STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

January 26, 2017

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

The Honorable Shane E. Pendergrass
Chair
House Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

RE: HB 70 – DHMH – Commissions, Programs and Reports – Revision (Ch. 656 of the Acts of 2009), and Health – General § 15-103.5 and Insurance Article § 19-807(d)(2)

Dear Chair Middleton and Chair Pendergrass:

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

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

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

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Edward J. Kasemeyer, Chair, Senate Budget and Taxation Committee
Maggie McIntosh, Chair, House Appropriations Committee
Shannon McMahon
Tricia Roddy
Audrey Parham-Stewart
Susan Tucker
Webster Ye
Sarah Albert, MSAR #7893 and #7417

Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates Fairness Act

Submitted by the Department of Health and Mental Hygiene

January 2017

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I. Introduction

Pursuant to SB 481 (Chapter 464 of the Acts of 2002), the Maryland Department of Health and Mental Hygiene (the Department) created an annual process to set the fee-for-service reimbursement rates for Maryland Medicaid and the Maryland Children's Health Insurance Program (CHIP) (together referred to as Maryland Medical Assistance) in a manner that ensures provider participation. The law further stipulated that, in developing the rate-setting process, the Department should take into account community reimbursement rates and annual medical inflation, or utilize the resource-based relative value scale (RBRVS) methodology and American Dental Association Current Dental Terminology (CDT-3) codes. The RBRVS methodology is used by the Centers for Medicare & Medicaid Services (CMS) to set the Medicare fee schedule.[1]

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

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

In addition, Section 15 of HB 70 (Chapter 656 of the Acts of 2009) requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare them with the fee-for-service rates for the same services paid to providers under the Maryland Medical Assistance program and within managed care organizations. On or before January 1 of every year, the Department must report this information and determine whether the fee-for-service rates and managed care organization 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 HB 1071 (Chapter 702 of the Acts of 2001), the Department prepared the first annual report analyzing the physician fees that are paid by Maryland Medicaid and CHIP. In 2002, SB 481 required the submission of this report on an annual basis. This is the sixteenth annual report.

[1]The Department used the RBRVS methodology as a benchmark, or point of reference, when it increased physician fees in fiscal years 2003, 2006, 2007, 2008, and 2009. The RBRVS methodology relates payments to the resources that physicians use and the complexity of services that they provide. See Appendix A for a more detailed description of the RBRVS methodology.

The Department's first annual report showed that Maryland Medicaid's reimbursement rates in 2001 were, on average, approximately 36 percent of Medicare rates. Results from an American Academy of Pediatrics study from 1998-99 included in the report showed that Maryland's physician reimbursement rates for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the state legislature allocated $50 million in additional total funds ($25 million state general funds) to increase physician fees in the Medicaid program beginning July 2002. The increase targeted evaluation and management procedure codes, which are used by both primary care and specialty care physicians.

SB 836 (Chapter 1 of the Acts of 2005) allocated funds to the Maryland Medical Assistance program to increase both fee-for-service physician reimbursement rates and capitation payments to managed care organizations to enable these organizations to raise their physician fees.[2] The legislation also allocated $15 million in additional State funds ($30 million total funds) in fiscal year (FY) 2006 to increase fees for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. The legislation targeted the fee increase to these physician specialties in response to the substantial rise in their malpractice insurance premiums.

SB 836 also created the Maryland Health Care Provider Rate Stabilization Fund, which is administered by the Maryland Insurance Commissioner. The Fund was established in part to increase and maintain prior increases in physician fees through the Maryland Medical Assistance program. The primary revenues of the fund are derived from a tax imposed on managed care organizations and health maintenance organizations. Table 1 shows the amounts of Rate Stabilization Funds that were used to increase and maintain prior increases in physician fees from FY06 through FY09.

Table 1. Rate Stabilization Funds to Increase and Maintain Physician Fees, FY06 – FY09 (Million Dollars)

	FY06	**FY07**	**FY08**	**FY09**
State Rate Stabilization Funds	$15.0	$28.8	$47.5	$67.1
Federal Matching Funds	$15.0	$28.8	$47.5	$67.1
Total Funds	**$30.0**	**$57.6**	**$95.0**	**$134.3**
Funds to Maintain Prior Fee Increases	**$0.0**	$32.4	$62.2	$102.6
Remaining Funds for Fee Increase	**$30.0**	**$25.2**	**$32.8**	**$31.7**

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

[2] To ensure that the MCOs use increased capitation payments to raise their physician fees, the Department requires MCOs to pay their network physicians at least 100 percent of the Medicaid physician fee schedule.

For FY07 and FY08, based on stakeholders' recommendations, the Department increased fees for procedures in different specialties, as shown in Table 2. In addition, procedures with the lowest fees were raised to a minimum of 50 percent of Medicare fees in FY08. Subsequently, the Department implemented other fee changes for FY09. In previous years, fees for many specialties, including orthopedics, gynecology/obstetrics, neurosurgery, otorhinolaryngology (ENT), and emergency medicine were set at 100 percent of their corresponding Medicare fees. Medicare fees in general had not increased substantially. However, updates in relative value units led to decreases in Medicare fees for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for other procedures remained at 50 percent of Medicare fees. Therefore, based on stakeholders' recommendations, the Department increased the lowest Medicaid fees and re-balanced any Medicaid fees that were higher than their corresponding Medicare fees.

Furthermore, separate fees for different sites of service were established in FY09 so that Medicaid fees would have site-of-service differentials for facilities and non-facilities. "Facilities" include inpatient hospitals, nursing homes, and other medical care facilities, whereas "non-facilities" include physician offices and homes of patients. Medicaid fees higher than the 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 Department used the RBRVS methodology as a benchmark, or point of reference, when it increased physician fees in fiscal years 2003, 2006, 2007, 2008, and 2009. Table 2 shows the percentage of Medicare fees for targeted groups of procedures at the times of fee increases in FYs 2003, 2006, 2007, 2008, and 2009.

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

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

III. Physician Fee Changes in FY10 through FY16

Physician Fees for FY10

The national economic recession reduced state revenues in FY10 necessitating an $11.5 million reduction in FY10 physician fee payments. Customized reductions were made to some codes, while most other procedures were subject to a 5.8 percent cut. Certain procedure codes and orthopedics, gynecology/obstetrics, neurosurgery, and emergency medicine procedure codes were excluded from the reduction in fees. In FY10, $111.7 million ($227.9 million with

matching federal funds) was allocated from the Rate Stabilization Fund to maintain prior fee increases.

Physician Fees for FY11

The Medicare program regularly updates relative value units for procedures, which results in fee *increases* for some procedures and fee *decreases* for other procedures. The Department compared the Maryland Medicaid fee for each procedure with its corresponding Medicare fee and then reduced fees for procedures that exceeded Medicare fees to the Medicare fee levels. Aside from these adjustments, the Department maintained FY11 physician fees at the same level as FY10 fees. $117.7 million from the Rate Stabilization Fund ($238.8 million with matching federal funds) was allocated to maintaining prior fee increases.

Physician Fees for FY12

The Department implemented a $6.5 million total funds reduction in payments for physician services for FY12. Some groups of procedure codes were excluded from the reduction in fees:

1. The four specialties mentioned in SB 836 (Orthopedics, Obstetrics/Gynecology, Neurosurgery, and Emergency) were maintained at a maximum of 100 percent of Medicare fees, without increasing their fees.
2. Four obstetric (delivery) procedures, three neonatal intensive care unit procedures, and 22 procedure codes used by educational institutions were maintained at their original FY11 levels.

Then, an across-the-board 1.2 percent reduction in fees was applied to all remaining procedures to achieve the required reduction in FY12 payments. Overall, fees were reduced from an average of 75 percent to an average of 74 percent of Medicare 2011 fees. In FY12, $104 million from the Rate Stabilization Fund ($211.7 million with matching federal funds) was allocated to maintain prior fee increases.

