STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 9, 2013

The Honorable Thomas M. Middleton
Chairman
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chairman
House Health and Government
Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

RE: HB 70 – DHMH – Commissions, Programs and Reports – Revision (Ch. 656 of the Acts of 2009), Previously SB 481 – Department of Health and Mental Hygiene – Reimbursement Rates (Ch. 464 of the Acts of 2002) and HB 627 – Community Health Care Access and Safety Net Act of 2005 (Ch. 280 of the Acts of 2005), and Health – General § 15-103.5

Dear Chairmen Middleton and Hammen:

In 2009, the General Assembly passed HB 70 – *Commissions, Programs and Reports – Revision* (Ch. 656 of the Acts of 2009), which consolidated two physician fee reporting requirements for the Medical Assistance Program. The Department of Health and Mental Hygiene is now required to submit a single report on physician fee issues to the legislature by January 1 each year.

The enclosed report includes a review of the rates paid to providers under the federal Medicare fee schedule and a comparison of 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; whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule; an analysis of other states' rates compared to Maryland; the schedule for raising rates; and an analysis of the estimated cost of implementing these changes.

If further information on this subject is required, please contact Christi Megna, Assistant Director of the Office of Governmental Affairs, at (410) 767-6480.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Chuck Milligan
Tricia Roddy
Audrey Parham-Stewart
Susan Tucker
Christi Megna
Sarah Albert, MSAR #7893

Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates December 2013

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Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates December 2013

I. Introduction

In 2002, Chapter 464 (SB 481) of the Laws of Maryland was enacted, directing the Maryland Department of Health and Mental Hygiene (the Department) to establish a process whereby the fee-for-service (FFS) reimbursement rates for Maryland Medicaid and the Maryland Children's Health Program (MCHP) (together referred to as Maryland Medical Assistance) would be established annually in a manner that ensures provider participation. The law further stipulated that, in developing the rate-setting process, the Department should take into account community reimbursement rates and annual medical inflation, or utilize the Resource-Based Relative Value Scale (RBRVS) methodology and American Dental Association (ADA) Current Dental Terminology (CDT-3) codes. The RBRVS methodology is used by the federal Medicare program to set the Medicare fee schedule.

The law also directed the Department to submit an annual report to the Governor and various state House and Senate committees regarding the following:

- the progress of the rate-setting process;
- a comparison of Maryland Medicaid's reimbursement rates with those of other states;
- the schedule for adjusting Maryland's reimbursement rates to a level that would ensure provider participation in the Medicaid program; and
- the estimated costs of implementing the above schedule and proposed changes to the FFS reimbursement rates.

In addition, the Department incorporated into this report information required by HB 70 from the 2009 session. Section 15 of this act requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare them with the FFS rates for the same services paid to providers under the Maryland Medical Assistance program and within managed care organizations (MCOs). On or before January 1 of every year, the Department is required to report this information and determine whether the FFS rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule. This report satisfies these requirements.

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 MCHP programs. In 2002, SB 481 required the submission of this report on an annual basis. This is the thirteenth annual report.

The Department's first annual report showed that Maryland Medicaid's reimbursement rates in 2001 were, on average, approximately 36 percent of Medicare rates. The report also included the results of a survey conducted by the American Academy of Pediatrics in 1998/1999, which

showed that Maryland's physician reimbursement rates for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the state legislature allocated $50 million in additional total funds ($25 million state general funds) to increase physician fees in the Medicaid program, beginning July 2002. The increase was targeted to evaluation and management (E&M) procedure codes, which are used by both primary care and specialty care physicians.

SB 836 (Chapter 1 of the Acts of 2005), entitled "Maryland Patients' Access to Quality Health Care Act of 2004 – Implementation and Corrective Provisions," created the Maryland Health Care Provider Rate Stabilization Fund. The primary revenues of the fund are derived from a tax imposed on MCOs and health maintenance organizations. SB 836 allocated funds to the Maryland Medical Assistance program to increase both FFS physician reimbursement rates and capitation payments to MCOs to enable these organizations to similarly raise their provider fees. The legislation allocated $15 million in additional state funds ($30 million total funds) in fiscal year (FY) 2006 for use by the Department to increase fees for procedures that are commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. The legislation targeted the fee increase to these physician specialties in response to the substantial rise in their malpractice insurance premiums. The bill also allocates additional funds each year to the Maryland Medical Assistance program for maintaining physician fees. Table 1 shows the amounts of Rate Stabilization Funds that were used to increase and maintain prior increases in physician fees in FY 2006 through FY 2009.

Table 1. Rate Stabilization Funds to Increase and Maintain Physician Fees (FYs 2006 – 2009)

	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**
State Rate Stabilization Funds	$15.0	$28.8	$47.5	$67.1
Federal Matching Funds	$15.0	$28.8	$47.5	$67.1
Total Funds	**$30.0**	**$57.6**	**$95.0**	**$134.3**
Funds to Maintain Prior Fee Increases	**$0.0**	$32.4	$62.2	$102.6
Remaining Funds for Fee Increase	**$30.0**	**$25.2**	**$32.8**	**$31.7**

SB 836 also required the Department to consult with the MCOs, the Maryland Hospital Association, the Maryland State Medical Society (MedChi), the Maryland Chapter of the American Academy of Pediatrics, the Maryland Chapter of the American College of Emergency Physicians, the Maryland State Dental Association, and the Maryland Dental Society to determine the new payment rates each year. These organizations are collectively referred to as stakeholders in this report.

The Department used the Medicare physician payment (RBRVS) methodology as a benchmark, or point of reference, when it increased physician fees in FYs 2003, 2006, 2007, 2008, and 2009. The RBRVS methodology relates payments to the resources that physicians use and the complexity of services that they provide. The Centers for Medicare & Medicaid Services (CMS) annually updates the Medicare fee schedule. (See Appendix A for a more detailed description of the RBRVS methodology).

For FYs 2007 and 2008, based on stakeholders' recommendations, the Department increased fees for procedures in different specialties, as shown in Table 2. In addition, procedures with the lowest fees were raised to a minimum of 50 percent of Medicare fees in FY 2008. Subsequently, the Department implemented other fee changes for FY 2009. In previous years, fees for many specialties, including orthopedics, gynecology/obstetrics, neurosurgery, otorhinolaryngology (ENT), and emergency medicine were set at 100 percent of their corresponding Medicare fees. Medicare fees in general had not increased substantially during the 2006 to 2008 period. However, updates in relative value units (RVUs) led to decreases in Medicare fees for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for many procedures were at 50 percent of Medicare fees. Therefore, based on stakeholders' recommendations, the Department increased the lowest Medicaid fees and re-balanced any Medicaid fees that were higher than their corresponding Medicare fees. In addition, separate fees for different sites of service were established so that Medicaid fees would have site-of-service differentials for facilities and non-facilities. "Facilities" include inpatient hospitals, nursing homes, and other medical care facilities, whereas "non-facilities" include physician offices and homes of patients.

Medicaid fees that were higher than Medicare fees were reduced to their corresponding Medicare fee levels by site of service, and the lowest fees were raised to 78.6 percent of their corresponding Medicare fees by site of service. The exceptions to this methodology were that fees for four obstetric procedures (normal and cesarean deliveries) were maintained at their original FY 2008 levels, which were higher than their corresponding Medicare fees. To this day, the Department continues to compare the Medicaid fee schedule with Medicare fees and reduces any Medicaid fees that exceed their corresponding Medicare facility or non-facility fees to the Medicare fee level.

SB 836 allocated funds to increase capitation payments to MCOs to enable these organizations to raise their physician fees. Accordingly, the Department increased the MCOs' capitation rates to reflect the costs of the physician fee increases. To ensure that the MCOs use these funds to raise their physician fees, the Department requires MCOs to pay their network physicians at least 100 percent of the Medicaid physician fee schedule. Furthermore, the Department reviews the physician fee schedule of each MCO to monitor compliance with this requirement.

Table 2 shows the percentage of Medicare fees for targeted groups of procedures at the times of fee increases in FYs 2003, 2006, 2007, 2008, and 2009.

Table 2. Prior Fee Increases to Percentage of Medicare Fees (FYs 2003 and 2006—2009)

Fiscal Year	Procedure Code Group	Percent of Medicare Fees at Time of Fee Increase
2003	Evaluation & Management (99201-99499)	80%
2006	Orthopedics (20000-29999) Gynecology/Obstetrics (56405-59899) Neurosurgery (61000-64999) Emergency Medicine (99281-99285)	 100% 100% 100% 100%
2007	Anesthesia (00100-01999) General Surgery (10000-19396) Digestive System (40490-49905) ENT (69000-69990, 92502-92700) Radiation Oncology (77261-77799) Allergy/Immunology (95004-95199) Dermatology (96900-96999)	100% 80% 80% 100% 80% 80% 80%
2008	Evaluation & Management (99201-99499) Evaluation & Management in hospital outpatient departments Neonatology (99294, 99296, 99299) Radiology (70010-79900, excluding 77261-77799) Vaccine Administration Psychiatry (90801-90911) Floor for the lowest fees	80% 50% 90% 53% 66% 61% 50%
2009	Set separate fees for facilities and non-facilities Floor for the lowest fees Orthopedics (20000-29999), Gynecology/Obstetrics (56405-59899) Neurosurgery (61000-64999) Emergency Medicine (99281-99285)	 78.6% 100% 100% 100% 100%

III. Physician Fee Changes in FYs 2010 through 2013

Physician Fees for FY 2010

The national economic recession reduced state revenues in FY 2010. Therefore, the Department implemented a reduction in physician fees for FY 2010. Effective July 1, 2009, physician fees were reduced to achieve an $11.5 million total reduction in payments for physician services in FY 2010. Some groups of procedure codes and specialties were excluded from the reduction in

fees. Then, fees for remaining procedures were reduced across the board by 5.8 percent to achieve the required $11.5 million reduction in FY 2010 payments. In FY 2010, $111.7 million ($227.9 million with matching federal funds) was allocated from the Rate Stabilization Fund to maintain prior fee increases.

Physician Fees for FY 2011

The Medicare program regularly updates RVUs for procedures, which results in fee *increases* for some procedures and fee *decreases* for other procedures. The Department compared the Maryland Medicaid fee for each procedure with its corresponding Medicare fee and then reduced fees for procedures that exceeded Medicare fees to the Medicare fee levels. Fees for four obstetric delivery procedure codes (59409, 59410, 59514, and 59515) remained at their original levels. Aside from these adjustments, the Department maintained FY 2011 physician fees at the same level as FY 2010 fees. $117.7 million from the Rate Stabilization Fund ($238.8 million with matching federal funds) was allocated for maintaining prior fee increases in FY 2011.

Physician Fees for FY 2012

The Department implemented a $6.52 million total funds reduction in payments for physician services for FY 2012. Some groups of procedure codes were excluded from the reduction in fees:

1. The four specialties mentioned in SB 836 (Orthopedics, Obstetrics/Gynecology, Neurosurgery, and Emergency) were maintained at a maximum of 100 percent of Medicare fees, without increasing their fees.
2. Four obstetric (delivery) procedures, three neonatal intensive care unit procedures, and 22 procedure codes used by educational institutions were maintained at their original FY 2011 levels.

