STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

ACCESS TO OBSTETRIC AND PEDIATRIC SERVICES

EXECUTIVE SUMMARY

The Wisconsin Department of Health and Family Services assures that Medical Assistance (Wisconsin Medicaid) recipients' access to obstetric and pediatric services is equal to that of the general population of the state. We demonstrate this under Category A of draft State Medicaid Manual Section 6306.1, "Practitioner Participation." We show that:

- In each of twelve substate regions of Wisconsin (defined as twelve geographic regions centered around one or more regional medical centers), at least 50% of the primary care providers available to the general public offer pediatric and obstetric services to Wisconsin Medicaid Program recipients, as evidenced by FY 1996 Medicaid paid claims data.

  Because Wisconsin is predominantly rural with a large number of health personnel shortage areas, many members of the general population must travel out of their communities to receive primary care services. Medicaid recipients must travel to the same degree as the general public. In light of these travel patterns, utilization was analyzed regionally in each of twelve substate regions.

- In addition, "border status" providers in Illinois, Iowa, Michigan and Minnesota are available to provide obstetric and pediatric services to both the general population and Medicaid recipients. Historically more than 900 border status primary care providers have been available to serve Wisconsin residents.

- The 1995-97 Biennial Budget contained a number of provisions favorable to promoting access to pediatric and obstetric services. These included:

  - Expansion of managed care services statewide. Wisconsin has operated a managed care program for AFDC and Healthy Start recipients in Milwaukee, Dane, Eau Claire, Waukesha and Kenosha counties.

    Beginning July 1, 1996, Wisconsin began statewide expansion of managed care programs for the Medicaid population. Enrollment is being phased-in during fiscal year 1997. When expansion is completed in May 1997, Wisconsin Medicaid expects to enroll up to 230,000 recipients in 68 counties in managed care.

    The goal of managed care is to provide primary care and other medically necessary services to Wisconsin Medicaid recipients in a manner more cost-effective than fee-for-service. Our initial experience in Southeastern Wisconsin has demonstrated that Medicaid recipients in managed care have greater access to primary care, immunizations and preventive services than their counterparts in fee-for-service.

- Reimbursement for primary care has been set at a level sufficient to ensure access to primary care by Medicaid recipients. These fee-for-service rates are reflected in Medicaid HMO capitation rates and contract provisions.

- Reimbursement for physician assistants and nurse midwives continues at 90% of physician reimbursement. Physician assistants receive the same reimbursement as physicians for immunizations, injections, lab handling fees and HealthCheck screens. Nurse practitioners receive the same reimbursement as physicians for all services they perform. These rates have been sufficient to assure access to these primary care providers.

These assurances clearly demonstrate that Wisconsin meets the provisions of Section 1926 of Title XIX of the Social Security Act.

INTRODUCTION

General Access

1995 Wisconsin Act 27 (the 1995-97 Biennial Budget) included a number of provisions favorable to promoting access to primary health care in Wisconsin. Most of these focused on the continued statewide expansion of managed care for Wisconsin Medicaid.

The Health Personnel Shortage Area (HPSA) incentive program continued to provide incentive payments for primary care services across the state. In FY 1996, 59 areas of the state were designated as Health Personnel Shortage Areas. (See Appendix 1 for a map of HPSA-designated areas.)

Wisconsin is fortunate to have a comparatively high percentage of physicians statewide who provide services to Medicaid recipients. In 1996, Wisconsin's Office of Health Care Information (OHCI) re-surveyed all physicians licensed in Wisconsin. (The original survey conducted in 1993 was used in previous editions of this state plan amendment.) The surveys were done in cooperation with the Wisconsin Department of Regulation and Licensing, which licenses health care professionals. The data was used in conjunction with Medicaid provider certification data to determine access to Medicaid providers by recipients.

Wisconsin Geographic Regions

Wisconsin is predominantly rural with only 19 of its 72 counties having the designation of metropolitan by the federal Bureau of the Census. By definition, rural counties lack sufficient population density to sustain the variety of economic enterprises that characterize urban counties. As a consequence, residents of rural counties often must travel substantial distances out of their home county to obtain necessary business and professional services.

This holds especially true for health care delivery. Residents of rural counties tend to travel to regional health clinics and hospitals to receive even primary health care. Health care services are so dispersed in Wisconsin that the state contained 59 federally designated Health Personnel Shortage Areas (HPSAs) in FY 1996. (See Appendix 1 for a map of HPSA-designated areas.)

Many Wisconsin residents located on Wisconsin's borders seek their health care across the state borders in more urbanized centers in neighboring Iowa, Illinois, Michigan, and Minnesota. Historically, more than 900 pediatricians, obstetricians, family practice and general practice physicians have been certified by Wisconsin's Medicaid Programs as "border status" providers eligible to provide services to Medicaid recipients.

From these analyses, it is clear the county is too small a unit by which to measure health care access. Using counties assumes: 1) that health care access is bounded by one's home county; and 2) that physicians practice in only one county. Neither assumption is true for the general population nor the Medicaid population in a rural state like Wisconsin. For a more complete picture of access, data must be aggregated into regions, each of which approximates normal travel patterns of the general population.

Therefore, as in previous editions of this plan, Wisconsin has elected to present the FY 1996 physician, nurse practitioner, and nurse midwife Medicaid participation data aggregated in 12 geographic health care regions centered around one or more regional medical centers. (See Appendix 2 for a map of the 12 regions.)

6306.1 Assurance of Adequacy of Access ***- The Department of Health and Family Services assures that the Medical Assistance (Medicaid) Program is meeting the requirements set forth in the Omnibus Budget Reconciliation Act of 1989 in this, the 1997 State Plan Amendment.***

I. Pediatric Standards

A. Provider Participation

1. Number Participating

For the purposes of the pediatric standards section of this submission, participation by a provider in the Wisconsin Medicaid Program is defined as (1) having been certified by the Medicaid program as a physician (MD or DO), nurse practitioner, or nurse midwife and (2) having filed one or more claims for evaluation and management visits (office, preventive medicine or emergency room procedures), EPSDT comprehensive screens, or immunizations provided to Medicaid recipients aged 18-years and under during the period from July 1, 1995 through June 30, 1996. Because providers can have more than one specialty (e.g., obstetrics and family practice), a few were counted more than once as available to serve either the general public and/or the Medicaid population.

The number of Wisconsin pediatricians, family practice, and general practice physicians available to the general public who participate in the Wisconsin Medicaid Program meets or exceeds 50% of the total number of pediatricians, family practice, and general practice physicians practicing in all twelve health care regions. (Appendix 3-PED)

Note: Appendix 3-PED includes only fee-for-service data. HMOs do not collect data in a manner that enables the data to be included in this table.

Substitute Page

Of the 2,247 estimated primary care providers practicing in Wisconsin who offer pediatric care services, 2,185 or 96% provided fee-for-service pediatric services to Medicaid recipients in FY 96. (Appendix 3-PED)

2. How Data was Compiled on Physicians Available to Provide Pediatric Care to Wisconsin Residents

To estimate the number of pediatricians, family practice, and general practice physicians available to provide pediatric services to Wisconsin residents, data from the Wisconsin Office of Health Care Information (OHCI) and from the Medicaid program were used. This resulted in the creation of two databases. Both databases were aggregated by county and region.

The first database was composed of data from a 1996 collaborative effort between OHCI and the Wisconsin Department of Regulation and Licensing. This effort surveyed physicians licensed and practicing in Wisconsin in order to identify actively practicing primary care providers.

From this database, OHCI identified each physician's county and region based on the primary practice location of physicians who identified themselves as having a specialty in pediatrics, family practice, general practice, or obstetrics. Some providers identified more than one specialty and were therefore assigned to more than one specialty.

