



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

SEP 17 2008

The Honorable Martin O'Malley
Governor
State House
100 State Circle
Annapolis, MD 21401-1925

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

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

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
131 Lowe House 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: 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 Governor O'Malley, Chairmen Currie, Conway, Middleton and Hammen:

The Department of Health and Mental Hygiene is required to annually submit a report pursuant to Section 1 of SB 481 – *Department of Health and Mental Hygiene – Reimbursement Rates*. The attached paper reports 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 provides analysis of other states' rates compared to Maryland; the schedule for raising rates; and an analysis of the estimated cost of implementing these changes. The report was due on September 1, 2008.

The Honorable Martin O'Malley
The Honorable Ulysses Currie
The Honorable Norman H. Conway
The Honorable Thomas M. Middleton
The Honorable Peter A. Hammen
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In addition, the Department has incorporated into this report information required by HB 627 – *Community Health Care Access and Safety Net Act of 2005*. Section 11 of this Act requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare those rates to the fee-for-service rates paid to similar providers for the same services under the Medical Assistance program and the rates paid to managed care organization providers for the same services. On or before January 1, the Department is to annually report this information and whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule. The report being submitted satisfies the reporting requirements for both SB 481 and HB 627.

If further information is required, please contact Tricia Roddy, Director of Planning, at (410) 767-5806.

Sincerely,



John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Tricia Roddy
Audrey Richardson
Diane Herr
Anne Hubbard
Sarah Albert, MSAR 2351 and 7226

**Report on the Maryland Medical Assistance Program and the
Maryland Children's Health Program – Reimbursement Rates
September 2008**

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**Report on the Maryland Medical Assistance Program and the
Maryland Children's Health Program – Reimbursement Rates
September 2008**

I. Introduction

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

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

In addition, the Department has incorporated into this report information required by Chapter 280 (HB 627) from the 2005 session. Section 11 of this act requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare those rates to the fee-for-service rates for the same services paid to: 1) providers under the Medical Assistance program, and 2) managed care organization (MCO) providers. On or before January 1 of every year, the Department is to report this information and whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule.

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

II. Background

In September 2001, in response to Chapter 702 (HB 1071) of the 2001 session, the Department prepared the first annual report analyzing the physician fees that are paid by the Maryland Medical Assistance and the Children's Health Programs. In 2002, SB 481 required the submission of this report on an annual basis. This is the eighth annual report.

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

of a survey conducted by the American Academy of Pediatrics¹ in 1998/1999, which showed that Maryland's physician reimbursement for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the Legislature appropriated \$50 million additional total funds (\$25 million state funds) for increasing physician fees in the Medicaid program beginning July 2002. The increase was targeted to Evaluation and Management (E&M) procedure codes largely used by primary care 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, in an effort to retain health care providers in the state, alleviated the impact of recent increases in the cost of physicians' malpractice liability insurance. This bill created the Maryland Health Care Provider Rate Stabilization Fund to subsidize physicians for the cost of obtaining malpractice insurance. The main revenues of the Fund are from a tax imposed on MCOs and health maintenance organizations (HMOs).

In addition to subsidizing physicians for the cost of obtaining malpractice liability insurance, SB 836 allocated funds to the Medical Assistance Program to increase both fee-for-service physician fees and capitation payments to MCOs to enable these organizations to similarly raise their provider fees. The legislation allocated \$15 million in state funds (\$30 million total funds) in fiscal year (FY) 2006 to be used by the Department to increase both fee-for-service physician fees and to pay physicians in MCOs' networks "consistent with fee-for-service health care provider rates for procedures commonly performed by obstetricians, 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 Medical Assistance Program for increasing and maintaining physician fees.

The Department used the Medicare physician payment methodology as a benchmark or point of reference when it increased physicians' fees in fiscal years 2003, 2006, 2007, and 2008. Medicare fees are based on the Resource-Based Relative Value Scale (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 Appendices 1 and 2 for a description of RBRVS and the Department's methodology for increasing fees.)

SB 836 also required the Department to consult with the managed care organizations, the Maryland Hospital Association, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Maryland Chapter of the American College of Emergency Room Physicians to determine the new payment rates. 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

¹ American Academy of Pediatrics, (1998/1999), *Medicaid Reimbursement Survey* – Retrieved from <http://www.aap.org/research/medreimintro.htm>

and the Maryland Dental Society among entities that the Department must consult to determine the payment rates.

For FY 2007, based on the stakeholders' recommendation, the Department increased fees for procedures that are mainly used for general surgery (10000-19396), digestive surgery (40490-49999), ear, nose, throat (ENT) /Otorhinolaryngology (69000-69990 and 92502-92625), allergy/immunology (95004-95199), dermatology (96900-96999), and radiation oncology (77261-77799) procedures.

For FY 2008, also based on the stakeholders' recommendation, the Department:

- Increased fees for evaluation and management procedures to a minimum of 80 percent of Medicare fees
- Increased fees for evaluation and management procedures performed in hospital outpatient departments to a minimum of 50 percent of corresponding Medicare fees
- Increased fees for the three neonatology procedures (99294, 99296, and 99299) to 90 percent of Medicare fees
- Increased fees for radiology procedures to a minimum of 53 percent of Medicare fees
- Increased fees for vaccine administration procedures from \$10 to \$13.50
- Increased fees for procedures with the lowest fees to a minimum of 50 percent of Medicare fees
- Increased fees for obstetric anesthesia procedures by about 9 percent
- Increased Medicaid fees for psychiatry procedures to the level of Mental Health Administration fees for these procedures

Table 1 shows the percentage of Medicare fees for targeted groups of procedures at the time of original fee increases in fiscal years 2003, 2006, 2007, and 2008. Because Medicare fees change over time, additional funds had to be allocated in FY 2008 to maintain fees for Evaluation and Management (E&M) fees at 80 percent of Medicare fees.

Table 1. Prior Fee Increases to Percentage of Medicare Fees

Fiscal Year	Procedure Code Group	Percent of Medicare Fees at the Time of Original Fee Increase
2003	Evaluation & Management (99201-99499)	80%
2006	Four Specialties: Orthopedic (20000-29999), Obstetric/Gynecology (56405-59899) Neurosurgery (61000-64999) Emergency (99281-99285)	99.6% 99.6% 99.6% 99.6%
2007	Anesthesia 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 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) Procedures with the lowest fees	80% 50% 90% 53% 66% 61% 50%

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

SB 836 of the 2005 session indicates that the Department shall submit its plan for increasing Medicaid reimbursement rates to the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health and Government Operations Committee “prior to adopting the regulations implementing the increase.” The Department submitted a report in May 2008 entitled “Report on FY 2009 Reimbursement Rate Increases for Physicians and Dentists Participating in the Maryland Medical Assistance Program and Maryland Children’s Health Program.” The report explained the Department’s plan to increase Medicaid physician fees for FY 2009, which is described in the following sections.

III. FY 2009 Increase in Medicaid Physicians' Fees

In FY 2006 and FY 2007, fees for many procedures, including orthopedic, obstetric/gynecology, neurosurgery, ear, nose, throat (ENT), and emergency medicine were set at 100 percent of their corresponding Medicare fee. While Medicare fees in general have not increased substantially over the past few years, CMS has updated the work and practice expense relative value units (RVUs) of most procedures in the past two years. According to the American Medical Association,² the work and practice expense RVUs, on average, account for about 96 percent of total RVUs for procedures. Therefore, the update in RVUs has led to a decrease in Medicare fees for many procedures, which has caused Maryland Medicaid fees for some of the aforementioned procedures to exceed current (2008) Medicare fees. At the same time, fees for many procedures were at 50 percent of Medicare fees. Hence, there was a need to rebalance Medicaid fees with Medicare fees.

The Department convened the stakeholders meeting on physician fees in March 2008. Representatives from MCOs, the Maryland Hospital Association, the Maryland Chapter of the American College of Emergency Physicians, Mercy Medical Center, Johns Hopkins Hospital, University of Maryland Medical Center, a radiation therapy group, and anesthesiology attended the meeting.

The stakeholder group stated in previous years' meetings that they would like to increase the procedures with the lowest fees compared to Medicare fees. Therefore, the Department proposed that the \$9 million available funds for increasing Medicaid physician fees for FY 2009 be used to increase the lowest fees to a minimum percentage of Medicare fees and re-balance Medicaid fees with Medicare fees. The proposal included Medicare's policy of setting separate fees for different sites of service so that physician fees would have site of service differentials for facilities (e.g., hospitals) and non-facilities (e.g., offices). The stakeholder group agreed with this proposal, which the Department implemented on July 1, 2008.

Therefore, Medicaid fees were determined using the following methodology:

- Fees that were higher than Medicare fees were reduced to their corresponding Medicare fee levels by site of service; funds were re-distributed to increase the lowest fees.
- Fees that were lower than 78.6% of Medicare fees were raised to 78.6% of their corresponding Medicare fees by site of service.
- Fees that were lower than the corresponding Medicare fee but higher than 78.6% of Medicare fees remained unchanged.

