the Maryland Medicaid Program

Physicians' claims and encounter data pertaining to FY 2002 (the year before the July 2002 fee increase), FY 2003, and FY 2004 were analyzed for the number of physicians who had either partial or full participation in the Medicaid program.[1] Because of lag-time in receiving MCOs encounters, FY 2005 data are not yet ready to be included in this analysis. Physicians who had fewer than 25 claims during the fiscal year were excluded from the data in the following tables. Physicians who had more than 25 claims but less than 50 patients were considered partial participants in the Medicaid program. Physicians were considered full participants in the Medicaid program if they had visits with at least 50 patients during the year.

[1] The data in these tables pertain to FY 2002 through FY 2004. Therefore, these tables do not measure the impact of FY 2006 and FY 2007 fee increases on physician participation in the Medicaid program.

Tables 10 and 11 show the percentage changes in the numbers of participating physicians of all specialties (including primary care) who participate in fee-for-service (FFS), MCO networks, and the total Medicaid program. As the data in these tables indicate, there were significant increases in physician participation in fee-for-service, MCO networks, and the total Medicaid program for both fiscal years 2003 and 2004.

Table 10. FY 2002-03 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid[2]
Partial Participation	8.0%	10.7%	12.5%
Full Participation	12.1%	9.6%	10.1%

Table 11. FY 2002-04 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	14.6%	30.0%	36.9%
Full Participation	24.8%	18.9%	21.9%

Caveats for Tables 10 and 11

It should be noted that percent increases in the number of physicians with partial participation in Medicaid in Tables 10 and 11 represent change in:

- The number of physicians who did not participate in the Medicaid program before the fee increase, and after the 2002 fee increase started to partially participate in the program, minus the number of physicians who were partial participants in the program before the fee increase, and decided to fully participate in the program after the 2002 fee increase.

Similarly, percent increases in the number of physicians with full participation in Tables 10 and 11 represent change in:

- The number of physicians who were partial participants in the program before the 2002 fee increase, and decided to fully participate in the program after the fee increase, plus the number of physicians who did not participate in the Medicaid program before the 2002 fee increase, and after the 2002 fee increase started to fully participate in the program.

VIII. Plan for Future Physician Fee Increases

SB 836 from 2005 allocated $15 million state funds ($30 million total funds) in FY 2006 for increasing reimbursement rates for the aforementioned four physician specialties. Moreover, the

[2] Because some physicians participate in fee-for-service and MCO networks, percents of total physicians participating in the Medicaid program are not the sum of FFS and MCO network physicians.

legislation provided additional funds to increase and maintain provider reimbursement rates in subsequent years.

The schedule of fund allocation provided by SB 836 regarding the "Rate Stabilization Fund" and funds that will be available for increasing and maintaining physicians' fee in FY 2008 through 2010 is shown in Table 12.

Table 12. Funds for Increasing Provider Rates (SB 836)

	FY 2007	FY 2008	FY 2009	FY 2010
State Funds	$12,600,000	$30,008,000	$48,246,402	$73,110,369
Total Funds	$25,200,000	$60,016,000	$96,492,804	$146,220,738

SB 836 allocated separate funds for maintaining fees for the four specialties that had fee increases in FY 2006. Therefore, funds for these procedures are not included in Tables 12 and 13.

The allocated funds for each fiscal year were adjusted by 8 percent in subsequent years for annual utilization and enrollment increases. Then, to derive the amounts of funds that will be available for increasing physicians' fees in each fiscal year, we subtracted the adjusted amounts for previous years from the total allocated funds for that year. Table 13 shows the amounts of funds (in million dollars) that would be available for increasing physicians' fees in each fiscal year.

Table 13. Projected Amounts of Funds Available for Physicians Fee Increases

Fiscal Year	2007	2008	2009	2010
Total Funds (Million $)	$25.20	$32.80	$31.68	$42.01

SB 836 required the Department to determine future fee increases in consultation with a variety of stakeholders, including MCOs, the Maryland Hospital Association, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Maryland Chapter of the American College of Emergency Room Physicians. The participants of the physician fee stakeholders meetings, which were held in February 2006, recommended increasing procedures codes typically billed by four specialties – anesthesiologists, general surgeons, otolaryngologists, and primary care providers (see table 14).

Table 14. Percentage of Medicare Fees in Each Fiscal Year with a Fee Increase

Procedure Group	FY 2007
Anesthesia Procedures	100%
General Surgery[1]	80%
ENT procedures	100%
E&M Procedures	78%

1- General Surgery stands for Integumentary, Digestive Surgery, Radiation Oncology, Allergy/ Immunology, and Dermatology procedures.

In addition, the participants made recommendations for future rate increases; focus on the procedures that have the lowest fees while continuing to provide some monies to maintain fees for evaluation and management procedures.

References and Notes

1 Centers for Medicare and Medicaid Services (CMS) and Medicare Payment Advisory Commission (MedPAC) publications. Section 601 of the Medicare Prescription Drug, Improvement and Modernization Act (MPDIMA) of 2003, Public Law 108-173, specified that the annual update of conversion factors for 2004 and 2005 would not be less than 1.5 percent.