Physician Fees for CY13 and CY14

There were no changes in Maryland Medicaid physician fees for the first six months of FY13. Under the Affordable Care Act, the federal government paid for increasing Medicaid payment rates in fee-for-service and managed care organizations for evaluation and management and vaccine administration procedures provided by primary care physicians to 100 percent of the Medicare payment rates for calendar years (CYs) 2013 and 2014. For services provided between January 1, 2013, and December 31, 2014, states received 100 percent federal financing for increasing payment rates for physicians who self-attested that they are primary care physicians.

However, Maryland Medicaid allows patients who have medically complex conditions to select specialists as their primary care physicians. In order to improve access to primary care and specialists, the fees for evaluation and management and vaccine administration procedures were increased for *all* providers, not just primary care physicians. The costs for the fee increase for

physicians who did not self-attest as primary care physicians were financed at the regular federal medical assistance percentage (FMAP).

In the first quarters of CY13 and CY14, CMS released the corresponding average Medicare fees for evaluation and management (E&M) and vaccine administration procedures in the three geographic regions of Maryland. The new fees were retroactive to include services provided on or after January 1 of each year. As specified in the Affordable Care Act, Medicaid fees that were effective on July 1, 2009, were used to estimate the costs of increasing primary care physician fees subject to the 100 percent federal financial participation (FFP). Because Maryland Medicaid fees for E&M procedures were reduced after July 1, 2009, the State paid for increasing fees to their July 1, 2009 levels at the regular FMAP rate.

Federal Share of Fee Increase for Primary Care Physicians

The federal government provided 100 percent FFP only for physicians who self-attested that they are primary care physicians.[3] The Department obtained self-attestations from approximately 3,600 physicians. Claims and encounter data from these physicians were identified, and payments for their 2013 evaluation and management and vaccine administration procedures were projected. Then payments for these procedures for all physicians in CY13 and CY14 were estimated. According to a "Technical Guide" released by CMS, base year utilization data for evaluation and management and vaccine administration procedures and the trend factors between the base years and implementation years, which were used for managed care organization rate setting, were utilized to estimate the CY13 and CY14 costs of the fee increases, as shown in Table 3.

Table 3. Projected Costs of E&M and Vaccine Administration Fee Increases to 100 Percent of Medicare Fees in CYs 2013 and 2014 (Million Dollars)

Year	Increase in FFS Payments	Increase in MCO Payments	Total Increase in Payments
CY 2013	$23.7	$155.5	$179.2
CY 2014	$21.6	$165.6	$187.2

CMS updated the practice expense relative value units for 2014 resulting in a decrease from the 2013 Medicare fees for evaluation and management procedures. The decrease in estimated fee-for-service payments in 2014 compared with 2013 in part reflects the decrease in Medicare 2014 fees. Enrollment growth due to the Affordable Care Act's Medicaid expansion resulted in an increase in the estimated payments to managed care organizations in 2014.

For the fee-for-service system, actual claims data for services provided in 2013 and 2014 by self-attesting primary care physicians were submitted to CMS to claim the 100 percent federal financial participation. The estimated payments to managed care organizations shown in Table 3 were multiplied by the corresponding percentages pertaining to self-attesting primary care

3 The ACA statute specified that higher payment applied to primary care services delivered by physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine.

physicians (shown in Table 4) to calculate the payments that were subject to 100 percent FFP. To derive the percentages of the total costs of fee increases in Table 4 that were subject to 100 percent federal financing, the estimated payments for evaluation and management and vaccine administration claims and encounter data from self-attesting primary care physicians were divided by the corresponding estimated payments for all physicians (shown in Table 3).

Table 4. Payments to Self-Attesting Primary Care Physicians as Percentage of Total Physician Payments for Evaluation and Management and Vaccine Administration Procedures

Procedures	FFS Payments	MCO Payments	Total Payments
Non-Facility E&M	37%	42%	42%
Facility E&M	25%	17%	18%
Vaccine Administration	74%	68%	69%
Total	**29.1%**	**37.2%**	**36.3%**

The pertinent numbers in Tables 3 and 4 correspond to payments for managed care organizations, as federal payments were based on actual claims in CY13 and CY14. Because claims and encounter data for self-attesting primary care physicians are primarily office-based, their non-facility services comprise 42 percent of all physician services, compared with only 18 percent of physician services provided in facilities. Overall, the increase in payments to self-attesting primary care physicians was 36.3 percent of the total cost of the fee increase for these procedures.

To determine the portion of the managed care organizations' costs of the fee increase that was subject to 100 percent federal financial participation, the estimated additional payments to managed care organizations (in Table 3) were multiplied by 37.2 percent. Table 5 shows the Department's estimated cost of fee increases for evaluation and management and vaccine administration procedures in CY13 and CY14 that were subject to 100 percent federal financing.

Table 5. Estimated Cost of Fee Increases for Primary Care Physicians Subject to 100% FMAP (Million Dollars)[4]

	FFS	MCOs	Total
CY 2013	$6.92	$57.86	$64.78
CY 2014	$6.29	$61.65	$67.94

The amount of funding distributed to the Maryland Medical Assistance program from the Rate Stabilization Fund in FY13 was $109.1 million. With 50 percent FMAP for Medicaid and 65

[4] The calculations shown in Table 5 were based on numbers corresponding to Tables 3 and 4 that were not rounded to the nearest dollar amount. Because rounded numbers are reported in these tables, they may not exactly add up.

percent FMAP for CHIP, the combined total amount of $221.6 million was allocated to maintaining prior fee increases and increasing provider reimbursement rates.

The amount of funding distributed to the Maryland Medical Assistance program from the Rate Stabilization Fund in FY14 was $122.5 million. With matching federal funds for Medicaid at 50 percent and for CHIP at 65 percent, total federal matching funds reached approximately $125 million. The combined total amount of $247.5 million was allocated for maintaining provider reimbursement rates. Furthermore, $9.5 million federal funds were allocated for physician services of adults that were covered by Medicaid expansion under the Affordable Care Act for the last six months of FY14.

Physician Fees for FY15, FY16, and FY17

Following expiration of 100 percent federal financial participation for evaluation and management procedures provided by primary care physicians, Medicaid fees for evaluation and management procedures were reduced to 87 percent of Medicare fee for April through June of 2015. Subsequently, with the support of the Governor, the Maryland legislature passed laws that increased Medicaid FY16 fees for evaluation and management procedures to 92 percent of Medicare 2015 fees.

The amount of funding distributed to the Maryland Medical Assistance program from the Rate Stabilization Fund in FY15 was $158.5 million. With matching federal funds for Medicaid at 50 percent and for CHIP at 65 percent, total federal matching funds reached approximately $168.8 million. The combined total amount of $327.3 million was allocated for maintaining provider reimbursement rates. Furthermore, $31.9 million federal funds were allocated for physician services of adults that were covered by Medicaid expansion under the Affordable Care Act for FY15.

The amount of funding distributed to the Maryland Medical Assistance program from the Rate Stabilization Fund in FY16 was $153.0 million. With matching federal funds for Medicaid at 50 percent and for CHIP at 82 percent[5], total federal matching funds reached an estimated amount of $214.5 million. The combined estimated total amount of $367.5 million was allocated for maintaining provider reimbursement rates. Furthermore, $36.1 million federal funds were allocated for physician services of adults that were covered by Medicaid expansion under the Affordable Care Act for FY16.

The Governor allocated approximately $5 million General Funds in FY17 for increasing Medicaid fees for evaluation and management procedures to 94 percent of Medicare 2016 fees effective October 1, 2016. Moreover, updates in relative value units led to decreases in Medicare fees for some procedures that caused Maryland Medicaid fees to exceed their corresponding Medicare fees. Therefore, effective January 1, 2017, the Department reduced any Medicaid fees that exceeded their corresponding Medicare fees, and increased the lowest Medicaid fees to approximately 72 percent of Medicare 2017 fees.

[5] Under the ACA, states receive a 23 percent increase in Federal Medical Assistance Percentage (FMAP) for CHIP for FFY 2016 through FFY 2019. Maryland's FMAP is currently 88 percent. The FMAP of 82 percent for CHIP was calculated based on (65 times 25%) plus (88 times 75%).