The second database contained actual FY 1996 fee-for-service Medicaid claims data. In this database, practice location was identified based on the first claim identified for each Medicaid certified provider. Provider specialty was also based on the Medicaid reference file created from certification information.

Appendix 3-PED lists the total number of physicians, nurse practitioners and nurse midwives, by county, providing pediatric services to the general public and to non-HMO Medicaid recipients. The number of providers serving Medicaid recipients is derived from fee-for-service Medicaid claims data. The number of providers serving the general public comes from the OHCI database. These data sources were also used to identify the number of family practice and general practice physicians specifically offering pediatric services to Medicaid recipients.

In addition to those providers listed in Appendix 3-PED, the Medicaid program certifies a number of out-of-state participating providers as border status providers. Border status providers have practices in towns and cities near the border of Wisconsin and regularly serve Wisconsin Medicaid recipients. Certified border status providers are subject to the same policies, regulations, and reimbursement rates as instate providers.

Historically, more than 900 border status pediatricians, family practice physicians, general practice physicians, and obstetricians have been certified to provide pediatric and obstetric services to Wisconsin Medicaid recipients. Their practice patterns are expected to be similar to those of Wisconsin physicians.

3. How Medicaid Participation was Derived

Medicaid claims for HCFA-designated pediatric procedures (detailed in Appendix 5) performed between 7/1/95 and 6/30/96 by all Medicaid-certified pediatricians, family practice and general practice physicians for pediatric patients (Medicaid recipients 18 years and under) were analyzed. Providers who were reimbursed for these services were counted as participating in the Wisconsin Medicaid Program. Each provider was assigned to only one county, based on the first reported claim for that provider and to a specialty based on the reference file created by Medicaid from certification information. This differs from the methodology used by the Office of Health Care Information to identify how many physicians are practicing in each county and region. OHCI uses primary practice location and specialty as identified in its licensure survey to assign providers to counties and specialties.

Medicaid participation percentages were calculated by dividing the number of physicians in each region who provide Medicaid recipients with pediatric care by the number of physicians offering those services to the general public in each region.

4. Explanation of Regional Data

Appendix 3-PED compares the total number of actively practicing pediatricians, family practice physicians, general practice physicians, based on OHCI data, with those submitting fee-for-service Medicaid claims for pediatric services during the period 7/1/95 through 6/30/96.

Contiguous counties are grouped into 12 geographic regions, each of which is centered around one or more regional health centers and encompasses the distances health care consumers regularly travel in Wisconsin to receive medical care.

Two counties--Milwaukee and Menominee--are listed separately. Milwaukee is listed separately because of its size and importance. Menominee County is listed separately because of the uniqueness of their health care delivery systems.

Milwaukee County is the state's largest county. Milwaukee County has the largest number of Medicaid recipients who are also recipients of Aid to Families with Dependent Children (AFDC) or are enrolled in Medicaid through Healthy Start. Most Milwaukee County AFDC and Healthy Start recipients have mandatory HMO coverage.

Menominee County is considered individually because the county is entirely contained within the Menominee Indian Reservation. Health services delivered at the Indian Health Service-subsidized Tribal Health Center are not entirely reflected in Medicaid fee-for-service claims data.

5. Nurse Provider Data Limitations

Nurse practitioners and certified nurse midwives in Wisconsin practice almost exclusively in group practices, clinics and hospitals with physicians in the collaborative practice model. To the extent Medicaid recipients have access to physicians in the regions of Wisconsin, they have access to nurse practitioners and certified nurse midwives and that access is equal to that of the general population in all twelve of the health care regions of Wisconsin.

a. Nurse Midwives

Even though nurse midwives can list themselves as the performing provider on Medicaid claims, very few nurse midwives bill the Medicaid program independently. Of the 44 Medicaid certified nurse midwives in Wisconsin, none billed independently in FY 96. Nurse midwives typically bill for services under the name of their supervising physician or clinic. Despite this, there is no reason to believe that nurse midwives are any less available to Medicaid recipients than they are to the general public.

b. Nurse Practitioners

Although 343 nurse practitioners were certified during FY 96 as Medicaid providers, only five independently billed Medicaid for pediatric or obstetrical procedures during that time. However, it is still not possible to determine exactly how many nurse practitioners are available to deliver pediatric and obstetrical services for Medicaid recipients or the general population. As indicated in prior submissions, the Wisconsin Department of Regulation and Licensing (DRL) does not separately license nurse practitioners, only nurse midwives. In contrast, Medicaid separately certifies nurse practitioners and midwives.

Based on studies of nurse practitioners conducted during the early 1990s, Wisconsin believes that few certified nurse practitioners plan to set up an independent practice. Most prefer practicing with physicians as a team. The many barriers to entering the medical market, (e.g., high investment, lack of good Medicare and commercial insurance coverage) often preclude nurses from establishing an independent practice.

Given the collaborative nature of nurse practitioners, we therefore conclude that, while Nurse Midwives and Nurse Practitioners practicing independently are few in number in Wisconsin, no evidence exists to indicate that they are any more or less available to Medicaid recipients for pediatric or obstetric services than they are to the general population.

B. Payment Rates

1995-97 Biennial Budget

Reimbursement rates for physicians and other primary care providers were unchanged from last year's rates. Rates for physician assistants and nurse midwives remained at 90% of the physician maximum allowable fees, although, as before, physician assistants receive the same reimbursement as physicians for injections, immunizations, lab handling fees and HealthCheck screens. Nurse practitioners in Wisconsin still receive 100% of the physician maximum allowable fee.

The Health Personnel Shortage Area (HPSA) incentive program remains in place making incentive payments available to physician assistants, nurse practitioners, nurse midwives, and physicians with a specialty of emergency medicine, in addition to physicians with specialties of general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics. The HPSA incentive payment applies to primary care services including evaluation and management visits (office, emergency department, and preventive medicine procedures,) immunizations, and selected obstetric procedures.

HPSA incentive payments remain at 20% of the physician maximum allowable fee for all primary care providers for affected pediatric codes described in Appendix 4-PED.

Maximum Allowable Fees

Appendix 4-PED lists current maximum allowable rates of reimbursement expected to be in effect as of July 1, 1997, for pediatric services (PD Modifier).

In his most recent budget address, the Governor has proposed rate increases of 1% per year for non-institutional providers in state FY 1998 and 1999. However, since these rate increases require legislative action, and if passed, would not become effective prior to July 1, 1997, they are not included in data tables for this report at this time.

FY 96 Average Payments

Appendix 4-PED lists the current maximum allowable rates of reimbursement anticipated to be in effect as of July 1, 1997, for pediatric services and the average payment to physicians, nurse practitioners and nurse midwives during FY 1996. This does not include any possible rate increases that may occur if the Governor's latest budget request passes the Legislature. Column one lists the pediatric CPT-4 codes and a description of each code. Maximum fees for pediatric services provided by primary care providers (that are "non-HPSA") are listed in the second column (Max Fee for Primary Prov.) Columns three through five list the average non-HPSA payment to physicians, NP and NM respectively. The last three columns list the average HPSA payment to primary care providers who had practices in or treated recipients from health personnel shortage areas. Reimbursement for HPSA services is 20% above the standard maximum allowable fee for eligible pediatric codes, recipients and providers.

In general, average payments for covered services cannot be higher than the amount billed by the provider or the Medicaid maximum allowable fee for the service, whichever is lower, except for HPSA and other bonus payments (PD modifier, HealthCheck, etc.) In FY 1996, only payments for preventive codes 99381 - 99384 and 99391 - 99394 exceeded the maximum allowable fee for those codes. That is because these codes are also used for HealthCheck screens, which are reimbursed at a much higher rate than ordinary preventive screens. Reimbursement for all other pediatric procedure codes was equal to or less than the current Medicaid maximum allowable fee.