The exceptions to this methodology were that fees for four specialties' (orthopedic, obstetric/gynecology, neurosurgery, and emergency room) procedures were set equal to 100% of Medicare fees, and fees for four obstetric procedures (normal and cesarean delivery procedures) were kept at their FY 2008 levels, which are higher than their corresponding Medicare fees. The reasons were that 1) the four specialties were identified by SB 836, and 2) the four obstetric

² American Medical Association: The RVS Update Process booklet (2007). Accessed at: http://www.ama-assn.org/ama1/pub/upload/mm/380/rvs_booklet_07.pdf

procedures were maintained at their FY 2008 levels in order to ensure participation of obstetricians in the Medical Assistance program.

IV. Maryland Medicaid Fees Compared to Medicare Fees

Table 2 shows the average percentage of Medicare 2008 fees for all specialty groups of procedures before and after the July 1, 2008 fee increase. The average percentages reported in Table 2 are weighted averages of Maryland fees as percentages of Medicare fees for all procedures in each specialty group.

Table 2 also shows the number of procedures in each specialty group that have a fee increase or a fee decrease in FY 2009. In Table 2, the numbers of procedures that had fee changes do not include changes in fees for modifier components of procedures. In other words, a procedure code that has a base fee and fees for two different modifiers corresponding to the main procedure code is counted as one procedure. However, procedures that had fee changes in both facilities and non-facilities are counted twice: once for the change in the facility fee, and once for the change in the non-facility fee.

The FY 2009 fee increase raised Medicaid physician fees to an average of 87 percent of Medicare 2008 fees. As indicated above, because of the decline in Medicare fees for procedures of some specialty groups, Medicaid fees that exceeded 100 percent of Medicare fees were reduced to 100 percent of Medicare fees, by site of service.

Medicare fees for anesthesia procedures increased by about 24 percent from 2007 to 2008. Maryland Medicaid reimbursement rates for anesthesia procedures were about 110 percent of Medicare 2007 rates. However, as a result of the increase in Medicare 2008 fees for anesthesia procedures, Maryland fees for these procedures currently stand, on average, at about 90 percent of their corresponding Medicare fees. Therefore, because fees for anesthesia procedures are between 78.6 and 100 percent of Medicare rates, they would not change in FY 2009.

**Table 2. Average Percentage of Medicare 2008 Fees by
Procedure Specialty Group (Sum of Facilities and Non-Facilities)**

Specialty Group	CPT Codes	Pre-Increase % of Medicare	Post-Increase % of Medicare	No. of Procedures with Fee Decrease	No. of Procedures with Fee Increase
Anesthesia	00100-01999	90%	90%	0	0
General Surgery/Integumentary	10000-19396	102%	92%	169	59
Musculoskeletal System	20000-29999	110%	100%	1,045	205
Respiratory	30000-32999	66%	82%	27	185
Cardiovascular	33010-37790	97%	85%	81	383
Lymphatic	38100-38794	68%	82%	7	38
Mediastinum	39000-39561	51%	79%	0	13
Digestive System	40490-49905	106%	88%	157	86
Urinary & Male Genital	50010-55999	67%	81%	29	290
Gynecology-Obstetric	56405-59899	105%	106%	236	74
Endocrine System	60000-60699	52%	79%	0	22
Neurosurgery	61000-64999	139%	100%	237	117
Eye Surgery	65091-68899	68%	84%	21	212
ENT/Ear Surgery	69000-69990	116%	100%	71	0
Radiology	70010-79900	73%	80%	79	766
Laboratory	80048- 89356	80%	90%	38	215
Vaccine Administration	90465-90779	66%	80%	6	65
Psychiatry	90801-90911	91%	91%	13	16
Dialysis	90918-90999	52%	79%	0	18
Gastroenterology	91000-91299	58%	79%	1	20
Ophthalmology	92002-92499	52%	79%	9	61
ENT (Otorhinolaryngology)	92502-92700	90%	91%	33	4
Cardiovascular	92950-93798	67%	79%	34	163
Non-Invasive Vascular Tests	93875-93990	83%	79%	0	42
Pulmonary	94010-94799	66%	81%	2	49
Allergy/Immunology	95004-95199	97%	96%	11	16
Neurology/Neuromuscular	95805-96004	58%	79%	4	106
CNS Assessment Tests	96100-96155	67%	82%	4	13
Chemotherapy Administration	96400-96571	54%	79%	2	25
Special Dermatological Procedures	96900-96999	64%	79%	0	7
Phys Medicine/Rehab/Therapy	97001-97804	57%	79%	7	64
Osteopathic/Chiropractic & Other Medicine	97810-99195	111%	92%	2	25
Evaluation & Management	99201-99499	83%	83%	32	43
Emergency	99281-99285	95%	100%	2	8
OPD Evaluation & Management (29 select E&M Procedures)	99201-99397	51%	79%	1	28
Total		85%	87%	2,360	3,438

Fees for some groups of procedures, like general surgery/integumentary and digestive system, were set at 80% of Medicare fees in FY 2007. Compared to 2007, Medicare 2008 fees for many procedures in these groups have decreased substantially, resulting in Medicaid fees for these

procedures to exceed their corresponding Medicare fees. This has caused the pre-adjustment Medicaid average for these groups of procedures to be higher than 100% of Medicare fees in Table 2. Once fees for these procedures were lowered to 100% of Medicare fees, the average for the whole group becomes less than 100% of Medicare fees because fees for the remaining procedures in these groups are still well-below Medicare fees. However, this situation does not apply to those groups of procedures like the four specialties that all of their fees were not set at 100% of Medicare fees.

V. Comparisons of Maryland Medicaid Fees with Other States' Fees

Like Maryland, the neighboring states have their own Medicaid fee schedules. For this report, we collected data on Medicaid physician fees of the neighboring states of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, DC. We obtained the latest physician fee schedules of Delaware, Virginia, and West Virginia from their fiscal agents or their websites. Washington, DC and Pennsylvania provided their fee schedule information directly. We compiled data on each state's current Medicaid fees for a sample of approximately 200 high-volume procedures in different specialties.

The following Tables 3 compares Maryland's old and new Medicaid fees with the corresponding Medicare and neighboring states' Medicaid fees for a sample of high-volume procedures in each specialty group. In Table 3, procedure fees are rounded to the nearest dollar amount. In this table, the last row of each section shows the average of each state's fees for surveyed procedures as a percent of Medicare fees in Maryland. It should be noted that the average percent of Medicare fees reported in this table are simple averages of percent of Medicare fees for surveyed procedures. However, the average percentages reported in Table 2 are weighted averages of Maryland fees as percentages of Medicare fees for all procedures in each specialty group.

For this report, we have compared Maryland Medicaid and other state Medicaid rates to the Medicare fee schedule for Maryland. Average Medicare fees in Maryland are about equal to average Medicare fees in Virginia, but are about 3 percent higher than Medicare fees in Delaware and Pennsylvania, and about 10 percent higher than Medicare fees in West Virginia. Average Medicare fees in Washington, DC are about 7 percent higher than average Medicare fees in Maryland.

In the following paragraphs, we compare Maryland fees with other states fees for evaluation and management and each group of specialty procedures.

Evaluation and Management Procedures

As the data in Table 3 indicate, as an average percentage of Medicare fees in Maryland, on average, Delaware has the highest fees in the region for the selected evaluation and management procedures. Maryland facility and non-facility fees are ranked second and third, followed by Virginia fees, West Virginia facility and non-facility fees, Washington, DC fees, and Pennsylvania fees.

Surgical Procedures

Integumentary Procedures

For integumentary procedures, Maryland's facility fees rank first, Delaware fees rank second, Maryland's non-facility fees rank third, and Virginia's fees rank fourth, West Virginia's facility and non-facility fees rank fifth and sixth, Washington, DC fees rank seventh, and Pennsylvania's fees rank eighth in the region.

Musculoskeletal System Procedures

Maryland's non-facility and facility fees for musculoskeletal system procedures were set at 100 percent of their corresponding Medicare fees and are the highest in the region, followed in order by Delaware, Virginia, West Virginia, Pennsylvania, and Washington DC.

Respiratory Procedures

Maryland facility fees for respiratory procedures rank highest in the region, followed by Delaware and Maryland's non-facility fees. The other neighboring states ranked as follows from highest to lowest: Virginia, West Virginia, Pennsylvania and Washington, DC.

Cardiovascular System Surgery Procedures

Maryland facility and non-facility fees for selected cardiovascular system surgery procedures are highest in the region, followed by Virginia fees, Delaware fees, West Virginia fees, Washington, D.C. fees, and Pennsylvania fees.

Hemic and Lymphatic Systems Procedures

Delaware fees for hemic and lymphatic systems procedures are highest in the region, followed by Maryland, Virginia, West Virginia, Washington, DC, and Pennsylvania fees.

Digestive System Procedures

Maryland facility and non-facility fees for selected digestive system procedures are highest in the region, followed by Delaware fees. The rank orders of the other neighboring states are: Virginia, West Virginia, Pennsylvania, and Washington, DC.

Urinary and Male Genital Procedures

Maryland facility and non-facility fees for urinary and male genital procedures rank highest in the region, followed by Delaware fees, West Virginia fees, Virginia fees, Pennsylvania fees, and Washington, DC fees.