2 'Medicaid Reimbursement Survey' – (2001), *American Academy of Pediatrics*, http://www.aap.org/research/medreimintro.htm

3 South Atlantic Region consists of: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia.

Appendix 1

Summary of Methodology to Determine Maryland Medicaid Physician Fees

The Department's methodology determines the new Medicaid fees for targeted procedures as a percentage of Medicare fees. First, we compare the existing Medicaid fee for each procedure with the new fee (as a percent of the Medicare fee). If the current Medicaid fee is higher than the new fee, then the Medicaid fee remains unchanged. The fees for the remaining procedures are set as a percentage of the corresponding Medicare fees. This percentage of Medicare fees is the same for groups of procedures with fee increases.

The percentage of Medicare fees is the dependent variable in the process of determining the fees. The independent variable is the total amount of funds that are available for the fee increase. For the FY 2007 fee increase, the total state and federal matching funds available for the physician fee increase were $25.2 million. For the FY 2007 fee increase, the percentage of 2006 Medicare fees was adjusted to 80 percent for integumentary, digestive surgery, radiation oncology, allergy /immunology, and dermatology procedures and to 100 percent of Medicare 2006 fees for ENT and anesthesia procedures. For evaluation and management procedures, the fees were raised to about 78 percent of Medicare fees. The projected total cost of fee increase would be equal to the $25.2 million available funds. The projected cost of fee increase incorporates projected enrollment and utilization increases between the base year and the implementation year.

Appendix 2

Medicare Resource-Based Relative Value Scale and Anesthesia Reimbursement System

Medicare payments for physician services are made according to a fee schedule. For about 13,000 physician procedures, Medicare RBRVS assigns the associated relative value units and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending upon the place of service that each procedure is performed. Medicare fees for some procedures are lower if they are performed in hospitals or skilled nursing facilities than if they are performed in offices or other places. Implementation of RBRVS resulted in increased payments to office-based procedures, and reduced payments to procedures that are provided in the hospital settings.

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

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

Currently, efforts are underway in the U.S. Congress to change the Medicare physicians' payments system to include "pay for performance" and quality improvement incentives instead of relying on the SGR formula for updating the physicians' reimbursement rates.

The conversion factor for year 2000 was $36.6137. The conversion factor for 2001 was $38.2581, which represents a 4.5 percent increase over the year 2000 conversion factor. The conversion factor for 2002 decreased by 5.4 percent from its 2001 value to $36.1992. The conversion factor for 2003 increased by 1.6 percent from its 2002 value to $36.7856. The conversion factor for 2004 increased by 1.5 percent from its 2003 value to $37.3374. The conversion factor for 2005 also increased by 1.5 percent from its 2004 value to $37.8975. The conversion factor for 2006 remained at its 2005 value of $37.8975.

Medicare payments for anesthesia services represent a departure from the RBRVS system. The most complex surgical, and usually primary procedure performed during any given surgical session is identified and linked to one and only one anesthesia code. The anesthesia time for any additional procedures during the same operative session is added to the time for the primary procedure. This time is then converted to units with 15 minutes equal to 1 unit.

Each anesthesia procedure code has a non-variable number of base units. Similar to the RBRVS work value, the base units represent the difficulty associated with a given group of procedures. The base units for the selected anesthesia code are added to the units related to anesthesia time, and the result is multiplied by a conversion factor to convert to dollars. Medicare's anesthesia conversion factor in the Baltimore area for 2006 is $18.04 per unit. The Medicaid Program calculates the payment slightly differently by using minutes instead of quarter hour blocks, but the net result is the same.

Appendix 3

Rate of Non-Federal Physicians per 100,000 Civilian Population, 2004

Rank		Physicians per 100,000 Population
Average	**United States**	**281**
1	District of Columbia	752
2	Massachusetts	451
3	New York	401
4	**Maryland**	**389**
5	Connecticut	369
6	Vermont	363
7	Rhode Island	361
8	New Jersey	333
9	Pennsylvania	332
10	Hawaii	302
11	Maine	302
12	Michigan	289
13	Ohio	289
14	Illinois	284
15	Minnesota	283
16	Delaware	272
17	Oregon	269
18	Colorado	268
19	Missouri	267
20	New Hampshire	267
21	Washington	266
22	Virginia	264
23	Louisiana	262
24	Tennessee	262
25	Wisconsin	262
26	California	261
27	Florida	258
28	West Virginia	254
29	Puerto Rico	254
30	North Carolina	252
31	North Dakota	244
32	Nebraska	243
33	New Mexico	238
34	Kansas	235

35	Kentucky	233
36	South Carolina	231
37	Arizona	225
38	Montana	224
39	Indiana	222
40	Georgia	219
41	Texas	219
42	Iowa	218
43	Alaska	217
44	South Dakota	217
45	Alabama	216
46	Utah	215
47	Arkansas	205
48	Oklahoma	205
49	Nevada	196
50	Wyoming	191
51	Mississippi	182
52	Idaho	175

Compared to the 2001 figures (shown in previous reports), numbers of physicians per 100,000 populations have increased in all states. United States average increased from 268 physicians per 100,000 populations in 2001 to 281 physicians per 100,000 populations in 2004. The ratio of physicians to 100,000 people in Maryland increased from 382 in 2001 to 389 in 2004. The fourth ranking of Maryland among the states stayed the same between 2001 and 2004.

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

Sources: Physicians data are from American Medical Association, Physicians Professional Data as of 2004, copyright 2005. Civilian population data are from Annual Population Estimates by State, July 1, 2004 Population, U.S. Census Bureau.
From: Kaiser Family Foundation State Health Facts Online: http://statehealthfacts.kff.org