Vaccine for Children (VFC) Program

The 1991-93 Biennial Budget enabled the Wisconsin Department of Health and Family Services to enter into a Vaccine Volume Purchase (VVP) Program with the Centers for Disease Control in order to increase the efficiency and number of immunizations given to Medicaid recipients. The VVP was changed to the federal Vaccine for Children (VFC) program in October 1994. Since we had VVP already in place, implementation of VFC was seamless.

Under VFC, physicians are provided vaccines free of charge and are reimbursed by the Medicaid program for the administration of each vaccine, at a rate of $3.00 per vaccine ($3.06 for primary care providers.) In addition, they may bill Wisconsin Medicaid for the office visit or other services provided during the patient encounter.

EPSDT/HealthCheck

HealthCheck activities focused on training HMOs on the requirements for HealthCheck screening and outreach and on assisting HMOs in setting up systems for screening, outreach and case management. Wisconsin Medicaid also focuses on simplifying billing, training other non-HMO primary care providers, and increasing the number of comprehensive screens billed to Medicaid.

Cooperation between the screening providers and HealthCheck outreach/case management agencies is important to the success of the program. This linkage has been stressed in all provider training and in contacts with individual providers.

As of July 1, 1994, home inspections by a qualified person and follow-up education are now covered as "HealthCheck other services" for children with lead poisoning.

Effective February 15, 1995, Wisconsin Medicaid adopted Common Procedural Terminology (CPT) codes instead of state-developed codes for billing HealthCheck comprehensive screens. CPT codes are used by most providers to bill Medicaid and other insurance companies. The State Medical Society, Wisconsin Chapters of American Academy of Pediatrics, the American Academy of Family Physicians, and the Wisconsin Medical Group Management Association reviewed this new system.

In November 1995, Wisconsin Medicaid granted waivers under Wisconsin Administrative Code HSS 106.13 (discretionary waivers and variances) to permit two organizations to be specially certified as HealthCheck outreach/case managers. These organizations, while not medically based, have strong community ties in Milwaukee's African-American and Latino communities and can be particularly effective in reaching this traditionally underserved population. As part of managed care expansion, Wisconsin Medicaid encourages HMOs to contract with both medically and non-medically oriented organizations for purposes of outreach.

Managed care expansion is expected to greatly increase the number of children receiving comprehensive screen. This has been demonstrated in counties in which managed care already exists. Additionally, DHFS' contracts with Medicaid HMOs require them to meet an 80% screening rate standard, and impose penalties if they do not.

II. Obstetric Standards

A. Provider Participation

1. Number Participating

For purposes of the obstetric standards section of this submission, participation by a provider in the Wisconsin Medicaid Program is defined as (1) having been certified by the Medicaid program as a physician (MD or DO), nurse practitioner, or nurse midwife and (2) having filed one or more claims for HCFA-designated obstetrical services to Medicaid recipients during the period from July 1, 1995 through June 30, 1996.

The number of Wisconsin primary care physicians who participate in the Wisconsin Medicaid Program exceeds 50% of the total number of primary care physicians practicing in all of the twelve health care regions (Appendix 3-OB). (Note: Appendix 3-OB includes only data from fee-for-service providers.)

Of the estimated 1,152 primary care providers offering obstetrical practices to the general public in Wisconsin, 1,120 or 97% provided fee-for-service obstetric services to Medicaid recipients in FY 96.

2. How Data was Compiled on Physicians Available to Provide Obstetric Care to Wisconsin Residents.

To estimate the number of primary care physicians available to provide obstetrical services to Wisconsin residents, data were used from the Wisconsin Office of Health Care Information (OHCI) and the Medicaid fee-for-service program. This resulted in the creation of two databases. Both databases were aggregated by county and region.

The first database was derived from a 1996 collaborative effort between OHCI and the Wisconsin Department of Regulation and Licensing. This effort surveyed physicians licensed and practicing in Wisconsin in order to identify actively practicing primary care providers.

From this survey, OHCI identified each physician's county and region, based on the primary practice location of physicians who identified themselves as having a specialty in pediatrics, family practice, general practice, or obstetrics.

The second database was composed of actual Medicaid fee-for-service claims data. In this database, practice location was identified based on the first claim identified for each Medicaid certified provider. Similarly, provider specialty was based on the Medicaid reference file created from the certification information.

Appendix 3-OB lists the total number of primary care physicians, by region, providing obstetric services to the general public and to Medicaid recipients. The number of providers serving Medicaid recipients is derived from Medicaid fee-for-service claims data. The number of providers serving the general public comes from the OHCI database.

3. How Medicaid Participation was Derived

The Department analyzed fee-for-service Medicaid claims for HCFA-designated obstetric procedures (detailed in Appendix 4-OB) performed between 7/1/95 and 6/30/96 by all Medicaid-

certified obstetricians, family practice physicians, general practice physicians, nurse midwives and nurse practitioners. Providers who were reimbursed for these services were counted as participating in the Wisconsin Medicaid Program. Each provider was counted only once in each county, based on the first reported claim identified for this purpose. Identification of specialty was based on the reference table created from certification information. This methodology differs from that used by the OHCI to identify the number of physicians practicing in each county -- OHCI used a survey to identify specialty and primary practice site.

4. Explanation of Regional Data

Appendix 3-OB lists the total number of primary care providers, by region providing obstetric services to the general public and to fee-for-service Medicaid recipients. Medicaid HMOs do collect data in a manner that can be incorporated in this analysis. The number of providers serving Medicaid recipients is derived from Medicaid claims data covering the period July 1, 1995 through June 30, 1996. The number of providers serving the general public comes from the OHCI database.

Contiguous counties are grouped into 12 geographic regions, each of which is centered around one or more regional health centers and encompasses the distances health care consumers regularly travel in Wisconsin to receive medical care.

Two counties--Milwaukee and Menominee--are listed separately. Milwaukee is listed separately because of its size and importance. Menominee County is listed separately because of the uniqueness of its health care delivery systems. Menominee County is entirely contained within the Menominee Indian Reservation.

Milwaukee County is the state's largest county. Milwaukee County has the largest number of Medicaid recipients who are also recipients of Aid to Families with Dependent Children (AFDC) or are enrolled in Medicaid through Healthy Start. Most Milwaukee County AFDC and Healthy Start recipients have mandatory HMO coverage.

Menominee County is considered individually because the county is entirely contained within the Menominee Indian Reservation. Health services delivered at the Indian Health Service subsidized Tribal Health Center are not entirely reflected in Medicaid fee-for-service claims data.

See pages 7 and 8 for an analysis of nurse practitioner and nurse midwife data.

B. Payment Rates

1995-97 Biennial Budget

Fee-for-service physicians and other primary care providers were reimbursed at FY 1994 rates for obstetric services during FY 1996. Rates for physician assistants and nurse midwives remained at 90% of the physician maximum allowable fees, although physician assistants receive the same reimbursement as physicians for injections, immunizations, lab handling fees and HealthCheck screens. Nurse practitioners in Wisconsin still receive 100% of the physician maximum allowable fee. In FY 1996, Wisconsin Medicaid permitted reimbursement for the new obstetrical procedure codes 59610 - 59622 (delivery following previous cesarean section) at the same maximum allowable fees as other vaginal and cesarean deliveries. These codes also qualify for incentive payments under the Health Professional Shortage Area program described below. Per federal directive, data for these new procedure codes is not included in Appendix 4-OB.