Gynecology and Obstetric Procedures

Most of the neighboring states have relatively high fees for gynecology and obstetric procedures. West Virginia has the highest fees, followed by Maryland, Virginia, Delaware, Washington, DC, and Pennsylvania.

Endocrine System Procedures

Delaware has the highest fees for the selected endocrine system procedures, followed by Maryland, Virginia, West Virginia, Pennsylvania, and Washington, DC.

Nervous System Procedures

Delaware has the highest fees for the selected nervous system procedures, followed by Maryland, Virginia, Washington, DC, West Virginia, and Pennsylvania.

Eye Surgery Procedures

Delaware has the highest fees for the selected eye surgery procedures, followed by Maryland, Pennsylvania, Virginia, West Virginia, and Washington, DC.

Ear Surgery Procedures

Maryland has the highest fees for the selected ear surgery procedures, followed by Virginia, West Virginia, Delaware, Pennsylvania, and Washington, DC. Because Delaware does not cover one of the selected procedures, its ranking was lowered among the neighboring states.

Office-Based Procedures

Radiology Procedures

Delaware has the highest fees for the selected radiology procedures, followed by Maryland, Virginia, West Virginia, Pennsylvania, and Washington, DC.

Laboratory Procedures

Maryland has the highest fees for the selected laboratory procedures, followed by Delaware, Virginia, Washington, DC, Pennsylvania, and West Virginia. West Virginia does not cover some of the selected procedures, which caused it to rank lowest among the neighboring states.

Vaccine Administration

Maryland has the highest fees for vaccine administration procedures, followed by West Virginia and Washington, DC. Vaccine administration fees for other states were not available and are not ranked.

Psychiatry Procedures

Delaware has the highest fees for the selected psychiatry procedures, followed by Maryland, Virginia, West Virginia, Washington, DC, and Pennsylvania.

Dialysis Procedures

Delaware fees for selected dialysis procedures are highest in the region, followed by Washington, D.C., Maryland, Virginia, West Virginia, and Pennsylvania fees.

Gastroenterology Procedures

Delaware has the highest fees for the selected gastroenterology procedures, followed by Maryland, Virginia, West Virginia, Washington, DC and Pennsylvania.

Ophthalmology Procedures

Delaware has the highest fees for the selected Ophthalmology procedures, followed by Washington, DC, Maryland, Virginia, West Virginia, and Pennsylvania.

Otorhinolaryngology (ENT) Procedures

Maryland facility and non-facility fees for Otorhinolaryngology procedures hold the first and second rank in the region, respectively, followed by Delaware, West Virginia, Virginia, Pennsylvania, and Washington, DC.

Cardiovascular Medicine Procedures

Delaware has the highest fees for the selected cardiovascular medicine procedures, followed by Maryland, Virginia, Washington, DC, West Virginia, and Pennsylvania. For three of the selected procedures, Pennsylvania fees are close to or higher than other states' fees. However, the fact that it does not cover one procedure caused it to rank lowest in the region.

Non-Invasive Vascular Diagnostic Studies

Delaware has the highest fees for the selected non-invasive vascular procedures, followed by Virginia, West Virginia, Maryland, Pennsylvania, and Washington, DC.

Pulmonary Procedures

Delaware has the highest fees for the selected pulmonary procedures, followed by Maryland, Washington, D.C., Virginia, West Virginia, and Pennsylvania.

Allergy and Immunology Procedures

Delaware has the highest fees in the region for the selected allergy and immunology procedures, followed by Maryland, Virginia, West Virginia, Washington, DC, and Pennsylvania.

Neurology and Neuromuscular Procedures

Delaware has the highest fees in the region for the selected neurology and neuromuscular procedures followed by Maryland, Virginia, West Virginia, Washington, DC, and Pennsylvania.

CNS Assessment Tests

Washington, DC and Maryland have the highest fees in the region for selected CNS assessment procedures, followed by West Virginia, Virginia, Delaware, and Pennsylvania.

Chemotherapy Administration and Dermatology Procedures

Delaware has the highest fees in the region for the selected chemotherapy administration and dermatology procedures, followed by Maryland, Virginia, West Virginia, Washington, DC, and Pennsylvania.

Physical Medicine and Rehabilitation Procedures

Delaware fees for selected physical medicine and rehabilitation procedures are highest in the region, followed by Washington, DC, Maryland, Virginia, Pennsylvania, and West Virginia.

Chiropractic and Other Medicine Procedure

Washington, DC, has the highest fees in the region for the selected chiropractic and other medicine procedures followed by Maryland, Pennsylvania, Delaware, West Virginia, and Virginia.

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Evaluation & Management												
99203	Office/outpatient visit, new	\$79	\$54	\$93	\$25	\$71	\$65	\$49	\$79	\$67	\$95	\$67
99204	Office/outpatient visit, new	\$116	\$76	\$141	\$60	\$109	\$100	\$81	\$116	\$112	\$144	\$112
99212	Office/outpatient visit, estab	\$32	\$21	\$37	\$26	\$29	\$26	\$16	\$32	\$23	\$39	\$23
99213	Office/outpatient visit, estab	\$50	\$30	\$60	\$35	\$48	\$42	\$31	\$50	\$43	\$62	\$43
99214	Office/outpatient visit, estab	\$75	\$46	\$91	\$43	\$72	\$64	\$48	\$75	\$67	\$93	\$67
99223	Initial hospital care	\$142	\$78	\$175	\$42	\$122	\$128	\$128	\$142	\$142	\$176	\$176
99232	Subsequent hospital care	\$52	\$28	\$64	\$17	\$52	\$47	\$47	\$52	\$52	\$65	\$65
99238	Hospital discharge day	\$57	\$0	\$66	\$17	\$52	\$47	\$47	\$57	\$57	\$67	\$67
99244	Office consultation	\$149	\$96	\$182	\$60	\$143	\$130	\$108	\$149	\$149	\$185	\$149
99254	Inpatient consultation	\$129	\$71	\$158	\$49	\$129	\$116	\$116	\$129	\$129	\$161	\$161
99282	Emergency dept visit	\$30	\$17	\$37	\$27	\$27	\$27	\$27	\$37	\$37	\$37	\$37
99284	Emergency dept visit	\$99	\$48	\$111	\$50	\$78	\$83	\$83	\$111	\$111	\$111	\$111
99285	Emergency dept visit	\$155	\$75	\$116	\$50	\$116	\$123	\$123	\$166	\$166	\$166	\$166
99291	Critical care, first hour	\$212	\$109	\$259	\$152	\$201	\$183	\$153	\$212	\$209	\$259	\$209
99391	Periodic comp prevent med	\$65	\$33	\$75	\$20	\$65	\$54	\$39	\$65	\$49	\$75	\$49
99392	Prev visit, est, age 1-4	\$73	\$33	\$83	\$20	\$73	\$61	\$45	\$73	\$57	\$83	\$57
99393	Prev visit, est, age 5-11	\$72	\$33	\$82	\$20	\$72	\$60	\$45	\$72	\$57	\$82	\$57
99394	Prev visit, est, age 12-17	\$79	\$50	\$90	\$20	\$79	\$67	\$52	\$79	\$65	\$90	\$65
	Average % of Medicare Fees	84%	45%	97%	38%	78%	71%	74%	86%	96%		

1- MD Old in all relevant tables refers to Maryland Medicaid fees prior to the July 2008 fee increase.

2- NFacil: Non-Facility (office, etc).

3- Facil: Facility (Hospital, etc).

4- Medicare 2008 Non-facility and Facility Fee schedule for Maryland in all relevant tables.

N/A: Data are Not Available.

