



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 – John M. Colmers, Secretary

DEC 28 2010

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
161 Lowe 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)

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 attached is the second report per the requirements of Ch. 656 of the Acts of 2009 concerning Medical Assistance reimbursement.

The Department was required to annually submit a report pursuant to Section 1 of SB 481 – *Department of Health and Mental Hygiene – Reimbursement Rates*. The Department was required to provide information on the progress in establishing a process for annually setting the fee-for-service reimbursement rates for Medical Assistance and the Maryland Children's Health Program. It also provided analysis of other states' rates compared to Maryland; the schedule for raising rates; and an analysis of the estimated cost of implementing these changes. This report was due on September 1 annually.

In addition, the Department incorporated into this report information required by HB 627 – *Community Health Care Access and Safety Net Act of 2005*. Section 11 of this Act required the Department to review the rates paid to providers under the federal Medicare fee schedule and compare those rates to the fee-for-service rates paid to similar providers for the same services under the Medical Assistance program and the rates paid to managed care organization providers for the same services. On or before January 1, the Department is to annually report this information and whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule.



The Honorable Thomas M. Middleton
The Honorable Peter A. Hammen
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The enclosed report satisfies the physician fee reporting requirements as stated. If further information on this subject is required, please contact Wynne Hawk, Director of the Office of Governmental Affairs, at (410) 767-6481.

Sincerely,

A handwritten signature in black ink, appearing to read "John Colmers". The signature is written in a cursive, flowing style.

John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Tricia Roddy
Audrey Richardson
Diane Herr

**Report on the Maryland Medical Assistance Program and the
Maryland Children’s Health Program—Reimbursement Rates
January 2011**

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Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program—Reimbursement Rates January 2011

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 the Maryland Medical Assistance (Medicaid) program and the Maryland Children's Health Program would be established annually in a manner that ensures provider participation. The law further stipulated that, in order to develop 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 Current Dental Terminology (CDT-3) codes. The RBRVS methodology is used in the federal Medicare program.

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

- The progress of the rate-setting process mentioned above
- A comparison of Maryland Medicaid's reimbursement rates with the rates of other states
- The schedule for bringing Maryland's reimbursement rates to a level that would ensure provider participation in the Medicaid program
- The estimated costs of implementing the above schedule and proposed changes to the fee-for-service reimbursement rates

In addition, the Department has 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 those rates with the fee-for-service rates for the same services paid to providers under the Maryland Medical Assistance program and managed care organizations (MCOs). On or before January 1 of every year, the Department is required to report this information and state whether the fee-for-service 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 Medical Assistance program and the Maryland Children's Health Program. In 2002, SB 481 required the submission of this report on an annual basis. This is the tenth annual report.

The Department's first annual report showed that Maryland's Medicaid 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 rate for a subset of procedures ranked 47th

among all Medicaid programs in the country. Based on the 2001 report, the Governor and the Legislature allocated \$50 million in additional total funds (\$25 million state funds) to increase physician fees in the Medicaid program, beginning July 2002. The increase was targeted to evaluation and management (E&M) procedure codes that are used by both primary care physicians and specialty care physicians.

SB 836 of the 2005 General Assembly session, 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 main revenues of the fund are from a tax imposed on MCOs and health maintenance organizations (HMOs). SB 836 allocated funds to the Maryland Medical Assistance program to increase both fee-for-service physician fees and capitation payments to MCOs to enable these organizations to similarly raise their provider fees. The legislation allocated \$15 million in additional state funds (\$30 million total funds) in fiscal year (FY) 2006 to be used 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 because of the substantial rise in their malpractice insurance premiums. The bill also allocates additional funds each year to the Maryland Medical Assistance program for maintaining and increasing physician fees.

SB 836 also required the Department to consult with the MCOs, the Maryland Hospital Association, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Maryland Chapter of the American College of Emergency Physicians to determine the new payment rates each year. These organizations are collectively referred to as stakeholders in this report. HB 1522 of the 2008 session modified provisions of the law enacted by SB 836 and included the Maryland State Dental Association and the Maryland Dental Society among entities with which the Department must consult to determine payment rates.

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

For FY 2007 and FY 2008, based on the stakeholders’ recommendations, the Department increased fees for procedures of different specialties, as shown in Table 1. In addition, procedures with the lowest fees were raised to a minimum of 50 percent of Medicare fees in FY 2008. The Department implemented other fee changes for FY 2009. In previous years, fees for many procedures, including orthopedic, gynecology/obstetrics, neurosurgery, otorhinolaryngology (ENT), and emergency medicine were set at 100 percent of their corresponding Medicare fee. Medicare fees in general had not increased substantially during the 2006 to 2008 period. However, updates in relative value units (RVUs) led to Medicare fee decreases 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 the 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 (e.g., hospitals) and non-facilities (e.g., offices).

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 procedures in four specialties (orthopedic, gynecology/obstetrics, neurosurgery, and emergency medicine) were set equal to 100 percent of Medicare fees, and fees for four obstetric procedures (normal and cesarean delivery procedures) were maintained at their FY 2008 levels, which are higher than their corresponding Medicare fees.

SB 836 allocated funds to increase capitation payments to MCOs to enable these organizations to raise their physician fees. Accordingly, the Department increased 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 1 shows the percentage of Medicare fees for targeted groups of procedures at the times of original fee increases in FYs 2003, 2006, 2007, 2008, and 2009.

Table 1. Prior Fee Increases to Percentage of Medicare Fees

Fiscal Year	Procedure Code Group	Percent of Medicare Fees at Time of Original Fee Increase
2003	Evaluation and management (99201-99499)	80%
2006	Four Specialties: Orthopedic (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 and management (99201-99499) Evaluation and management in hospital outpatient departments Neonatology procedures (99294, 99296, 99299) Radiology procedures (70010-79900, excluding 77261-77799) Vaccine administration procedures 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 Orthopedic (20000-29999), Gynecology/Obstetrics (56405-59899) Neurosurgery (61000-64999) Emergency Medicine (99281-99285)	 78.6% 100% 100% 100% 100%

III. Physician Fee Changes in FY 2010 and FY 2011

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 funds (\$4.5 million state funds) reduction in payment for physician services for FY 2010. Some groups of procedure codes and protected specialties were excluded from the reduction in fees.

Following is an explanation of how fees for different procedures were affected:

1. Fees for procedures performed by the four specialties that are protected by law (orthopedic, gynecology/obstetrics, neurosurgery, and emergency medicine) remained at a maximum of 100 percent of Medicare fees, without increasing their fees. In other words, if the current Medicaid fee for one of these procedures was greater than the Medicare fee, it was set equal to the Medicare fee; however, if it was lower than the Medicare fee, it did not change. Fees for four obstetric delivery procedure codes (59409, 59410, 59514, and 59515) were maintained at their original FY 2008 levels. Currently, fees for the four procedures are between 100 and 109 percent of Medicare 2010 fees.
2. Because evaluation and management procedures are used by primary care physicians and specialists, fees for 99201-99215 and preventive medicine procedure codes (99381-99397) were held at their FY 2009 levels.
3. Fees for evaluation and management procedures performed in outpatient hospitals were set at the levels of their corresponding facility fees to consistently pay the same fee for the same procedure performed in all facilities.
4. Fees for the 146 codes with modifier 26 (professional component) that do not have Medicare base fees were maintained at their FY 2009 levels.
5. Payments for anesthesia procedures were reduced by 4.5 percent, which reduced the obstetric anesthesia rates to 87.6 percent of Medicare and the non-obstetric anesthesia rates to 80.6 percent of Medicare payment rates.

Enrollment growth rates were set consistent with recent historical trends, which equated to a 21 percent increase from the data base year (FY 2008) to the implementation year (FY 2010). Then, fees for all remaining procedures were reduced across-the-board by 5.8 percent to achieve the required reduction of the \$11.5 million in FY 2010 payments.

Fees for procedures performed in non-facilities decreased from an average of 80 percent to an average of 79 percent of Medicare fees. Fees for procedures performed in facilities were reduced, from an average of 86 percent to an average of 83 percent of Medicare fees. Across all procedure codes, Medicaid fees were reduced to 81 percent of Medicare 2009 fees in FY 2010.

Of the \$11.5 million total funds reduction in payments, about \$3.0 million was from fee-for-service payments and approximately \$8.5 million was from the reduction of HealthChoice MCOs' payments for physician services.

FY 2011 Physician Fees

The Medicare program regularly updates Relative Value Units for procedures. This 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 reduced fees for procedures that exceeded Medicare fees to the Medicare fee levels. Fees for the four obstetric delivery procedure codes (59409, 59410, 59514, and 59515) remained at their original levels. Aside from these minor adjustments, the Department kept FY 2011 physician fees at the same level as FY 2010 fees.

Medicare's reimbursement rates for anesthesia procedures increased 3.1 percent between 2009 and 2010. Therefore, Medicaid anesthesia payments are at 78 percent of Medicare fees for non-obstetric procedures and 85 percent of Medicare reimbursement rates for obstetric anesthesia procedures. Medicare fees for other procedures increased 2.2 percent in 2010. Therefore, overall Medicaid fees for non-anesthesia procedures in FY 2011 are 79 percent of Medicare 2010 fees. Medicaid fees for E&M procedures are, on average, 76 percent of Medicare 2010 fees.

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

Like Maryland, its 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, DC. We obtained the current physician fee schedules from their websites and compiled data on each state's Medicaid fees for a sample of approximately 200 high-volume procedures in various specialties.