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

Maryland's neighboring states have their own Medicaid fee schedules. For this report, we collected data on the Medicaid physician fees of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, DC. We obtained the current physician fee schedules from the states' websites and compiled data on each state's Medicaid fees.

Table 6 compares Maryland's 2017 Medicaid fees with the corresponding Medicare 2017 reimbursement rates for Baltimore region, and neighboring states' Medicaid fees for a sample of approximately 260 high-volume procedures in various specialty groups. In this table, procedure fees are rounded to the nearest dollar amount, and the last row of each section shows each state's weighted average Medicaid fees for the surveyed procedures as a percentage of Medicare fees in the Baltimore region. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percentages of Medicare fees reported in this table correspond to the appropriate Medicare non-facility and facility fees. More specifically, Medicaid non-facility fees are compared with Medicare non-facility fees, and Medicaid facility fees, reported for Maryland and West Virginia, are compared with Medicare facility fees.

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

Maryland and West Virginia have separate facility and non-facility fees. However, Delaware and Pennsylvania do not separate non-facility and facility fees. Therefore, their fees are compared with Medicare non-facility fees. Hence, for Delaware and Pennsylvania, the percentages of Medicare fees reported in Table 6 underestimate the percentages of Medicare fees for procedures performed in facilities. Virginia and Washington, DC have separate facility and non-facility fees for some procedures, but they did not report facility fees for some of the procedures that are included in Table 6. Therefore, the table only compares Medicaid non-facility fees of Virginia and Washington, DC with the corresponding Medicare non-facility fees for Baltimore region.

For this report, we compared Maryland's and other states' Medicaid reimbursement rates with the Medicare fee schedule for Maryland. Average Medicare fees in Maryland are approximately 4 percent higher than Medicare fees in Delaware and Pennsylvania, 1 percent higher than Medicare fees in Virginia, and 12 percent higher than Medicare fees in West Virginia. On the other hand, average Medicare fees in Maryland are approximately 5 percent lower than average Medicare fees in Washington, DC.

Comparisons of Evaluation and Management and Specialty Procedures

The following paragraphs compare Maryland's fees with other states' fees for evaluation and management and each group of specialty procedures shown in Table 6.

Evaluation and Management Procedures

As an average percentage of Medicare 2017 fees for Baltimore region, evaluation and management fees in Maryland non-facility and facility fees rank first and second, respectively; Delaware fees are ranked as third; Washington DC fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; Virginia non-facility fees rank seventh; and Pennsylvania fees rank eighth. Washington, DC's Medicaid fee data includes one zero fee for procedure code 99238 (hospital discharge day), and Delaware data also includes one zero fee for procedure code 99244 (Office Consultation).

Surgery

Integumentary Procedures

Similar to last year's ranking order, Delaware fees still rank first, followed by Washington, DC, fees (second), Virginia non-facility fees (third), Maryland non-facility fees (fourth), Maryland facility fees (fifth), West Virginia facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth).

Musculoskeletal System Procedures

Similar to integumentary procedures, the state ranking order of musculoskeletal system procedures did not change from last year. Delaware fees for musculoskeletal system procedures are still the highest in the region. Maryland non-facility fees rank second; Maryland facility fees rank third; Washington, DC fees rank fourth; Virginia non-facility fees rank fifth; West Virginia facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank last. Washington, DC data include one zero fee for procedure code 20552 (injection trigger point, one or two muscles), and Pennsylvania data are missing a value for procedure code 29130 (application of finger splint).

Respiratory Procedures

Similar to last year's ranking order, Washington, DC respiratory procedure fees rank first, followed, in ranking order, by Delaware fees, Virginia non-facility fees, Maryland non-facility fees, Maryland facility fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees.

Cardiovascular Surgical Procedures

For cardiovascular surgical procedures, Washington, DC has the highest fees. Virginia non-facility fees rank second; Maryland non-facility fees rank third; Maryland facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; Delaware fees rank seventh; and Pennsylvania fees rank eighth. Because Pennsylvania data have missing fees for three surveyed procedures (procedure codes 36400, 36406, and 36410), the state's percentage of Medicare fees is lower than it would have been if these procedures were covered.

Hemic, Lymphatic, and Mediastinum Procedures

For selected hemic, lymphatic, and mediastinum procedures, Delaware has the highest fees in the region followed by Washington, DC fees (second), Virginia non-facility fees (third), Maryland non-facility fees (fourth), Maryland facility fees (fifth), West Virginia facility fees

(sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth). Pennsylvania data have missing fees for procedure 38792 (identify sentinel node).

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

Urinary and Male Genital Procedures
Similar to last year's state ranking order of urinary and male genital procedures, Washington, DC fees rank highest in the region. Maryland non-facility fees rank second; Virginia non-facility fees rank third; Maryland facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; and Delaware fees rank seventh. Pennsylvania fees rank last in the region.

Gynecology and Obstetrics Procedures
Pennsylvania fees for the selected gynecology and obstetrics procedures rank highest in the region. Maryland non-facility fees rank second; Maryland facility fees rank third; West Virginia facility fees rank fourth; West Virginia non-facility fees rank fifth; Delaware fees rank sixth; Washington, DC fees rank seventh; and Virginia non-facility fees rank eighth. Delaware data include one zero fee for procedure code 58300 (Insert intrauterine device), and Pennsylvania data have missing fees for one procedure, 59430 (care after delivery).

Endocrine System Procedures
For the selected endocrine system procedures, Delaware fees rank the highest. Washington, DC fees rank second; Virginia non-facility fees rank third; Maryland facility fees rank fourth; Maryland non-facility fees rank fifth; West Virginia facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank eighth.

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

Eye Surgery Procedures
For eye surgery procedures, Delaware fees rank first; Washington, DC fees rank second; Pennsylvania fees rank third; Virginia non-facility fees rank fourth; Maryland non-facility fees rank fifth; Maryland facility fees rank sixth; West Virginia facility fees rank seventh; and West Virginia non-facility fees have the last ranking.

Ear Surgery Procedures
Similar to last year's ranking order, Washington, DC has the highest fees for ear surgery procedures in the region, followed by Maryland non-facility fees (second), Maryland facility

fees (third), Virginia non-facility fees (fourth), West Virginia facility fees (fifth), West Virginia non-facility fees (sixth), Delaware fees (seventh), and Pennsylvania fees (eighth).

Delaware data have missing fees for procedure code 69210 (remove impacted ear wax), and Pennsylvania data have missing fees for procedure code 69990 (Microsurgery add-on), which reduce their percentage of Medicare fees.

Radiology Procedures

For the selected radiology procedures, Delaware fees are highest in the region. Following Delaware, in ranking order, are: Washington, DC fees (second), Virginia non-facility fees (third), Maryland facility and non-facility fees (fourth, tie), Pennsylvania (sixth), West Virginia non-facility fees (seventh), and West Virginia facility fees (eighth).

Laboratory Procedures

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

Medicine

Psychiatry Procedures

For selected psychiatry procedures, Maryland non-facility fees rank first in the region; Maryland facility fees rank second; Delaware fees rank third; Washington, DC fees rank fourth; Virginia non-facility fees rank fifth; West Virginia facility and non-facility fees rank sixth and seventh, respectively. Pennsylvania fees rank last.

Dialysis Procedures

Delaware fees for dialysis procedures are highest in the region, followed, in ranking order, by Washington, DC, Virginia non-facility, Maryland non-facility and Maryland facility (tie), West Virginia non-facility, West Virginia facility, and Pennsylvania fees. Pennsylvania data have missing fees for four procedures: 90960 (ESRD service with 4 visits per month, age 20+), 90961 (ESRD service, 2-3 visits per month, age 20+), 90962 (ESRD service, 1 visit per month, age 20+), and 90970 (ESRD services, per day, age 20+).

Gastroenterology Procedures

Delaware's gastroenterology fees are highest in the region, followed, in ranking order, by Washington, DC, Virginia, Maryland, Pennsylvania, and West Virginia fees.