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	WVA NFacil ²	WVA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Integumentary												
10060	Drainage of skin abscess	\$80	\$59	\$95	\$24	\$71	\$69	\$60	\$80	\$80	\$100	\$86
12002	Repair superficial wound(s)	\$131	\$83	\$147	\$36	\$110	\$102	\$76	\$131	\$106	\$149	\$106
17000	Destruct premalignant lesion	\$52	\$33	\$64	\$20	\$47	\$46	\$33	\$56	\$48	\$71	\$48
17003	Destruct premalign les, 2-14	\$9	\$5	\$7	\$5	\$5	\$4	\$3	\$7	\$5	\$7	\$5
17250	Chemical cautery, tissue	\$58	\$35	\$68	\$26	\$49	\$46	\$24	\$58	\$34	\$71	\$34
	Average % of Medicare Fees	88%	57%	95%	35%	70%	66%	68%	85%	99%		
Musculoskeletal System												
20550	Inj tendon sheath/ligament	\$61	\$31	\$55	\$32	\$45	\$39	\$29	\$56	\$39	\$56	\$39
20552	Inj trigger point, 1/2 muscl	\$57	\$0	\$51	\$31	\$38	\$35	\$24	\$51	\$33	\$51	\$33
20610	Drain/inject, joint/bursa	\$73	\$36	\$69	\$24	\$51	\$49	\$34	\$72	\$48	\$72	\$48
29075	Application of forearm cast	\$85	\$38	\$79	\$46	\$58	\$55	\$41	\$82	\$58	\$82	\$58
29125	Apply forearm splint	\$67	\$31	\$62	\$26	\$45	\$42	\$28	\$63	\$39	\$63	\$39
29515	Application lower leg splint	\$67	\$31	\$62	\$35	\$47	\$44	\$33	\$65	\$47	\$65	\$47
	Average % of Medicare Fees	105%	41%	97%	50%	73%	68%	72%	100%	100%		
Respiratory												
31231	Nasal endoscopy, dx	\$110	\$63	\$171	\$59	\$124	\$117	\$52	\$144	\$74	\$183	\$74
31500	Insert emergency airway	\$54	\$66	\$106	\$72	\$82	\$78	\$78	\$83	\$83	\$105	\$105
31515	Laryngoscopy for aspiration	\$104	\$85	\$199	\$70	\$146	\$135	\$76	\$160	\$104	\$204	\$106
31575	Diagnostic laryngoscopy	\$67	\$64	\$111	\$69	\$82	\$76	\$52	\$90	\$67	\$114	\$75
31622	Dx bronchoscope/wash	\$165	\$125	\$141	\$135	\$231	\$212	\$102	\$254	\$141	\$323	\$141
	Average % of Medicare Fees	54%	47%	87%	47%	72%	67%	71%	79%	93%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Cardiovascular System Surgery												
36406	Bl draw < 3 yrs other vein	\$14	\$11	\$18	N/A	\$13	\$11	\$6	\$14	\$9	\$17	\$9
36410	Non-routine blood draw >3 yrs	\$14	\$12	\$18	N/A	\$13	\$12	\$6	\$15	\$9	\$19	\$9
36556	Insert non-tunnel cv catheter	\$147	\$171	\$120	\$115	\$207	\$176	\$88	\$208	\$119	\$265	\$119
36569	Insert picc catheter	\$169	\$191	\$91	N/A	\$233	\$199	\$70	\$243	\$94	\$310	\$94
36620	Insertion catheter, artery	\$25	\$36	\$50	\$49	\$39	\$37	\$37	\$39	\$39	\$49	\$49
	Average % of Medicare Fees	64%	65%	75%	28%	76%	67%	72%	79%	96%		
Hemic and Lymphatic Systems												
38220	Bone marrow aspiration	\$90	\$193	\$173	\$55	\$125	\$108	\$41	\$133	\$58	\$169	\$58
38525	Biopsy/removal, lymph nodes	\$192	\$211	\$374	\$156	\$285	\$279	\$279	\$302	\$302	\$384	\$384
38792	Identify sentinel node	\$67	\$14	\$37	N/A	\$28	\$27	\$27	\$39	\$39	\$39	\$39
	Average % of Medicare Fees	92%	69%	99%	24%	73%	68%	71%	86%	93%		
Digestive System												
42830	Removal of adenoids	\$171	\$100	\$192	\$134	\$144	\$136	\$136	\$171	\$171	\$198	\$198
43246	Place gastrostomy tube	\$234	\$181	\$230	\$219	\$176	\$171	\$171	\$234	\$234	\$237	\$237
45385	Lesion removal colonoscopy	\$437	\$322	\$504	\$268	\$371	\$352	\$210	\$437	\$290	\$526	\$290
47562	Laparoscopic cholecystectomy	\$548	\$364	\$645	\$589	\$494	\$486	\$486	\$548	\$548	\$660	\$660
49080	Puncture, peritoneal cavity	\$177	\$117	\$66	\$64	\$138	\$120	\$49	\$177	\$68	\$186	\$68
	Average % of Medicare Fees	89%	61%	85%	67%	73%	69%	72%	89%	94%		
Urinary & Male Genital												
51701	Insert bladder catheter	\$39	\$0	\$75	\$25	\$54	\$46	\$19	\$56	\$27	\$72	\$27
51798	Us urine capacity measure	\$10	\$0	\$18	\$14	\$13	\$15	\$15	\$17	\$17	\$22	\$22
54150	Circumcision w/regionl block	\$66	\$148	\$113	\$79	\$97	\$132	\$73	\$156	\$79	\$198	\$100
54160	Circumcision, neonate	\$129	\$151	\$139	\$128	\$183	\$169	\$103	\$199	\$129	\$254	\$144
	Average % of Medicare Fees	45%	34%	74%	47%	64%	66%	70%	79%	87%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	Micare NFacil ⁴	Micare Facil ⁴
Gynecology-Obstetric												
57454	Bx/curett of cervix w/scope	\$166	\$87	\$151	\$69	\$141	\$175	\$157	\$152	\$133	\$152	\$133
59025	Fetal non-stress test	\$43	\$24	\$42	\$18	\$39	\$53	\$53	\$46	\$46	\$46	\$46
59409	Routine delivery	\$860	\$900	\$762	N/A	\$728	\$956	\$956	\$860	\$860	\$765	\$765
59410	Delivery w. postpartum	\$942	\$900	\$875	\$2,050	\$834	\$1,095	\$1,095	\$942	\$942	\$883	\$883
59430	Care after delivery only	\$149	\$66	\$136	N/A	\$129	\$167	\$154	\$139	\$125	\$139	\$125
59514	Cesarean delivery only	\$993	\$950	\$762	N/A	\$860	\$1,130	\$1,130	\$993	\$993	\$904	\$904
59515	Cesarean delivery w. postpart	\$1,124	\$950	\$875	\$2,050	\$1,004	\$1,314	\$1,314	\$1,124	\$1,124	\$1,063	\$1,063
	Average % of Medicare Fees	107%	82%	94%	N/A	93%	121%	122%	105%	105%		
Endocrine System												
60100	Biopsy of thyroid	\$56	\$68	\$109	\$66	\$82	\$77	\$56	\$88	\$61	\$112	\$78
60240	Removal of thyroid	\$460	\$527	\$899	\$591	\$687	\$665	\$665	\$711	\$711	\$905	\$905
	Average % of Medicare Fees	50%	59%	98%	62%	74%	71%	73%	79%	79%		
Nervous System												
62311	Inject spine l/s (cd)	\$263	\$133	\$224	\$75	\$163	\$136	\$56	\$210	\$79	\$210	\$79
64450	N block, other peripheral	\$104	\$52	\$96	\$21	\$72	\$68	\$49	\$99	\$68	\$99	\$68
64475	Inj paravertebral l/s	\$339	\$123	\$287	\$72	\$206	\$169	\$55	\$266	\$76	\$266	\$76
64614	Destroy nerve, extrem musc	\$220	\$244	\$188	\$123	\$139	\$120	\$92	\$177	\$132	\$177	\$132
	Average % of Medicare Fees	120%	75%	104%	38%	76%	66%	72%	100%	100%		
Eye Surgery												
66984	Cataract surg w/iol, 1 stage	\$728	\$426	\$650	\$613	\$489	\$451	\$451	\$649	\$649	\$649	\$649
67210	Treatment of retinal lesion	\$302	\$366	\$588	\$375	\$442	\$411	\$397	\$462	\$444	\$588	\$565
67228	Treatment of retinal lesion	\$476	\$447	\$925	\$491	\$693	\$685	\$607	\$785	\$683	\$999	\$870
67311	Revise eye muscle	\$281	\$273	\$504	\$469	\$378	\$351	\$351	\$398	\$398	\$506	\$506
	Average % of Medicare Fees	67%	57%	98%	75%	74%	69%	70%	84%	84%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Ear Surgery												
69200	Clear outer ear canal	\$132	\$45	\$117	\$30	\$85	\$77	\$36	\$121	\$52	\$121	\$52
69210	Remove impacted ear wax	\$52	\$24	\$0	\$20	\$35	\$32	\$22	\$47	\$31	\$47	\$31
69990	Microsurgery add-on	\$239	\$111	\$213	\$202	\$164	\$164	\$164	\$214	\$214	\$214	\$214
	Average % of Medicare Fees	110%	47%	65%	54%	73%	70%	73%	100%	100%		
Radiology												
70450	CT head/brain w/o dye	\$184	\$123	\$229	\$117	\$165	\$156	\$156	\$190	\$190	\$242	\$242
71010	Chest x-ray, single view	\$15	\$15	\$26	\$19	\$19	\$17	\$17	\$21	\$21	\$27	\$27
71020	Chest x-ray, two views	\$19	\$19	\$35	\$25	\$25	\$23	\$23	\$27	\$27	\$35	\$35
71260	CT thorax w/dye	\$226	\$182	\$328	\$145	\$249	\$240	\$240	\$280	\$280	\$357	\$357
72193	CT pelvis w/dye	\$181	\$176	\$323	\$140	\$239	\$228	\$228	\$278	\$278	\$354	\$354
74000	X-ray exam of abdomen	\$16	\$16	\$28	\$18	\$21	\$18	\$18	\$22	\$22	\$28	\$28
74160	CT abdomen w/dye	\$226	\$179	\$329	\$149	\$251	\$248	\$248	\$282	\$282	\$359	\$359
76805	Ob us >/= 14 wks, sngl fetus	\$77	\$71	\$138	\$78	\$126	\$99	\$99	\$118	\$118	\$150	\$150
76830	Transvaginal US, non-ob	\$58	\$51	\$104	\$77	\$94	\$78	\$78	\$95	\$95	\$121	\$121
	Average % of Medicare Fees	57%	51%	94%	54%	73%	65%	65%	79%	79%		
Laboratory												
81002	Urinalysis nonauto w/o scope	\$4	\$2	\$4	\$4	\$4	N/A	N/A	\$4	\$4	\$4	\$4
85025	Complete CBC auto diff wbc	\$11	\$5	\$11	\$6	\$11	N/A	N/A	\$11	\$11	\$11	\$11
86580	TB intradermal test	\$5	\$6	\$5	\$6	\$7	\$5	\$5	\$7	\$7	\$9	\$9
87081	Culture screen only	\$9	\$4	\$9	\$5	\$9	N/A	N/A	\$9	\$9	\$9	\$9