Table 2 compares Maryland's FY 2011 Medicaid fees with the corresponding Medicare and neighboring states' Medicaid fees for a sample of high-volume procedures in each specialty group. In this table, procedure fees are rounded to the nearest dollar amount and the last row of each section shows the weighted average of each state's fees for surveyed procedures as a percent of Medicare fees in Maryland. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percent of Medicare fees reported in this table correspond to the appropriate Medicare non-facility and facility fees.

Facilities include inpatient hospitals, nursing homes, and other medical care facilities. Non-facilities mainly include physician offices. Physician fees include three components: physician's work, practice expenses (e.g., costs of maintaining an office), and malpractice insurance expenses. Practice components of fees are, on average, approximately 40 percent of total fees. When physicians render services in facilities, they do not incur a practice expense. Hence, facility fees are usually lower than non-facility fees.

Maryland, Virginia, and West Virginia have separate facility and non-facility fees. Therefore, their facility and non-facility fees are compared with the corresponding Medicare fees. However, for Washington, DC, Delaware, and Pennsylvania, which have one fee for each procedure, fees are compared with Medicare non-facility fees. Hence, for Washington, DC, Delaware, and Pennsylvania, the percentages of Medicare fees reported in the table underestimate the percent of Medicare fees for procedures performed in facilities. In 2009, Washington, DC set its Medicaid fees to 100 percent of its Medicare non-facility fees. Therefore, it generally has the highest physician reimbursement rates in the region. Virginia did not report facility fees for some procedures that are mainly performed in facilities. We assumed that this was due to an oversight, and reported Virginia's non-facility fees for these procedures as their facility fees. However, we did not extend this assumption to medicine procedures, and reported only the non-facility fees that were included in the Virginia Medicaid fee schedule.

For this report, we have compared Maryland Medicaid and other states' Medicaid rates with the Medicare fee schedule for Maryland. Average Medicare fees in Maryland are nearly equal to average Medicare fees in Pennsylvania, but are approximately 3 percent higher than Medicare

fees in Virginia, 5 percent higher than Medicare fees in Delaware, and 7 percent higher than Medicare fees in West Virginia. Average Medicare fees in Washington, DC are approximately 7 percent higher than average Medicare fees in Maryland.

Comparisons of Evaluation and Management (E&M) and Specialty Procedures

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

Evaluation and Management Procedures

As the data in Table 2 show, as an average percentage of Medicare fees, Washington, DC has the highest fees in the region for the selected E&M procedures. Delaware fees rank second; Maryland's facility and non-facility fees rank third; Virginia's non-facility fees rank fifth; West Virginia's facility and non-facility fees rank sixth and seventh, respectively; Virginia's facility fees rank eighth; and Pennsylvania fees rank ninth.

Integumentary and General Surgery Procedures

For integumentary¹ procedures, Washington, DC fees rank first, followed by Delaware fees (second), Virginia facility fees (third), Virginia non-facility fees (fourth), Maryland non-facility fees (fifth), Maryland facility fees (sixth), West Virginia facility fees (seventh), West Virginia non-facility fees (eighth), and Pennsylvania fees (ninth).

Musculoskeletal System Procedures

Washington, DC fees for musculoskeletal system procedures are the highest in the region. Maryland non-facility fees rank second, Maryland facility fees and Delaware fees rank third, Virginia facility fees rank fifth, Virginia non-facility fees rank sixth, West Virginia facility fees rank seventh, West Virginia non-facility fees rank eighth, and Pennsylvania fees rank last in the region. Because Pennsylvania fee for procedure code 29130 (application of finger splint) is missing, its percentage of Medicare fees is lower than it would have been had it covered this procedure.

Respiratory Procedures

Washington, DC fees for respiratory procedures rank highest in the region, followed by Virginia facility fees (second), Delaware fees (third), Virginia non-facility fees (fourth), Maryland non-facility fees (fifth), Maryland facility fees (sixth), West Virginia facility fees (seventh), West Virginia non-facility fees (eighth), and Pennsylvania fees (ninth). Virginia did not report a facility fee for procedure code 31500 (insert emergency airway), which is mainly performed in facilities. Therefore, we report the non-facility fees for this procedure as facility fees.

Cardiovascular System Surgery Procedures

Washington, DC fees for selected cardiovascular system surgery procedures are the highest in the region, followed, in ranking order, by Virginia facility fees, Maryland non-facility fees, Virginia non-facility fees, Maryland facility fees, West Virginia facility fees, West Virginia non-facility fees, Delaware fees, and Pennsylvania fees. Because Pennsylvania has missing fees for

¹ Integumentary procedures are related to skin.

three surveyed procedures, its percentage of Medicare fees is lower than it would have been had it covered these procedures.

Hemic, Lymphatic, and Mediastinum Systems Procedures

Washington, DC fees for hemic, lymphatic and mediastinum systems procedures are the highest in the region. Delaware fees rank second, Virginia facility fees rank third, and Maryland non-facility fees rank fourth, and Virginia non-facility fees rank fifth. Maryland facility fees and West Virginia facility fees both rank sixth, West Virginia non-facility fees rank eighth, and Pennsylvania fees rank ninth. Because Pennsylvania has a missing fee, its percentage of Medicare fees is lower than it would have been had it covered this procedure. Virginia did not report facility fees for procedure codes 38525 and 38792 that are mainly performed in facilities. Therefore, we substituted Virginia's non-facility fees for these procedures as facility fees.

Digestive System Procedures

Washington, DC fees for selected digestive system procedures are the highest in the region, followed, in ranking order, by Delaware fees, Virginia facility fees, Maryland non-facility fees, Virginia non-facility fees, Maryland facility fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees. Virginia did not report facility fees for procedure codes 42820, 42830 and 47562 that are mainly performed in facilities. Therefore, we counted Virginia's non-facility fees for these procedures as facility fees.

Urinary and Male Genital Procedures

Washington, DC fees for urinary and male genital procedures rank highest in the region. Virginia facility fees rank second, Maryland non-facility fees rank third, Virginia non-facility fees rank fourth, Maryland facility fees rank fifth, West Virginia facility fees rank sixth, West Virginia non-facility fees rank seventh, and Delaware fees rank eighth. Pennsylvania fees rank last in the region.

Gynecology and Obstetrics Procedures

Most of the neighboring states have relatively high fees for gynecology/obstetrics procedures. Pennsylvania has the highest fees, followed by West Virginia facility and non-facility fees (second), Maryland non-facility and facility fees (fourth), Washington, DC fees (sixth), and Virginia facility and non-facility fees (seventh). Delaware fees rank last in the region. Because Delaware reports zero dollars for procedure code 58300 (inserting intrauterine device), its percentage of Medicare is lower than it would have been had it covered this procedure.

Endocrine System Procedures

Washington, DC has the highest fees for the selected endocrine system procedures, followed by Delaware fees (second), Virginia facility fees (third), Virginia non-facility fees (fourth), West Virginia facility fees (fifth), and West Virginia non-facility and Maryland non-facility fees (sixth). Maryland facility fees rank eighth and Pennsylvania fees rank ninth.

Nervous System Procedures

Washington, DC has the highest fees for Nervous System procedures in the region, followed, in ranking order, by Virginia facility fees, Maryland non-facility fees, Delaware fees, Maryland

facility fees, Virginia non-facility fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees.

Eye Surgery Procedures

Washington, DC Medicaid fees for eye surgery procedures rank first in the region. Delaware fees rank second; Virginia facility fees rank third; Virginia non-facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility, Maryland non-facility, and Pennsylvania fees all rank sixth; and Maryland facility fees rank last.

Ear Surgery Procedures

Washington, DC has the highest fees for the selected ear surgery procedures, followed, in ranking order, by Maryland non-facility fees, Maryland facility fees, Virginia facility fees, Virginia non-facility fees, West Virginia facility fees, West Virginia non-facility fees, Delaware fees, and Pennsylvania fees. Virginia did not report facility fees for procedures 69436 and 69990; therefore, we considered the non-facility fees for these procedures as facility fees.

Radiology Procedures

For radiology procedures, Washington, DC Medicaid fees rank first in the region. Delaware fees rank second, Maryland facility and non-facility fees rank third, Virginia non-facility and facility fees rank fifth, West Virginia facility and non-facility fees rank seventh, and Pennsylvania fees rank ninth. Because Virginia does not report facility fees for selected radiology procedures, we reported the corresponding non-facility fees in Virginia.

Laboratory Procedures

Delaware has the highest fees for the selected laboratory procedures, followed by Virginia facility and non-facility fees (second), Maryland facility and non-facility fees (third), Pennsylvania fees (fourth), and Washington, DC fees (fifth). West Virginia facility and non-facility fees for the selected procedures were not reported in the fee schedules and are therefore not ranked.

Psychiatry Procedures

Washington, DC has the highest fees for the selected psychiatry procedures, followed, in ranking order, by Delaware fees, Maryland facility fees, Maryland non-facility fees, Virginia facility fees, Virginia non-facility fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees.

Dialysis Procedures

For dialysis procedures, Virginia non-facility fees rank first in the region, followed by Washington, DC fees (second), Delaware fees (third), and Maryland facility and non-facility fees (fourth). Pennsylvania fees and West Virginia facility and non-facility fees rank last. Virginia's fee schedule does not provide facility fees for these procedures.