Ophthalmology and Vision Care Procedures

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

Otorhinolaryngology Procedures

Delaware fees are the highest for the selected Otorhinolaryngology (Ear, Nose, and Throat) procedures in the region. Washington, DC fees rank second; Virginia non-facility fees rank third; Maryland non-facility and facility fees rank fourth and fifth, respectively; Pennsylvania fees rank sixth; and West Virginia facility and non-facility fees rank seventh and eighth, respectively. Pennsylvania did not report a fee for procedure 92504 (ear microscopy examination).

Cardiovascular Medicine Procedures
For the selected cardiovascular medicine procedures, Delaware fees rank first, followed in ranking order by Washington, DC, Maryland, Virginia, Pennsylvania, and West Virginia fees. Delaware data include one zero fee for procedure code 93016 (cardiovascular stress test), and Pennsylvania has a missing fee for procedure code 93325 (Doppler color flow add-on).

Noninvasive Vascular Diagnostic Studies
For the selected procedures, Delaware fees rank first, followed in ranking order by Washington DC fees, Maryland non-facility and facility fees (tie), Virginia non-facility fees, Pennsylvania fees, and West Virginia non-facility and facility fees, respectively.

Pulmonary Procedures
Similar to last year's report, for the selected pulmonary procedures, Delaware fees rank first in the region followed in ranking order by Washington, DC, Virginia non-facility, Maryland, West Virginia, and Pennsylvania fees. Pennsylvania's fee schedule does not provide a fee for procedure 94640 (airway inhalation treatment).

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

Neurology and Neuromuscular Procedures
Washington, DC fees are the highest in the region for neurology and neuromuscular procedures, followed in ranking order by Maryland fees, Delaware fees, Virginia fees, West Virginia fees, and Pennsylvania fees. Delaware and West Virginia data include one zero fee for procedure code 95951 (EEG monitoring/video record).

Central Nervous System (CNS) Assessment Tests
For the selected CNS assessment procedures, Washington, DC fees rank first; Maryland facility and non-facility fees rank second and third, respectively; Virginia non-facility fees rank fourth; West Virginia facility and non-facility fees rank fifth and sixth, respectively; Pennsylvania fees rank seventh; and Delaware fees rank eighth.

Because Delaware's fee schedule lists $0 for 96111 and 96116, its ranking as a percentage of Medicare fees are the lowest. Similarly, Pennsylvania's fees for the procedure codes 96102 are not available.

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

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

Because Washington, DC has missing values for three surveyed procedures (96920, 96921, and 96922), its percentages of Medicare fees are lower than they would have been if these procedures were covered.

Physical Medicine and Rehabilitation Procedures
Delaware fees rank highest for physical medicine and rehabilitation procedures followed in ranking order by Washington, DC, Virginia, Maryland, West Virginia, and Pennsylvania fees.

Osteopathy, Chiropractic, and Other Medicine Procedures
For the selected osteopathy, chiropractic, and other medicine procedures, Pennsylvania fees are highest, followed in ranking order by Delaware fees, Washington, DC fees, Maryland non-facility fees, Virginia non-facility fees, Maryland facility fees, and West Virginia facility and non-facility fees. Washington, DC data have a zero fee for 98941.

Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2017

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Evaluation & Management											
99203	Office/outpatient visit, new	$117	$82	$109	$77	$110	$73	$75	$55	$54	$99
99204	Office/outpatient visit, new	$177	$139	$166	$130	$167	$112	$115	$93	$90	$150
99212	Office/outpatient visit, est	$47	$27	$44	$25	$44	$30	$29	$18	$26	$40
99213	Office/outpatient visit, est	$79	$54	$73	$51	$74	$49	$50	$36	$35	$67
99214	Office/outpatient visit, est	$116	$84	$108	$78	$109	$73	$74	$56	$54	$98
99223	Initial hospital care	$217	$217	$202	$202	$204	$137	$145	$145	$42	$181
99232	Subsequent hospital care	$77	$77	$72	$72	$73	$49	$52	$52	$17	$64
99238	Hospital discharge day	$78	$78	$72	$72	$73	$49	$51	$51	$17	$0
99244	Office consultation	$196	$164	$184	$153	$0	$124	$128	$110	$121	$165
99283	Emergency dept visit	$66	$66	$62	$62	$63	$44	$45	$45	$35	$55
99284	Emergency dept visit	$125	$125	$117	$117	$119	$83	$86	$86	$50	$104
99285	Emergency dept visit	$185	$185	$172	$172	$175	$122	$128	$128	$50	$153
99291	Critical care, first hour	$295	$239	$276	$223	$278	$186	$194	$162	$152	$248
99308	Nursing fac care, subseq	$74	$74	$69	$69	$70	$47	$49	$49	$37	$62
99381	Init pm e/m, new pat, inf	$119	$82	$111	$76	$112	$75	$76	$55	$20	$101
99391	Per pm reeval, est pat, inf	$107	$75	$100	$70	$100	$67	$68	$50	$20	$90
99392	Prev visit, est, age 1-4	$114	$82	$107	$76	$107	$72	$73	$55	$20	$96
99393	Prev visit, est, age 5-11	$113	$82	$106	$76	$107	$71	$73	$55	$20	$96
99394	Prev visit, est, age 12-17	$124	$92	$116	$87	$117	$78	$80	$62	$20	$105
99469	Neonate crit care, subsq	$426	$426	$397	$397	$402	$309	$287	$287	$240	$354
99472	Ped critical care, subsq	$441	$441	$409	$409	$414	$319	$295	$295	$240	$365
99479	Ic lbw inf 1500-2500 g subsq	$133	$133	$124	$124	$126	$97	$90	$90	$76	$111
	Weighted Average % of Medicare Fees			93%	93%	92%	64%	65%	67%	41%	83%
	Ranking			1	2	3	7	6	5	8	4

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Integumentary / General Surgery											
10060	Drainage of skin abscess	$128	$107	$93	$77	$120	$101	$80	$67	$24	$109
10061	Drainage of skin abscess	$226	$197	$163	$143	$211	$179	$142	$126	$53	$192
11042	Debride skin/tissue	$128	$68	$93	$49	$119	$101	$78	$45	$33	$110
11056	Trim skin lesions 2 to 4	$64	$24	$46	$24	$59	$50	$39	$17	$30	$54
11100	Biopsy skin lesion	$114	$54	$82	$39	$106	$89	$69	$35	$35	$97
11721	Debride nail, 6 or more	$49	$27	$35	$21	$46	$39	$31	$18	$20	$42
12001	Repair superficial wound(s)	$98	$48	$88	$43	$91	$77	$60	$33	$25	$84
12011	Repair superficial wound(s)	$120	$60	$113	$54	$111	$94	$74	$41	$32	$102
17110	Destruct b9 lesion, 1-14	$122	$77	$89	$56	$113	$96	$73	$48	$49	$105
17250	Chemical cautery, tissue	$87	$41	$63	$30	$81	$69	$52	$26	$26	$75
	Weighted Average % of Medicare Fees			77%	76%	93%	79%	61%	65%	29%	85%
	Ranking			4	5	1	3	7	6	8	2
Musculoskeletal System											
20550	Inj tendon sheath/ligament	$57	$43	$56	$39	$60	$51	$41	$31	$32	$55
20552	Inj trigger point, 1/2 muscl	$60	$42	$50	$33	$57	$48	$38	$28	$31	$0
20553	Inject trigger points 3/>	$70	$47	$55	$37	$65	$55	$44	$31	$34	$59
20610	Drain/inject, joint/bursa	$66	$51	$66	$48	$62	$53	$42	$34	$24	$56
25600	Treat fracture radius/ulna	$362	$342	$262	$248	$340	$287	$222	$211	$115	$311
29075	Application of forearm cast	$96	$69	$80	$58	$91	$77	$59	$44	$46	$83
29125	Apply forearm splint	$71	$43	$61	$39	$67	$57	$43	$28	$26	$61
29130	Application of finger splint	$45	$31	$37	$27	$43	$36	$29	$21	N/A	$38
29515	Application lower leg splint	$80	$55	$65	$47	$74	$63	$49	$35	$35	$68
29540	Strapping of ankle and/or ft	$28	$20	$28	$20	$27	$23	$18	$13	$20	$24
	Weighted Average % of Medicare Fees			87%	85%	94%	80%	63%	65%	39%	82%
	Ranking			2	3	1	5	7	6	8	4