87880	Strep a assay w/optic	\$17	\$7	\$15	\$6	\$17	N/A	N/A	\$17	\$17	\$17	\$17
88141	Cytopathology c/v, interpret	\$24	\$14	\$23	\$7	\$18	\$17	\$17	\$24	\$24	\$26	\$26
88305	Tissue exam by pathologist	\$54	\$51	\$98	\$34	\$76	\$70	\$70	\$85	\$85	\$108	\$108
88312	Special stains	\$92	\$44	\$74	N/A	\$63	\$62	\$62	\$92	\$92	\$97	\$97
	Average % of Medicare Fees	87%	51%	88%	46%	86%	32%	32%	93%	93%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Vaccine Administration												
90465	Immune admin I injec <8 yrs	\$14	\$0	N/A	N/A	N/A	\$14	\$14	\$17	\$17	\$22	\$22
90471	Immunization administration	\$14	\$5	N/A	N/A	N/A	\$14	\$14	\$17	\$17	\$22	\$22
90472	Immuniz admin, each add'l	\$14	\$3	N/A	N/A	N/A	\$7	\$7	\$11	\$11	\$11	\$11
	Average % of Medicare Fees	84%	18%	0%	0%	0%	64%	64%	86%	86%		
Psychiatry												
90801	Psych Diagnostic interview	\$141	\$85	\$147	\$26	\$112	\$106	\$92	\$141	\$128	\$152	\$128
90805	Psytx, off, 20-30 min w/e&m	\$68	\$37	\$69	N/A	\$52	\$50	\$44	\$68	\$61	\$70	\$61
90806	Psychotherapy, 45-50 min	\$85	\$50	\$91	\$39	\$70	\$64	\$60	\$85	\$83	\$90	\$83
90853	Group psychotherapy	\$23	\$18	\$31	N/A	\$23	\$22	\$20	\$24	\$23	\$31	\$29
90862	Medication management	\$53	\$29	\$51	N/A	\$39	\$37	\$32	\$53	\$45	\$54	\$45
	Average % of Medicare Fees	91%	55%	98%	12%	75%	70%	71%	92%	96%		
Dialysis												
90935	Hemodialysis, one evaluation	\$35	\$52	\$68	\$50	\$52	\$47	\$47	\$53	\$53	\$67	\$67
90937	Hemodialysis, repeated eval	\$57	\$92	\$111	\$50	\$85	\$78	\$78	\$86	\$86	\$110	\$110
90945	Dialysis, one evaluation	\$36	\$90	\$71	\$35	\$54	\$49	\$49	\$55	\$55	\$70	\$70
	Average % of Medicare Fees	52%	96%	101%	57%	77%	70%	70%	79%	79%		
Gastroenterology												
91010	Esophagus motility study	\$110	\$81	\$210	\$28	\$152	\$136	\$136	\$166	\$166	\$212	\$212
91105	Gastric intubation treatment	\$48	\$13	\$91	N/A	\$66	\$57	\$12	\$71	\$17	\$91	\$17
91110	Gi tract capsule endoscopy	\$511	\$512	\$972	N/A	\$695	\$626	\$626	\$787	\$787	\$1,002	\$1,002
	Average % of Medicare Fees	52%	35%	99%	13%	71%	63%	66%	79%	86%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Ophthalmology												
92004	Eye exam, new patient	\$64	\$88	\$123	\$17	\$92	\$88	\$63	\$102	\$70	\$130	\$88
92012	Eye exam established patient	\$33	\$50	\$63	\$17	\$46	\$49	\$31	\$57	\$35	\$73	\$44
92014	Eye exam & treatment	\$48	\$88	\$93	\$17	\$69	\$71	\$48	\$83	\$53	\$106	\$68
92015	Refraction	\$30	\$80	\$57	\$5	\$48	\$42	\$13	\$36	\$18	\$45	\$18
92060	Special eye evaluation	\$28	\$30	\$54	N/A	\$40	\$37	\$37	\$43	\$43	\$55	\$55
92081	Visual field examination(s)	\$26	\$49	\$50	\$28	\$36	\$33	\$33	\$41	\$41	\$52	\$52
	Average % of Medicare Fees	51%	91%	98%	19%	75%	71%	69%	79%	82%		
Otorhinolaryngology (ENT)												
92551	Pure tone hearing test, air	\$5	\$8	\$10	\$8	\$7	\$6	\$6	\$8	\$8	\$11	\$11
92552	Pure tone audiometry, air	\$20	\$10	\$20	\$8	\$14	\$14	\$14	\$20	\$20	\$23	\$23
92557	Comprehensive hearing test	\$54	\$26	\$51	\$29	\$36	\$38	\$37	\$54	\$53	\$55	\$53
92567	Tympanometry	\$24	\$12	\$22	\$12	\$16	\$16	\$14	\$23	\$21	\$23	\$21
92568	Acoustic reflex threshold test	\$17	\$8	\$14	\$10	\$10	\$14	\$14	\$17	\$17	\$21	\$21
92587	Evoked auditory test	\$66	\$32	\$55	\$48	\$39	\$33	\$33	\$50	\$50	\$50	\$50
	Average % of Medicare Fees	92%	54%	90%	60%	64%	65%	65%	91%	91%		
Cardiovascular Medicine												
93000	Electrocardiogram, complete	\$13	\$18	\$25	\$22	\$18	\$16	\$16	\$19	\$19	\$24	\$24
93010	Electrocardiogram report	\$7	\$6	\$8	\$8	\$7	\$6	\$6	\$7	\$7	\$9	\$9
93042	Rhythm ECG, report	\$4	\$5	\$8	\$7	\$6	\$5	\$5	\$6	\$6	\$8	\$8
93307	Echo exam of heart	\$104	\$129	\$199	\$140	\$144	\$132	\$132	\$159	\$159	\$203	\$203
93320	Doppler echo exam, heart	\$52	\$56	\$88	\$65	\$63	\$58	\$58	\$71	\$71	\$90	\$90
93325	Doppler color flow add-on	\$53	\$73	\$101	N/A	\$72	\$55	\$55	\$66	\$66	\$84	\$84
	Average % of Medicare Fees	59%	70%	102%	57%	76%	66%	66%	79%	79%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Non-Invasive Vascular Tests												
93880	Complete Extracranial study	\$100	\$115	\$191	\$148	\$181	\$175	\$175	\$151	\$151	\$192	\$192
93970	Extremity study, complete	\$102	\$123	\$195	\$147	\$179	\$177	\$177	\$154	\$154	\$196	\$196
93971	Extremity study, limited	\$65	\$75	\$124	\$100	\$120	\$118	\$118	\$98	\$98	\$125	\$125
93975	Vascular study, complete	\$131	\$163	\$251	\$182	\$276	\$267	\$267	\$199	\$199	\$253	\$253
93976	Vascular study, limited	\$115	\$100	\$219	\$131	\$160	\$155	\$155	\$174	\$174	\$221	\$221
	Average % of Medicare Fees	52%	59%	99%	73%	93%	90%	90%	79%	79%		
Pulmonary												
94010	Breathing capacity test	\$18	\$22	\$33	\$15	\$24	\$23	\$23	\$28	\$28	\$36	\$36
94060	Evaluation of wheezing	\$30	\$38	\$57	\$19	\$41	\$40	\$40	\$48	\$48	\$62	\$62
94375	Respiratory flow volume loop	\$19	\$20	\$36	\$32	\$26	\$25	\$25	\$30	\$30	\$38	\$38
94640	Airway inhalation treatment	\$7	\$16	\$13	N/A	\$9	\$9	\$9	\$11	\$11	\$15	\$15
94664	Evaluate pt use of inhaler	\$7	\$11	\$14	\$12	\$10	\$10	\$10	\$13	\$13	\$16	\$16
94680	Exhaled air analysis, o2	\$40	\$45	\$76	\$25	\$54	\$45	\$45	\$56	\$56	\$71	\$71
94761	Measure blood oxygen level	\$6	\$6	\$5	\$4	\$4	\$4	\$4	\$6	\$6	\$6	\$6
	Average % of Medicare Fees	56%	74%	93%	48%	67%	65%	65%	81%	81%		
Allergy and Immunology												
95004	Percutaneous allergy skin tests	\$4	\$2	\$5	\$2	\$4	\$3	\$3	\$5	\$5	\$6	\$6
95024	Id allergy test, drug/bug	\$5	\$3	\$7	\$5	\$5	\$4	\$4	\$6	\$6	\$7	\$7
95115	Immunotherapy, one injection	\$14	\$8	\$14	\$4	\$11	\$8	\$8	\$13	\$13	\$13	\$13
95117	Immunotherapy injections	\$17	\$11	\$18	\$7	\$13	\$10	\$10	\$17	\$17	\$17	\$17
95165	Antigen therapy services	\$8	\$5	\$10	\$3	\$8	\$7	\$2	\$9	\$3	\$12	\$3
	Average % of Medicare Fees	82%	51%	96%	37%	70%	59%	60%	87%	91%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	W VA NFacil ²	W VA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Neurology and Neuromuscular												
95811	Polysomnography w/cpap	\$472	\$442	\$898	\$23	\$645	\$600	\$600	\$742	\$742	\$944	\$944
95816	Eeg, awake and drowsy	\$105	\$98	\$201	\$23	\$145	\$144	\$144	\$177	\$177	\$226	\$226
95861	Muscle test, 2 limbs	\$59	\$67	\$115	\$38	\$86	\$82	\$82	\$94	\$94	\$120	\$120
95900	Motor nerve conduction test	\$32	\$31	\$62	\$45	\$45	\$39	\$39	\$47	\$47	\$60	\$60
95904	Sense nerve conduction test	\$28	\$26	\$53	\$22	\$38	\$34	\$34	\$41	\$41	\$53	\$53
95934	H-reflex test	\$21	\$21	\$40	N/A	\$30	\$30	\$30	\$35	\$35	\$45	\$45
95951	EEG monitoring/videorecord	\$244	\$449	\$1,769	\$228	\$258	\$219	\$219	\$244	\$244	\$302	\$302
	Average % of Medicare Fees	54%	63%	166%	34%	72%	66%	66%	79%	79%		
CNS Assessment Tests												
96110	Developmental test, lim	\$13	\$20	\$13	N/A	\$10	\$12	\$12	\$13	\$13	\$14	\$14
96111	Developmental test, extend	\$75	\$39	\$0	\$50	\$102	\$95	\$93	\$103	\$111	\$131	\$128
	Average % of Medicare Fees	73%	85%	45%	19%	73%	77%	77%	83%	87%		
Chemotherapy - Dermatology												
96413	Chemo, iv infusion, 1 hr	\$89	\$111	\$169	\$125	\$120	\$106	\$106	\$135	\$135	\$172	\$172
96415	Chemo, iv infusion, addl hr	\$20	\$24	\$37	\$28	\$27	\$25	\$25	\$30	\$30	\$38	\$38
96417	Chemo iv infus each addl seq	\$44	\$54	\$83	\$62	\$59	\$53	\$53	\$66	\$66	\$85	\$85
96523	Irrig drug delivery device	\$15	\$18	\$28	\$19	\$20	\$18	\$18	\$23	\$23	\$29	\$29
96910	Photochemotherapy with UV-B	\$34	\$33	\$49	\$20	\$35	\$38	\$38	\$49	\$49	\$63	\$63
96912	Photochemotherapy with UV-A	\$43	\$38	\$63	\$20	\$33	\$49	\$49	\$63	\$63	\$80	\$80
	Average % of Medicare Fees	52%	59%	91%	57%	63%	62%	62%	79%	79%		