Gastroenterology Procedures

Washington, DC fees for the selected gastroenterology procedures rank first in the region. Delaware fees rank second, Maryland facility and non-facility fees rank third, Virginia non-facility fees rank fifth, West Virginia facility and non-facility fees rank sixth, Pennsylvania fees

rank eighth, and Virginia facility fees rank last. Because Virginia has missing facility fees for selected gastroenterology procedures, its percentage of Medicare fees is very low and is not reported in Table 2.

Ophthalmology and Vision Care Procedures

Washington, DC has the highest fees for the selected ophthalmology and vision care procedures, followed, in ranking order, by Delaware fees, Virginia facility fees, Virginia non-facility fees, Maryland non-facility fees, West Virginia facility fees, West Virginia non-facility fees, Maryland facility fees, and Pennsylvania fees.

ENT (Otorhinolaryngology) Procedures

Washington, DC fees for otorhinolaryngology procedures are highest in the region. At about 96 percent of the corresponding Medicare fees, Delaware, Maryland facility, and Maryland non-facility fees rank second, Virginia non-facility fees and Pennsylvania fees rank fifth and sixth, and West Virginia facility and non-facility fees rank seventh. Virginia facility fees rank last because facility fees for several selected ENT procedures are not reported in the fee schedule and are likely not covered.

Cardiovascular Medicine Procedures

Washington, DC fees for the selected cardiovascular medicine procedures rank first in the region, followed by Delaware fees (second), Maryland facility and non-facility fees (third), Virginia non-facility fees (fifth), Pennsylvania fees (sixth), and West Virginia facility and non-facility fees (seventh). Virginia does not report facility fees for these procedures and likely does not cover the selected procedures when they are performed in facilities.

Non-Invasive Vascular Diagnostic Studies

Washington, DC fees for the selected non-invasive vascular diagnostic studies procedures rank first in the region, followed by Delaware fees (second), Virginia non-facility fees (third), Maryland facility and non-facility fees (fourth), and West Virginia facility and non-facility fees (sixth). Pennsylvania fees rank last in the region. Virginia does not have facility fees for these procedures.

Pulmonary Procedures

Washington, DC has the highest fees in the region for the selected pulmonary procedures. Delaware fees rank second, Maryland facility and non-facility fees rank third, Virginia non-facility fees rank fifth, West Virginia facility and non-facility fees rank sixth, and Pennsylvania fees rank last. Virginia does not report facility fees for these procedures.

Allergy and Immunology Procedures

For allergy and immunology procedures, Washington, DC has the highest fees in the region, followed, in ranking order, by Maryland facility fees, Delaware fees, Maryland non-facility fees, Virginia non-facility fees, West Virginia non-facility fees, West Virginia facility fees, Pennsylvania fees, and Virginia facility fees. Because Virginia has missing fees for most of the selected procedures, its ranking is lower than it would have been had it covered these procedures.

Neurology and Neuromuscular Procedures

Washington, DC has the highest fees in the region for the selected neurology and neuromuscular procedures. Delaware fees rank second, Virginia non-facility fees rank third, Maryland facility and non-facility fees rank fourth, West Virginia facility and non-facility fees rank sixth, and Pennsylvania fees rank last. Virginia does not have facility fees for these procedures.

CNS Assessment Tests

Washington, DC has the highest fees in the region for selected CNS assessment procedures. Maryland facility fees rank second, Maryland non-facility fees rank third, and Virginia non-facility fees rank fourth. West Virginia facility and non-facility fees rank fifth, Virginia facility fees rank seventh, Pennsylvania fees rank eighth, and Delaware fees rank ninth.

Chemotherapy Administration

For the selected chemotherapy administration procedures, Washington, DC fees rank first in the region, followed by Delaware fees (second), Maryland non-facility fees (third), Maryland facility fees (fourth), Pennsylvania fees (fifth), Virginia non-facility fees (sixth), and West Virginia facility and non-facility fees (seventh). Virginia facility fees rank last because Virginia has missing fees for most of the selected procedures.

Dermatology Procedures

Washington, DC has the highest fees in the region for the selected dermatology procedures. Delaware fees rank second, Virginia non-facility fees rank third, Maryland facility and non-facility fees rank fourth, West Virginia facility and non-facility fees rank sixth, and Pennsylvania fees rank last in the region. Virginia does not have facility fees for these procedures.

Physical Medicine and Rehabilitation Procedures

Washington, DC fees for the selected physical medicine and rehabilitation procedures rank first in the region, followed by Delaware fees (second), Maryland facility and non-facility fees (third), Virginia non-facility fees (fifth), and West Virginia facility and non-facility fees (sixth). Pennsylvania fees are the lowest in the region. Virginia does not have facility fees for these procedures.

Osteopathy, Chiropractic, and Other Medicine Procedure

For osteopathy, chiropractic, and other medicine procedures, Virginia facility fees are the highest in the region. Pennsylvania fees rank second, Washington, DC fees rank third, Maryland non-facility fees rank fourth, Maryland facility fees and Delaware fees rank fifth, West Virginia non-facility fees rank seventh, Virginia facility fees rank eighth, and West Virginia facility fees rank ninth. Because Virginia, West Virginia, Pennsylvania, and Washington, DC have missing fees for some of the selected procedures, their rankings are lower than they would have been had they covered these procedures. The Virginia non-facility fee for procedure code 99173 (visual acuity screening) is 21 times larger than the Medicare fee for this procedure.

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees

Procedure Code	Procedure Description	MC		MD		MD		VA		WV		WV		PA	DC
		NF	FA	NF	FA	DE	NF	FA	NF	FA	NF	FA			
	Evaluation & Management														
99203	Office/outpatient visit, new	\$103	\$76	\$77	\$66	\$97	\$76	\$62	\$69	\$53	\$54	\$103			
99204	Office/outpatient visit, new	\$160	\$129	\$113	\$109	\$150	\$118	\$102	\$108	\$89	\$90	\$158			
99212	Office/outpatient visit, establish	\$41	\$26	\$31	\$22	\$39	\$30	\$22	\$27	\$18	\$26	\$42			
99213	Office/outpatient visit, establish	\$69	\$51	\$48	\$42	\$65	\$51	\$41	\$46	\$35	\$35	\$69			
99214	Office/outpatient visit, establish	\$103	\$78	\$73	\$65	\$97	\$77	\$63	\$69	\$54	\$54	\$103			
99223	Initial hospital care	\$199	\$199	\$134	\$134	\$187	\$146	N/A	\$136	\$136	\$42	\$196			
99232	Subsequent hospital care	\$72	\$72	\$49	\$49	\$68	\$54	N/A	\$50	\$50	\$17	\$73			
99238	Hospital discharge day	\$71	\$71	\$51	\$51	\$67	\$53	N/A	\$49	\$49	\$17	\$73			
99244	Office consultation	\$191	\$160	\$140	\$115	\$0	\$145	\$128	\$0	\$0	\$121	\$205			
99283	Emergency dept visit	\$64	\$64	\$60	\$60	\$60	\$43	N/A	\$45	\$45	\$35	\$66			
99284	Emergency dept visit	\$121	\$121	\$111	\$111	\$114	\$80	N/A	\$85	\$85	\$50	\$123			
99285	Emergency dept visit	\$179	\$179	\$166	\$166	\$168	\$118	N/A	\$126	\$126	\$50	\$182			
99291	Critical care, first hour	\$272	\$226	\$200	\$161	\$256	\$202	\$177	\$184	\$158	\$152	\$280			
99308	Nursing fac care, subseq	\$66	\$66	\$44	\$44	\$62	\$49	N/A	\$44	\$44	\$37	\$66			
99381	Init pm e/m, new pat, infant	\$92	\$63	\$86	\$57	\$91	\$81	\$60	\$63	\$43	\$20	\$103			
99391	Per pm reeval, est pat, infant	\$78	\$53	\$65	\$49	\$76	\$68	\$51	\$53	\$37	\$20	\$85			
99392	Prev visit, est, age 1-4	\$88	\$63	\$73	\$57	\$85	\$76	\$59	\$59	\$43	\$20	\$95			
99393	Prev visit, est, age 5-11	\$87	\$63	\$72	\$57	\$85	\$76	\$59	\$59	\$43	\$20	\$94			
99394	Prev visit, est, age 12-17	\$96	\$71	\$79	\$65	\$93	\$83	\$67	\$65	\$50	\$20	\$103			
99469	Neonate crit care, subsequent	\$403	\$403	\$325	\$325	\$380	\$305	N/A	\$283	\$283	\$240	\$411			
99472	Ped critical care, subsequent	\$405	\$405	\$325	\$325	\$382	\$305	N/A	\$283	\$283	\$240	\$416			
99479	Ic lbw inf 1500-2500 g subsequent	\$129	\$129	\$107	\$107	\$121	\$97	N/A	\$90	\$90	\$76	\$132			
	Average % of Medicare Fees			76%	76%	92%	75%	53%	66%	67%	45%	102%			