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Respiratory											
30300	Remove nasal foreign body	$196	$116	$161	$88	$192	$162	$123	$73	$23	$179
31231	Nasal endoscopy, dx	$231	$71	$167	$57	$217	$183	$138	$48	$59	$203
31237	Nasal/sinus endoscopy surg	$283	$176	$232	$136	$267	$226	$178	$118	$160	$245
31500	Insert emergency airway	$154	$154	$112	$112	$114	$97	$83	$83	$72	$99
31575	Diagnostic laryngoscopy	$125	$75	$91	$57	$118	$100	$78	$55	$69	$108
31622	Dx bronchoscope/wash	$265	$145	$236	$108	$149	$264	$206	$107	$134	$288
31624	Dx bronchoscope/lavage	$277	$148	$241	$108	$153	$272	$211	$109	$135	$296
32551	Insertion of chest tube	$174	$174	$128	$128	$177	$150	$128	$128	$133	$156
	Weighted Average % of Medicare Fees			76%	75%	85%	80%	62%	65%	41%	86%
	Ranking			4	5	2	3	7	6	8	1
Cardiovascular System Surgery											
36400	Bl draw < 3 yrs fem/jugular	$30	$20	$21	$14	$31	$26	$21	$15	N/A	$28
36406	Bl draw < 3 yrs other vein	$20	$10	$15	$7	$17	$15	$12	$6	N/A	$15
36410	Non-routine bl draw > 3 yrs	$19	$10	$14	$7	$17	$15	$12	$7	N/A	$16
36556	Insert non-tunnel cv cath	$256	$132	$194	$96	$126	$205	$160	$91	$113	$219
36558	Insert tunneled cv cath	$792	$291	$670	$217	$288	$680	$518	$205	$266	$750
36561	Insert tunneled cv cath	$1,206	$377	$938	$273	$371	$1,024	$774	$264	$319	$1,133
36569	Insert picc cath	$275	$100	$226	$73	$95	$217	$166	$68	$87	$238
36620	Insertion catheter, artery	$55	$55	$40	$40	$53	$46	$38	$38	$48	$46
	Weighted Average % of Medicare Fees			78%	73%	45%	83%	64%	69%	35%	90%
	Ranking			3	4	7	2	6	5	8	1

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Hemic, Lymphatic and Mediastinum											
38220	Bone marrow aspiration	$186	$68	$134	$49	$169	$143	$109	$45	$55	$157
38221	Bone marrow biopsy	$184	$81	$136	$59	$171	$145	$112	$54	$70	$158
38500	Biopsy/removal lymph nodes	$368	$283	$266	$205	$345	$292	$235	$188	$114	$314
38505	Needle biopsy lymph nodes	$139	$79	$101	$57	$130	$110	$86	$51	$67	$120
38525	Biopsy/removal, lymph nodes	$487	$487	$353	$353	$457	$387	$323	$323	$156	$411
38792	Identify sentinel node	$44	$44	$32	$32	$41	$35	$28	$28		$38
38900	Io map of sent lymph node	$154	$154	$113	$113	$145	$122	$106	$106	$110	$129
	Weighted Average % of Medicare Fees			73%	73%	93%	79%	63%	66%	35%	85%
	Ranking			4	5	1	3	7	6	8	2
Digestive System											
42820	Remove tonsils and adenoids	$319	$319	$231	$231	$304	$258	$211	$211	$184	$274
42830	Removal of adenoids	$230	$230	$167	$167	$217	$184	$148	$148	$134	$197
43235	Upper GI endoscopy, diagnosis	$282	$138	$229	$104	$319	$270	$207	$95	$125	$296
43239	Upper GI endoscopy, biopsy	$378	$156	$274	$123	$408	$345	$262	$108	$149	$379
45378	Diagnostic colonoscopy	$347	$208	$299	$155	$389	$329	$256	$143	$181	$358
45380	Colonoscopy and biopsy	$445	$225	$357	$186	$481	$407	$314	$154	$225	$444
45385	Lesion removal colonoscopy	$467	$285	$400	$221	$504	$427	$334	$195	$268	$463
47562	Laparoscopic cholecystectomy	$734	$734	$532	$532	$688	$582	$492	$492	$589	$617
49082	Abd paracentesis	$213	$82	$154	$60	$197	$167	$127	$55	$55	$183
	Weighted Average % of Medicare Fees			77%	76%	105%	89%	70%	68%	53%	97%
	Ranking			4	5	1	3	6	7	8	2

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Urinary & Male Genital											
51600	Injection for bladder x-ray	$203	$48	$162	$35	$46	$159	$119	$33	$32	$176
51700	Irrigation of bladder	$80	$40	$70	$34	$85	$72	$57	$33	$29	$78
51701	Insert bladder catheter	$52	$28	$47	$21	$56	$47	$37	$20	$25	$51
51741	Electro-uroflowmetry first	$17	$17	$16	$16	$16	$14	$11	$11	$24	$15
51798	Us urine capacity measure	$22	$22	$16	$16	$20	$16	$12	$12	$14	$14
52000	Cystoscopy	$181	$113	$163	$94	$130	$177	$140	$92	$75	$191
52332	Cystoscopy and treatment	$542	$172	$393	$124	$161	$422	$319	$114	$144	$465
54150	Circumcision w/regionl block	$170	$108	$145	$78	$101	$134	$107	$72	$79	$143
54161	Circum 28 days or older	$217	$217	$157	$157	$203	$173	$143	$143	$128	$181
	Weighted Average % of Medicare Fees			81%	73%	35%	79%	60%	69%	25%	86%
	Ranking			2	4	7	3	6	5	8	1
Gynecology-Obstetric											
57452	Exam of cervix w/scope	$119	$101	$108	$88	$112	$97	$77	$67	$40	$100
57454	Bx/curett of cervix w/scope	$166	$148	$152	$133	$156	$136	$108	$98	$106	$140
58100	Biopsy of uterus lining	$119	$95	$109	$85	$111	$97	$77	$63	$51	$100
58300	Insert intrauterine device	$79	$59	$76	$52	$0	$65	$51	$40	$17	$67
58301	Remove intrauterine device	$103	$73	$95	$66	$96	$84	$66	$49	$17	$87
59025	Fetal non-stress test	$54	$54	$46	$46	$50	$43	$34	$34	$18	$46
59409	Obstetrical care	$907	$907	$860	$860	$852	$742	$891	$891	$1,200	$757
59410	Obstetrical care	$1,159	$1,159	$942	$942	$1,085	$945	$1,133	$1,133	$1,200	$967
59430	Care after delivery	$205	$155	$149	$125	$191	$166	$192	$152	N/A	$173
59514	Cesarean delivery only	$1,023	$1,023	$993	$993	$852	$837	$1,005	$1,005	$1,200	$854
59515	Cesarean delivery w postpartum	$1,411	$1,411	$1,124	$1,124	$1,085	$1,150	$1,377	$1,377	$2,050	$1,177
	Weighted Average % of Medicare Fees			91%	90%	87%	82%	88%	90%	93%	84%
	Ranking			2	3	6	8	5	4	1	7