Table 3. Comparison of Maryland and Neighboring States Medicaid Fees with Medicare Fees, Continued

Procedure Code	Procedure Description	MD Old ¹	DC	DE	PA	VA	WVA NFacil ²	WVA Facil ³	MD FY09 NFacil ²	MD FY09 Facil ³	M'care NFacil ⁴	M'care Facil ⁴
Phys Medicine and Rehabilitation												
97014	Electric stimulation therapy	\$10	\$31	\$14	\$17	\$10	\$9	\$9	\$11	\$11	\$14	\$14
97035	Ultrasound therapy	\$10	\$6	\$11	\$10	\$9	\$8	\$8	\$10	\$10	\$11	\$11
97110	Therapeutic exercises	\$14	\$15	\$27	\$8	\$20	\$19	\$19	\$22	\$22	\$28	\$28
97112	Neuromuscular reeducation	\$14	\$15	\$28	\$17	\$20	\$20	\$20	\$23	\$23	\$29	\$29
97140	Manual therapy	\$13	\$25	\$25	\$21	\$19	\$18	\$18	\$20	\$20	\$26	\$26
97530	Therapeutic activities	\$15	\$15	\$29	\$13	\$21	\$20	\$20	\$23	\$23	\$30	\$30
	Average % of Medicare Fees	60%	88%	98%	71%	72%	67%	67%	80%	80%		
Chiropractic & Other Medicine												
98941	Chiropractic manipulation	\$17	\$19	\$0	N/A	\$26	\$24	\$21	\$27	\$23	\$34	\$29
99173	Visual acuity screen	\$5	\$15	\$3	\$6	\$64	\$1	\$1	\$3	\$3	\$3	\$3
99183	Hyperbaric oxygen therapy	\$106	\$72	\$205	\$108	\$152	\$138	\$82	\$161	\$106	\$204	\$112
99195	Phlebotomy	\$20	\$18	\$39	\$10	\$27	\$37	\$37	\$49	\$49	\$62	\$62
	Average % of Medicare Fees	76%	162%	64%	70%	48%	62%	64%	84%	88%		

1 - MD Old in all relevant tables refers to Maryland Medicaid fees prior to the July 2008 fee increase.

2 - NFacil: Non-Facility (office, etc).

3 - Facil: Facility (Hospital, etc).

4 - Medicare 2008 Non-facility and Facility Fee schedule for Maryland in all relevant tables.

N/A: Data are 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 rate (Medicare facility rate for the Baltimore area) when they provide trauma care to Medicaid's fee-for-service and HealthChoice program enrollees. The enhanced Medicaid fee only applies to services rendered in a trauma center designated by Maryland Institute for Emergency Medical Services Systems (MIEMSS) for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fee was limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, the passage of HB 1164 during the 2006 legislative session extends the enhanced rate to any physician beginning July 1, 2006. MHCC and HSCRC fully cover the additional outlay of general funds that the Maryland Medical Assistance program incurs due to enhanced trauma fees (relevant percent of the difference between 100 percent of Medicare rates and Medicaid's current rates). MHCC pays physicians directly for uncompensated care and on-call services.

VII. Reimbursement for Oral Health Services

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

During the 2003 session of the Maryland General Assembly, the legislature included budgetary language in HB 40, which stated, "It is also the intent of the General Assembly that \$7.5 million of the funds included in the CY 2004 Managed Care rates for dental services be restricted to increasing fees for restorative procedures." The \$7.5 million funding increase was based on a University of Maryland Dental School analysis of the impact of increasing certain restorative procedure fees to the 50th percentile levels of the ADA survey. In compliance with the budgetary language, effective March 1, 2004, MCOs were required to reimburse their contracted providers at ADA's then current 50th percentile of charges for 12 restorative procedures. At the same time, Medicaid increased fee-for-service rates to ADA's 50th percentile levels for the same restorative procedures. Maryland Medicaid tripled average reimbursement rates for dentists in July 2000 and increased reimbursement for 12 restorative procedures in 2004.

In June 2007, the Secretary of the Maryland Department of Health and Mental Hygiene convened the Dental Action Committee in response to continuing concerns about access to oral health care services, and following the death due to a dental infection of a 12-year-old Prince George's County child who had been enrolled in the Medicaid program. 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 General Assembly indicated that \$7 million of the Maryland Health Care Provider Rate Stabilization Fund account (\$14 million total funds) shall be transferred to the Medical Assistance Program account to be used for increasing "provider rates to dentists in Fiscal Year 2009".

The Reimbursement Rate Subcommittee of the Dental Action Committee recommended allocating the \$14 million available total funds to 12 high-volume dental procedures. ADA's 50th percentiles of charges were used as the benchmarks or points of reference for 11 of the 12 procedures. ADA's survey did not report percentile charges for procedure code D9248 (conscious sedation), which was on the list of procedures targeted for the fee increase. Comparison of ADA's and NDAS's survey of charges showed that NDAS's 40th percentiles of charges are close to ADA's 50th percentiles of charges. Therefore, the NDAS's 40th percentile of charges was used for this procedure.

The new FY 2009 Medicaid fees for the 12 targeted procedures were set at about 83 percent of the benchmark fees. Per the recommendation of the Reimbursement Rate Subcommittee of the Dental Action Committee, the fee for procedure code D0145, oral evaluation of less than three years old child, was set at ADA's 50th percentile of charges.

Table 4 shows FY 2008 and new FY 2009 Medicaid fees for the 12 selected dental procedures. It also shows the benchmark (ADA's 50th percentile of charges in the South Atlantic region)³ for these procedures.

Delaware Medicaid pays 85 percent of the charges for all dental procedures and it does not have specified fees for dental procedures. Also, West Virginia dental fees were not included in its current fee schedule. Therefore, dental reimbursement rates for Delaware and West Virginia are not included Table 4.

³ Note: South Atlantic Region consists of: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. The South Atlantic 50th percentile of charges is based on data from the 2007 American Dental Association survey.