The Health Personnel Shortage Area (HPSA) incentive program remains in place making incentive payments available to physician assistants, nurse practitioners, nurse midwives, and physicians with a specialty of emergency medicine, in addition to physicians with specialties of general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics. The HPSA incentive payments apply to primary care services including evaluation and management visits (office, emergency department, and preventive medicine procedures), immunizations, and selected obstetric procedures.

The HPSA incentive payment for Medicaid-certified obstetric service providers remains at 50% above the primary care maximum allowable fees paid to other primary care physicians for affected codes.

Fifty-nine areas of the state have received HPSA designation and are eligible for HPSA bonuses.

Maximum Allowable Fees/Average Payments

Appendix 4-OB lists the current maximum allowable rates of reimbursement anticipated to be in effect as of July 1, 1997, for fee-for-service obstetric services and the average payment to physicians, nurse practitioners and nurse midwives during FY 1996.

It does not reflect any possible rate increases that may occur if the Governor's current budget request is approved by the Legislature. Column 1 lists the maternity CPT-4 codes and a description of each code. Maximum fees for obstetrical services provided by primary care providers (that are "non-HPSA") are listed in the second column (Max Fee for Primary Prov.) Columns three through five list the average non-HPSA payment to physicians, nurse practitioner and nurse midwife respectively. The last three columns list the average HPSA payment to primary care providers who had practices in or treated recipients from health personnel shortage areas. Reimbursement for HPSA services is 50% above the standard maximum allowable fee for eligible obstetric codes, recipients and providers. Nurse Midwives receive 90% of the primary care provider rate and bill only for total obstetric care (procedure code 59400) or vaginal delivery with postpartum care (procedure code 59410).

As a rule, average payments for covered services cannot be higher than the amount billed by the provider or the Medicaid maximum allowable fee for the service, whichever is lower, except for HPSA and other bonus payments (PD modifier, HealthCheck, etc.). As demonstrated in Appendix 4-OB, no payments exceed the maximum allowable fee (effective July 1, 1997) for affected obstetric service procedure codes, except for those paid with a HPSA bonus.

III. Other Wisconsin Initiatives

Wisconsin has demonstrated its commitment to ensuring equal access to medical care for women and children who are Medicaid recipients. Ongoing initiatives include:

A. Prenatal Care Coordination

Wisconsin Act 39 (the 1991-93 Biennial Budget) provided $3.4 million (all funds) annually to create a new Medicaid benefit, care coordination for high-risk pregnant women, which became effective January 1, 1993. Care coordination agencies have as a primary task assisting pregnant recipients to access regular prenatal care and follow their physician's instructions. Prenatal care coordination services were delivered to more than 5,100 recipients in FY 1994, 8,600 in FY 1995 and 9,413 in FY 1996.

Prenatal care coordination improves high-risk recipients' access to prenatal care, and as a result, improves birth outcomes for these recipients. The Medicaid program works closely with other state agencies, local public health agencies, community-based organizations, health care providers, tribal agencies and the Wisconsin State Medical Society to ensure that women are identified early and informed about the availability of the service.

The program has gained acceptance from physicians and other obstetric providers. As of January 1, 1997 there are 151 (up from 144 last year) Medicaid-certified prenatal care coordination service providers. Almost 96 percent of Wisconsin's 72 counties have at least one Medicaid-certified prenatal care coordination provider and all of Wisconsin's tribal agencies have obtained Medicaid certification to provide the benefit.

1995 Wisconsin Act 303 added $2.8 million to the Medicaid budget to provide case management services to Milwaukee County children at risk for poor health outcomes. Among the goals of the benefit are higher immunization rates, more routine health screens, and fewer referrals to child protective services.

The goal of this 1995 legislative enhancement to prenatal care coordination is to reach as many families as possible. To date, 282 families have received this enhanced child coordination benefit.

B. Annual Report to the Joint Committee on Finance on Access to Care and Reimbursement Rates of Obstetrical and Pediatric Services.

Section 101 of Wisconsin Act 336 (the 1990 Wisconsin Annual Agency Budget Adjustment Act) created Section 49.45(2)(a)21 of the statutes which requires the Medicaid program to "submit a report by October 1, 1990 and annually thereafter on access to obstetric and pediatric services under the medical assistance program, including the effect of medical assistance reimbursement rates." The Joint Committee on Finance is the bipartisan committee, made up of members of both houses, which reviews all appropriations and taxation measures before the legislature. The seventh annual report will be submitted to the Joint Committee on October 1, 1997.

C. Primary Care Expansion by FQHCs

The 100% cost-based reimbursement to twenty-four (24) Federally Qualified Health Centers (FQHCs) in Wisconsin, five (5) of which are located in the city of Milwaukee has helped to support the expansion of primary care services to a pediatric and obstetric population. In addition, seven tribal FQHCs have sought Medicaid reimbursement and two others will seek reimbursement in the next fiscal year. These centers have used these funds to hire primary care providers who will provide pediatric or obstetric services, or both. In addition, funds have been used to add new exam rooms at most sites to accommodate the increase in patients served.

D. Rural Health Clinics

Rural Health Clinic (RHC) certification, like FQHC designation, is intended to increase the availability and accessibility of primary care services for residents of underserved communities. It provides cost-based reimbursement to certain providers in underserved rural areas. This certification supports the use of non-physician providers and may help primary care clinics operate in communities where they might not otherwise be financially viable.

As of January 1997, Wisconsin had forty eight (48) rural health clinic sites, up from thirty-six (36) in the previous year. The number of rural health clinics has more than tripled over the past three years, as providers seek more viable ways to sustain services in underserved rural communities.

E. Targeted Case Management

Targeted case management is Wisconsin Medicaid's program for helping recipients gain access to needed medical, social, vocational and rehabilitative services. The 1995-97 biennial budget allowed expanded target populations, with special emphasis on services to children. These programs became operational in January 1996. New populations include: children at risk of physical, mental or emotional dysfunction; children with asthma; and children in the Birth to Three program, which focuses on children with physical disabilities. Previously, targeted case management was aimed only at children with developmental disabilities.

F. Presumptive Eligibility

The Presumptive Eligibility (PE) Program has operated in Wisconsin since 1987. This program entitles pregnant women to Medicaid-covered ambulatory prenatal care services, including prenatal care coordination and dental services. Presumptive eligibility enables women to obtain early prenatal care prior to a formal determination of eligibility for Medicaid.

The period of presumptive eligibility begins the day on which a provider medically verifies the pregnancy and determines, based on preliminary income information, that a woman's family income does not exceed 185% of the poverty level. The presumptively eligible woman must receive a formal determination of eligibility by the end of the month following the month in which PE was allowed.

Approximately 500 women per year receive PE; more than 90% of whom ultimately become formally eligible. Wisconsin spends about $900,000 annually on this PE benefit.

G. High Cost Case Management

High Cost Case Management (HCCM) is a new program that will provide case management services to pediatric and adult Medicaid recipients with high-cost chronic conditions (i.e., annual medical expense greater than $25,000). This includes children and adults who are ventilator-dependent or have other high-cost medical conditions.

HCCM's objectives are to improve the quality of care provided to this population and save tax dollars through improved case management. As the Department moves toward revision of the state's long term care services programs, these case management efforts will offer an opportunity to learn more about the needs of this high-cost population.

Assurance of HMO Obstetrical and Pediatric Services - Contract Activities

The Department assures that the Wisconsin Medical Assistance Program's 1903(m) (HMO) contract rate-setting activities are consistent with and substantiated by the data submitted in the State Plan Amendments concerning these services. The assurances are based on funding allocated in 1990 Wisconsin Acts 336 and 351, 1991 Acts 39 and 269, and 1993 Act 16.