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Endocrine System											
60100	Biopsy of thyroid	$123	$86	$89	$63	$116	$98	$79	$59	$66	$105
60220	Partial removal of thyroid	$780	$780	$565	$565	$737	$625	$522	$522	$521	$661
60240	Removal of thyroid	$1,017	$1,017	$737	$737	$959	$813	$684	$684	$591	$858
60500	Explore parathyroid glands	$1,070	$1,070	$775	$775	$1,007	$853	$718	$718	$705	$902
	Weighted Average % of Medicare Fees			72%	72%	94%	80%	67%	67%	61%	85%
	Ranking			5	4	1	3	7	6	8	2
Neurosurgery											
62270	Spinal fluid tap, diagnostic	$175	$86	$150	$73	$163	$138	$108	$57	$42	$151
62311	Inject spine l/s (cd)	$245	$98	$183	$79	$231	$195	$147	$65	$75	$212
64450	N block, other peripheral	$88	$50	$88	$50	$82	$70	$54	$33	$21	$75
64483	Inj foramen epidural l/s	$238	$122	$238	$101	$227	$192	$148	$81	$95	$208
64484	Inj foramen epidural add-on	$95	$56	$95	$55	$91	$77	$60	$38	$60	$82
64494	Inj paravert f jnt l/s 2 lev	$94	$56	$87	$54	$54	$76	$60	$38	$42	$81
64495	Inj paravert f jnt l/s 3 lev	$94	$57	$88	$55	$55	$76	$60	$39	$42	$81
	Weighted Average % of Medicare Fees			95%	89%	112%	102%	72%	94%	47%	111%
	Ranking			4	6	1	3	7	5	8	2

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Eye Surgery											
65222	Remove foreign body from eye	$72	$56	$52	$41	$68	$57	$45	$36	$26	$61
65855	Laser surgery of eye	$265	$225	$227	$195	$278	$236	$183	$163	$237	$255
66821	After cataract laser surgery	$359	$339	$260	$246	$336	$285	$222	$211	$217	$307
66982	Cataract surgery complex	$862	$862	$678	$678	$808	$687	$552	$552	$697	$730
66984	Cataract surg w/iol, 1 stage	$694	$694	$503	$503	$644	$547	$441	$441	$603	$589
67028	Injection eye drug	$110	$109	$99	$98	$104	$88	$71	$70	$106	$94
67210	Treatment of retinal lesion	$563	$544	$430	$413	$528	$449	$354	$344	$375	$479
67228	Treatment of retinal lesion	$370	$333	$333	$300	$348	$295	$234	$214	$491	$314
67311	Revise eye muscle	$649	$649	$470	$470	$611	$519	$412	$412	$468	$552
67800	Remove eyelid lesion	$138	$112	$100	$81	$130	$110	$86	$72	$41	$118
	Weighted Average % of Medicare Fees			77%	77%	97%	80%	64%	64%	84%	85%
	Ranking			5	6	1	4	8	7	3	2
Ear Surgery											
69200	Clear outer ear canal	$91	$52	$82	$49	$102	$86	$67	$34	$30	$95
69205	Clear outer ear canal	$112	$112	$91	$91	$106	$89	$72	$72	$89	$96
69210	Remove impacted ear wax	$53	$36	$44	$29	N/A	$43	$34	$24	$20	$46
69424	Remove ventilating tube	$140	$68	$115	$55	$132	$111	$85	$44	$54	$123
69436	Create eardrum opening	$176	$176	$149	$149	$167	$142	$114	$114	$99	$152
69990	Microsurgery add-on	$251	$251	$199	$199	$231	$195	$172	$172	N/A	$210
	Weighted Average % of Medicare Fees			84%	83%	50%	82%	65%	67%	41%	88%
	Ranking			2	3	7	4	6	5	8	1

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Radiology											
70450	Ct head/brain w/o dye	$127	$127	$114	$114	$117	$99	$76	$76	$117	$109
71010	Chest x-ray	$25	$25	$20	$20	$23	$19	$15	$15	$19	$21
71020	Chest x-ray	$31	$31	$26	$26	$28	$24	$18	$18	$25	$26
72193	Ct pelvis w/dye	$248	$248	$223	$223	$229	$194	$145	$145	$140	$215
73610	X-ray exam of ankle	$35	$35	$25	$25	$32	$27	$20	$20	$27	$29
73630	X-ray exam of foot	$32	$32	$24	$24	$30	$25	$19	$19	$19	$27
74000	X-ray exam of abdomen	$26	$26	$21	$21	$24	$20	$15	$15	$18	$22
74160	Ct abdomen w/dye	$254	$254	$228	$228	$234	$198	$149	$149	$149	$219
74177	Ct abd & pelv w/contrast	$342	$342	$287	$287	$315	$267	$201	$201	$263	$294
76805	Ob us >/= 14 wks, sngl fetus	$158	$158	$114	$114	$145	$126	$93	$93	$78	$135
76815	Ob us, limited, fetus(s)	$94	$94	$70	$70	$86	$75	$56	$56	$64	$80
76816	Ob us follow-up per fetus	$128	$128	$93	$93	$118	$103	$76	$76	$72	$109
76817	Transvaginal us obstetric	$108	$108	$78	$78	$100	$87	$65	$65	$88	$92
76819	Fetal biophys profil w/o nst	$100	$100	$78	$78	$91	$79	$59	$59	$86	$84
76820	Umbilical artery echo	$53	$53	$50	$50	$49	$43	$32	$32	$46	$44
76830	Transvaginal us non-ob	$135	$135	$98	$98	$125	$108	$79	$79	$77	$116
76856	Us exam pelvic complete	$122	$122	$88	$88	$112	$98	$72	$72	$77	$104
	Weighted Average % of Medicare Fees			78%	78%	92%	79%	60%	60%	71%	85%
	Ranking			4	4	1	3	7	8	6	2

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Laboratory											
80053	Comprehen metabolic panel	$14	$14	$11	$11	$14	$12	$13	$13	$12	$12
80061	Lipid panel	$17	$17	$13	$13	$18	$15	$16	$16	$14	$15
81002	Urinalysis nonauto w/o scope	$3	$3	$3	$3	$3	$3	$3	$3	$4	$2
83655	Assay of lead	$16	$16	$13	$13	$16	$14	$15	$15	$10	$8
85025	Complete cbc w/auto diff wbc	$11	$11	$8	$8	$10	$9	$10	$10	$6	$8
86592	Blood serology, qualitative	$5	$5	$4	$4	$6	$4	$5	$5	$4	$5
87081	Culture screen only	$9	$9	$7	$7	$9	$8	$8	$8	$5	$7
87086	Urine culture/colony count	$11	$11	$9	$9	$11	$8	$10	$10	$8	$9
87491	Chylmd trach, dna, amp probe	$42	$42	$34	$34	$47	$38	$43	$43	$23	$38
87880	Strep a assay w/optic	$16	$16	$13	$13	$15	$14	$15	$15	$6	$7
	Weighted Average % of Medicare Fees			79%	79%	102%	87%	95%	95%	63%	77%
	Ranking			5	5	1	4	2	2	8	7
Psychiatry											
90834	Psytx, pt&/ family 45 minutes	$89	$88	$88	$88	$85	$73	$62	$61	$39	$73
90837	Psytx, pt&/ family 60 minutes	$133	$132	$133	$133	$127	$109	$93	$92	$52	$111
90847	Family psytx w/ patient	$112	$111	$111	$107	$107	$91	$77	$77	$13	$92
	Weighted Average % of Medicare Fees			100%	99%	96%	82%	70%	70%	35%	83%
	Ranking			1	2	3	5	7	6	8	4

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Dialysis											
90935	Hemodialysis, one evaluation	$77	$77	$56	$56	$73	$62	$52	$52	$35	$64
90937	Hemodialysis, repeated eval	$111	$111	$80	$80	$105	$89	$75	$75	$35	$92
90945	Dialysis, one evaluation	$92	$92	$66	$66	$87	$74	$61	$61	$35	$77
90960	Esrd srv 4 visits p mo 20+	$303	$303	$219	$219	$286	$244	$202	$202	N/A	$255
90961	Esrd srv 2-3 vsts p mo 20+	$254	$254	$184	$184	$241	$205	$169	$169	N/A	$214
90962	Esrd serv 1 visit p mo 20+	$196	$196	$142	$142	$186	$158	$130	$130	N/A	$166
90970	Esrd home pt serv p day 20+	$8	$8	$6	$6	$8	$7	$6	$6	N/A	$7
	Weighted Average % of Medicare Fees			72%	72%	95%	81%	67%	67%	17%	84%
	Ranking			4	4	1	3	6	7	8	2
Gastroenterology											
91034	Gastroesophageal reflux test	$207	$207	$167	$167	$193	$163	$122	$122	$172	$181
91038	Esoph imped funct test > 1hr	$495	$495	$359	$359	$459	$388	$284	$284	$98	$432
91065	Breath hydrogen/methane test	$83	$83	$60	$60	$80	$68	$50	$50	$17	$75
91110	Gi tract capsule endoscopy	$933	$933	$733	$733	$900	$761	$564	$564	$680	$843
91122	Anal pressure record	$251	$251	$190	$190	$231	$196	$150	$150	$69	$214
	Weighted Average % of Medicare Fees			78%	78%	96%	81%	60%	60%	64%	90%
	Ranking			4	4	1	3	7	8	6	2