Then, an across-the-board 1.22 percent reduction in fees was applied to all remaining procedures to achieve the required reduction in FY 2012 payments. Overall, fees were reduced from an average of 75 percent to an average of 74 percent of Medicare 2011 fees. In FY 2012, $104 million from the Rate Stabilization Fund ($211.7 million with matching federal funds) was allocated for maintaining prior fee increases.

Physician Fees for FY 2013

There were no changes in Maryland Medicaid physician fees for the first six months of FY 2013. Under the Affordable Care Act (ACA), the federal government will pay for increasing Medicaid payment rates in FFS and managed care organizations for E&M and vaccine administration procedures provided by primary care physicians (PCPs) to 100 percent of the Medicare payment rates for calendar years (CYs) 2013 and 2014. For services provided on or after January 1, 2013, and before January 1, 2015, states will receive 100 percent federal financing for increasing payment rates for physicians who self-attest that they are PCPs.

However, Maryland Medicaid allows patients who have medically complex conditions to select a specialist as their PCP. In order to improve access to primary care and specialists, the fees for E&M and vaccine administration procedures were increased for all providers, not just PCPs. The costs for this fee increase for physicians who do not self-attest as PCPs will be financed at the regular federal medical assistance percentage (FMAP).

In March 2013, CMS released the average Medicare fees for E&M and vaccine administration procedures in the three geographic regions of Maryland. The fees, which were uploaded to the Medicaid payment system on April 1, 2013, were retroactive to services provided on or after January 1, 2013. As specified in the ACA, Medicaid fees that were effective on July 1, 2009, were used to estimate the costs of increasing PCP fees, which will be subject to the 100 percent federal financial participation (FFP). Because Maryland Medicaid fees for E&M procedures were reduced after July 1, 2009, the state will have to pay (at the regular FMAP rate) for increasing fees to their July 1, 2009, levels.

Federal Share of Fee Increase for PCPs

According to CMS, the federal government will provide 100 percent FFP only for physicians who self-attest that they are PCPs. The Department has obtained self-attestations from approximately 3,600 physicians. Claims and encounter data from these physicians were identified, and payments for their 2013 E&M and vaccine administration procedures were projected. Then payments for these procedures for all physicians in FY 2013 were estimated. According to a "Technical Guide" released by CMS, CY 2010 utilization data for E&M and vaccine administration procedures and the trend factor (between CY 2010 and CY 2013) that were used for MCO rate setting were utilized to estimate the CY 2013 costs of the fee increase. The estimated costs for FFS, HealthChoice and Primary Adult Care (PAC) program enrollees, which will be used by CMS to determine 100% federal financing, are shown in Table 3.

Table 3. Projected Cost of E&M and Vaccine Administration Fee Increase to 100 Percent of Medicare in CY 2013

Procedures	Projected Increase in FFS Payments	Increase in MCO Payments for HealthChoice Beneficiaries	Increase in MCO Payments for PAC Enrollees	Increase in Total Payments
E&M	$23.5	$143.5	$4.8	$171.8
Vaccine Administration	$0.2	$7.1	$0.1	$7.4
Total	**$23.7**	**$150.6**	**$4.9**	**$179.2**

For the FFS system, actual claims data for services provided in 2013 by self-attesting physicians will be used to claim the 100 percent FFP. The estimated payments to MCOs for HealthChoice and PAC program enrollees shown in Table 3 will be multiplied by their corresponding percentages pertaining to self-attesting physicians (shown in Table 4) to derive the amounts of payments that will be subject to 100 percent FFP. For Table 4, the estimated payments for E&M

and vaccine administration claims and encounter data from self-attesting physicians were divided by the corresponding estimated payments for all physicians to derive the percentages of the total costs of fee increase (shown in Table 3) that will be subject to 100% FFP.

Table 4. Payments to Self-Attesting Physicians as Percentage of Total Physician Payments for E&M and Vaccine Administration Procedures

Procedures	FFS Payments	MCO Payments for HealthChoice Beneficiaries	MCO Payments for PAC Enrollees	Total Payments
Non-Facility E&M	37%	**42%**	44%	42%
Facility E&M	25%	**17%**	7%	18%
Vaccine Administration	74%	**68%**	78%	69%
Total	**29%**	**37%**	**38%**	**36%**

The pertinent numbers in Tables 3 and 4 correspond to payments for MCO and PAC enrollees, as federal payments for FFS will be based on actual claims in CY 2013. Because claims and encounter data for self-attesting PCPs are mostly office-based, their non-facility services comprise 42 percent of all physician services for HealthChoice and 44 percent for PAC enrollees. However, because of the lower facility percentages, estimated payments for the self-attesting PCP encounters are 37 percent and 38 percent of the corresponding encounters with all physicians for HealthChoice and PAC enrollees. Overall, the increase in payments to self-attesting physicians is approximately 36 percent of the total costs of the fee increase for these procedures.

To determine the portion of the MCOs' costs of the fee increase that is subject to 100 percent FFP, the estimated $150.6 million additional payments to MCOs for HealthChoice beneficiaries and $4.9 million for PAC enrollees (in Table 3) will be multiplied by 37 percent and 38 percent, respectively.

State Share of Fee Increase

The amount of funding distributed to the Maryland Medical Assistance program from the state Rate Stabilization Fund under §19-807 of the Insurance Article in FY 2013 was $109.1 million. With 50 percent FMAP for Medicaid and 65 percent FMAP for the CHIP program, the combined total funds of $221.6 million were allocated for maintaining prior fee increases and increasing provider reimbursement rates.

Table 5 shows the Department's estimated costs of CY 2013 fee increase for E&M and vaccine administration procedures, separated by federal and state of Maryland costs.

Table 5. Estimated Cost of Physician Fee Increase in CY 2013
(Million Dollars)

	FFS	MCOs	Total
Estimated Cost of Fee Increase for Self-Attested PCPs subject to 100% FMAP	$6.92	$57.86	$64.78
Estimated Cost of Fee Increase for Specialists and Dually-Eligible subject to Regular FMAP	$20.47	$109.87	$130.34
Estimated State Cost of Fee Increase	**$10.07**	**$54.06**	**$64.13**
Estimated Federal Cost of Fee Increase	**$17.31**	**$113.68**	**$130.99**
Total Cost of Fee Increase	**$27.38**	**$167.74**	**$195.12**

Caveat:

For physician services provided to dually eligible beneficiaries, Medicare pays physicians 80 percent of its reimbursement rate, and Medicaid pays the remaining portion up to the Medicaid rate. There are 3 different Medicare fees in Maryland based on geographic location of physicians. The 2013 statewide Medicaid fees are higher than Medicare fees in Baltimore and other counties and lower than Medicare fees for Maryland suburbs of Washington, D.C., (Montgomery and Prince George's counties). In areas where the statewide Medicaid reimbursement rates are higher than Medicare rates, Medicaid co-payment will be 20 percent of Medicare rates, which would be slightly less than 20 percent of Medicaid reimbursement rate. In Maryland suburbs of Washington, D.C., with higher Medicare rates, the co-payment will be 20 percent of Medicaid rates. Therefore, it was assumed that Medicaid cost of fee increase for dually eligible beneficiaries is based on 20 percent of current Medicaid fees for each procedure.

Savings from Reductions in RVUs for Non-E&M Procedures

Increases in Medicare fees for E&M procedures resulting from increases in their RVUs were offset by decreases in RVUs and fees for specialty procedures. However, because Medicaid fees for many specialty procedures already are substantially lower than their corresponding Medicare fees, the reductions in Medicare fees resulting from decreases in RVUs do not affect the Medicaid fees for many procedures. For example, if the Medicaid fee for a procedure is $75, and the Medicare fee was reduced from $100 to $90, the change in the Medicare fee does not affect the Medicaid fee. Therefore, although the increase in Medicare E&M fees results in additional payments, reducing the fees that exceeded Medicare fees results in substantially smaller savings.

IV. Maryland's Medicaid Fees Compared with Medicare and Other States' Fees

Maryland's neighboring states have their own Medicaid fee schedules. For this report, we collected data on the Medicaid physician fees of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, D.C. We obtained the current physician fee schedules from the states' websites and compiled data on each state's Medicaid fees for a sample of approximately 200 high-volume procedures in various specialties.

Table 6 compares Maryland's FY 2014 Medicaid fees with the corresponding Medicare 2013 reimbursement rates in Maryland and neighboring states' Medicaid fees for a sample of high-volume procedures in various specialty groups. In this table, procedure fees are rounded to the nearest dollar amount, and the last row of each section shows each state's weighted average Medicaid fees for surveyed procedures as a percentage of Medicare fees in Baltimore region of Maryland. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percentages of Medicare fees reported in this table correspond to the appropriate Medicare non-facility and facility fees. More specifically, non-facility fees are compared with Medicare non-facility fees, and facility fees reported for Maryland and West Virginia are compared with Medicare facility fees.

Physician fees include three components: physician's work, practice expense (e.g., costs of maintaining an office), and malpractice insurance expense. The practice expense component is, on average, approximately 40 percent of the total physician fee. When physicians render services in facilities, they do not incur a practice expense; therefore, facility fees are typically lower than non-facility fees.

Maryland and West Virginia have separate facility and non-facility fees. Therefore, their facility and non-facility fees are compared with the corresponding Medicare facility and non-facility fees. Washington, D.C., Delaware, and Pennsylvania have only one fee for each procedure, so their fees are compared with Medicare non-facility fees. Hence, for Washington, D.C., Delaware, and Pennsylvania, the percentages of Medicare fees reported in Table 6 underestimate the percentages of Medicare fees for procedures performed in facilities. In 2009, Washington, D.C., set its Medicaid fees to 100 percent of its Medicare non-facility fees. As a result, for some procedure groups, Washington, D.C., has the highest or second highest physician reimbursement rates in the region. Virginia has separate facility and non-facility fees for some procedures, but it did not report facility fees for many procedures that are included in Table 6. Therefore, we only reported Virginia Medicaid's non-facility fees and compared them with their corresponding Medicare non-facility fees.

For this report, we compared Maryland's and other states' Medicaid reimbursement rates with the Medicare fee schedule for Maryland. Average Medicare fees in Maryland are approximately 16 percent higher than Medicare fees in Delaware, 6 percent higher than Medicare fees in Virginia, and 4 percent higher than Medicare fees in West Virginia. On the other hand, average Medicare fees in Maryland are approximately 4 percent lower than average Medicare fees in Washington, D.C., and 3 percent lower than average Medicare fees in Pennsylvania.

Comparisons of E&M and Specialty Procedures

In the following paragraphs, we compare Maryland's fees with other states' fees for E&M and each group of specialty procedures, as shown in Table 6.

E&M Procedures

As an average percentage of Medicare 2013 fees in Maryland, E&M fees in Delaware are highest in the region. Washington, D.C., fees rank second; Maryland facility fees and non-facility fees rank third and fourth, respectively; Virginia non-facility fees rank fifth; West

Virginia non-facility fees and facility fees rank sixth and seventh, respectively; and Pennsylvania fees rank eighth. As required by the ACA, Maryland established its fees for E&M and vaccine administration procedures equal to their corresponding Medicare fees. The benchmark Medicare reimbursement rates were provided by CMS. They represent the average of Medicare fees in Maryland counties, using the 2009 Medicare conversion factor, as required by the law. The 2009 Medicare conversion factor was greater than the 2013 conversion factor. Therefore, these fees are slightly higher than the corresponding current Medicare fees in the state of Maryland.