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		MD		VA		WV		WV		PA		DC	
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA
	Integumentary																
10060	Drainage of skin abscess	\$108	\$92	\$75	\$66	\$101	\$80	\$71	\$70	\$61	\$24	\$111					
11042	Debride skin/tissue	\$71	\$44	\$55	\$35	\$67	\$53	\$38	\$47	\$31	\$33	\$77					
11721	Debride nail, 6 or more	\$42	\$28	\$31	\$22	\$40	\$31	\$23	\$27	\$19	\$20	\$46					
12001	Repair superficial wound(s)	\$147	\$105	\$108	\$73	\$137	\$109	\$86	\$98	\$73	\$25	\$148					
12011	Repair superficial wound(s)	\$157	\$109	\$115	\$76	\$146	\$116	\$90	\$103	\$75	\$32	\$158					
17110	Destruct b9 lesion, 1-14	\$107	\$68	\$71	\$44	\$101	\$79	\$57	\$67	\$44	\$49	\$114					
17250	Chemical cautery, tissue	\$73	\$36	\$55	\$26	\$68	\$54	\$33	\$45	\$24	\$26	\$77					
	Average % of Medicare Fees			72%	71%	94%	74%	82%	65%	68%	29%	104%					
	Musculoskeletal System																
20550	Inj tendon sheath/ligament	\$57	\$42	\$56	\$39	\$53	\$42	\$34	\$38	\$28	\$32	\$60					
20552	Inj trigger point, 1/2 muscl	\$52	\$37	\$50	\$33	\$49	\$39	\$30	\$34	\$25	\$31	\$54					
20610	Drain/inject, joint/bursa	\$76	\$50	\$72	\$48	\$71	\$56	\$42	\$49	\$34	\$24	\$80					
25600	Treat fracture radius/ulna	\$274	\$249	\$259	\$232	\$256	\$202	\$188	\$178	\$164	\$115	\$283					
29075	Application of forearm cast	\$84	\$60	\$80	\$58	\$78	\$62	\$49	\$54	\$40	\$46	\$89					
29125	Apply forearm splint	\$65	\$42	\$61	\$39	\$61	\$48	\$36	\$42	\$28	\$26	\$68					
29130	Application of finger splint	\$39	\$29	\$37	\$27	\$36	\$29	\$24	\$26	\$20	N/A	\$40					
29515	Application lower leg splint	\$68	\$49	\$65	\$47	\$64	\$51	\$40	\$44	\$33	\$35	\$71					
	Average % of Medicare Fees			95%	94%	94%	74%	81%	65%	67%	40%	104%					

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		MD		DE		VA		WV		WV		PA		DC		
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF
	Respiratory																			
30300	Remove nasal foreign body	\$219	\$121	\$163	\$89	\$207	\$161	\$107	\$135	\$77	\$23	\$233								
31231	Nasal endoscopy, dx	\$186	\$78	\$135	\$57	\$175	\$137	\$78	\$116	\$53	\$59	\$199								
31500	Insert emergency airway	\$115	\$115	\$78	\$78	\$107	\$86	\$86	\$81	\$81	\$72	\$115								
31575	Diagnostic laryngoscopy	\$114	\$78	\$85	\$58	\$108	\$85	\$65	\$74	\$52	\$69	\$121								
31622	Dx bronchoscope/wash	\$318	\$152	\$239	\$109	\$142	\$234	\$144	\$203	\$106	\$134	\$342								
31624	Dx bronchoscope/lavage	\$320	\$154	\$244	\$110	\$144	\$237	\$145	\$204	\$106	\$135	\$348								
	Average % of Medicare Fees			73%	71%	79%	74%	87%	65%	69%	44%	106%								
	Cardiovascular System Surgery																			
36400	Bl draw < 3 yrs fem/jugular	\$28	\$20	\$19	\$14	\$26	\$21	\$17	\$18	\$14	N/A	\$28								
36406	Bl draw < 3 yrs other vein	\$18	\$10	\$13	\$7	\$17	\$14	\$9	\$12	\$6	N/A	\$19								
36410	Non-routine bl draw > 3 yrs	\$20	\$9	\$14	\$7	\$19	\$15	\$9	\$12	\$6	N/A	\$21								
36556	Insert non-tunnel cv cath	\$240	\$128	\$196	\$91	\$119	\$178	\$116	\$156	\$90	\$113	\$258								
36569	Insert picc cath	\$269	\$100	\$229	\$73	\$93	\$198	\$105	\$168	\$69	\$87	\$305								
36620	Insertion catheter, artery	\$53	\$53	\$37	\$37	\$49	\$40	\$40	\$37	\$37	\$48	\$53								
	Average % of Medicare Fees			80%	71%	54%	74%	91%	65%	70%	41%	108%								
	Hemic, Lymphatic, and Mediastinum																			
38220	Bone marrow aspiration	\$155	\$63	\$125	\$45	\$146	\$114	\$64	\$97	\$44	\$55	\$172								
38221	Bone marrow biopsy	\$170	\$78	\$138	\$57	\$161	\$125	\$75	\$107	\$53	\$70	\$190								
38525	Biopsy/removal, lymph nodes	\$427	\$427	\$284	\$284	\$393	\$316	\$316	\$294	\$294	\$156	\$422								
38792	Identify sentinel node	\$41	\$41	\$30	\$30	\$38	\$31	\$31	\$27	\$27	N/A	\$43								
	Average % of Medicare Fees			76%	69%	94%	74%	85%	65%	69%	37%	108%								

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		DE		VA		WV		PA		DC		
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF
	Digestive System															
42820	Remove tonsils and adenoids	\$297	\$297	\$215	\$215	\$278	\$278	\$221	\$221	\$200	\$200	\$184	\$184	\$301	\$301	
42830	Removal of adenoids	\$211	\$211	\$152	\$152	\$197	\$197	\$156	\$156	\$139	\$139	\$134	\$134	\$214	\$214	
43235	Upper GI endoscopy, diagnosis	\$300	\$151	\$232	\$105	\$281	\$281	\$221	\$140	\$191	\$104	\$125	\$324	\$324	\$324	
43239	Upper GI endoscopy, biopsy	\$347	\$179	\$267	\$125	\$326	\$326	\$256	\$164	\$222	\$124	\$149	\$374	\$374	\$374	
45378	Diagnostic colonoscopy	\$398	\$226	\$302	\$157	\$373	\$373	\$294	\$199	\$0	\$0	\$181	\$425	\$425	\$425	
45380	Colonoscopy and biopsy	\$476	\$271	\$361	\$189	\$446	\$446	\$352	\$239	\$308	\$187	\$225	\$510	\$510	\$510	
45385	Lesion removal colonoscopy	\$537	\$322	\$405	\$224	\$504	\$504	\$397	\$279	\$349	\$222	\$268	\$573	\$573	\$573	
47562	Laparoscopic cholecystectomy	\$738	\$738	\$509	\$509	\$679	\$679	\$549	\$549	\$514	\$514	\$589	\$727	\$727	\$727	
49080	Puncture, peritoneal cavity	\$169	\$73	\$143	\$52	\$69	\$69	\$125	\$73	\$107	\$51	\$64	\$188	\$188	\$188	
	Average % of Medicare Fees			75%	70%	92%	92%	74%	84%	55%	59%	52%	106%	106%	106%	
	Urinary and Male Genital															
51600	Injection for bladder x-ray	\$202	\$48	\$164	\$34	\$45	\$45	\$148	\$64	\$123	\$33	\$32	\$230	\$230	\$230	
51701	Insert bladder catheter	\$64	\$30	\$53	\$21	\$60	\$60	\$47	\$28	\$40	\$20	\$25	\$72	\$72	\$72	
51798	Us urine capacity measure	\$20	\$20	\$16	\$16	\$19	\$19	\$15	\$15	\$12	\$12	\$14	\$26	\$26	\$26	
52000	Cystoscopy	\$224	\$137	\$165	\$95	\$128	\$128	\$165	\$118	\$144	\$93	\$75	\$247	\$247	\$247	
54150	Circumcision w/ regional block	\$179	\$107	\$147	\$74	\$99	\$99	\$132	\$92	\$116	\$73	\$79	\$198	\$198	\$198	
	Average % of Medicare Fees			81%	70%	55%	55%	74%	88%	64%	69%	41%	111%	111%	111%	

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		MD		VA		VA		WV		WV		PA	DC
		NF	FA	NF	FA	DE	FA	NF	FA	NF	FA	NF	FA	NF	FA		
	Gynecology/Obstetric																
57452	Exam of cervix w/ scope	\$111	\$94	\$108	\$88	\$103	\$88	\$102	\$90	\$74	\$65	\$40	\$116				
57454	Bx/curett of cervix w/ scope	\$157	\$140	\$152	\$133	\$146	\$133	\$145	\$133	\$107	\$97	\$106	\$163				
58300	Insert intrauterine device	\$69	\$53	\$77	\$52	\$0	\$52	\$69	\$55	\$50	\$37	\$17	\$84				
59025	Fetal non-stress test	\$47	\$47	\$46	\$46	\$44	\$46	\$43	\$43	\$31	\$31	\$18	\$51				
59409	Obstetrical care	\$792	\$792	\$860	\$860	\$717	\$860	\$726	\$726	\$890	\$890	\$1,200	\$817				
59410	Obstetrical care	\$927	\$927	\$942	\$942	\$841	\$942	\$849	\$849	\$1,036	\$1,036	\$1,200	\$950				
59430	Care after delivery	\$143	\$129	\$139	\$125	\$130	\$125	\$131	\$122	\$156	\$144	N/A	\$149				
59514	Cesarean delivery only	\$941	\$941	\$993	\$993	\$717	\$993	\$863	\$863	\$1,059	\$1,059	\$1,200	\$968				
59515	Cesarean delivery with postpartum	\$1,123	\$1,123	\$1,124	\$1,124	\$841	\$1,124	\$1,027	\$1,027	\$1,253	\$1,253	\$2,050	\$1,144				
	Average % of Medicare Fees			104%	104%	85%	104%	92%	92%	110%	110%	133%	103%				
	Endocrine System																
60100	Biopsy of thyroid	\$116	\$84	\$83	\$58	\$109	\$58	\$86	\$69	\$77	\$58	\$66	\$123				
60240	Removal of thyroid	\$983	\$983	\$670	\$670	\$908	\$670	\$732	\$732	\$685	\$685	\$591	\$985				
	Average % of Medicare Fees			69%	68%	93%	68%	74%	75%	69%	70%	59%	101%				
	Nervous System																
62270	Spinal fluid tap, diagnostic	\$157	\$81	\$150	\$73	\$147	\$73	\$115	\$74	\$100	\$56	\$42	\$166				
62311	Inject spine I/s (cd)	\$192	\$86	\$183	\$79	\$182	\$79	\$142	\$84	\$122	\$59	\$75	\$204				
64450	N block, other peripheral	\$102	\$70	\$99	\$68	\$96	\$68	\$76	\$58	\$67	\$48	\$21	\$108				
64483	Inj foramen epidural I/s	\$268	\$110	\$258	\$101	\$254	\$101	\$198	\$111	\$168	\$75	\$95	\$288				
64614	Destroy nerve, extrem muscle	\$176	\$151	\$161	\$132	\$163	\$132	\$130	\$116	\$118	\$103	\$123	\$175				
	Average % of Medicare Fees			95%	91%	94%	91%	89%	109%	64%	69%	41%	128%				