Table 4. Dental Procedures Targeted for Fee Increase in FY 2009

Proc Code	Description	MD (FY08)	DC	PA	VA	MD (FY09)	Benchmark (ADA/NDAS)
D0120	Periodic Oral Examination	\$15.00	\$35.00	\$20.00	\$20.15	\$29.08	\$35.00
D0140	Oral Evaluation-Limited-Problem Focused	\$24.00	\$50.00	N/A	\$24.83	\$43.20	\$52.00
D0145	Oral Evaluation, Patient < 3 Years Old	\$20.00	\$0.00	N/A	\$20.15	\$40.00	\$40.00
D0150	Comprehensive Oral Evaluation	\$25.00	\$77.50	\$20.00	\$31.31	\$51.50	\$62.00
D1110	Prophylaxis Adult 14 years and Over	\$36.00	\$77.50	\$36.00	\$47.19	\$58.15	\$70.00
D1120	Prophylaxis Child Up to Age 14	\$24.00	\$47.00	\$30.00	\$33.52	\$42.37	\$51.00
D1203	Topical Application of Fluoride, child (Exclude Prophylaxis)	\$14.00	\$29.00	\$18.00	\$20.79	\$21.60	\$26.00
D1204	Topical Application of Fluoride, adult (Exclude Prophylaxis)	\$14.00	\$26.00	N/A	\$20.79	\$23.26	\$28.00
D1206	Topical Fluoride Varnish	\$20.00	\$0.00	\$18.00	\$20.79	\$24.92	\$30.00
D1351	Topical Application of Sealant per Tooth	\$9.00	\$38.00	\$25.00	\$32.28	\$33.23	\$40.00
D7140	Extraction Erupted Tooth or Exposed Root	\$42.00	\$110.00	\$60.00	\$69.00	\$103.01	\$124.00
D9248	Non-Intravenous Conscious Sedation	\$0.00	\$0.00	\$184.00	\$110.00	\$186.91	\$225.00

Note: South Atlantic Region consists of: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. The South Atlantic 50th percentile of charges is based on data from the 2005 American Dental Association survey.

Fees for the 12 target procedures would, on average, increase by about 94 percent in FY 2009. The last column of Table 4 shows the median (ADA's 50th percentile) of fees charged by dentists in 2007 in the South Atlantic region. The median (50th percentile) of charges in South Atlantic region means that 50 percent of dentists in this region charge this amount or less. It is important to note, however, that the South Atlantic median is based on the charges by dentists for the services performed, which do not equate to the payments received as reimbursement from insurance companies, public agencies, or private pay patients.

Table 5 shows Maryland Medicaid FY 2008 and FY 2009 average dental fees by groups of procedures as percentages of ADA's 50th percentile of charges.

**Table 5. Average Medicaid Dental Fees as
Percent of ADA's 50th Percentile of Charges**

Procedure Groups	Medicaid FY08 Fees	Medicaid FY09 Fees
Target Procedures	43%	83%
Restorative Procedures	64%	64%
All Other Procedures (excluding 12 target procedures and restorative procedures)	36%	36%
All Procedures Combined	47%	61%

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 2005, FY 2006 and FY 2007 were analyzed for the number of physicians who had either partial or full participation in the Medicaid program.⁴ In the following tables, physicians who had fewer than 25 claims during the fiscal year are included in the data for all physicians. Physicians who had more than 25 claims but less than 50 patients were considered partial participants in the Medicaid program. Physicians who had at least 50 patients during the year were considered full participants in the Medicaid program.

Tables 6, 7, and 8 show the percentage changes in the numbers of participating physicians of all specialties (including primary care) who participate in fee-for-service (FFS), MCO networks, and the total Medicaid program. As the data in Table 6 indicate, there were significant increases in physician participation in fee-for-service, MCO networks, and the total Medicaid program between fiscal years 2002 and 2007.

**Table 6. FY 2002-07 Percent Change in Number
of Participating Physicians of All Specialties**

	FFS	MCO Networks	Total Medicaid⁵
Partial Participation	24.1%	15.0%	60.0%
Full Participation	33.7%	15.1%	22.1%
All Physicians	17.8%	22.7%	59.0%

Similarly, the data in Table 7 indicate that following the FY 2006 and FY 2007 fee increases, there were significant increases in physician participation between FY 2005 and FY 2007.

⁴ The data in these tables pertain to FY 2002 through FY 2007. Therefore, these tables do not measure the impact of FY 2008 and FY 2009 fee increases on physician participation in the Medicaid program.

⁵ Because some physicians participate in both FFS and MCO networks, percents of total physicians participating in the Medicaid program are not the sum of FFS and MCO network physicians.

Table 7. FY 2005-07 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	3.2%	4.7%	18.1%
Full Participation	-1.2%	16.3%	9.9%
All Physicians	2.3%	6.2%	20.0%

The 4.7% increase in number of physicians who are partial participants in the MCO networks and the 16.3% increase in number of physicians that are full participant in the HealthChoice program indicates that, following the FY 2006 fee increase, many physicians who were not participating in the HealthChoice program decided to become full or partial participant. Also, some physicians who were partial participants decided to become full participants in the program.

Similarly, the data in Table 8 indicate that increasing trend in physician participation in the Medicaid program has continued between FY 2006 and FY 2007.

Table 8. FY 2006-07 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	1.2%	-2.9%	4.7%
Full Participation	-1.6%	12.1%	7.4%
All Physicians	-0.6%	-2.5%	5.1%

The reduction in number of physicians who are partial participants in the MCO networks and the 12.1 percent increase in number of physicians that are full participant in the HealthChoice program indicate that, following the FY2007 fee increase, many physicians who were partial participants in the HealthChoice program decided to become full participants. Furthermore, the reduction in the total number of physicians in MCO networks and the increase in the number of physicians who fully participate in the HealthChoice program indicate that provision of care has become more concentrated among physicians participating in the program, which is consistent with national trends.

Analysis of data also indicates that in FY 2002, many of the fee-for-service providers were also participating in the HealthChoice program, and that MCOs were relying on many traditional Medicaid providers. However, as the Medicaid fees increased, new physicians started participating in the HealthChoice program, and there is less overlap between the fee-for-service providers and physicians in MCOs' networks.

Caveats for Tables 6, 7, and 8

It should be noted that percent increases in the number of physicians with partial participation in Medicaid in Tables 6, 7, and 8 represent a change in the number of physicians who did not participate in the Medicaid program before the fee increase, but started to partially participate in the program after the fee increase, minus the number of physicians who were partial participants in the program before the fee increases, and decided to fully participate in the program after the fee increases.

Similarly, percent increases in the number of physicians with full participation in Tables 6, 7 and 8 represent a change in the number of physicians who were partial participants in the program before the fee increase, but decided to fully participate in the program after the fee increases, plus the number of physicians who did not participate in the Medicaid program before the fee increases, but started to fully participate in the program after the fee increases.

In addition, both fee-for-service and the MCO data show that concentration of care among physicians participating in the program has stabilized. In FY 2002, about 21 percent of physicians provided 86 percent of services. In both FY 2006 and FY 2007, about 16 percent of physicians provided about 84 percent of physician services. The increased concentration of Medicaid patients among physicians is consistent with national trends.

IX. Plan for Future Fee Increases

The Department will continue to consult with stakeholders on future physician and dental fee increases. One of the Department's goals remains reimbursing physicians at 100 percent of Medicare reimbursement rates. Another goal is to increase the dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges for all dental procedures.

Appendix 1

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 a conversion factor are used to convert the weights to fees. Medicare rates are adjusted annually. In some years, including 2002, overall Medicare rates actually decreased. However, following federal legislative mandates, Medicare physician fees increased by 1.6 percent in 2003 and 1.5 percent in 2004 and 2005. Following similar legislative mandates, Medicare fees were held constant at the 2005 level in 2006 and 2007, and increased by 0.5 percent in 2008.

For approximately 13,000 physician procedures, Medicare RBRVS assigns the associated relative value units (RVUs) and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending on the place where each procedure is performed. Medicare fees for some procedures are lower if they are performed in facilities like hospitals or skilled nursing facilities than if they are performed in non-facilities (e.g., offices) where physicians have to pay more 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 RBRVS determines RVUs for all procedures. These weights reflect resource requirements of each procedure performed by physicians. The Medicare physician fees are adjusted to reflect the variations in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice expense). The GPCIs are 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. The Centers for Medicare and Medicaid Services (CMS) annually updates the conversion factor based on the Sustainable Growth Rate (SGR) system, which ties the updates to growth in the national economy, as a measure of change in funds available for payments to physicians. The SGR system is based on formulas designed to control overall spending while accounting for factors that affect the costs of providing care.

Efforts are currently underway in the United States Congress to change the Medicare physician payment system to include "pay for performance" and quality improvement incentives instead of relying on the SGR formula for updating the physicians' reimbursement rates.

Table A1 shows the Medicare conversion factor and its percentage change for years 2000 through 2008.