I. Fee for Service Reimbursement for Pediatric and Obstetric Services

As described above, the Department establishes maximum reimbursement rates for pediatric practitioner and obstetrical practitioner services to assure that these services are available to Medicaid recipients at least to the extent that such services are available to the general population in the geographic area.

A. Pediatric Practitioner Services

Listed in Appendix 4-PED are the Medicaid program maximum fee-for-service reimbursement rates for pediatric services provided by physicians to children 18 years-of-age and under which were effective for dates of service on and after July 1, 1997. It does not include any possible rate increases that may occur if the Governor's current budget request or other legislation is approved by the Legislature. Maximum reimbursement rates for the same services performed by certified nurse practitioners are the same as for physicians.

B. Obstetrical Practitioner Services

Listed in Appendix 4-OB are the maximum fee-for-service reimbursement rates for obstetrical services provided by physicians effective for dates of service on and after July 1, 1997.

Reimbursement for certified nurse midwives is made as a percentage of the supervising physician's payment. Specifically, payment is made at the lesser of the usual and customary charge or 90% of the physician's maximum allowable fee for that procedure.

Maximum reimbursement rates for obstetrical services performed by certified nurse practitioners are the same as for physicians.

II. HMO Reimbursement Rates for Obstetrical and Pediatric Services

A. Introduction

As of January 1997, 163,078 Medicaid recipients were enrolled in HMOs in 40 counties across the state.

This is a result of the 1995-97 biennial budget, which mandates statewide expansion of managed care for AFDC recipients in areas where HMOs indicate a willingness and ability to provide services. Wisconsin anticipates that, based on responses from interested HMOs, that more than 230,000 recipients in all but a few northern counties in Wisconsin will be covered by managed care contracts by the end of the biennium.

Expansion is being implemented in three stages, starting with Southeastern Wisconsin and moving north and west. In designing managed care expansion, the Department required HMOs to demonstrate 20-mile service access to primary care services. Recipients outside the 20-mile access area will not be mandatorily enrolled in HMOs.

Recipients in the Medicaid HMO program have a choice of HMOs. In order for a county to be considered mandatory for HMO enrollment, two or more HMOs must participate. Once recipients have chosen an HMO, they have a choice of primary care physicians (PCP) within the HMO.

Comparison studies indicate that HMO recipients are more likely to receive required immunizations, well-child visits, and pap smears and have lower C-Section rates than their fee-for-service counterparts. Therefore, Medicaid managed care not only saves money; it also improves access to primary care services.

Wisconsin is undertaking a major quality assurance effort to better measure and improve service provided to recipients enrolled in HMOs. These efforts include: the establishment of measurable goals and objectives to be included in HMO contracts; data collection and analysis; routine and regular audits of HMOs and providers; and provider/recipient satisfaction surveys. In addition, Wisconsin routinely measures and publishes utilization data comparing managed care to fee-for-service for a number of selected services, such as immunizations, births, routine HealthCheck screens and hospitalizations for preventable diseases.

The calendar year 1996 maximum capitation rate (per person per month) for Milwaukee County HMOs: $120.19; for Dane County HMOs: $104.11; for Eau Claire County HMOs: $103.76; and for Waukesha County HMOs, $117.03. Capitation rates are based on Medicaid fee-for-service payments which were made in the HMO counties prior to the Medicaid HMO Initiative (1984). Total annual payments per county are divided by total eligible months for the county. Capitation rates for 1996 were increased by 2.2% over 1995 levels.

Attachment A describes the methodology for establishing capitation rates and lists those rates for AFDC/Healthy Start children and Healthy Start pregnant women through calendar year 1997.

B. Capitation Rate Adjustments

In CY 91 obstetric services provided by physicians (not including inpatient or outpatient hospital services) equal an average rate of $5.45 per person per month in the HMO counties or approximately 5% of the total HMO rate. Pediatric services provided by physicians (not including inpatient or outpatient hospital services) make up approximately 3.6% of the total rate or $3.92 per person per month. These estimates were based on the average amount of obstetrical and pediatric fee-for-service payments made in 1984, inflated forward to 1991 levels and discounted by 7.48 - 8.22%, and on the funding increases provided to the HMOs on January 1, 1991 and July 1, 1990.

Adjustments to the HMO capitation rate have been made for the years since 1991 to parallel the changes made in the fee-for-service program. In 1992, we added $.96 for obstetric services and $1.47 for pediatric services. The increases in 1993 included $.93 for obstetrics, $1.47 for pediatrics as well as $.22 for HPSA bonus payments (10% for primary care services provided in HPSAs or to recipients who reside in HPSAs). The 1994 capitation rates were increased $.71 for the 2% increase to all primary care providers as well as $1.27 for additional HPSA bonus payments.

Adjustments to the 1995, 1996 and 1997 rates are summarized in the table below. The adjustments include those made for primary care, HPSA bonuses, pediatric dental, vaccine administration and physician assistants/nurse midwives. Pediatric dental and HPSA adjustments were made in each of these three years. The other adjustments were made only in 1995.

HMO Capitation Adjustments
1995-1997

Year	2% Primary Care	HPSA Bonus	Pediatric Dental	Vaccine Administration	Physician Assistant/Nurse Midwives
1995	$0.91	$2.60	$0.21	$0.03	$0.01
1996		$2.06	$0.79		
1997		$2.06	$0.79		

ATTACHMENT A

METHODOLOGY FOR ESTABLISHING HMO CAPITATION RATES

The Wisconsin Medicaid HMO program was operational in five urban counties prior to statewide expansion. The pre-expansion HMO counties include Dane, Eau Claire, Kenosha, Milwaukee and Waukesha Counties. Capitation rates in the HMO counties are county-specific and based on a comparison of pre and post-HMO fee-for-service (FFS) payments for the HMO counties.

Since actual FFS cost data for HMO eligibles do not exist in current HMO counties, the Medicaid program collects FFS cost and eligible month data from eight control counties. (The control counties were selected by our contracted actuary, Milliman and Robertson, Inc.) An average per member per month cost (or composite FFS equivalent) is calculated for the control counties and inflated from the cost year to the rate year. (CY 1995 cost data were used to calculate the FFS equivalent for CY 1997.) The FFS equivalent is also adjusted for budgeted program initiatives which are not reflected in the cost data. The resulting FFS equivalent is then compared to the FFS equivalents from the last year actual FFS data was available in the HMO counties.

This method, which was developed by Milliman and Robertson, assumes that HMO counties would have experienced the same rate of growth in FFS costs as the eight control counties. Milliman and Robertson also calculate the inflation adjustment factor based on an analysis of actual Medicaid expenditures over the past several years. Based on the resulting 1997 FFS equivalent, a decision was made to maintain CY 1997 capitation rates at the 1996 levels for each HMO county.

The same rate-setting method was used to calculate the FFS equivalents for the HMO expansion areas with one exception - the rates are not county-specific. The HMO expansion area was divided into nine rate regions. A composite FFS equivalent was developed for each of the nine rate regions, adjusted for inflation and relevant program initiatives and discounted accordingly. However, the resulting rates revealed severe disparities and variances between rate regions.