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		MD		VA		WV		WV		PA		DC		
		NF	FA	NF	FA	DE	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA
	Eye Surgery																	
65855	Laser surgery of eye	\$325	\$288	\$230	\$197	\$303	\$241	\$220	\$216	\$194	\$320	\$237	\$194	\$237	\$603	\$712	\$203	\$647
66984	Cataract surg w/ iol, 1 stage	\$738	\$738	\$500	\$500	\$687	\$548	\$548	\$500	\$500	\$712	\$603	\$500	\$603	\$712	\$203	\$647	\$1,126
67028	Injection eye drug	\$203	\$164	\$146	\$112	\$189	\$150	\$129	\$135	\$112	\$203	\$136	\$112	\$136	\$203	\$203	\$203	\$647
67210	Treatment of retinal lesion	\$664	\$643	\$435	\$418	\$619	\$493	\$481	\$449	\$437	\$647	\$375	\$437	\$375	\$647	\$647	\$647	\$647
67228	Treatment of retinal lesion	\$1,148	\$1,015	\$740	\$644	\$1,072	\$850	\$777	\$761	\$683	\$1,126	\$491	\$683	\$491	\$1,126	\$1,126	\$1,126	\$1,126
67311	Revise eye muscle	\$576	\$576	\$375	\$375	\$536	\$427	\$427	\$388	\$388	\$556	\$468	\$388	\$468	\$556	\$556	\$556	\$556
	Average % of Medicare Fees			67%	66%	93%	74%	75%	67%	68%	97%	67%	68%	67%	67%	97%	97%	97%
	Ear Surgery																	
69200	Clear outer ear canal	\$120	\$56	\$114	\$49	\$113	\$88	\$54	\$75	\$38	\$128	\$30	\$38	\$20	\$51	\$170	\$228	\$104%
69210	Remove impacted ear wax	\$49	\$33	\$44	\$29	\$0	\$37	\$28	\$33	\$23	\$51	\$20	\$23	\$20	\$51	\$170	\$228	\$104%
69436	Create eardrum opening	\$164	\$164	\$151	\$151	\$154	\$122	\$122	\$108	\$108	\$170	\$99	\$108	\$99	\$170	\$170	\$170	\$170
69990	Microsurgery add-on	\$222	\$222	\$202	\$202	\$200	\$165	\$165	\$158	\$158	\$228	\$201	\$158	\$201	\$228	\$228	\$228	\$228
	Average % of Medicare Fees			91%	90%	56%	74%	79%	66%	68%	104%	50%	68%	50%	104%	104%	104%	104%
	Radiology																	
70450	Ct head/brain w/o dye	\$206	\$206	\$179	\$179	\$196	\$151	\$151	\$125	\$125	\$259	\$117	\$125	\$117	\$259	\$259	\$259	\$259
71010	Chest x-ray	\$25	\$25	\$20	\$20	\$23	\$18	\$18	\$15	\$15	\$28	\$19	\$15	\$19	\$28	\$28	\$28	\$28
71020	Chest x-ray	\$32	\$32	\$26	\$26	\$31	\$24	\$24	\$20	\$20	\$37	\$25	\$20	\$25	\$37	\$37	\$37	\$37
72193	Ct pelvis w/ dye	\$308	\$308	\$262	\$262	\$291	\$225	\$225	\$186	\$186	\$385	\$140	\$186	\$140	\$385	\$385	\$385	\$385
73610	X-ray exam of ankle	\$32	\$32	\$24	\$24	\$31	\$24	\$24	\$20	\$20	\$36	\$27	\$20	\$27	\$36	\$36	\$36	\$36
73630	X-ray exam of foot	\$32	\$32	\$24	\$24	\$30	\$24	\$24	\$19	\$19	\$35	\$19	\$19	\$19	\$35	\$35	\$35	\$35
74000	X-ray exam of abdomen	\$26	\$26	\$21	\$21	\$25	\$19	\$19	\$16	\$16	\$29	\$18	\$16	\$18	\$29	\$29	\$29	\$29
74160	Ct abdomen w/ dye	\$347	\$347	\$266	\$266	\$329	\$254	\$254	\$210	\$210	\$432	\$149	\$210	\$149	\$432	\$432	\$432	\$432
76805	Ob us >= 14 wks, singl fetus	\$151	\$151	\$111	\$111	\$143	\$137	\$137	\$93	\$93	\$170	\$78	\$93	\$78	\$170	\$170	\$170	\$170
76815	Ob us, limited, fetus(s)	\$93	\$93	\$71	\$71	\$88	\$84	\$84	\$57	\$57	\$106	\$64	\$57	\$64	\$106	\$106	\$106	\$106
	Average % of Medicare Fees			81%	81%	95%	77%	77%	61%	61%	120%	56%	61%	56%	120%	120%	120%	120%

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Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		VA		WV		PA		DC	
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA
	Laboratory												
80053	Comprehen metabolic panel	\$15	\$15	\$11	\$11	\$14	\$14	N/A	N/A	\$12	\$12	N/A	N/A
80061	Lipid panel	\$17	\$17	\$13	\$13	\$18	\$18	N/A	N/A	\$14	\$14	\$17	\$17
81002	Urinalysis nonauto w/o scope	\$4	\$4	\$3	\$3	\$3	\$3	N/A	N/A	\$4	\$4	\$2	\$2
83655	Assay of lead	\$17	\$17	\$13	\$13	\$16	\$16	N/A	N/A	\$10	\$10	\$8	\$8
85025	Complete cbc w/ auto diff wbc	\$11	\$11	\$8	\$8	\$10	\$10	N/A	N/A	\$6	\$6	\$5	\$5
86592	Blood serology, qualitative	\$5	\$5	\$4	\$4	\$5	\$5	N/A	N/A	\$4	\$4	\$3	\$3
87081	Culture screen only	\$10	\$10	\$7	\$7	\$9	\$9	N/A	N/A	\$5	\$5	\$4	\$4
87086	Urine culture/colony count	\$12	\$12	\$9	\$9	\$10	\$10	N/A	N/A	\$8	\$8	\$6	\$6
87491	Chylind trach, dna, amp probe	\$45	\$45	\$33	\$33	\$43	\$43	N/A	N/A	\$23	\$23	\$23	\$23
87880	Strep a assay w/ optic	\$17	\$17	\$13	\$13	\$16	\$16	N/A	N/A	\$6	\$6	\$7	\$7
	Average % of Medicare Fees			75%	75%	93%	93%			60%	60%	48%	48%
	Psychiatry												
90801	Psy dx interview	\$161	\$133	\$147	\$122	\$153	\$105	\$109	\$92	\$26	\$26	\$169	\$169
90804	Psytx, office, 20-30 min	\$70	\$58	\$48	\$43	\$66	\$44	\$45	\$39	\$26	\$26	\$70	\$70
90805	Psytx, off, 20-30 min w/ E&M	\$79	\$67	\$54	\$47	\$75	\$50	\$51	\$44	\$26	\$26	\$78	\$78
90806	Psytx, off, 45-50 min	\$97	\$90	\$88	\$82	\$92	\$66	\$63	\$59	\$39	\$39	\$97	\$97
90847	Family psytx w/ patient	\$113	\$106	\$92	\$87	\$107	\$81	\$78	\$73	\$13	\$13	\$118	\$118
90853	Group psychotherapy	\$33	\$31	\$24	\$23	\$32	\$24	\$22	\$21	\$4	\$4	\$34	\$34
90862	Medication management	\$59	\$48	\$42	\$35	\$56	\$38	\$39	\$33	\$15	\$15	\$61	\$61
	Average % of Medicare Fees			84%	85%	95%	76%	66%	68%	25%	25%	102%	102%