Surgery

Integumentary Procedures

For integumentary[1] procedures, Delaware fees rank first, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), Maryland facility fees (fourth), Maryland non-facility fees (fifth), West Virginia facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth).

Musculoskeletal System Procedures

Delaware fees for musculoskeletal system procedures are the highest in the region. Maryland non-facility fees rank second; Maryland facility fees rank third; Washington, D.C., fees rank fourth; Virginia non-facility fees rank fifth; West Virginia facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank last.

Respiratory Procedures

For respiratory procedures, Washington, D.C., fees rank first, followed, in ranking order, by Virginia non-facility fees, Delaware fees, Maryland facility fees, West Virginia facility fees, West Virginia non-facility fees, Maryland non-facility fees, and Pennsylvania fees.

Cardiovascular Surgical Procedures

For selected cardiovascular system surgical procedures, Washington, D.C., has the highest fees. Virginia non-facility fees rank second; Maryland non-facility fees rank third; Maryland facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; Delaware fees rank seventh; and Pennsylvania fees rank eighth. Because Pennsylvania has missing fees for three surveyed procedures, its percentage of Medicare fees is lower than it would have been if these procedures were included.

Hemic, Lymphatic, and Mediastinum Procedures

Delaware has the highest fees for hemic, lymphatic, and mediastinum systems procedures in the region, followed by Washington, D.C., fees, Virginia non-facility fees, Maryland non-facility fees, West Virginia facility fees, Maryland facility fees, West Virginia non-facility fees, and Pennsylvania fees. Pennsylvania has a missing fee for procedure 38792 (identify sentinel node), so its percentage of Medicare fees is lower than it would have been had it covered this procedure.

[1] Integumentary procedures are related to skin.

Digestive Procedures
For selected digestive system procedures, Delaware fees rank the highest, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), Maryland non-facility fees (fourth), West Virginia facility fees (fifth), Maryland facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth).

Urinary and Male Genital Procedures
Maryland non-facility fees for urinary and male genital procedures rank highest in the region. Washington, D.C., fees rank second, Virginia non-facility fees rank third; Maryland facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; and Delaware fees rank seventh. Pennsylvania fees rank last in the region.

Gynecology and Obstetrics Procedures
Pennsylvania has the highest fees for the selected gynecology and obstetrics procedures, although it is missing a fee for procedure 59430 (care after delivery). Following Pennsylvania, in ranking order are: West Virginia facility fees, West Virginia non-facility fees, Maryland facility fees, Maryland non-facility fees, Delaware fees, Virginia non-facility fees, and Washington, D.C., fees.

Endocrine System Procedures
For selected endocrine system procedures, Delaware fees rank the highest. Washington, D.C., fees rank second, Virginia non-facility fees rank third, West Virginia facility fees rank fourth, West Virginia non-facility fees rank fifth, Maryland non-facility fees rank sixth, Maryland facility fees rank seventh, and Pennsylvania fees have the last ranking.

Nervous System Procedures
Delaware fees for nervous system procedures are the highest in the region, followed, in ranking order, by Virginia non-facility fees, Maryland facility fees, Maryland non-facility fees, Washington, D.C., fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees.

Eye Surgery Procedures
For selected eye surgery procedures, Delaware fees rank first; Washington, D.C., fees rank second; Virginia non-facility fees rank third; Pennsylvania fees rank fourth; Maryland non-facility fees rank fifth; Maryland facility fees rank sixth; West Virginia facility fees rank seventh; and West Virginia non-facility fees rank eighth.

Ear Surgery Procedures
Washington, D.C., has the highest fees for ear surgery procedures in the region, followed by Maryland facility fees (second), Maryland non-facility fees (third), Virginia non-facility fees (fourth), West Virginia facility fees (fifth), West Virginia non-facility fees (sixth), Delaware fees (seventh), and Pennsylvania fees (eighth). Delaware does not pay for procedure code 69210 and Pennsylvania does not pay for procedure code 69990, which reduces their ranking.

Radiology Procedures

For the selected radiology procedures, Delaware fees rank first; Washington, D.C., fees rank second; Maryland facility and non-facility fees rank third and fourth, respectively; Virginia non-facility fees rank fifth; West Virginia facility and non-facility fees rank sixth and seventh; and Pennsylvania fees rank eighth.

Laboratory Procedures

Medicare has one fee for each laboratory procedure, regardless of place of service. Delaware has the highest fees for the selected laboratory procedures in the region, followed, in ranking order, by Virginia, West Virginia, Maryland, Pennsylvania, and Washington, D.C.

Medicine

Psychiatry Procedures

There were major changes[2] to the codes in the Psychiatry section of the AMA's Current Procedural Terminology. These changes apply to services provided since January 1, 2013. Procedure 90801 is now divided into procedures 90791 and 90792. Procedure code 90791 is used for a psychiatric diagnostic evaluation. CPT code 90792 is used when additional medical services such as physical examination and prescription of pharmaceuticals are provided in addition to the diagnostic evaluation. The psychotherapy codes 90832, 90834, and 90837 replace codes 90804, 90805, and 90806, respectively. Maryland non-facility fees for psychiatry procedures rank first in the region; Delaware fees rank second; Washington, D.C., fees rank third; Virginia non-facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; and Pennsylvania fees rank seventh. Maryland facility fees were not used for ranking due to missing data.

Dialysis Procedures

For selected dialysis procedures, Delaware fees rank the highest in the region, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), West Virginia facility (fourth) and non-facility (fifth) fees, Maryland facility (sixth) and non-facility (seventh) fees, and Pennsylvania fees (eighth).

Gastroenterology Procedures

Delaware fees for gastroenterology procedures are the highest in the region. Washington, D.C., fees rank second; Virginia non-facility fees rank third; Maryland facility and non-facility fees rank fourth and fifth, respectively, West Virginia facility and non-facility fees rank sixth and seventh, respectively; and Pennsylvania fees rank eighth. Because Pennsylvania has a missing fee for procedure 91110 (GI tract capsule endoscopy), its ranking is lower than it would have been if this procedure was covered.

Ophthalmology and Vision Care Procedures

[2] Current Procedural Terminology (CPT) code changes for 2013: http://www.psychiatry.org/practice/managing-a-practice/cpt-changes-2013

For the selected ophthalmology and vision care procedures, Delaware fees rank first in the region, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), West Virginia facility fees (fourth), West Virginia non-facility fees (fifth), Maryland non-facility fees (sixth), Maryland facility fees (seventh), and Pennsylvania fees (eighth).

Otorhinolaryngology Procedures

For the selected ear, nose, and throat (ENT) otorhinolaryngology procedures, Delaware fees rank first, followed, in ranking order, by Maryland facility fees, Washington, D.C., fees, Maryland non-facility fees, Virginia non-facility fees, Pennsylvania fees, West Virginia facility fees, and West Virginia non-facility fees.

Cardiovascular Medicine Procedures

Pennsylvania fees are the highest for cardiovascular medicine procedures in the region. Delaware fees rank second; Maryland facility and non-facility fees rank third and fourth, respectively; Washington, D.C., fees rank fifth; Virginia non-facility fees rank sixth; and West Virginia facility and non-facility fees rank seventh and eighth, respectively. Although Pennsylvania did not report a fee for procedure 93325 (Doppler color flow add-on), its percentage of Medicare fees is still ranked highest.

Non-Invasive Vascular Diagnostic Studies

For the selected non-invasive vascular diagnostic study procedures, Delaware fees rank first; Washington, D.C., fees rank second; Virginia non-facility fees rank third; Maryland facility and non-facility fees rank fourth and fifth, respectively; Pennsylvania fees rank sixth; and West Virginia facility and non-facility fees rank seventh and eighth, respectively.

Pulmonary Procedures

Delaware has the highest fees for pulmonary procedures in the region. Washington, D.C., fees rank second; Virginia non-facility fees rank third; Maryland facility and non-facility fees rank fourth and fifth, respectively; West Virginia facility and non-facility fees rank sixth and seventh, respectively; and Pennsylvania ranks eighth. Pennsylvania's fee schedule does not provide a fee for procedure 94640 (airway inhalation treatment).

Allergy and Immunology Procedures

For selected allergy and immunology procedures, Maryland facility fees rank first; Maryland non-facility fees rank second; Delaware fees rank third; Washington, D.C., fees rank fourth; Virginia non-facility fees rank fifth; West Virginia facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank eighth.

Neurology and Neuromuscular Procedures

Delaware fees are the highest in the region for neurology and neuromuscular procedures, followed, in ranking order, by Washington, D.C., fees, Virginia non-facility fees, West Virginia facility and non-facility fees, Maryland facility and non-facility fees, and Pennsylvania fees.

Central Nervous System Assessment Tests
For the selected central nervous system (CNS) assessment procedures, Washington, D.C., fees rank first; Virginia non-facility fees rank second; Maryland facility fees rank third; Maryland non-facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; Pennsylvania fees rank seventh; and Delaware fees rank eighth. Because Delaware has listed a fee of $0 for procedure 96111 (developmental test, extended), its ranking as a percentage of Medicare fees in Maryland is the lowest.

Chemotherapy Administration
For chemotherapy administration procedures, Delaware fees rank first, followed by Washington, D.C., fees (second), Maryland non-facility fees (third), Maryland facility fees (fourth), Virginia non-facility fees (fifth), Pennsylvania fees (sixth), West Virginia facility fees (seventh), and West Virginia non-facility fees (eighth).

Dermatology Procedures
As an average percentage of Medicare fees in Maryland for the selected dermatology procedures, Delaware has the highest fees. Washington, D.C., fees rank second; Virginia non-facility fees rank third; West Virginia facility and non-facility fees rank fourth and fifth, respectively; Maryland facility and non-facility fees rank sixth and seventh, respectively; and Pennsylvania fees rank eighth.

Physical Medicine and Rehabilitation Procedures
For the selected physical medicine and rehabilitation procedures, Delaware fees rank first, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), Maryland facility and non-facility fees (fourth and fifth), West Virginia facility and non-facility fees (sixth and seventh), and Pennsylvania fees (eighth).