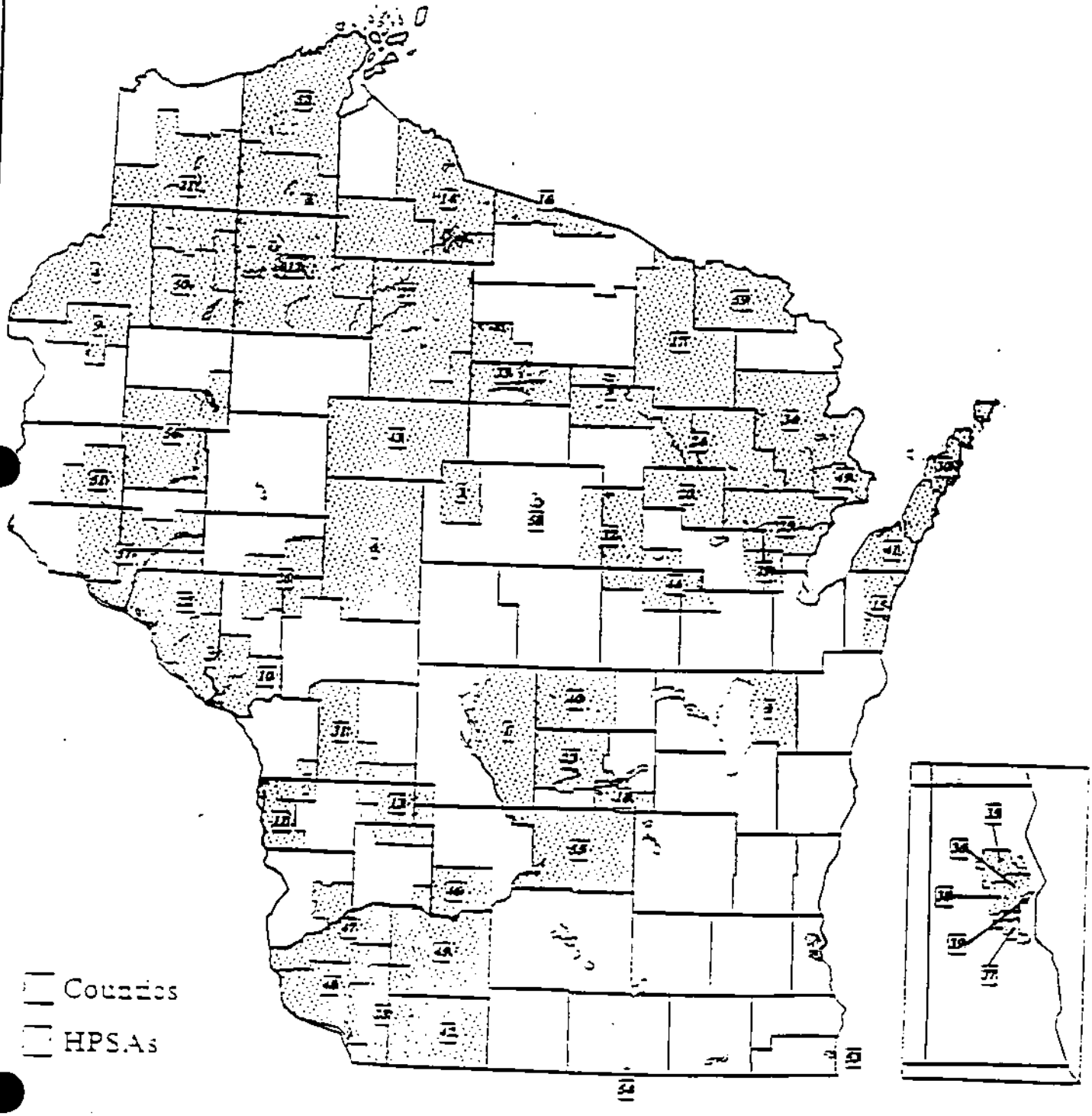
Recognizing that an across-the-board discount to the regional FFS equivalent would have continued historical inequities existing in the rural areas of the state, a final adjustment to the FFS equivalent was necessary. The discounted composite FFS equivalents were adjusted by raising regional capitation rates up to the discounted median rate of all counties and rate regions. This adjustment was applied to both AFDC/Healthy Start Children and Healthy Start Pregnant Women rates. Regions with capitation rates below the median for all counties and regions were brought up to the median rate. Other regions with capitation rates above the median were not affected by this adjustment. In total, seven rate regions had their respective rates adjusted to the median.

A summary of county and regional capitation rates in effect through December 31, 1997 is attached.

HMO Capitation Rates Through December 31, 1997
Assumes Dental and Chiropractic Furnished by HMO

HMO County/ Rate Region	AFDC/HS Children	HS Pregnant Women
Dane	$106.42	$478.13
Eau Claire	$106.06	$544.49
Kenosha	$114.03	$494.29
Milwaukee	$122.86	$534.87
Waukesha	$119.63	$456.07
Region 1	$105.49	$443.23
Region 2	$102.85	$443.23
Region 3	$102.85	$443.23
Region 4	$102.85	$443.23
Region 5	$102.85	$453.05
Region 6	$103.72	$443.23
Region 7	$102.85	$443.23
Region 8	$102.85	$457.10
Region 9	$102.85	$443.23

Wisconsin
Health Professional Shortage Areas
January 1996



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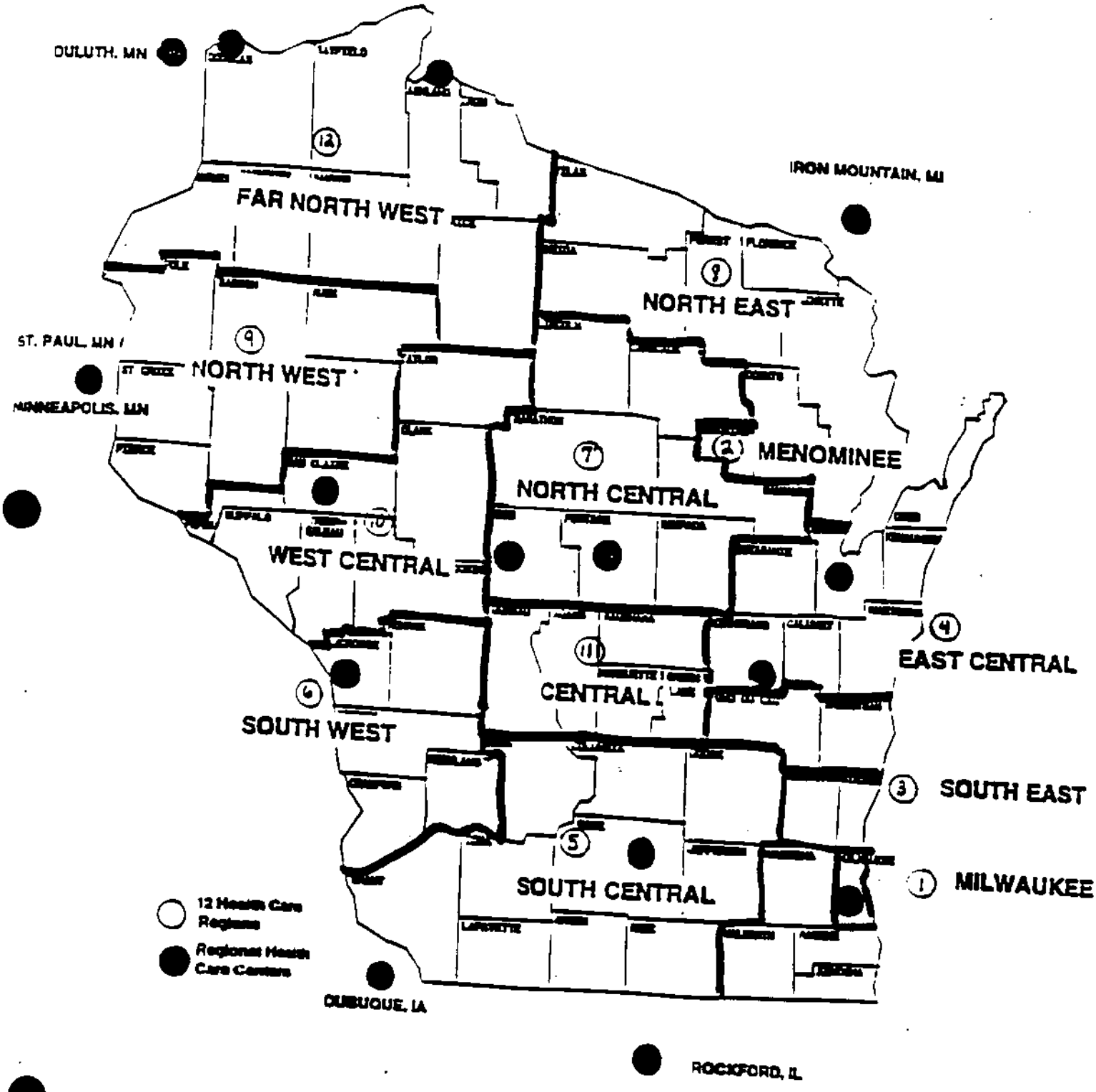
APPENDIX C