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Ophthalmology/Vision Care											
92004	Eye exam, new patient	$161	$107	$117	$77	$150	$127	$100	$71	$59	$136
92012	Eye exam established pat	$93	$57	$67	$41	$86	$73	$57	$37	$29	$79
92014	Eye exam & treatment	$134	$86	$97	$62	$125	$106	$83	$56	$45	$114
92015	Refraction	$21	$21	$19	$15	$20	$17	$14	$14	$5	$18
92060	Special eye evaluation	$71	$71	$51	$51	$66	$56	$44	$44	$34	$60
92081	Visual field examination(s)	$37	$37	$33	$33	$34	$29	$23	$23	$28	$32
92083	Visual field examination(s)	$70	$70	$57	$57	$65	$55	$42	$42	$63	$60
92250	Eye exam with photos	$72	$72	$54	$54	$79	$67	$51	$51	$53	$75
	Weighted Average % of Medicare Fees			73%	73%	93%	79%	62%	66%	37%	85%
	Ranking			4	5	1	3	7	6	8	2
ENT (Otorhinolaryngology)											
92504	Ear microscopy examination	$33	$10	$26	$9	$31	$26	$19	$7	N/A	$29
92546	Sinusoidal rotational test	$113	$113	$82	$82	$105	$89	$66	$66	$22	$99
92547	Supplemental electrical test	$7	$7	$5	$5	$6	$5	$4	$4	$4	$6
92551	Pure tone hearing test, air	$13	$13	$10	$10	$12	$10	$8	$8	$8	$12
92552	Pure tone audiometry, air	$35	$35	$25	$25	$32	$27	$19	$19	$8	$30
92557	Comprehensive hearing test	$41	$35	$37	$32	$38	$32	$26	$23	$29	$34
92567	Tympanometry	$16	$12	$14	$11	$15	$13	$10	$8	$12	$13
92568	Acoustic refl threshold tst	$17	$17	$16	$16	$16	$14	$12	$11	$10	$14
92585	Auditory evoked potentials (ABR comprehensive)	$150	$150	$108	$108	$138	$117	$87	$87	$27	$130
92587	Evoked auditory (otoacoustic emission) testing	$23	$23	$21	$21	$22	$19	$15	$15	$34	$20
	Weighted Average % of Medicare Fees			78%	77%	92%	78%	58%	60%	60%	86%
	Ranking			4	5	1	3	8	7	6	2

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Cardiovascular											
93000	Electrocardiogram, complete	$19	$19	$18	$18	$17	$15	$12	$12	$19	$16
93010	Electrocardiogram report	$9	$9	$7	$7	$9	$7	$6	$6	$8	$8
93015	Cardiovascular stress test	$83	$83	$80	$80	$77	$65	$51	$51	$90	$71
93016	Cardiovascular stress test	$24	$24	$18	$18	$0	$19	$16	$16	$22	$20
93018	Cardiovascular stress test	$16	$16	$12	$12	$15	$13	$10	$10	$15	$13
93042	Rhythm ECG, report	$8	$8	$6	$6	$7	$6	$5	$5	$7	$6
93303	Echo transthoracic	$260	$260	$188	$188	$243	$205	$154	$154	$157	$227
93306	Tte w/doppler complete	$251	$251	$206	$206	$232	$196	$148	$148	$141	$216
93307	Tte w/o doppler, complete	$142	$142	$128	$128	$132	$112	$85	$85	$140	$123
93320	Doppler echo exam, heart	$59	$59	$53	$53	$55	$47	$35	$35	$61	$51
93325	Doppler color flow add-on	$28	$28	$25	$25	$26	$22	$16	$16	N/A	$25
	Weighted Average % of Medicare Fees			81%	81%	92%	79%	60%	60%	65%	86%
	Ranking			3	3	1	5	7	8	6	2
Non-Invasive Vascular Tests											
93880	Extracranial study	$224	$224	$162	$162	$196	$175	$131	$131	$148	$195
93922	Upr/l xtremity art 2 levels	$98	$98	$97	$97	$91	$77	$57	$57	$49	$86
93970	Extremity study	$218	$218	$158	$158	$190	$171	$127	$127	$147	$191
93971	Extremity study	$133	$133	$96	$96	$123	$104	$78	$78	$100	$117
93975	Vascular study	$310	$310	$225	$225	$214	$245	$183	$183	$182	$273
93976	Vascular study	$167	$167	$162	$162	$167	$141	$106	$106	$131	$157
	Weighted Average % of Medicare Fees			82%	82%	91%	81%	60%	60%	71%	90%
	Ranking			3	3	1	5	7	8	6	2

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Pulmonary											
94010	Breathing capacity test	$39	$39	$29	$29	$36	$31	$23	$23	$15	$35
94060	Evaluation of wheezing	$67	$67	$49	$49	$62	$53	$39	$39	$19	$58
94375	Respiratory flow volume loop	$43	$43	$31	$31	$40	$34	$26	$26	$31	$37
94640	Airway inhalation treatment	$21	$21	$15	$15	$19	$16	$12	$12	N/A	$18
94664	Evaluate pt use of inhaler	$19	$19	$14	$14	$18	$15	$11	$11	$12	$17
94760	Measure blood oxygen level	$4	$4	$3	$3	$3	$3	$2	$2	$2	$3
94761	Measure blood oxygen level	$5	$5	$5	$5	$5	$4	$3	$3	$4	$5
	Weighted Average % of Medicare Fees			73%	73%	92%	78%	58%	58%	34%	87%
	Ranking			4	4	1	3	7	6	8	2
Allergy/Immunology											
95004	Percut allergy skin tests	$8	$8	$5	$5	$7	$6	$4	$4	$2	$7
95024	Id allergy test, drug/bug	$9	$1	$6	$1	$8	$7	$5	$1	$5	$8
95115	Immunotherapy, one injection	$10	$10	$9	$9	$9	$8	$6	$6	$4	$9
95117	Immunotherapy injections	$11	$11	$10	$10	$11	$9	$6	$6	$7	$10
95165	Antigen therapy services	$14	$3	$10	$2	$13	$11	$8	$2	$8	$12
	Weighted Average % of Medicare Fees			86%	88%	92%	77%	55%	56%	53%	87%
	Ranking			4	2	1	5	7	6	8	3