Osteopathy, Chiropractic, and Other Medicine Procedures
Virginia non-facility fees rank highest for osteopathy, chiropractic, and other medicine procedures, followed, in ranking order, by Pennsylvania fees, Maryland facility fees, Delaware fees, Washington, D.C., fees, West Virginia facility fees, Maryland non-facility fees, and West Virginia non-facility fees. The Virginia non-facility fee for procedure code 99173 (visual acuity screening) is nearly 19 times the Medicare fee for this procedure.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Evaluation & Management										
99203	Office/outpatient visit, new	$116	$80	$119	$82	$107	$84	$75	$54	$54	$98
99204	Office/outpatient visit, new	$176	$136	$182	$140	$163	$128	$116	$93	$90	$148
99212	Office/outpatient visit, established	$47	$26	$49	$27	$44	$34	$30	$18	$26	$40
99213	Office/outpatient visit, established	$78	$52	$80	$54	$73	$57	$50	$36	$35	$66
99214	Office/outpatient visit, established	$114	$81	$118	$84	$106	$83	$74	$55	$54	$96
99223	Initial hospital care	N/A	$209	N/A	$216	$195	$154	$143	$143	$42	$174
99232	Subsequent hospital care	N/A	$74	N/A	$77	$69	$55	$51	$51	$17	$61
99238	Hospital discharge day	N/A	$75	N/A	$78	$70	$55	$50	$50	$17	$0
99244	Office consultation	$188	$157	$194	$163	$0	$138	$126	$108	$121	$157
99283	Emergency department visit	N/A	$63	N/A	$65	$59	$43	$44	$44	$35	$52
99284	Emergency department visit	N/A	$121	N/A	$125	$112	$83	$84	$84	$50	$99
99285	Emergency department visit	N/A	$176	N/A	$183	$164	$122	$124	$124	$50	$145
99291	Critical care, first hour	$289	$229	$299	$238	$269	$212	$193	$158	$152	$242
99308	Nursing facility care, subsequent	$72	$72	$74	$74	$67	$53	$48	$48	$37	$60
99381	Initial pm e/m, new patient, infant	$117	$79	$121	$82	$110	$81	$76	$54	$20	$99
99391	Periodic reevaluation, established patient, infant	$105	$72	$109	$75	$98	$73	$69	$50	$20	$89
99392	Preventive visit, est, aged 1-4	$113	$79	$116	$82	$105	$78	$73	$54	$20	$95
99393	Preventive visit, est, aged 5-11	$112	$79	$116	$82	$105	$78	$73	$54	$20	$94
99394	Preventive visit, est, aged 12-17	$122	$89	$126	$93	$114	$85	$80	$61	$20	$103
99469	Neonate critical care, subsequent	N/A	$405	N/A	$420	$380	$300	$278	$278	$240	$336
99472	Pediatric critical care, subsequent	N/A	$418	N/A	$434	$391	$309	$286	$286	$240	$347
99479	Subs IC LBW infant 1500-2500 g	N/A	$132	N/A	$137	$123	$97	$90	$90	$76	$109
	Average % of Medicare Fees			**103%**	**104%**	**125%**	**98%**	**90%**	**69%**	**55%**	**113%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Surgery										
	Integumentary										
10060	Drainage of skin abscess	$127	$105	$74	$66	$118	$100	$81	$68	$24	$108
11042	Debride skin/tissue	$130	$66	$54	$35	$120	$102	$82	$45	$33	$111
11721	Debride nail, 6 or more	$48	$26	$31	$21	$45	$38	$31	$18	$20	$41
12001	Repair superficial wound(s)	$100	$48	$102	$58	$92	$78	$63	$33	$25	$85
12011	Repair superficial wound(s)	$122	$60	$113	$69	$112	$96	$78	$42	$32	$104
17110	Destruct b9 lesion, 1-14	$124	$77	$70	$43	$115	$97	$76	$49	$49	$107
17250	Chemical cautery, tissue	$89	$40	$54	$26	$83	$70	$55	$26	$26	$77
	Average % of Medicare Fees			**69%**	**77%**	**93%**	**78%**	**63%**	**66%**	**28%**	**85%**
	Musculoskeletal System										
20550	Inj tendon sheath/ligament	$63	$44	$56	$39	$58	$50	$41	$30	$32	$53
20552	Inj trigger point, 1/2 muscl	$60	$40	$50	$33	$56	$47	$39	$27	$31	$0
20610	Drain/inject, joint/bursa	$65	$49	$72	$48	$60	$51	$42	$33	$24	$55
25600	Treat fracture radius/ulna	$366	$345	$259	$232	$336	$286	$230	$219	$115	$311
29075	Application of forearm cast	$97	$68	$80	$58	$89	$76	$61	$45	$46	$82
29125	Apply forearm splint	$73	$44	$61	$39	$67	$57	$46	$29	$26	$62
29130	Application of finger splint	$45	$30	$37	$27	$41	$35	$29	$21	N/A	$38
29515	Application lower leg splint	$80	$54	$65	$47	$74	$63	$51	$36	$35	$68
	Average % of Medicare Fees			**87%**	**83%**	**92%**	**79%**	**64%**	**66%**	**37%**	**80%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Respiratory										
30300	Remove nasal foreign body	$269	$143	$161	$88	$249	$209	$162	$90	$23	$232
31231	Nasal endoscopy, dx	$238	$69	$134	$57	$221	$185	$148	$47	$59	$205
31500	Insert emergency airway	$116	$116	$77	$77	$106	$93	$81	$81	$72	$95
31575	Diagnostic laryngoscopy	$127	$83	$83	$57	$118	$100	$80	$55	$69	$108
31622	Dx bronchoscope/wash	$353	$157	$236	$108	$145	$277	$222	$108	$134	$301
31624	Dx bronchoscope/lavage	$351	$158	$241	$108	$147	$275	$221	$108	$135	$300
	Average % of Medicare Fees			**63%**	**69%**	**77%**	**79%**	**64%**	**68%**	**39%**	**85%**
	Cardiovascular Surgery										
36400	Bl draw < 3 yrs fem/jugular	$32	$21	$18	$13	$29	$25	$21	$14	N/A	$27
36406	Bl draw < 3 yrs other vein	$22	$11	$13	$7	$20	$17	$14	$7	N/A	$18
36410	Non-routine bl draw > 3 yrs	$19	$10	$14	$7	$17	$15	$12	$7	N/A	$16
36556	Insert non-tunnel cv cath	$259	$128	$194	$90	$118	$204	$165	$89	$113	$220
36569	Insert picc cath	$274	$96	$226	$72	$89	$214	$171	$67	$87	$235
36620	Insertion catheter, artery	$53	$53	$36	$36	$49	$43	$37	$37	$48	$44
	Average % of Medicare Fees			**75%**	**70%**	**51%**	**79%**	**64%**	**70%**	**39%**	**85%**
	Hemic, Lymphatic, and Mediastinum										
38220	Bone marrow aspiration	$179	$64	$123	$44	$166	$140	$110	$43	$55	$154
38221	Bone marrow biopsy	$181	$78	$136	$56	$169	$142	$113	$53	$70	$155
38525	Biopsy/removal, lymph nodes	$475	$475	$281	$281	$428	$374	$319	$319	$156	$395
38792	Identify sentinel node	$44	$44	$30	$30	$41	$35	$29	$29	N/A	$37
	Average % of Medicare Fees			**68%**	**65%**	**92%**	**79%**	**64%**	**67%**	**33%**	**85%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Digestive										
42820	Remove tonsils and adenoids	$320	$320	$212	$212	$295	$253	$211	$211	$184	$268
42830	Removal of adenoids	$232	$232	$151	$151	$214	$183	$151	$151	$134	$196
43235	Upper GI endoscopy, diagnosis	$338	$158	$229	$104	$312	$264	$211	$107	$125	$288
43239	Upper GI endoscopy, biopsy	$389	$186	$263	$123	$359	$304	$244	$126	$149	$332
45378	Diagnostic colonoscopy	$444	$235	$299	$155	$409	$348	$281	$160	$181	$378
45380	Colonoscopy and biopsy	$529	$280	$357	$186	$488	$414	$335	$191	$225	$450
45385	Lesion removal colonoscopy	$594	$333	$400	$221	$548	$466	$378	$226	$268	$505
47562	Laparoscopic cholecystectomy	$711	$711	$502	$502	$640	$562	$483	$483	$589	$589
49082	Abdominal paracentesis without imaging	$196	$77	$141	$59	$182	$134	$121	$52	$64	$168
	Average % of Medicare Fees			**68%**	**67%**	**92%**	**78%**	**64%**	**67%**	**47%**	**85%**
	Urinary and Male Genital										
51600	Injection for bladder x-ray	$201	$46	$162	$34	$42	$156	$123	$32	$32	$173
51701	Insert bladder catheter	$59	$29	$53	$21	$55	$47	$37	$20	$25	$51
51798	Us urine capacity measure	$22	$22	$16	$16	$20	$17	$13	$13	$14	$0
52000	Cystoscopy	$218	$132	$163	$94	$122	$171	$141	$90	$75	$185
54150	Circumcision w/ regional block	$166	$103	$145	$73	$94	$131	$109	$71	$79	$140
	Average % of Medicare Fees			**85%**	**72%**	**55%**	**79%**	**65%**	**69%**	**43%**	**84%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Gynecology and Obstetrics										
57452	Exam of cervix w/ scope	$119	$100	$108	$88	$109	$98	$78	$67	$40	$100
57454	Bx/curett of cervix w/ scope	$167	$148	$152	$133	$153	$138	$112	$101	$106	$140
58300	Insert intrauterine device	$75	$53	$76	$52	$0	$62	$49	$37	$17	$63
59025	Fetal non-stress test	$53	$53	$46	$46	$48	$44	$35	$35	$18	$45
59409	Obstetrical care	$898	$898	$860	$860	$791	$740	$892	$892	$1,200	$736
59410	Obstetrical care	$1,145	$1,145	$942	$942	$1,010	$943	$1,135	$1,135	$1,200	$940
59430	Care after delivery	$206	$153	$139	$125	$184	$169	$196	$152	N/A	$171
59514	Cesarean delivery only	$1,011	$1,011	$993	$993	$791	$832	$1,005	$1,005	$1,200	$828
59515	Cesarean delivery with postpartum	$1,390	$1,390	$1,124	$1,124	$1,010	$1,144	$1,375	$1,375	$2,050	$1,141
	Average % of Medicare Fees			**87%**	**88%**	**83%**	**81%**	**97%**	**97%**	**112%**	**81%**
	Endocrine System										
60100	Biopsy of thyroid	$120	$83	$82	$57	$111	$95	$79	$57	$66	$101
60240	Removal of thyroid	$994	$994	$662	$662	$901	$787	$674	$674	$591	$825
	Average % of Medicare Fees			**67%**	**67%**	**91%**	**79%**	**67%**	**68%**	**59%**	**83%**
	Nervous System										
62270	Spinal fluid tap, diagnostic	$177	$84	$150	$73	$163	$139	$112	$58	$42	$151
62311	Inject spine l/s (cd)	$231	$96	$183	$79	$215	$181	$142	$64	$75	$198
64450	N block, other peripheral	$88	$48	$99	$68	$82	$69	$55	$32	$21	$75
64483	Inj foramen epidural l/s	$252	$123	$257	$101	$235	$198	$157	$82	$95	$216
64614	Destroy nerve, extrem muscle	$203	$179	$161	$132	$185	$159	$132	$119	$123	$171
	Average % of Medicare Fees			**89%**	**90%**	**93%**	**92%**	**63%**	**67%**	**32%**	**85%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Eye Surgery										
65855	Laser surgery of eye	$380	$334	$227	$195	$349	$299	$246	$218	$237	$321
66984	Cataract surg w/ iol, 1 stage	$717	$717	$494	$494	$658	$566	$470	$470	$603	$603
67028	Injection eye drug	$113	$111	$136	$111	$104	$89	$74	$73	$106	$95
67210	Treatment of retinal lesion	$580	$559	$430	$413	$533	$456	$376	$364	$375	$489
67228	Treatment of retinal lesion	$1,115	$1,055	$731	$636	$1,023	$880	$733	$698	$491	$936
67311	Revise eye muscle	$674	$674	$370	$370	$617	$531	$441	$441	$468	$567
	Average % of Medicare Fees			**68%**	**66%**	**92%**	**79%**	**65%**	**66%**	**69%**	**84%**
	Ear Surgery										
69200	Clear outer ear canal	$141	$64	$113	$49	$131	$110	$86	$42	$30	$121
69210	Remove impacted ear wax	$57	$35	$44	$29	N/A	$45	$37	$24	$20	$48
69436	Create eardrum opening	$178	$178	$149	$149	$164	$140	$115	$115	$99	$150