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		MD		DE		VA		WV		WV		PA		DC		
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF
	Dialysis																			
90935	Hemodialysis, one evaluation	\$71	\$71	\$50	\$50	\$67	\$67	\$138	\$138	N/A	N/A	\$48	\$48	\$50	\$50	\$73				
90937	Hemodialysis, repeated eval	\$116	\$116	\$81	\$81	\$110	\$110	\$138	\$138	N/A	N/A	\$80	\$80	\$50	\$50	\$119				
90945	Dialysis, one evaluation	\$74	\$74	\$52	\$52	\$70	\$70	\$138	\$138	N/A	N/A	\$50	\$50	\$35	\$35	\$76				
	Average % of Medicare Fees			70%	70%	94%	94%	188%	188%			67%	67%	67%	67%	103%				
	Gastroenterology																			
91034	Gastroesophageal reflux test	\$201	\$201	\$169	\$169	\$191	\$191	\$147	\$147	N/A	N/A	\$123	\$123	\$172	\$172	\$230				
91105	Gastric intubation treatment	\$86	\$18	\$67	\$13	\$81	\$81	\$63	\$63	\$26	\$26	\$52	\$12	N/A	N/A	\$92				
91110	Gi tract capsule endoscopy	\$924	\$924	\$742	\$742	\$876	\$876	\$677	\$677	N/A	N/A	\$561	\$561	N/A	N/A	\$1,044				
	Average % of Medicare Fees			81%	81%	95%	95%	73%	73%			61%	61%	22%	22%	113%				
	Ophthalmology/Vision Care																			
92004	Eye exam, new patient	\$140	\$99	\$96	\$65	\$132	\$132	\$104	\$104	\$82	\$82	\$92	\$68	\$59	\$59	\$142				
92012	Eye exam established pat	\$79	\$51	\$54	\$33	\$74	\$74	\$59	\$59	\$43	\$43	\$51	\$35	\$29	\$29	\$80				
92014	Eye exam & treatment	\$115	\$78	\$78	\$50	\$109	\$109	\$86	\$86	\$65	\$65	\$75	\$54	\$45	\$45	\$117				
92015	Refraction	\$20	\$20	\$33	\$14	\$29	\$29	\$23	\$23	\$17	\$17	\$20	\$13	\$5	\$5	\$36				
92060	Special eye evaluation	\$59	\$59	\$41	\$41	\$56	\$56	\$44	\$44	N/A	N/A	\$38	\$38	\$34	\$34	\$61				
92081	Visual field examination(s)	\$54	\$54	\$38	\$38	\$51	\$51	\$39	\$39	N/A	N/A	\$33	\$33	\$28	\$28	\$56				
	Average % of Medicare Fees			73%	66%	97%	97%	76%	76%	78%	78%	67%	68%	41%	41%	105%				

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

Table 2. 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	VA FA	WV NF	WV FA	PA	DC
	ENT (Otorhinolaryngology)											
92551	Pure tone hearing test, air	\$10	\$10	\$8	\$8	\$11	\$8	N/A	\$7	\$7	\$8	\$13
92552	Pure tone audiometry, air	\$23	\$23	\$19	\$19	\$22	\$17	N/A	\$14	\$14	\$8	\$26
92557	Comprehensive hearing test	\$43	\$40	\$47	\$44	\$40	\$32	\$30	\$28	\$26	\$29	\$50
92567	Tympanometry	\$16	\$14	\$18	\$17	\$16	\$12	\$11	\$10	\$9	\$12	\$20
92568	Acoustic refl threshold tst	\$17	\$17	\$16	\$16	\$17	\$13	N/A	\$12	\$12	\$10	\$20
92585	Auditory evoked potentials (ABR comprehensive)	\$106	\$106	\$102	\$102	\$100	\$78	N/A	\$64	\$64	\$27	\$117
92587	Evoked auditory (otoacoustic emission) testing	\$37	\$37	\$41	\$41	\$35	\$27	N/A	\$22	\$22	\$34	\$46
	Average % of Medicare Fees			96%	96%	96%	75%		62%	62%	67%	119%
	Cardiovascular Medicine											
93000	Electrocardiogram, complete	\$21	\$21	\$18	\$18	\$20	\$16	N/A	\$13	\$13	\$19	\$24
93010	Electrocardiogram report	\$9	\$9	\$6	\$6	\$9	\$7	N/A	\$6	\$6	\$8	\$10
93016	Cardiovascular stress test	\$25	\$25	\$18	\$18	\$0	\$19	N/A	\$17	\$17	\$22	\$27
93042	Rhythm ECG, report	\$8	\$8	\$6	\$6	\$8	\$6	N/A	\$6	\$6	\$7	\$9
93303	Echo transthoracic	\$218	\$218	\$173	\$173	\$206	\$160	N/A	\$135	\$135	\$157	\$256
93307	Tte w/o doppler, complete	\$165	\$165	\$150	\$150	\$156	\$121	N/A	\$101	\$101	\$140	\$208
93320	Doppler echo exam, heart	\$72	\$72	\$66	\$66	\$68	\$53	N/A	\$44	\$44	\$65	\$92
93325	Doppler color flow add-on	\$43	\$43	\$57	\$57	\$41	\$32	N/A	\$26	\$26	N/A	\$64
	Average % of Medicare Fees			92%	92%	94%	74%		61%	61%	72%	125%
	Non-Invasive Vascular Diagnostic Studies											
93880	Extracranial study	\$196	\$196	\$142	\$142	\$189	\$185	N/A	\$151	\$151	\$148	\$296
93970	Extremity study	\$200	\$200	\$145	\$145	\$193	\$189	N/A	\$155	\$155	\$147	\$302
93971	Extremity study	\$127	\$127	\$92	\$92	\$122	\$125	N/A	\$102	\$102	\$100	\$200
93976	Vascular study	\$221	\$221	\$164	\$164	\$209	\$162	N/A	\$136	\$136	\$131	\$256
	Average % of Medicare Fees			73%	73%	96%	88%		72%	72%	70%	140%

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		MD		DE		VA		WV		WV		PA		DC		
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF
	Pulmonary																			
94010	Breathing capacity test	\$35	\$35	\$27	\$27	\$27	\$27	\$33	\$33	N/A	N/A	\$22	\$22	\$22	\$22	\$15	\$15	\$39	\$39	
94060	Evaluation of wheezing	\$61	\$61	\$46	\$46	\$46	\$46	\$57	\$57	N/A	N/A	\$37	\$37	\$37	\$37	\$19	\$19	\$68	\$68	
94375	Respiratory flow volume loop	\$39	\$39	\$28	\$28	\$28	\$28	\$37	\$37	N/A	N/A	\$25	\$25	\$25	\$25	\$31	\$31	\$43	\$43	
94640	Airway inhalation treatment	\$15	\$15	\$11	\$11	\$11	\$11	\$14	\$14	N/A	N/A	\$9	\$9	\$9	\$9	N/A	N/A	\$16	\$16	
94664	Evaluate pt use of inhaler	\$15	\$15	\$12	\$12	\$12	\$12	\$14	\$14	N/A	N/A	\$9	\$9	\$9	\$9	\$12	\$12	\$18	\$18	
94760	Measure blood oxygen level	\$3	\$3	\$2	\$2	\$2	\$2	\$2	\$2	N/A	N/A	\$0	\$0	\$0	\$0	\$2	\$2	\$3	\$3	
94761	Measure blood oxygen level	\$4	\$4	\$5	\$5	\$5	\$5	\$4	\$4	N/A	N/A	\$0	\$0	\$0	\$0	\$4	\$4	\$7	\$7	
	Average % of Medicare Fees			76%	76%	76%	76%	94%	94%	73%	73%	53%	53%	53%	53%	39%	39%	113%	113%	
	Allergy/Immunology																			
95004	Percut allergy skin tests	\$6	\$6	\$4	\$4	\$4	\$4	\$6	\$6	N/A	N/A	\$3	\$3	\$3	\$3	\$2	\$2	\$7	\$7	
95024	Id allergy test, drug/bug	\$7	\$7	\$5	\$5	\$5	\$5	\$7	\$7	N/A	N/A	\$4	\$4	\$4	\$4	\$5	\$5	\$8	\$8	
95115	Immunotherapy, one injection	\$11	\$11	\$10	\$10	\$10	\$10	\$10	\$10	N/A	N/A	\$6	\$6	\$6	\$6	\$4	\$4	\$13	\$13	
95117	Immunotherapy injections	\$13	\$13	\$13	\$13	\$13	\$13	\$12	\$12	N/A	N/A	\$7	\$7	\$7	\$7	\$7	\$7	\$15	\$15	
95165	Antigen therapy services	\$12	\$3	\$9	\$2	\$2	\$2	\$12	\$12	\$4	\$4	\$7	\$7	\$2	\$2	\$8	\$8	\$14	\$14	
	Average % of Medicare Fees			93%	95%	95%	95%	94%	94%	73%	73%	58%	57%	57%	57%	48%	48%	117%	117%	
	Neurology/Neuromuscular																			
95810	Polysomnography, 4 or more	\$804	\$804	\$636	\$636	\$636	\$636	\$762	\$762	N/A	N/A	\$492	\$492	\$492	\$492	\$347	\$347	\$909	\$909	
95816	Eeg, awake and drowsy	\$257	\$257	\$167	\$167	\$167	\$167	\$243	\$243	N/A	N/A	\$157	\$157	\$157	\$157	\$23	\$23	\$255	\$255	
95819	Eeg, awake and asleep	\$281	\$281	\$169	\$169	\$169	\$169	\$267	\$267	N/A	N/A	\$171	\$171	\$171	\$171	\$23	\$23	\$274	\$274	
95860	Muscle test, one limb	\$88	\$88	\$65	\$65	\$65	\$65	\$83	\$83	N/A	N/A	\$56	\$56	\$56	\$56	\$30	\$30	\$92	\$92	
95903	Motor nerve conduction test	\$67	\$67	\$50	\$50	\$50	\$50	\$64	\$64	N/A	N/A	\$43	\$43	\$43	\$43	\$38	\$38	\$71	\$71	
95904	Sense nerve conduction test	\$51	\$51	\$39	\$39	\$39	\$39	\$48	\$48	N/A	N/A	\$32	\$32	\$32	\$32	\$22	\$22	\$54	\$54	
95926	Somatosensory testing	\$135	\$135	\$79	\$79	\$79	\$79	\$128	\$128	N/A	N/A	\$82	\$82	\$82	\$82	\$58	\$58	\$135	\$135	
95934	H-reflex test	\$53	\$53	\$33	\$33	\$33	\$33	\$51	\$51	N/A	N/A	\$34	\$34	\$34	\$34	\$30	\$30	\$54	\$54	
95957	EEG digital analysis	\$302	\$302	\$183	\$183	\$183	\$183	\$286	\$286	N/A	N/A	\$188	\$188	\$188	\$188	\$138	\$138	\$298	\$298	
	Average % of Medicare Fees			72%	72%	72%	72%	95%	95%	74%	74%	61%	61%	61%	61%	32%	32%	107%	107%	