WISCONSIN HEALTH CARE REGIONS



Appendix 3-OB. Wisconsin Medicaid Program:

Number and Percent of Providers Performing Obstetric Services by Region, July 1, 1995 - June 30, 1996

REGION NUMBER AND NAME	Primary Care Providers* Serving General Public	Primary Care Providers* Serving Medicaid Recipients	Percent Serving Medicaid Recipients
1. MILWAUKEE	222	199	89.6
2. MENOMINEE	6	6	100.0
3. SOUTH EAST	191	186	97.4
4. EAST CENTRAL	120	119	99.2
5. SOUTH CENTRAL	232	230	99.1
6. SOUTH WEST	63	63	100.0
7. NORTH CENTRAL	88	88	100.0
8. NORTH EAST	17	17	100.0
9. NORTH WEST	101	101	100.0
10. WEST CENTRAL	46	46	100.0
11. CENTRAL	22	22	100.0
12. FAR NORTH WEST	44	43	97.7
STATE TOTAL	1,152	1,120	97.2

* Primary Care Providers include Family Practice, General Practice, OB/GYN and Pediatrics.

Data are not available for Nurse Practitioners and Nurse Midwives.

Appendix 3-PED. Wisconsin Medicaid Program:

Number and Percent of Providers Performing Pediatric Services by Region, July 1, 1995 - June 30, 1996

REGION NUMBER AND NAME	Primary Care Providers* Serving General Public	Primary Care Providers* Serving Medicaid Recipients	Percent Serving Medicaid Recipients
1. MILWAUKEE	489	447	91.4
2. MENOMINEE	6	6	100.0
3. SOUTH EAST	380	361	95.0
4. EAST CENTRAL	242	237	97.9
5. SOUTH CENTRAL	473	468	98.9
6. SOUTH WEST	115	112	97.4
7. NORTH CENTRAL	171	170	99.4
8. NORTH EAST	53	52	98.1
9. NORTH WEST	127	127	100.0
10. WEST CENTRAL	94	91	96.8
11. CENTRAL	33	33	100.0
12. FAR NORTH WEST	64	61	95.3
STATE TOTAL	2,247	2,165	96.4

* Primary Care Providers include Family Practice, General Practice, OB/GYN and Pediatrics. Data are not available for Nurse Practitioners and Nurse Midwives.

Appendix 4-OB. Wisconsin Medical Assistance Program:

Maximum Fees and Average Payments for Obstetric Services for Selected Provider Categories, July 1, 1995 - June 30, 1996.

PROCEDURE CODE AND DESCRIPTION	MAX FEE FOR PRIMARY PROVIDER 7/1/97	AVERAGE PAYMENT FOR OBSTETRIC SERVICES					
		Non-HPSA			HPSA (HP, HK) **		
		PHYSICIANS	NURSE PRACTITIONERS	NURSE MIDWIVES	PHYSICIANS	NURSE PRACTITIONERS	NURSE MIDWIVES
Delivery, Antepartum and Postpartum Care							
59400 Routine obstetric care (all-inclusive)	$963 23	$960.92	$963 23	$849 90	$1,408.33	$1,444 52	$1,274 85
59409 Vaginal delivery only	570 43	566.27	--	513.39	824 58	--	--
59410 including postpartum care	614 60	611.53	614.60	542.30	903 83	904 00	813 45
59412 External cephalic version, with or w/o tocolysis	135 41	134 54	--	--	185.10	--	--
59414 Delivery of placenta	358.80	280.67	--	--	329 00	--	--
59425 Antepartum care only; 4-6 visits	197.01	176.17	191.25	67.89	268.94	288 88	265 97
59426 7 or more visits		277.11	145.32	47.94	457.98	447.64	419 21
59430 Postpartum care only (separate procedure)	44.19	39.21	44.19	39.76	54.52	51.07	--
Cesarean Delivery							
59510 Routine obstetrical care (all-inclusive)	1,262 40	1,136 88	--	--	1,772 31	--	--
59514 Cesarean delivery only	753 25	313 61	--	--	748 91	--	--
59515 including postpartum care	753 25	523.54	--	--	931 39	--	--
59525 Subtotal or total hysterectomy after cesarean delivery	852.94	451.22	--	--	--	--	--

** HP = HPSA bonus for adults
HK = HPSA bonus for children 18 years or younger

Appendix 4-PED. Wisconsin Medical Assistance Program:

Maximum Fees and Average Payments for Pediatric Services for Selected Provider Categories, July 1, 1995 - June 30, 1996

PROCEDURE CODE AND DESCRIPTION	MAX FEE FOR PED MODIFIER 7/1/97	AVERAGE PAYMENT FOR PEDIATRIC SERVICES			
		Non-HPSA		HPSA (HK*)	
		PHYSICIANS	NURSE PRACTITIONERS	PHYSICIANS	NURSE PRACTITIONERS
EVALUATION AND MANAGEMENT					
Office or Other Outpatient Services					
New Patient					
99201 Physicians typically spend 10 minutes, minor problem	$25.80	$22 33	$20 82	$30 73	$30.93
99202 Physicians typically spend 20 minutes, low to moderate severity	29 85	26 53	23.70	35.70	34.70
99203 Physicians typically spend 30 minutes, moderate severity	36 86	30 41	25.61	44.10	44 20
99204 Physicians typically spend 45 minutes, moderate to high severity	51.82	41.09	35 45	72.59	--
99205 Physicians typically spend 60 minutes, moderate to high severity	56.29	49 87	33 33	87.31	--
Established Patient					
99211 Typically 5 minutes are spent supervising or performing these services	11.60	11.00	10.76	13 79	13 83
99212 Physicians typically spend 10 minutes, minor problem	21.11	20 51	20.18	25.10	25 18
99213 Physicians typically spend 15 minutes, low to moderate severity	28 90	28 06	29 99	41.94	39 81
99214 Physicians typically spend 25 minutes, moderate to high severity	44.26	41 06	38 94	52 56	52 06
99215 Physicians typically spend 40 minutes, moderate to high severity	57.86	57.94	41.04	71.33	--
Preventive Medicine Services**					
New Patient					
99381 Initial eval. and mgmt , Infant (age under 1 year)	27.81	40 54	49.50	33.30	33 37
99382 Initial eval. and mgmt , Early childhood (age 1 through 4 years)	29 87	44 69	51.60	35 55	35 84
99383 Initial eval and mgmt , Late childhood (age 5 through 11 years)	31.97	45 37	51.73	38.36	38 36
99384 Initial eval. and mgmt , Adolescent (age 12 through 17 years)	35 89	45 31	50 40	42 68	43 07
Established Patient					
99391 Periodic reeval and mgmt , Infant (age under 1 year)	22.87	39 59	34.51	27.27	26 89
99392 Periodic reeval. and mgmt , Early childhood (age 1 through 4 years)	24.84	42 42	34 94	28 67	28 53
99393 Periodic reeval. and mgmt , Late childhood (age 5 through 11 years)	26.16	44.10	36.58	31.24	31.20
99394 Periodic reeval. and mgmt., Adolescent (age 12 through 17 years)	27.76	43 85	35.84	33.10	31.79

* HK = HPSA bonus for children 18 years or younger

** Preventive Medicine Codes include HealthCheck screens which are reimbursed at a level greater than the maximum allowable fee for the procedure code.