69990	Microsurgery add-on	$234	$234	$199	$199	$204	$184	$163	$163	N/A	$192
	Average % of Medicare Fees			**80%**	**83%**	**54%**	**79%**	**65%**	**67%**	**39%**	**85%**
	Radiology										
70450	Ct head/brain w/o dye	$182	$182	$177	$177	$170	$142	$111	$111	$117	$157
71010	Chest x-ray	$26	$26	$20	$20	$24	$20	$16	$16	$19	$22
71020	Chest x-ray	$34	$34	$26	$26	$31	$26	$20	$20	$25	$29
72193	Ct pelvis w/ dye	$302	$302	$259	$259	$282	$235	$177	$177	$140	$262
73610	X-ray exam of ankle	$38	$38	$24	$24	$35	$29	$23	$23	$27	$33
73630	X-ray exam of foot	$36	$36	$24	$24	$33	$28	$22	$22	$19	$31
74000	X-ray exam of abdomen	$27	$27	$21	$21	$25	$21	$17	$17	$18	$23
74160	Ct abdomen w/ dye	$307	$307	$263	$263	$287	$239	$180	$180	$149	$266
76805	Ob us >/= 14 wks, sngl fetus	$160	$160	$110	$110	$150	$133	$100	$100	$78	$140
76815	Ob us, limited, fetus(s)	$99	$99	$70	$70	$93	$81	$61	$61	$64	$85
	Average % of Medicare Fees			**82%**	**82%**	**93%**	**79%**	**60%**	**60%**	**58%**	**86%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Laboratory										
80053	Comprehen metabolic panel	$15	$15	$11	$11	$14	$14	$13	$13	$12	$12
80061	Lipid panel	$17	$17	$13	$13	$18	$18	$17	$17	$14	$17
81002	Urinalysis nonauto w/o scope	$4	$4	$3	$3	$3	$3	$3	$3	$4	$2
83655	Assay of lead	$17	$17	$12	$12	$16	$16	$15	$15	$10	$8
85025	Complete cbc w/ auto diff wbc	$11	$11	$8	$8	$10	$10	$10	$10	$6	$5
86592	Blood serology, qualitative	$5	$5	$4	$4	$6	$5	$5	$5	$4	$3
87081	Culture screen only	$9	$9	$7	$7	$9	$9	$8	$8	$5	$4
87086	Urine culture/colony count	$11	$11	$9	$9	$11	$10	$10	$10	$8	$6
87491	Chylmd trach, dna, amp probe	$43	$43	$33	$33	$47	$43	$43	$43	$23	$23
87880	Strep a assay w/ optic	$16	$16	$13	$13	$15	$16	$15	$15	$6	$7
	Average % of Medicare Fees			**77%**	**77%**	**101%**	**97%**	**94%**	**94%**	**62%**	**59%**
	Medicine										
	Psychiatry										
90791	Psy dx evaluation (no medical)	$159	$122	$147	N/A	$150	$128	$108	$86	$26	$133
90792	Psy dx evaluation (w/ medical)	$130	$126	$147	N/A	$123	$105	$91	$89	$75	$107
90832	Psytx, 30 min	$66	$51	$48	N/A	$62	$53	$45	$36	$26	$55
90834	Psytx, 45 min	$84	$76	$88	N/A	$80	$68	$59	$55	$39	$69
90837	Psytx, 60 min	$123	$115	$98	N/A	$116	$100	$87	$82	$52	$101
90847	Family psytx w/ patient	$92	$96	$92	$87	$87	$75	$65	$68	N/A	$76
90853	Group psychotherapy	$26	$26	$24	N/A	$24	$21	$18	$18	N/A	$21
	Average % of Medicare Fees			**98%**	**N/A**	**95%**	**81%**	**70%**	**71%**	**19%**	**83%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Dialysis										
90935	Hemodialysis, one evaluation	$75	$75	$49	$49	$70	$60	$52	$52	$50	$62
90937	Hemodialysis, repeated eval	$107	$107	$80	$80	$100	$86	$74	$74	$50	$89
90945	Dialysis, one evaluation	$90	$90	$51	$51	$84	$72	$60	$60	$35	$75
	Average % of Medicare Fees			**66%**	**66%**	**94%**	**81%**	**69%**	**69%**	**64%**	**83%**
	Gastroenterology										
91034	Gastroesophageal reflux test	$219	$219	$167	$167	$205	$171	$133	$133	$172	$189
91110	Gi tract capsule endoscopy	$1,028	$1,028	$733	$733	$960	$822	$635	$635	N/A	$915
	Average % of Medicare Fees			**73%**	**73%**	**93%**	**85%**	**61%**	**61%**	**21%**	**88%**
	Ophthalmology and Vision Care										
92004	Eye exam, new patient	$162	$106	$95	$65	$151	$128	$104	$72	$59	$138
92012	Eye exam established pat	$94	$56	$53	$32	$88	$74	$60	$38	$29	$80
92014	Eye exam & treatment	$135	$85	$77	$50	$126	$107	$87	$57	$45	$115
92015	Refraction	$21	$20	$28	$14	$19	$17	$14	$14	$5	$17
92060	Special eye evaluation	$72	$72	$40	$40	$67	$56	$45	$45	$34	$61
92081	Visual field examination(s)	$38	$38	$38	$38	$35	$30	$28	$28	$28	$32
	Average % of Medicare Fees			**62%**	**62%**	**93%**	**79%**	**65%**	**68%**	**35%**	**85%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Otorhinolaryngology										
92551	Pure tone hearing test, air	$14	$14	$8	$8	$13	$11	$8	$8	$8	$12
92552	Pure tone audiometry, air	$35	$35	$18	$18	$33	$27	$21	$21	$8	$31
92557	Comprehensive hearing test	$40	$34	$47	$44	$37	$32	$26	$23	$29	$33
92567	Tympanometry	$15	$11	$16	$13	$14	$12	$10	$7	$12	$13
92568	Acoustic refl threshold tst	$16	$16	$16	$16	$15	$13	$11	$11	$10	$13
92585	Auditory evoked potentials (ABR comprehensive)	$143	$143	$101	$101	$133	$111	$85	$85	$27	$123
92587	Evoked auditory testing	$23	$23	$40	$40	$21	$18	$16	$16	$34	$19
	Average % of Medicare Fees			**85%**	**86%**	**93%**	**78%**	**62%**	**62%**	**62%**	**86%**
	Cardiovascular Medicine										
93000	Electrocardiogram, complete	$20	$20	$18	$18	$18	$16	$12	$12	$19	$17
93010	Electrocardiogram report	$9	$9	$6	$6	$8	$7	$6	$6	$8	$7
93016	Cardiovascular stress test	$22	$22	$18	$18	$0	$18	$15	$15	$22	$19
93042	Rhythm ECG, report	$8	$8	$6	$6	$7	$6	$5	$5	$7	$6
93303	Echo transthoracic	$214	$214	$171	$171	$200	$167	$131	$131	$157	$184
93307	Tte w/o doppler, complete	$123	$123	$123	$123	$115	$97	$77	$77	$140	$106
93320	Doppler echo exam, heart	$48	$48	$48	$48	$45	$38	$30	$30	$61	$41
93325	Doppler color flow add-on	$22	$22	$22	$22	$20	$17	$13	$13	N/A	$19
	Average % of Medicare Fees			**91%**	**91%**	**92%**	**79%**	**62%**	**62%**	**92%**	**85%**
	Non-Invasive Vascular Diagnostic Studies										
93880	Extracranial study	$200	$200	$140	$140	$187	$207	$159	$159	$148	$232
93970	Extremity study	$206	$206	$143	$143	$192	$164	$126	$126	$147	$183
93971	Extremity study	$128	$128	$91	$91	$119	$99	$77	$77	$100	$110
93976	Vascular study	$231	$231	$162	$162	$216	$182	$143	$143	$131	$200
	Average % of Medicare Fees			**70%**	**70%**	**93%**	**82%**	**64%**	**64%**	**68%**	**91%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Pulmonary										
94010	Breathing capacity test	$41	$41	$26	$26	$38	$32	$24	$24	$15	$35
94060	Evaluation of wheezing	$70	$70	$45	$45	$65	$54	$42	$42	$19	$61
94375	Respiratory flow volume loop	$44	$44	$28	$28	$41	$34	$27	$27	$31	$38
94640	Airway inhalation treatment	$21	$21	$11	$11	$20	$16	$12	$12	N/A	$19
94664	Evaluate pt use of inhaler	$21	$21	$12	$12	$19	$16	$12	$12	$12	$18
94760	Measure blood oxygen level	$4	$4	$2	$2	$3	$3	$2	$2	$2	$3
94761	Measure blood oxygen level	$6	$6	$5	$5	$5	$4	$3	$3	$4	$5
	Average % of Medicare Fees			**59%**	**59%**	**92%**	**77%**	**59%**	**59%**	**31%**	**87%**
	Allergy and Immunology										
95004	Percut allergy skin tests	$7	$7	$4	$4	$7	$6	$4	$4	$2	$6
95024	Id allergy test, drug/bug	$9	$1	$5	$5	$8	$7	$5	$1	$5	$8
95115	Immunotherapy, one injection	$10	$10	$10	$10	$10	$8	$6	$6	$4	$9
95117	Immunotherapy injections	$12	$12	$13	$13	$11	$9	$7	$7	$7	$10
95165	Antigen therapy services	$14	$4	$9	$2	$13	$11	$9	$2	$8	$12
	Average % of Medicare Fees			**92%**	**99%**	**92%**	**77%**	**59%**	**59%**	**48%**	**87%**
	Neurology and Neuromuscular										
95810	Polysomnography, 4 or more	$703	$703	$628	$628	$655	$547	$423	$423	$347	$608
95816	EEG, awake and drowsy	$454	$454	$165	$165	$423	$352	$270	$270	$23	$394
95819	EEG, awake and asleep	$522	$522	$167	$167	$487	$405	$309	$309	$23	$453
95860	Muscle test, one limb	$137	$137	$64	$64	$129	$108	$85	$85	$30	$118
95926	Somatosensory testing	$208	$208	$78	$78	$194	$161	$124	$124	$58	$180
95957	EEG digital analysis	$507	$507	$181	$181	$473	$394	$305	$305	$138	$438
	Average % of Medicare Fees			**57%**	**57%**	**93%**	**78%**	**60%**	**60%**	**25%**	**87%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	CNS Assessment Tests										
96110	Developmental test, lim	$10	$10	$9	$9	$9	$8	$6	$6	$7	$9
96111	Developmental test, extend	$134	$126	$96	$94	$0	$107	$92	$87	$50	$111
	Average % of Medicare Fees			**75%**	**78%**	**21%**	**80%**	**67%**	**67%**	**45%**	**84%**
	Chemotherapy Administration										
96411	Chemo, iv push, addl drug	$68	$68	$53	$53	$63	$53	$41	$41	$53	$59
96413	Chemo, iv infusion, 1 hr	$157	$157	$126	$126	$146	$121	$93	$93	$125	$136
96415	Chemo, iv infusion, addl hr	$33	$33	$28	$28	$31	$26	$20	$20	$28	$29
96417	Chemo iv infus each addl seq	$78	$78	$62	$62	$72	$60	$46	$46	$62	$67
96450	Chemotherapy, into CNS	$195	$83	$212	$75	$182	$153	$122	$57	$77	$167
96523	Irrig drug delivery device	$28	$28	$21	$21	$26	$21	$16	$16	$19	$24
	Average % of Medicare Fees			**82%**	**80%**	**93%**	**78%**	**60%**	**60%**	**77%**	**87%**
	Dermatology										
96910	Photochemotherapy with UV-B	$84	$84	$46	$46	$78	$65	$49	$49	$20	$73
96912	Photochemotherapy with UV-A	$107	$107	$59	$59	$100	$83	$62	$62	$20	$94
	Average % of Medicare Fees			**55%**	**55%**	**93%**	**77%**	**58%**	**58%**	**21%**	**87%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Physical Medicine and Rehabilitation										
97001	Physical therapy evaluation	$79	$79	$72	$72	$75	$63	$52	$52	$45	$67
97010	Hot or cold packs therapy	$7	$7	$4	$4	$6	$5	$4	$4	$17	$6
97014	Electric stimulation therapy	$17	$17	$10	$10	$16	$14	$11	$11	$17	$15
97035	Ultrasound therapy	$13	$13	$9	$9	$13	$11	$9	$9	$10	$11
97110	Therapeutic exercises	$34	$34	$29	$29	$32	$27	$22	$22	$8	$29
97112	Neuromuscular reeducation	$36	$36	$21	$21	$34	$28	$23	$23	$17	$30
97140	Manual therapy	$32	$32	$19	$19	$30	$25	$20	$20	$21	$27
97530	Therapeutic activities	$37	$37	$31	$31	$35	$30	$24	$24	$13	$32
	Average % of Medicare Fees			**75%**	**75%**	**94%**	**80%**	**65%**	**65%**	**52%**	**85%**
	Osteopathy, Chiropractic and Other Medicine										
98941	Chiropractic manipulation	$38	$32	$25	$21	$0	$31	$26	$22	N/A	$32
99144	Mod sedation by same phys, age 5 years or older	$44	$0	$28	$28	$0	$61	$0	$0	N/A	$0
99173	Visual acuity screen	$3	$3	$2	$2	$3	$64	$2	$2	$6	$3
99183	Hyperbaric oxygen therapy	$235	$127	$150	$85	$217	$185	$150	$87	$107	$199
	Average % of Medicare Fees			**64%**	**80%**	**75%**	**826%**	**53%**	**64%**	**91%**	**72%**