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		VA		WV		PA		DC	
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA
	CNS Assessment Tests												
96110	Developmental test, lim	\$8	\$8	\$11	\$11	\$7	\$6	\$4	\$4	\$7	\$7	\$4	\$15
96111	Developmental test, extend	\$137	\$133	\$97	\$95	\$0	\$102	\$94	\$94	\$50	\$50	\$92	\$141
	Average % of Medicare Fees			84%	85%	17%	75%	67%	67%	46%	46%	67%	119%
	Chemotherapy Administration												
96411	Chemo, iv push, addl drug	\$65	\$65	\$54	\$54	\$61	\$47	\$39	\$39	\$53	\$53	\$39	\$76
96413	Chemo, iv infusion, 1 hr	\$151	\$151	\$127	\$127	\$143	\$111	\$90	\$90	\$125	\$125	\$90	\$177
96415	Chemo, iv infusion, addl hr	\$32	\$32	\$28	\$28	\$31	\$24	\$20	\$20	\$28	\$28	\$20	\$39
96417	Chemo iv infus each addl seq	\$75	\$75	\$63	\$63	\$70	\$54	\$44	\$44	\$62	\$62	\$44	\$88
96450	Chemotherapy, into CNS	\$212	\$91	\$218	\$76	\$200	\$156	\$90	\$133	\$77	\$77	\$62	\$243
96523	Irrig drug delivery device	\$26	\$26	\$22	\$22	\$25	\$19	N/A	\$0	\$19	\$19	\$0	\$30
	Average % of Medicare Fees			86%	84%	95%	73%		56%	79%	79%	56%	118%
	Dermatology												
96910	Photochemotherapy with UV-B	\$67	\$67	\$46	\$46	\$63	\$49	N/A	\$39	\$20	\$20	\$39	\$76
96912	Photochemotherapy with UV-A	\$86	\$86	\$59	\$59	\$82	\$63	N/A	\$50	\$20	\$20	\$50	\$98
	Average % of Medicare Fees			69%	69%	95%	73%		58%	26%	26%	58%	113%

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

Table 2. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC		MD		VA		WV		PA		DC	
		NF	FA	NF	FA	NF	FA	NF	FA	NF	FA	NF	FA
	Phys Medicine/Rehab Therapy												
97001	Pt evaluation	\$74	\$74	\$72	\$72	\$56	N/A	\$50	\$50	\$45	\$78		
97010	Hot or cold packs therapy	\$6	\$6	\$4	\$4	\$4	N/A	\$3	\$3	\$17	\$5		
97014	Electric stimulation therapy	\$15	\$15	\$10	\$10	\$11	N/A	\$9	\$9	\$17	\$15		
97035	Ultrasound therapy	\$13	\$13	\$9	\$9	\$9	N/A	\$8	\$8	\$10	\$13		
97110	Therapeutic exercises	\$30	\$30	\$29	\$29	\$22	N/A	\$20	\$20	\$8	\$31		
97112	Neuromuscular reeducation	\$31	\$31	\$22	\$22	\$24	N/A	\$20	\$20	\$17	\$32		
97140	Manual therapy	\$28	\$28	\$19	\$19	\$21	N/A	\$18	\$18	\$21	\$29		
97530	Therapeutic activities	\$32	\$32	\$31	\$31	\$24	N/A	\$21	\$21	\$13	\$33		
	Average % of Medicare Fees			85%	85%	74%		65%	65%	59%	103%		
	Osteopathy, Chiropractic and Other Medicine												
98941	Chiropractic manipulation	\$36	\$31	\$25	\$22	\$27	\$25	\$24	\$22	\$13	\$37		
99144	Mod sedation by same phys, 5 yrs +	\$44	\$44	\$28	\$28	\$62	N/A	N/A	N/A	N/A	N/A		
99173	Visual acuity screen	\$3	\$3	\$2	\$2	\$64	N/A	N/A	N/A	\$6	\$3		
99183	Hyperbaric oxygen therapy	\$207	\$122	\$151	\$86	\$153	\$106	\$135	\$85	\$107	\$215		
	Average % of Medicare Fees			75%	74%	950%				106%	88%		

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

VI. Trauma Center Payment Issues

During the 2003 legislative session, the Maryland General Assembly passed, and the Governor signed into law, SB 479, which created a Trauma and Emergency Medical Fund that is financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the fund. Based on the legislation, Maryland Medicaid is required to pay physicians 100 percent of the Medicare facility rates for the Baltimore area when they provide trauma care to Medicaid's fee-for-service 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 (MIEMSS) 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 of the 2006 legislative session extended the enhanced rate 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.

VII. Reimbursement for Oral Health Services

Historically, the Maryland Medical Assistance program has had low dental fees. Unlike for physician service fees, 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 (NDAS) 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 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 same 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 of the 2008 session of the Maryland General Assembly allocated \$7 million in state funds (\$14 million total 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)—Doral Dental—coordinates the provision of dental services for Medicaid beneficiaries in the fee-for-service program. Fees for some of the dental procedures were streamlined and adjusted effective July 1, 2009, to coincide with the provision of dental services through the ASO. Fees for dental procedures have not changed in FY 2011 from their FY 2010 levels. Table 3 shows Maryland Medicaid FY 2009 and FY 2011 weighted average dental fees by groups of procedures as percentages of the ADA’s 50th percentile of charges in 2009.

Table 3. Average of Maryland Medicaid Dental Fees as a Percentage of the ADA's 50th Percentile of Charges

Procedure Groups	Medicaid FY 2009 Fees	Medicaid FY 2011 Fees
D0100-D1999 Diagnostic and Preventive Procedures	41%	68%
D2000-D2999 Restorative Procedures	67%	68%
D3000-D3999 Endodontic Procedures	38%	67%
D4210-D6999 Periodontics and Prosthodontics	55%	56%
D7000-D7999 Oral and Maxillofacial Surgery	28%	67%
D8000-D9999 Orthodontics and Adjunctive General Services	32%	33%
All Procedures Combined	47%	62%

VIII. Physician Participation in the Maryland Medicaid Program

Physicians’ claims and encounter data pertaining to FY 2002 (the year before the July 2002 fee increase), FY 2007, FY 2008, and FY 2009 were analyzed for the number of physicians who had either partial or full participation in the Medicaid program.² In Tables 4, 5, and 6, physicians who had fewer than 25 claims during the fiscal year are included in the data for all physicians. Physicians who submitted more than 25 claims but had fewer than 50 Medicaid patients were considered partial participants in the Medicaid program. Physicians who had at least 50 Medicaid patients during the year were considered full participants in the Medicaid program.

Tables 4, 5, and 6 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. As the data in Table 4 demonstrate, there were significant increases in physician participation in the FFS program, MCO networks, and the total Medicaid program between FYs 2002 and 2009, compared to the increase between 2002 and 2008 (these figures are not presented in the table). For example, comparable figures for the 2002-2008 period for

² The data in these tables pertain to FY 2002 through FY 2009. Therefore, these tables to some extent include the impact of fee changes in FY 2009 on physician participation in the Medicaid program.

physicians with full participation in the FFS program, MCO networks, and total Medicaid program are 38.3, 26.1, and 33.5 percent, respectively.

Table 4. FY 2002-2009 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	31.8%	45.5%	89.0%
Full Participation	86.2%	83.6%	88.6%
All Physicians	28.1%	59.2%	86.7%

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, the data in Table 5 indicate that, following the FY 2007 and FY 2008 fee increases, there were significant increases in physician participation between FY 2007 and FY 2009.

Table 5. FY 2007-2009 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	5.8%	24.5%	17.6%
Full Participation	38.6%	54.7%	51.1%
All Physicians	8.8%	24.7%	15.1%

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

Data in Table 6 show that the increasing trend in physician participation in the Medicaid program continued between FY 2008 and FY 2009.

Table 6. FY 2008-2009 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	1.7%	10.9%	7.1%
Full Participation	33.8%	42.4%	38.7%
All Physicians	4.6%	4.7%	4.2%

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

The increases in physician participation across the FFS program and MCO networks (particularly the increase in full participation among physicians) likely can be attributed to the increase in the physician fees and Medicaid enrollment during FY 2008 and FY 2009, when many physicians who were not participating in the HealthChoice program decided to become partial or full participants.