Table A1. Medicare Conversion Factor

Year	Conversion Factor	Percent Change from Prior Year
2000	\$36.6137	
2001	\$38.2581	4.5%
2002	\$36.1992	-5.4%
2003	\$36.7856	1.6%
2004	\$37.3374	1.5%
2005	\$37.8975	1.5%
2006	\$37.8975	0.0%
2007	\$37.8975	0.0%
2008	\$38.0870	0.5%

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

Each anesthesia procedure code has a non-variable number of base units. Similar to the RBRVS work value, the base units represent the difficulty associated with a given group of procedures. The base units for the selected anesthesia code are added to the units related to anesthesia time, and the result is multiplied by a conversion factor to convert to dollars. The Baltimore area Medicare conversion factor for 2008 is \$20.33 per unit. The Maryland Medicaid program calculates the payment slightly differently by using minutes instead of quarter hour blocks, but the net result is the same.

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. Since that time, all anesthesia services have been identified based on the anesthesia CPT codes. More than 5,000 surgical procedure codes exist, but there are less than 300 anesthesia codes. Payment for anesthesia services could no longer be linked to individual procedures, and the Medicaid program started the transition from a fixed anesthesia rate for each surgical procedure to the national methodology, which recognized anesthesia time as the key element.

Appendix 2

Summary of Methodology to Determine Maryland Medicaid Physician Fees

The Department's methodology determines the new Medicaid fees for targeted procedures as a percentage of Medicare fees. The minimum percent of Medicare fees is the dependent variable in the process of determining the fees. The independent variable is the total amount of funds available for the fee increase. The minimum percent of Medicare fees (78.6 percent) is derived in a process that equates the total cost of the fee increase with the total available funds for the fee increase. For each procedure, we compare the existing Medicaid fee with the corresponding Medicare fees:

- If the current Medicaid fee is higher than the Medicare fee, then the Medicaid fee is set equal to the Medicare fee, by site of service, and funds are re-distributed to increase the lowest fees.
- If the current Medicaid fee is lower than 78.6% of the Medicare fee, then it is raised to 78.6% of its corresponding Medicare fee, by site of service.
- Fees that are lower than the corresponding Medicare fee but higher than 78.6% of the Medicare fee are left unchanged.

The minimum of 78.6% of the corresponding Medicare fees would make the projected total cost of the fee increase equal to the available funds. The projected cost of the fee increase incorporates projected enrollment and utilization increases between the base year and the implementation year.

Appendix 3

Rate of Non-Federal Physicians per 100,000 Civilian Population, 2007

Rank	Geographic Area	Number of Non-Federal Physicians, 2007	2007 Population	Number of Physicians per 100,000 Population
Average	United States	973,524	301,621,157	323
1	District of Columbia	4,854	588,292	825
2	Massachusetts	33,409	6,449,755	518
3	New York	87,030	19,297,729	451
4	Vermont	2,778	621,254	447
5	Maryland	25,037	5,618,344	446
6	Rhode Island	4,531	1,057,832	428
7	Connecticut	14,930	3,502,309	426
8	Pennsylvania	48,633	12,432,792	391
9	New Jersey	33,242	8,685,920	383
10	Maine	4,858	1,317,207	369
11	Hawaii	4,586	1,283,388	357
12	Michigan	33,627	10,071,822	334
13	Ohio	38,239	11,466,917	333
14	Minnesota	17,295	5,197,621	333
15	Oregon	12,305	3,747,455	328
16	New Hampshire	4,304	1,315,828	327
17	Illinois	41,826	12,852,548	325
18	Washington	20,383	6,468,424	315
19	Florida	57,400	18,251,243	314
20	California	113,624	36,553,215	311
21	Colorado	15,080	4,861,515	310
22	Delaware	2,671	864,764	309
23	Virginia	23,676	7,712,091	307
24	Wisconsin	16,979	5,601,640	303
25	Missouri	17,762	5,878,415	302
26	Puerto Rico	11,687	3,941,459	297
27	Tennessee	18,255	6,156,719	297
28	Louisiana	12,660	4,293,204	295
29	West Virginia	5,295	1,812,035	292
30	North Carolina	25,968	9,061,032	287
31	Nebraska	5,044	1,774,571	284
32	New Mexico	5,495	1,969,915	279
33	North Dakota	1,782	639,715	279
34	Kansas	7,665	2,775,997	276
35	Montana	2,631	957,861	275
36	Arizona	16,883	6,338,755	266
37	Kentucky	11,225	4,241,474	265

Rank	Geographic Area	Number of Non-Federal Physicians, 2007	2007 Population	Number of Physicians per 100,000 Population
38	South Carolina	11,599	4,407,709	263
39	Iowa	7,641	2,988,046	256
40	Indiana	16,122	6,345,289	254
41	South Dakota	2,015	796,214	253
42	Alaska	1,694	683,478	248
43	Alabama	11,352	4,627,851	245
44	Texas	58,223	23,904,380	244
45	Utah	6,399	2,645,330	242
46	Georgia	23,037	9,544,750	241
47	Oklahoma	8,629	3,617,316	239
48	Arkansas	6,597	2,834,797	233
49	Wyoming	1,193	522,830	228
50	Nevada	5,851	2,565,382	228
51	Mississippi	6,053	2,918,785	207
52	Idaho	3,106	1,499,402	207

Compared to the 2006 figures (shown in last year's report), the number of physicians per 100,000 populations has increased in all states. The United States' average increased from 315 physicians per 100,000 population in 2006 to 323 physicians per 100,000 populations in 2007. The ratio of physicians to 100,000 people in Maryland increased from 439 in 2006 to 446 in 2007. The ranking of Maryland among all states dropped from 4th in 2006 to 5th in 2007.

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

Sources: Data for physicians are from American Medical Association, Physicians Professional Data as of 2007, copyright 2007. Downloaded from: Kaiser Family Foundation State Health Facts Online: <http://statehealthfacts.org>

Data for civilian population are from Annual Estimates of the Population for the United States, Regions, and States and Puerto Rico, July 1, 2007. Release Date: December 27, 2007.

Appendix 4

Rate of Non-Federal Dentists per 100,000 Civilian Population, 2007

Rank	Geographic Area	Total Number of 2007 Dentists	2007 Population	Dentists per 100,000 Population
Average	United States	201,604	301,621,157	67
1	District of Columbia	825	588,292	140
2	Massachusetts	6,356	6,449,755	99
3	Nebraska	1,622	1,774,571	91
4	New York	16,896	19,297,729	88
5	New Jersey	7,524	8,685,920	87
6	Maryland	4,831	5,618,344	86
7	California	30,772	36,553,215	84
8	Connecticut	2,833	3,502,309	81
9	Hawaii	1,032	1,283,388	80
10	Pennsylvania	9,096	12,432,792	73
11	Washington	4,710	6,468,424	73
12	Alaska	492	683,478	72
13	Colorado	3,436	4,861,515	71
14	Minnesota	3,583	5,197,621	69
15	Kentucky	2,918	4,241,474	69
16	Illinois	8,705	12,852,548	68
17	Michigan	6,807	10,071,822	68
18	Virginia	4,995	7,712,091	65
19	Utah	1,704	2,645,330	64
20	Iowa	1,884	2,988,046	63
21	New Hampshire	815	1,315,828	62
22	Wisconsin	3,452	5,601,640	62
23	Oregon	2,264	3,747,455	60
24	Idaho	902	1,499,402	60
25	Ohio	6,758	11,466,917	59
26	Vermont	360	621,254	58
27	Nevada	1,483	2,565,382	58
28	West Virginia	1,046	1,812,035	58
29	Florida	10,279	18,251,243	56
30	Tennessee	3,440	6,156,719	56
31	Oklahoma	2,011	3,617,316	56
32	Arizona	3,518	6,338,755	55
33	Montana	526	957,861	55
34	Louisiana	2,328	4,293,204	54
35	Indiana	3,410	6,345,289	54
36	Kansas	1,475	2,775,997	53
37	Rhode Island	562	1,057,832	53

Rank	Geographic Area	Total Number of 2007 Dentists	2007 Population	Dentists per 100,000 Population
38	Missouri	3,089	5,878,415	53
39	North Dakota	336	639,715	53
40	South Carolina	2,288	4,407,709	52
41	Maine	671	1,317,207	51
42	Texas	12,125	23,904,380	51
43	North Carolina	4,549	9,061,032	50
44	Wyoming	256	522,830	49
45	Alabama	2,251	4,627,851	49
46	South Dakota	379	796,214	48
47	Georgia	4,528	9,544,750	47
48	Delaware	398	864,764	46
49	Mississippi	1,321	2,918,785	45
50	New Mexico	871	1,969,915	44
51	Puerto Rico	1,647	3,941,459	42
52	Arkansas	1,158	2,834,797	41

The ranking of Maryland among all states dropped from 5th in 2006 to 6th in 2007.

Sources: American Dental Association, Dental Data, copyright 2007: Special data request. Data are for December 2007. US total does not include the territories. Downloaded from: Kaiser Family Foundation State Health Facts Online: <http://statehealthfacts.org>

Data for civilian population, that are used to derive dentist to population rates, are from Annual Estimates of the Population for the United States, Regions, and States and Puerto Rico, July 1, 2007. Release Date: December 27, 2007.

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