MC: Medicare; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available.

V. Trauma Center Payment Issues

During the 2003 legislative session, the Maryland General Assembly passed, and the Governor signed into law, SB 479 (Chapter 385 of the Acts of 2003) 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 law, Maryland Medicaid is required to pay physicians 100 percent of the Medicare facility rates for the Baltimore area when they provide trauma care to Medicaid's FFS and HealthChoice program enrollees. The enhanced Medicaid fees apply only to services rendered in trauma centers designated by the Maryland Institute for Emergency Medical Services Systems for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fees were limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, HB 1164 (Chapter 484) of the 2006 legislative session extended the enhanced rates to any physician who provides trauma care to Medicaid beneficiaries, beginning July 1, 2006. MHCC and the HSCRC fully cover the additional outlay of general funds that the Maryland Medical Assistance program incurs due to enhanced trauma fees (the state's share of the difference between current Medicare rates and Medicaid rates). MHCC pays physicians directly for uncompensated care and on-call services.

VI. Reimbursement for Oral Health Services

Historically, the Maryland Medical Assistance program has had low dental fees. Unlike fees for physician services, there is no federal public program (such as Medicare) to serve as a benchmark for oral health service fees. However, every two years, the American Dental Association (ADA) publishes a survey, reporting the national and regional average charges for approximately 165 of the most common dental procedures, offering data for comparison. Also, a book entitled the National Dental Advisory Service contains the percentile of charges for approximately 520 (of a total of approximately 580) dental procedures.

During the 2003 session of the Maryland General Assembly, the legislature included budgetary language in HB 40 (Chapter 202) that 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 the ADA survey. In compliance with the budgetary language, effective March 1, 2004, MCOs were required to reimburse their contracted providers at the ADA's then-current 50th percentile of charges for 12 restorative procedures. At the same time, Medicaid increased FFS rates to the ADA's 50th percentile levels for the corresponding restorative procedures.

In June 2007, the Secretary of the Maryland Department of Health and Mental Hygiene convened the Dental Action Committee to increase access to dental care services for Maryland children whose families have low incomes. The Dental Action Committee recommended increasing the dental reimbursement rates to the 50th percentile of the ADA's South Atlantic

region charges for all dental procedures. Subsequently, SB 545 (Chapter 589) of the 2008 session of the Maryland General Assembly allocated $7 million in state funds ($14 million with matching federal funds) for increasing dental fees in FY 2009. The rate increase targeted preventive procedures and went into effect on July 1, 2008.

Based on the recommendations of the Dental Action Committee, effective July 1, 2009, an administrative service organization (ASO)—DentaQuest, formerly Doral Dental—coordinates the provision of dental services for Medicaid beneficiaries in the FFS program. Fees for some of the dental procedures were streamlined and adjusted, effective July 1, 2009, to coincide with the provision of all Medicaid dental services through the ASO. Fees for dental procedures did not change in FY 2013 from their FY 2012 levels.

Table 7 shows Maryland Medicaid FY 2014 weighted average dental fees by groups of procedures as percentages of the ADA's 50th percentile of charges in 2011.

Table 7. Average of Maryland Medicaid Dental Fees as a Percentage of the ADA's 50th Percentile of Charges in 2011

Procedure Groups	**FY 2014 Weighted Average Medicaid Fees**
D0100-D1999 Diagnostic & Preventive Procedures	66%
D2000-D2999 Restorative Procedures	60%
D3000-D3999 Endodontic Procedures	63%
D4210-D6999 Periodontics and Prosthodontics	56%
D7000-D7999 Oral and Maxillofacial Surgery	62%
D8000-D9999 Orthodontics & Adjunctive General Services	75%
All Procedures Combined	**64%**

Table 8 compares Maryland Medicaid dental fees for selected high-volume procedures with the corresponding fees in Delaware, Virginia, and Washington, D.C. Because West Virginia had some missing fees, its fees are not included in the table. We used Maryland's number of claims for these dental procedures to determine the weighted average rank of Maryland and neighboring states' fees. The ranking of states' fees are: Delaware (first), Washington, D.C., (second), Maryland (third), Virginia (fourth), and Pennsylvania (fifth).

Table 8. Maryland Medicaid and Neighboring States' FY 2014 Dental Fees

Procedure Code	Procedure Description	ADA 2011	MD	DE	PA	VA	DC
D0120	Periodic Oral Examination	$42	$29	$44	$20	$20	$35
D0140	Oral Evaluation-Limited- Focused	$65	$43	$66	N/A	$25	$50
D0145	Oral Evaluation, Patient < 3 Yrs Old	$53	$40	$59	N/A	$20	$40
D0150	Comprehensive Oral Evaluation	$73	$52	$77	$20	$31	$78
D1110	Prophylaxis Adult 14 and Over	$80	$58	$79	$36	$47	$78
D1120	Prophylaxis Child Up to Age 14	$59	$42	$59	$30	$34	$47
D1203	Topic Appl of Fluor Exclud Proph-	$30	$22	N/A	$18	$21	N/A
D1204	Topical Appl of Fluoride (No Prophylxs)	$31	$23	N/A	N/A	$21	N/A
D1206	Topical Fluoride Varnish	$35	$25	$38	$18	$21	$29
D1351	Sealant per Tooth, Max 4 Per Quad	$46	$33	$47	$25	$32	$38
D7140	Extraction, Erupted Tooth or Exposed	$150	$103	$153	$65	$69	$110
D9248	Non-Intravenous Conscious Sedation	N/A	$187	$277	$184	$110	$0
	State Rank		**3**	**1**	**5**	**4**	**2**

VII. Physician Participation in the Maryland Medicaid Program

Physician claims and encounter data pertaining to FY 2002 (the year before the July 2002 fee increase), FY 2010, FY 2011, and FY 2012 were analyzed to determine the number of physicians who had partial or full participation in the Medicaid program.[3] In Tables 9, 10, and 11, physicians with fewer than 25 claims during the fiscal year are included in the data for all physicians, but are not shown separately. Physicians who submitted more than 25 claims, but had fewer than 50 Medicaid patients, were considered partial participants in the Medicaid program. Physicians with at least 50 Medicaid patients during the year were considered full participants in the Medicaid program.

Tables 9, 10, and 11 show the percentage changes in the numbers of participating physicians from all specialties (including primary care) who participated in FFS programs, MCO networks, and the total Medicaid program. The data in Table 9 demonstrate significant increases in physician participation in the FFS program, MCO networks, and the total Medicaid program between FY 2002 and FY 2012. Comparable figures for the FY 2002 through FY 2011 period for "All Physicians" in the FFS program, MCO networks, and total Medicaid program were 37 percent, 66.3 percent, and 106.1 percent, respectively.

[3] The data in these tables pertain to FY 2002 through FY 2012. Therefore, to some extent, these tables include the impact of fee changes in FY 2010 and FY 2012 on physician participation in the Medicaid program.

Table 9. FY 2002-2012 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	51.0%	66.1%	122.8%
Full Participation	65.3%	163.1%	145.3%
All Physicians	41.7%	86.4%	125.2%

FFS: fee-for-service program; MCO: managed care organization

Because some physicians participate in both FFS and MCO networks, the percentages of total physicians participating in the Medicaid program are not the sum of FFS and MCO network physicians.

Similarly, examination of the data in Table 10 shows that, following the FY 2008 and FY 2009 fee increases, except for full participation in the FFS program, physician participation increased significantly between FY 2010 and FY 2012. During this period, the total number of physicians participating in the FFS program increased from approximately 15,908 in FY 2010 to 16,368 in FY 2011 and 16,911 in FY 2012. The decrease in the number of physicians who fully participate in the FFS program may reflect the fact that some physicians reduced their levels of participation in the Medicaid FFS program following the fee decrease in FY 2012.