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PROCEDURE CODE AND DESCRIPTION	MAX FEE FOR PED MODIFIER 7/1/97	AVERAGE PAYMENT FOR PEDIATRIC SERVICES			
		Non-HPSA		HPSA (HK*)	
		PHYSICIANS	NURSE PRACTITIONERS	PHYSICIANS	NURSE PRACTITIONERS
MEDICINE					
Immunization Injections***					
90701 Diphtheria, tetanus toxoids and pertussis (DTP) vaccine	3 06	3 05	3 06	3 61	3 67
90707 Measles, mumps and rubella virus vaccine	3 06	3 05	3 04	3 60	3 56
90712 Poliovirus vaccine, live, oral	3 06	3.04	3 05	3 61	3 59
90737 Hemophilus influenza B	3 06	3 05	3.06	3.59	3 67
90744 Hepatitis B vaccine, newborn to 11 years	3 00	--	--	--	--
90745 Hepatitis B vaccine, 11 - 19 years	3 00	--	--	--	--

* HK = HPSA bonus for children 18 years or younger

*** Administration fee only

Maximum Allowable Fee for Selected Procedures
Effective for July 1, 1997

Procedure Code	Description	Primary Care Maximum Allowable Fee
MATERNITY, GYNECOLOGICAL AND ABORTION SERVICES		
Antepartum Services		
59000	Amniocentesis, any method	$50.55
59012	Cordocentesis (intrauterine), any method	546.63
59015	Chorionic villus sampling, any method	200.99
59020	Fetal contraction stress test	61.00
59025	Fetal non-stress test	51.14
59030	Fetal scalp blood sampling	82.01
59050	Fetal monitoring during labor by consulting physician, with written report (separate procedure); supervision and interpretation	76.58
59051	Fetal monitoring during labor by consulting physician, with written report (separate procedure); interpretation only	53.75
Excision		
59100	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)	614.04
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	618.91
59121	Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy	618.91
59130	Surgical treatment of ectopic pregnancy; abdominal pregnancy	694.71
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	833.66
59136	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus	694.41
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation	manual pricing
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	551.98

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59151	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy	$551.98
59160	Laparoscopic treatment of ectopic pregnancy; curettage, postpartum (separate procedure)	208.42
Introduction		
59200	Insertion of cervical dilator	79.49
Repair		
59300	Episiotomy or vaginal repair, by other than attending physician	219.33
59320	Cerclage of cervix, during pregnancy, vaginal	276.00
59325	Cerclage of cervix, during pregnancy, abdominal	manual pricing
59350	Hysterorrhaphy of ruptured uterus	555.76
Abortion		
59812	Treatment of incomplete abortion, any trimester, completed surgically	308.54
59820	Treatment of missed abortion, completed surgically, first trimester	299.78
59821	Treatment of missed abortion, completed surgically, second trimester	393.26
59830	Treatment of septic abortion, completed surgically	390.14
59840	Induced abortion, by dilation and curettage	321.26
59841	Induced abortion, by one or more intra-amniotic injections	321.26
59851	Induced abortion, by one or more intra-amniotic injections, with dilation and curettage and/or evacuation	321.26
59852	Induced abortion, by one or more intra-amniotic injections, with hysterotomy (failed intra-amniotic injection)	321.26
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria)	311.87
59856	Induced abortion, by one or more vaginal suppositories, with dilation and curettage and/or evacuation	502.33
59857	Induced abortion, by one or more vaginal suppositories, with hysterotomy (failed medical evacuation)	610.89
59870	Uterine evacuation and curettage for hydatidiform mole	331.19
58999	Unlisted procedure, maternity care and delivery	manual pricing

PEDIATRIC PRACTITIONER SERVICES		
Office Visits - Consultations (New or Established Patient)		
99241	15 Minutes	$43.86
99242	30 Minutes	53.59
99243	40 Minutes	73.11
99244	60 Minutes	91.37
99245	80 Minutes	92.29
Office Visits - Confirmatory Consultations (New or Established Patient)		
99271	Problem self-limited or minor	28.16
99272	Problem of low severity	32.00
99273	Problem of moderate severity	43.65
99274	Problem of moderate to high severity	47.95
99275	Problem of moderate to high severity	54.55
Home Services - New Patient		
99341	Problem of low severity	21.74
99342	Problem of moderate severity	31.08
99343	Problem of high severity	43.50
Home Services - Established Patient		
99351	Patient is stable, recovering or improving	18.64
99352	Patient is responding inadequately to therapy or has minor complication	24.86
99353	Patient is unstable or has significant complication or significant new problem.	36.54
Prolonged Services with Direct Face to Face Patient Contact		
99354	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	manual pricing
99355	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service, each additional 30 minutes	manual pricing

Prolonged Services without Direct Face to Face Patient Contact		
99358	Prolonged evaluation and managed service before and/or after direct patient care; first hour	not covered
99359	Prolonged evaluation and managed service before and/or after direct patient care. each additional 30 minutes	not covered
Counseling and/or Risk Factor Reduction Intervention		
99401	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes	not covered
99402	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 30 minutes	not covered
99403	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 45 minutes	not covered
99404	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 60 minutes	not covered
99411	Group Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting , approximately 30 minutes	not covered
99412	Group Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting , approximately 60 minutes	not covered
99420	Interpretation of health risk assessment instrument (e.g., health hazard appraisal)	not covered
99429	Unlisted preventive medicine service	manual pricing
99432	Newborn Care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	$71.41
Immunizations		
90700	DtaP vaccine	3.06
90702	DTP vaccine	3.06
90703	Tetanus toxoid vaccine	4.09
90704	Mumps virus vaccine, live	21.70
90705	Measles virus vaccine, live	18.60
90706	Rubella virus vaccine, live	19.76
90708	Measles and rubella virus vaccine, live	25.55
90709	Rubella and mumps virus, live	28.37

90710	Measles, mumps, rubella and varicella vaccine	manual pricing
90711	DTP and injectable poliomyelitis vaccine	manual pricing
90713	Poliomyelitis vaccine	$3.06
90714	Typhoid vaccine	3.30
90716	Varicella (chicken pox) vaccine	3.00
90717	Yellow Fever vaccine	13.81
90719	Diphtheria toxoid vaccine	7.73
90720	DTP and Hemophilus influenza B (HIB) vaccine	3.06
90721	DTaP and HIB vaccine	manual pricing
90724	Influenza virus vaccine	7.19
90725	Cholera vaccine	4.64
90726	Rabies vaccine	85.00
90727	Plague vaccine	36.65
90728	BCG vaccine	28.70
90730	Hepatitis A vaccine	54.21
90732	Pneumococcal vaccine, polyvalent	14.08
90733	Meningococcal polysaccharide vaccine (any group(s))	8.83
90741	ISG, human	7.40
90742	Specific hyper immune serum globulin (e.g., hepatitis B, measles, rabies, Rho (D), etc.)	55.20
90749	Unlisted immunization	manual pricing