Between FY 2008 and FY 2009, the number of physicians who had fewer than 25 claims decreased 6.3 percent (figure not presented here). This decrease, along with an increase of approximately 39 percent in the number of fully participating physicians, may indicate that many of the physicians who had fewer than 25 claims started to fully participate in the Medicaid program. Additional analysis of data shows that between FY 2008 and FY 2009, the number of partial and full participating physicians who had more than 25 claims increased more than the decrease in the number of physicians who had fewer than 25 claims. After taking into account the increase in the number of partial and fully participating physicians and the decrease in the number of physicians who had fewer than 25 claims, the data show that approximately 1,700 additional physicians participated in the Medicaid program in FY 2009. This indicates that some of the partial and full participants are physicians who did not previously participate in the Medicaid program.

As mentioned above, to some extent, the increase in the number of participating physicians is likely the result of Medicaid expansion and increased enrollment. Therefore, to separate the effects of increase in physician fees from the effects of 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 7). For this analysis, we excluded radiology and laboratory procedures for all years, as they may not be representative of patients' access to physician services.

Table 7. 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 % Increase in Claims Per Enrollee	Increase in Claims Per Enrollee From Each Year to 2009
2002	617,929	3,919,805	6.3	N/A	42%
2003	652,414	4,281,928	6.6	3.5%	37%
2004	669,021	4,789,248	7.2	9.1%	25%
2005	687,269	4,891,558	7.1	-0.6%	26%
2006	690,227	5,253,246	7.6	6.9%	18%
2007	676,522	5,601,598	8.3	8.8%	8%
2008	709,239	6,079,365	8.6	3.5%	5%
2009	771,732	6,929,659	9.0	4.8%	N/A

N/A: Not Applicable

Medicaid enrollees' utilization of physician services increased steadily, from an average of 6.3 claims per enrollee in FY 2002 to an average of 9 claims per enrollee in FY 2009. This is a 42 percent increase in Medicaid enrollees' utilization of physician services. An increase in utilization of physician services is a proxy for an increase in participation of physicians in the Maryland Medicaid program and may be interpreted as an increase in Medicaid enrollees' access to physician services.

IX. Plan for Future Fee Increases

The Affordable Care Act provides additional funding to increase Medicaid rates for certain services provided between January 1, 2013 and January 1, 2015. Specifically, states will receive 100 federal funding to increase their payments rates for evaluation and management services provided by physicians in family medicine and general internal medicine. The payment rate will be no less than 100 percent of the adjusted Medicare Part B rates for these services.

With the additional federal monies and as additional state fund become available, the Department will continue to work towards its goal of reimbursing physicians at 100 percent of Medicare reimbursement rates. Additionally, it will work to increase rates for dentists to the 50th percentile of the American Dental Association's South Atlantic region charges.

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. Three types of resources 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 13,000 physician procedures, the Centers for Medicare and Medicaid Services (CMS) determine 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 (such as hospitals and skilled nursing facilities) than if they are performed in non-facilities (offices), where physicians must pay for practice expenses. The implementation of RBRVS resulted in increased payments to 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 in the calculation of fee amounts 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 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.

Prior to December 1, 2003, the 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 the Medicaid program started the transition 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 system. Medicare's methodology recognizes anesthesia time as the key element for determining payment

rate. The anesthesia time for any additional procedures during the same operative session is added to the time for the primary procedure. This time is then converted to units, with 15 minutes equal to 1 unit.

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 payment amount.

The Baltimore area Medicare conversion factor for 2010 is \$22.04. The Maryland Medicaid program calculates the payment slightly differently but the net result is the same.

Appendix B
Rate of Non-Federal Physicians per 100,000 Civilian Population, 2009

Rank	Geographic Area	Number of Non-Federal Physicians, 2009	2009 Population	Number of Physicians per 100,000 Population
Average	United States	1,077,683	310,973,838	347
1	Washington, D.C.	5,432	599,657	906
2	Massachusetts	37,284	6,593,587	565
3	New York	94,836	19,541,453	485
4	Maryland	27,450	5,699,478	482
5	Vermont	2,980	621,760	479
6	Connecticut	16,568	3,518,288	471
7	Rhode Island	4,938	1,053,209	469
8	Pennsylvania	53,564	12,604,767	425
9	New Jersey	36,036	8,707,739	414
10	Maine	5,353	1,318,301	406
11	Hawaii	5,028	1,295,178	388
12	New Hampshire	4,974	1,324,575	376
13	Michigan	36,450	9,969,727	366
14	Oregon	13,947	3,825,657	365
15	Ohio	41,763	11,542,645	362
16	Minnesota	18,979	5,266,214	360
17	Illinois	45,705	12,910,409	354
18	Florida	65,122	18,537,969	351
19	California	126,893	36,961,664	343
20	Washington	22,791	6,664,195	342
21	Virginia	26,402	7,882,590	335
22	Colorado	16,775	5,024,748	334
23	Wisconsin	18,703	5,654,774	331
24	Delaware	2,912	885,122	329
25	Missouri	19,575	5,987,580	327
26	Tennessee	20,174	6,296,254	320
27	Puerto Rico	12,698	3,967,288	320
28	West Virginia	5,813	1,819,777	319
29	Louisiana	14,108	4,492,076	314
30	North Carolina	28,995	9,380,884	309
31	Nebraska	5,540	1,796,619	308
32	Kansas	8,587	2,818,747	305
33	New Mexico	6,064	2,009,671	302
34	North Dakota	1,938	646,844	300

Rank	Geographic Area	Number of Non-Federal Physicians, 2009	2009 Population	Number of Physicians per 100,000 Population
35	Montana	2,914	974,989	299
36	Arizona	19,348	6,595,778	293
37	Kentucky	12,408	4,314,113	288
38	South Carolina	12,910	4,561,242	283
39	South Dakota	2,259	812,383	278
40	Indiana	17,802	6,423,113	277
41	Iowa	8,280	3,007,856	275
42	Alabama	12,545	4,708,708	266
43	Texas	65,622	24,782,302	265
44	Oklahoma	9,626	3,687,050	261
45	Utah	7,233	2,784,572	260
46	Georgia	25,306	9,829,211	257
47	Alaska	1,783	698,473	255
48	Arkansas	7,254	2,889,450	251
49	Wyoming	1,351	544,270	248
50	Nevada	6,524	2,643,085	247
51	Idaho	3,522	1,545,801	228
52	Mississippi	6,619	2,951,996	224

Maryland ranks fourth among all states, same as 2008.

Note: Nonfederal physicians are members of the U.S. physician population who are employed in the private sector. They include allopathic physicians (MDs) and osteopathic physicians (DOs), and represent 97% of total physicians. Data include all licensed nonfederal physicians.

Sources: Data for physicians are from American Medical Association (2009). Data for civilian population are from the U.S. Census Bureau (November 23, 2010).

Appendix C
Rate of Dentists per 100,000 Civilian Population, 2009

Rank	Geographic Area	Total Number of Dentists, 2009	2009 Population	Dentists per 100,000 Population
Average	United States	247,670	310,973,838	80
1	Washington, D.C.	817	599,657	136
2	Massachusetts	7,560	6,593,587	115
3	Hawaii	1,318	1,295,178	102
4	California	37,390	36,961,664	101
5	New Jersey	8,701	8,707,739	100
6	Maryland	5,681	5,699,478	100
7	New York	19,207	19,541,453	98
8	Connecticut	3,447	3,518,288	98
9	Nebraska	1,751	1,796,619	97
10	Washington	6,342	6,664,195	95
11	Colorado	4,655	5,024,748	93
12	Alaska	628	698,473	90
13	Minnesota	4,469	5,266,214	85
14	Utah	2,359	2,784,572	85
15	Montana	821	974,989	84
16	Pennsylvania	10,607	12,604,767	84
17	Michigan	8,176	9,969,727	82
18	Florida	15,021	18,537,969	81
19	Idaho	1,228	1,545,801	79
20	Kentucky	3,423	4,314,113	79
21	Vermont	492	621,760	79
22	Illinois	10,156	12,910,409	79
23	Iowa	2,360	3,007,856	78
24	Virginia	6,175	7,882,590	78
25	New Hampshire	1,034	1,324,575	78
26	Arizona	5,007	6,595,778	76
27	Wisconsin	4,232	5,654,774	75
28	Nevada	1,935	2,643,085	73
29	Ohio	8,025	11,542,645	70
30	North Dakota	443	646,844	68
31	Rhode Island	718	1,053,209	68
32	South Carolina	3,084	4,561,242	68
33	Tennessee	4,240	6,296,254	67
34	West Virginia	1,222	1,819,777	67
35	Wyoming	363	544,270	67
36	Kansas	1,858	2,818,747	66
37	Oregon	2,507	3,825,657	66

Rank	Geographic Area	Total Number of Dentists, 2009	2009 Population	Dentists per 100,000 Population
38	Oklahoma	2,404	3,687,050	65
39	Louisiana	2,867	4,492,076	64
40	Indiana	4,090	6,423,113	64
41	Maine	836	1,318,301	63
42	Missouri	3,754	5,987,580	63
43	North Carolina	5,796	9,380,884	62
44	South Dakota	500	812,383	62
45	Texas	15,132	24,782,302	61
46	New Mexico	1,223	2,009,671	61
47	Alabama	2,736	4,708,708	58
48	Delaware	508	885,122	57
49	Georgia	5,525	9,829,211	56
50	Mississippi	1,559	2,951,996	53
51	Arkansas	1,469	2,889,450	51
52	Puerto Rico	1,819	3,967,288	46

The ranking of Maryland among all states increased from eighth in 2008 to sixth in 2009.

Note: Data include all licensed dentists.

Sources: American Dental Association (2009). Data for civilian population are from the U.S. Census Bureau (November 23, 2010).

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