Table 10. FY 2010-2012 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	5.0%	10.9%	10.2%
Full Participation	-15.0%	23.3%	14.2%
All Physicians	6.3%	16.1%	15.5%

FFS: fee-for-service program; MCO: managed care organization

Data in Table 11 show that the increasing trend in total physician participation in the Medicaid program continued between FY 2011 and FY 2012.

Table 11. FY 2011-2012 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	2.9%	9.5%	6.6%
Full Participation	-9.4%	10.8%	6.9%
All Physicians	3.3%	10.9%	8.5%

FFS: fee-for-service program; MCO: managed care organization

It is likely that, with the reductions in Medicaid physician fees in FY 2010 and FY 2012 and increasing costs, some physicians have decided to reduce their levels of participation in the Medicaid FFS program. However, the decrease in the number of physicians with full

participation from 2,251 in FY 2010 to 2,112 in FY 2011, and the subsequent reduction to 1,914 full-participation physicians in FY 2012 should not pose a problem for access of FFS Medicaid beneficiaries to physician services. The increase in total physician participation within the FFS program (particularly the increase in partial participation among physicians) compensates for the 337 physicians who have reduced their levels of participation in the FFS program. Furthermore, there was an increase in the number of physicians who participate in MCO networks, both partial and full participants.

Between FY 2011 and FY 2012, the number of physicians who had fewer than 25 claims increased by 10.2 percent (figure not presented in the table). Moreover, the number of partially and fully participating physicians with more than 25 claims increased by 6.6 percent and 6.9 percent, respectively. After taking into account these increases, the data show that 3,965 additional physicians participated in the Medicaid program in FY 2012, compared with FY 2011. This indicates that some of the partial- and full-participation physicians did not previously participate in the Medicaid program.

The increase in the number of participating physicians is, to some extent, the result of Medicaid expansion and increased enrollment. Therefore, to separate the effects of the increase in physician fees from the effects of the increase in Medicaid enrollment, we conducted an additional analysis in which we calculated the number of claims per enrollee for each year, beginning in FY 2002 (see Table 12). For this analysis, we excluded radiology and laboratory procedures for all years, because they may not be representative of patient access to physician services.

Table 12. Number of Claims per Medicaid Enrollee

Fiscal Year	Average Monthly Medicaid Enrollment	Number of Physician Claims and Encounters	Average Number of Claims Per Enrollee	Annual % Change in Claims Per Enrollee	Increase in Claims Per Enrollee From Each Year to 2012
2002	617,929	3,919,805	6.3	N/A	51.0%
2003	652,414	4,281,928	6.6	3.5%	45.9%
2004	669,021	4,789,248	7.2	9.1%	33.8%
2005	687,269	4,891,558	7.1	-0.6%	34.6%
2006	690,227	5,253,246	7.6	6.9%	25.9%
2007	700,930	5,527,421	7.9	3.6%	21.5%
2008	709,832	6,079,603	8.6	8.6%	11.8%
2009	772,582	6,933,686	9.0	4.8%	6.7%
2010	867,788	8,168,381	9.4	4.9%	1.8%
2011	951,716	9,185,395	9.7	2.5%	-0.8%
2012	1,013,158	9,704,541	9.6	-0.8%	N/A

N/A: Not Applicable

The continued increase in the average number of claims per enrollee shows that, as physician reimbursement rates increased during the FY 2006 to FY 2009 period, Medicaid enrollees' utilization of physician services also increased steadily, from an average of 6.3 claims per enrollee in FY 2002 to an average of 9.6 claims per enrollee in FY 2012. This is a 51 percent increase in utilization of physician services by Medicaid enrollees, which is a proxy for an increase in the participation of physicians in the Maryland Medicaid program and may be interpreted as an increase in the access of Medicaid enrollees to physician services. The small decrease in numbers of claims per enrollee, from 9.7 in FY 2011 to 9.6 in FY 2012, is not significant and may be due to FY 2012 claims data not being completed, i.e., incurred but not reported (IBNR) claims.

Comparison of Access to Medical Care for Medicaid and Private Coverage

In a report published in November 2012, the U.S. Government Accountability Office (GAO) analyzed two national surveys – the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS) – for 2008 and 2009 to evaluate the extent to which Medicaid beneficiaries reported difficulties obtaining medical care. These national surveys rely on information reported by individuals who voluntarily participate in the surveys. The GAO also compared the results for Medicaid with private/commercial insurance coverage.

The GAO found that, "Beneficiaries covered by Medicaid for a full year reported low rates of difficulty obtaining necessary medical care and prescription medicine, similar to those with private insurance coverage for a full year. In calendar years 2008 and 2009, approximately 3.7 percent of Medicaid beneficiaries enrolled for a full year and 3 percent of individuals enrolled in private insurance for a full year reported difficulties obtaining needed medical care; the difference between these two groups was not statistically significant. In addition, 2.7 percent of full-year Medicaid beneficiaries reported difficulty obtaining needed prescription medicines and about 2.4 percent of individuals with full-year private insurance reported the same issue—also not statistically significant." However, 5.4 percent of full-year Medicaid beneficiaries, compared with 3.7 percent with full-year private insurance coverage, reported experiencing difficulty obtaining necessary dental care.

VIII. Plan for Future

One of the Department's goals remains to reimburse physicians at 100 percent of Medicare reimbursement rates. The ACA provides temporary enhanced federal funding for increasing the reimbursement rates of physicians who self-attest to being primary care providers, which helps Maryland achieve this goal for some procedures. Specifically, the ACA requires states to pay 100 percent of Medicare rates for E&M services and vaccine administration provided by PCPs during calendar years 2013 and 2014. The federal government will pay 100 percent of the increase in reimbursement rates for these two years. Maryland will pay non-PCPs for these services at the Medicare rate as well. The federal government will match the cost of the services provided by non-PCPs at Maryland's normal matching rate of 50 percent. Another goal of the Department is to increase the dental reimbursement rates to the 50th percentile of the ADA's South Atlantic region charges for all dental procedures.

Appendix A: Medicare Resource-Based Relative Value Scale and Anesthesia Reimbursement

Medicare payments for physician services are made according to a fee schedule. The Medicare Resource-Based Relative Value Scale (RBRVS) methodology relates payments to the resources and skills that physicians use to provide services. There are three components that determine the relative weight of each procedure: physician work, malpractice expense, and practice expense. A geographic cost index and conversion factor are used to convert the weights to fees.

For approximately 11,000 physician procedures, the Centers for Medicare & Medicaid Services (CMS) determines the associated relative value units (RVUs) and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending on the site in which each procedure is performed. For example, Medicare fees for some procedures are lower if they are performed in facilities (e.g., hospitals and skilled nursing facilities) than if they are performed in non-facilities (e.g., offices), where physicians must pay for practice expenses. The implementation of RBRVS in 1992 resulted in increased payments for office-based (non-facility) procedures and reduced payments for hospital-based procedures.

The RVU weights reflect the resource requirements of each procedure performed by physicians. The Medicare physician fees are adjusted to reflect the variations in practice costs for different areas. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's RVU (i.e., physician work, practice expense, and malpractice expense). Each locality's GPCI is used to calculate fees 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.

CMS updates the conversion factor based on the Sustainable Growth Rate (SGR) system, which ties the updates to growth in the national economy. The SGR system is based on formulas that are designed to control overall spending, while accounting for factors that affect the costs of providing care. Medicare rates are adjusted annually. In 2002, overall Medicare rates actually decreased. However, following federal legislative mandates, Medicare physician fees increased by small percentages in subsequent years.

Currently, a proposal is under consideration in the US Congress that would permanently repeal the SGR update mechanism, reform the FFS payment system through greater focus on value over volume, and encourage participation in alternative payment models. The revised FFS system would freeze current payment levels through the ten-year budget window, while allowing individual physicians and other health care professionals to earn performance-based incentive payments through a budget-neutral program starting in 2016.

Payment for Anesthesia Procedures

Prior to December 1, 2003, the Maryland Medicaid program reimbursed anesthesia services based on a percentage of the surgical fee. The program in general did not use the anesthesia CPT 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. In late

2003, the Medicaid program complied with the federal standards and began transitioning from a fixed anesthesia rate for each surgical procedure to Medicare's national methodology.

Medicare payments for anesthesia services represent a departure from the RBRVS methodology. Medicare's methodology recognizes anesthesia time as the key element for determining the payment rate. The anesthesia time for any additional procedures performed 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.

More than 5,000 surgical procedure codes exist, but there are less than 300 anesthesia codes. Each anesthesia procedure code has a non-variable number of base units. Similar to the RBRVS, the base units represent the difficulty associated with a given group of procedures. The base units for the selected anesthesia codes are added to the units related to anesthesia time, and the result is multiplied by a conversion factor to determine the payment amount. The Maryland Medicaid program calculates the payment slightly differently, but the net result is the same.

Appendix B: Number of Physicians and Dentists in Each State, and per 10,000 Population in 2012

Source: All data in this appendix were downloaded from the website of the Kaiser Family Foundation, State Health Facts:
http://www.statehealthfacts.org

Table B.1. Number of Physicians by State in 2012, Ranked by Number per 10,000 Population

Rank	Geographic Area	Primary Care Physicians	Specialist Physicians	Total Physicians	Physicians in Patient Care per 10,000
	United States	**394,623**	**435,050**	**829,673**	**25.7**
1	District of Columbia	2,559	3,639	6,198	65.9
2	Massachusetts	13,424	16,400	29,824	39.7
3	**Maryland**	**9,033**	**10,886**	**19,919**	**35.3**
4	New York	29,917	38,216	68,133	34.8
5	Rhode Island	1,977	2,044	4,021	34.5
6	Connecticut	5,478	6,701	12,179	33.5
7	Vermont	974	1,041	2,015	33.3
8	New Jersey	11,903	13,083	24,986	30.0
9	Hawaii	1,730	1,737	3,467	29.6
10	Pennsylvania	19,288	21,835	41,123	29.6
11	Maine	2,072	2,025	4,097	28.2
12	Minnesota	7,428	7,934	15,362	27.0
13	New Hampshire	1,741	1,925	3,666	26.9
14	Oregon	5,060	5,307	10,367	26.1
15	Ohio	15,949	18,433	34,382	25.9
16	Illinois	17,666	17,641	35,307	25.8
17	Michigan	14,795	16,070	30,865	25.5
18	Virginia	9,872	10,743	20,615	25.5
19	Washington	9,048	9,654	18,702	25.1
20	Colorado	6,278	6,490	12,768	24.7
21	Delaware	1,266	1,381	2,647	24.7
22	Tennessee	7,675	8,796	16,471	24.6
23	Wisconsin	7,236	7,959	15,195	24.6
24	California	45,486	49,197	94,683	24.4
25	Florida	22,624	23,993	46,617	24.2
26	Louisiana	5,055	6,077	11,132	24.2
27	Missouri	7,874	8,833	16,707	24.1

Rank	Geographic Area	Primary Care Physicians	Specialist Physicians	Total Physicians	Physicians in patient care per 10,000 Population
28	North Dakota	860	756	1,616	23.6
29	North Carolina	11,098	12,098	23,196	23.4
30	West Virginia	2,324	2,407	4,731	23.3
31	Nebraska	2,265	2,191	4,456	23.1
32	Alaska	867	777	1,644	22.5
33	New Mexico	2,408	2,412	4,820	22.3
34	Kansas	3,335	3,063	6,398	22.0
35	Montana	1,012	1,061	2,073	21.9
36	South Dakota	959	915	1,874	21.8
37	Kentucky	4,668	5,510	10,178	21.7
38	South Carolina	5,166	5,226	10,392	21.7
39	Indiana	7,129	7,557	14,686	21.0
40	Alabama	4,979	5,426	10,405	20.6
41	Arizona	7,400	7,822	15,222	20.6
42	Texas	25,608	28,214	53,822	20.2
43	Georgia	10,670	10,826	21,496	20.1
44	Iowa	3,677	3,428	7,105	19.5
45	Arkansas	2,884	2,845	5,729	19.4
46	Utah	2,553	3,152	5,705	19.3
47	Oklahoma	4,033	4,008	8,041	18.9
48	Wyoming	535	516	1,051	18.7
49	Nevada	2,549	2,666	5,215	18.5
50	Mississippi	2,843	2,806	5,649	17.3
51	Idaho	1,393	1,328	2,721	17.0

Note: Physician data include all active allopathic and osteopathic physicians. The last column is based on numbers of physicians in patient care per 10,000 population. Maryland ranks third in number of physicians per 10,000 population among all states and the District of Columbia.

Table B.2. Primary Care Physicians by Specialty, August 2012

	Internal Medicine	Family Medicine/ General Practice	Obstetrics/ Gynecology	Pediatrics	Total Primary Care
United States	161,929	117,340	44,845	70,509	394,623
Alabama	1,986	1,573	586	834	4,979
Alaska	193	469	87	118	867
Arizona	2,942	2,373	846	1,239	7,400
Arkansas	726	1,425	273	460	2,884
California	18,947	12,709	5,162	8,668	45,486
Colorado	2,205	2,343	724	1,006	6,278
Connecticut	3,041	649	757	1,031	5,478
Delaware	451	336	139	340	1,266
District of Columbia	1,286	303	292	678	2,559
Florida	9,516	6,899	2,380	3,829	22,624
Georgia	4,261	2,888	1,464	2,057	10,670
Hawaii	735	444	243	308	1,730
Idaho	328	777	148	140	1,393
Illinois	7,769	4,829	2,038	3,030	17,666
Indiana	2,347	2,960	770	1,052	7,129
Iowa	1,049	1,840	287	501	3,677
Kansas	1,018	1,543	350	424	3,335
Kentucky	1,705	1,617	574	772	4,668
Louisiana	1,968	1,426	705	956	5,055
Maine	701	922	169	280	2,072
Maryland	**4,656**	**1,437**	**1,109**	**1,831**	**9,033**
Massachusetts	7,912	1,632	1,210	2,670	13,424
Michigan	5,999	4,876	1,808	2,112	14,795
Minnesota	2,722	3,024	683	999	7,428
Mississippi	999	1,033	376	435	2,843
Missouri	3,179	2,291	850	1,554	7,874
Montana	303	500	111	98	1,012

	Internal Medicine	Family Medicine/ General Practice	Obstetrics/ Gynecology	Pediatrics	Total Primary Care
Nebraska	713	974	227	351	2,265
Nevada	1,123	781	293	352	2,549
New Hampshire	735	532	183	291	1,741
New Jersey	5,690	2,179	1,433	2,601	11,903
New Mexico	804	950	239	415	2,408
New York	15,308	4,706	3,598	6,305	29,917
North Carolina	3,359	4,318	1,354	2,067	11,098
North Dakota	256	457	54	93	860
Ohio	6,447	4,633	1,738	3,131	15,949
Oklahoma	1,130	1,869	413	621	4,033
Oregon	2,094	1,736	540	690	5,060
Pennsylvania	8,470	5,878	2,016	2,924	19,288
Rhode Island	1,120	217	220	420	1,977
South Carolina	1,736	1,958	641	831	5,166
South Dakota	308	475	73	103	959
Tennessee	3,098	2,198	938	1,441	7,675
Texas	9,057	8,246	3,303	5,002	25,608
Utah	798	863	346	546	2,553
Vermont	364	332	98	180	974
Virginia	3,684	3,123	1,181	1,884	9,872
Washington	3,150	3,655	848	1,395	9,048
West Virginia	777	1,010	220	317	2,324
Wisconsin	2,635	2,836	690	1,075	7,236
Wyoming	129	296	58	52	535

Note: Physician data include allopathic and osteopathic physicians.

Table B.3. Non-Primary Care Physicians by Specialty, August 2012

	Anesthesiology	Emergency Medicine	Oncology (Cancer)	Psychiatry	Surgery	Endocrinology, Diabetes, and Metabolism	Cardiology	All Other Specialties	Total Specialty Physicians
United States	**43,473**	**41,255**	**14,583**	**47,005**	**44,900**	**6,012**	**26,993**	**210,829**	**435,050**
Alabama	514	359	169	436	668	52	354	2,874	5,426
Alaska	74	115	12	100	76	5	34	361	777
Arizona	960	873	197	744	834	86	439	3,689	7,822
Arkansas	261	233	85	264	296	26	171	1,509	2,845
California	5,255	4,700	1,409	6,258	4,637	645	2,742	23,551	49,197
Colorado	783	782	185	725	630	88	289	3,008	6,490
Connecticut	525	549	214	1,026	644	135	447	3,161	6,701
Delaware	91	175	52	143	149	12	101	658	1,381
District of Columbia	272	245	136	493	373	54	194	1,872	3,639
Florida	2,511	2,168	823	1,916	2,427	343	1,853	11,952	23,993
Georgia	1,106	1,106	363	1,080	1,275	134	689	5,073	10,826
Hawaii	166	192	39	268	174	23	70	805	1,737
Idaho	113	147	28	99	149	10	50	732	1,328
Illinois	1,861	1,923	561	1,792	1,795	250	1,118	8,341	17,641
Indiana	1,082	763	263	599	742	107	506	3,495	7,557
Iowa	388	254	105	291	440	28	231	1,691	3,428
Kansas	334	220	94	368	390	33	171	1,453	3,063
Kentucky	531	527	159	493	710	63	331	2,696	5,510
Louisiana	488	619	177	513	692	70	400	3,118	6,077
Maine	192	247	58	289	239	13	117	870	2,025
Maryland	**959**	**805**	**479**	**1,416**	**1,024**	**207**	**656**	**5,340**	**10,886**
Massachusetts	1,482	1,331	788	2,538	1,598	349	1,236	7,078	16,400
Michigan	1,351	2,267	464	1,339	1,842	164	866	7,777	16,070
Minnesota	608	709	294	679	840	142	552	4,110	7,934
Mississippi	272	290	92	245	354	35	173	1,345	2,806
Missouri	929	830	310	818	935	143	529	4,339	8,833
Montana	136	112	28	101	129	6	48	501	1,061

	Anesthesiology	Emergency Medicine	Oncology (Cancer)	Psychiatry	Surgery	Endocrinology, Diabetes, and Metabolism	Cardiology	All Other Specialties	Total Specialty Physicians
Nebraska	264	165	72	204	275	25	152	1,034	2,191
Nevada	336	317	68	226	252	32	158	1,277	2,666
New Hampshire	192	185	66	221	207	26	124	904	1,925
New Jersey	1,468	1,038	418	1,464	1,247	218	1,051	6,179	13,083
New Mexico	244	275	66	332	229	34	120	1,112	2,412
New York	3,478	2,812	1,387	5,558	3,221	578	2,404	18,778	38,216
North Carolina	977	1,249	438	1,332	1,253	163	789	5,897	12,098
North Dakota	65	68	25	109	95	9	33	352	756
Ohio	1,695	1,962	600	1,483	2,002	224	1,163	9,304	18,433
Oklahoma	473	431	121	361	440	35	215	1,932	4,008
Oregon	564	601	176	593	582	71	254	2,466	5,307
Pennsylvania	1,988	2,280	820	2,444	2,503	307	1,557	9,936	21,835
Rhode Island	122	269	82	226	245	35	128	937	2,044
South Carolina	457	552	143	601	665	63	317	2,428	5,226
South Dakota	63	46	25	83	120	9	50	519	915
Tennessee	795	672	355	679	1,033	116	550	4,596	8,796
Texas	3,277	2,292	1,021	2,518	3,064	367	1,766	13,909	28,214
Utah	406	364	73	264	271	32	142	1,600	3,152
Vermont	102	79	34	166	114	14	51	481	1,041
Virginia	1,004	1,072	293	1,186	1,048	176	610	5,354	10,743
Washington	1,136	953	379	927	901	114	454	4,790	9,654
West Virginia	204	249	65	209	292	32	121	1,235	2,407
Wisconsin	861	713	264	745	763	105	399	4,109	7,959
Wyoming	58	70	8	41	16	4	18	301	516

Note: Physician data include allopathic and osteopathic physicians.

Table B.4. Number of Dentists per State in 2012, Ranked by Number per 10,000 Population

Rank	Geographic Area	Number of Dentists	Dentists per 10,000 Population
Average	**United States**	**195,628**	**6.0**
1	District of Columbia	632	10.4
2	Massachusetts	5,725	8.2
3	Hawaii	1,068	8.1
4	New Jersey	7,272	8.1
5	New York	15,575	7.9
6	Connecticut	2,838	7.7
7	Alaska	572	7.6
8	California	30,591	7.6
9	**Maryland**	**4,491**	**7.5**
10	Washington	5,021	7.0
11	Oregon	1,706	6.8
12	Colorado	3,656	6.5
13	Utah	1,899	6.5
14	Illinois	8,711	6.4
15	Nebraska	1,238	6.3
16	New Hampshire	860	6.3
17	Pennsylvania	8,160	6.2
18	Michigan	6,151	6.1
19	Minnesota	3,324	6.1
20	Virginia	5,157	5.9
21	Idaho	912	5.8
22	Vermont	372	5.8
23	Montana	639	5.7
24	Wisconsin	3,310	5.7
25	Kentucky	2,580	5.6
26	Iowa	1,684	5.4
27	Rhode Island	580	5.4
28	Florida	10,362	5.3
29	Ohio	6,193	5.3
30	Kansas	1,463	5.2
31	Arizona	3,688	5.1
32	North Dakota	398	5.1
33	Wyoming	292	5.1
34	Maine	680	5.0
35	Nevada	1,460	5.0

Rank	Geographic Area	Number of Dentists	Dentists per 10,000 Population
36	Oklahoma	1,937	5.0
37	South Dakota	433	5.0
38	Tennessee	3,335	5.0
39	Louisiana	2,307	4.9
40	Indiana	3,196	4.8
41	Missouri	2,986	4.8
42	Delaware	419	4.7
43	West Virginia	916	4.7
44	New Mexico	1,062	4.6
45	South Carolina	2,328	4.6
46	Texas	13,293	4.6
47	Georgia	4,723	4.5
48	North Carolina	4,767	4.5
49	Alabama	2,169	4.4
50	Arkansas	1,216	4.1
51	Mississippi	1,281	4.1

Maryland has the ninth highest number of dentists per 10,000 people among all states.

Note: Data are for August 2012. Data include all professionally active dentists.
Source: American Dental Association, Dental Data, August 2012.

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