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Neurology/Neuromuscular											
95810	Polysomnography, 4 or more	$686	$686	$628	$628	$636	$538	$400	$400	$347	$598
95811	Polysom 6/>yrs cpap 4/> parm	$721	$721	$691	$691	$668	$565	$420	$420	$648	$629
95816	Eeg, awake and drowsy	$399	$399	$289	$289	$369	$312	$230	$230	$23	$349
95819	Eeg, awake and asleep	$459	$459	$333	$333	$422	$356	$263	$263	$23	$400
95860	Muscle test, one limb	$134	$134	$97	$97	$124	$105	$80	$80	$30	$115
95886	Musc test done w/n test comp	$99	$99	$72	$72	$93	$79	$61	$61	$66	$85
95926	Somatosensory testing	$148	$148	$107	$107	$140	$119	$88	$88	$58	$132
95930	Visual evoked potential test	$143	$143	$104	$104	$131	$110	$82	$82	$74	$125
95951	Eeg monitoring/videorecord	$2,039	$2,039	$450	$450	$0	$266	$0	$0	$228	$449
95957	EEG digital analysis	$335	$335	$243	$243	$320	$271	$206	$206	$138	$299
	Weighted Average % of Medicare Fees			63%	63%	61%	56%	39%	39%	33%	65%
	Ranking			2	2	4	5	7	6	8	1
CNS Assessment Tests											
96102	Psycho testing by technician	$68	$25	$49	$23	$65	$55	$42	$17	N/A	$60
96110	Developmental test, lim	$11	$11	$9	$9	$9	$8	$6	$6	$7	$9
96111	Developmental test, extend	$140	$133	$101	$96	$0	$111	$93	$89	$50	$115
96116	Neurobehavioral status exam	$98	$92	$72	$70	$0	$80	$67	$63	$53	$82
96118	Neuropsych tst by psych/phys	$104	$83	$84	$68	$99	$84	$69	$57	$40	$87
	Weighted Average % of Medicare Fees			77%	78%	41%	76%	60%	60%	50%	82%
	Ranking			3	2	8	4	6	5	7	1

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Chemotherapy Administration											
96411	Chemo, iv push, addl drug	$69	$69	$53	$53	$63	$53	$40	$40	$53	$60
96413	Chemo, iv infusion, 1 hr	$153	$153	$126	$126	$138	$116	$86	$86	$125	$130
96415	Chemo, iv infusion, addl hr	$31	$31	$28	$28	$29	$24	$19	$19	$28	$27
96417	Chemo iv infus each addl seq	$72	$72	$62	$62	$64	$54	$40	$40	$62	$60
96450	Chemotherapy, into CNS	$198	$87	$179	$75	$185	$157	$121	$58	$77	$171
96523	Irrig drug delivery device	$27	$27	$21	$21	$25	$21	$15	$15	$19	$24
	Weighted Average % of Medicare Fees			83%	83%	90%	76%	57%	57%	78%	85%
	Ranking			3	4	1	6	8	7	5	2
Special Dermatological Procedures											
96910	Photochemotherapy with UV-B	$79	$79	$57	$57	$73	$62	$44	$44	$20	$69
96912	Photochemotherapy with UV-A	$102	$102	$74	$74	$93	$79	$56	$56	$20	$89
96920	Laser tx skin < 250 sq cm	$171	$73	$124	$53	$158	$134	$102	$48	$59	N/A
96921	Laser tx skin 250-500 sq cm	$188	$82	$136	$60	$174	$148	$112	$54	$59	N/A
96922	Laser tx skin >500 sq cm	$259	$132	$188	$96	$242	$205	$157	$86	$98	N/A
	Weighted Average % of Medicare Fees			72%	72%	93%	78%	46%	71%	28%	57%
	Ranking			4	3	1	2	7	5	8	6

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Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
Phys Medicine/Rehab/Therapy											
97001	Pt evaluation			$72	$72	$76	$64	$52	$52	$45	$68
97010	Hot or cold packs therapy	$7	$7	$5	$5	$6	$5	$4	$4	$17	$6
97014	Electric stimulation therapy	$17	$17	$13	$13	$16	$14	$11	$11	$17	$15
97035	Ultrasound therapy	$14	$14	$10	$10	$13	$11	$9	$9	$10	$12
97110	Therapeutic exercises	$35	$35	$29	$29	$33	$28	$22	$22	$8	$29
97112	Neuromuscular reeducation	$37	$37	$27	$27	$34	$29	$23	$23	$17	$31
97140	Manual therapy	$32	$32	$23	$23	$30	$26	$20	$20	$21	$27
97530	Therapeutic activities	$38	$38	$31	$31	$35	$30	$23	$23	$13	$32
	Weighted Average % of Medicare Fees			87%	87%	103%	88%	70%	70%	54%	93%
	Ranking			4	4	1	3	7	6	8	2
Osteo/Chiropractic & Other Medicine											
98941	Chiropractic manipulation	$43	$37	$32	$27	$41	$35	$29	$25	$13	$0
99173	Visual acuity screen	$4	$4	$3	$3	$3	$2	$2	$2	$6	$3
99183	Hyperbaric oxygen therapy	$119	$119	$107	$86	$112	$96	$81	$81	$107	$99
	Weighted Average % of Medicare Fees			78%	72%	92%	73%	62%	62%	138%	83%
	Ranking			4	6	2	5	8	7	1	3

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Table 7. Comparison of States' Medicaid Reimbursement Rates as Percentages of Medicare Rates (Region Rank), by Specialty, in 2017

	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
1-Evaluation & Management	93% (1)	93% (2)	92% (3)	64% (7)	65% (6)	67% (5)	41% (8)	83% (4)
2-Integumentary and General Surgery	77% (4)	76% (5)	93% (1)	79% (3)	61% (7)	65% (6)	29% (8)	85% (2)
3-Musculoskeletal System	87% (2)	85% (3)	94% (1)	80% (5)	63% (7)	35% (6)	39% (8)	82% (4)
4-Respiratory	76% (4)	75% (5)	85% (2)	80% (3)	62% (7)	65% (6)	41% (8)	86% (1)
5-Cardiovascular System Surgery	78% (3)	73% (4)	45% (7)	83% (2)	64% (6)	69% (5)	35% (8)	90% (1)
6-Hemic, Lymphatic, and Mediastinum	73% (4)	73% (5)	93% (1)	79% (3)	63% (7)	66% (6)	35% (8)	85% (2)
7-Digestive System	77% (4)	76% (5)	105% (1)	89% (3)	70% (6)	68% (7)	53% (8)	97% (2)
8-Urinary and Male Genital	81% (2)	73% (4)	35% (7)	79% (3)	60% (6)	69% (5)	25% (8)	86% (1)
9-Gynecology and Obstetrics	91% (2)	90% (3)	87% (6)	82% (8)	88% (5)	90% (4)	93% (1)	84% (7)
10-Endocrine System	72% (5)	72% (4)	94% (1)	80% (3)	67% (7)	67% (6)	61% (8)	85% (2)
11-Neurosurgery	95% (4)	89% (6)	112% (1)	102% (3)	72% (7)	94% (5)	47% (8)	111% (2)
12-Eye Surgery	77% (5)	77% (6)	97% (1)	80% (4)	64% (8)	64% (7)	84% (3)	85% (2)
13-Ear Surgery	84% (2)	83% (3)	50% (7)	82% (4)	65% (6)	67% (5)	41% (8)	88% (1)
14-Radiology	78% (4)	78% (4)	92% (1)	79% (3)	60% (7)	60% (8)	71% (6)	85% (2)
15-Laboratory	79% (5)	79% (5)	102% (1)	87% (4)	95% (2)	95% (2)	63% (8)	77% (7)
16-Psychiatry	100% (1)	99% (2)	96% (3)	82% (5)	70% (7)	70% (6)	35% (8)	83% (4)
17-Dialysis	72% (4)	72% (4)	95% (1)	81% (3)	67% (6)	67% (7)	17% (8)	84% (2)
18-Gastroenterology	78% (4)	78% (4)	96% (1)	81% (3)	60% (7)	60% (8)	64% (6)	90% (2)
19-Ophthalmology and Vision Care	73% (4)	73% (5)	93% (1)	79% (3)	62% (7)	66% (6)	37% (8)	85% (2)
20-ENT (Otorhinolaryngology)	78% (4)	77% (5)	92% (1)	78% (3)	58% (8)	60% (7)	60% (6)	86% (2)
21-Cardiovascular Medicine Procedures	81% (3)	81% (3)	92% (1)	79% (5)	60% (7)	60% (8)	65% (6)	86% (2)
22-Noninvasive Vascular Tests	82% (3)	82% (3)	91% (1)	81% (5)	60% (7)	60% (8)	71% (6)	90% (2)
23-Pulmonary	73% (4)	73% (4)	92% (1)	78% (3)	58% (7)	58% (6)	34% (8)	87% (2)
24-Allergy and Immunology	86% (4)	88% (2)	92% (1)	77% (5)	55% (7)	56% (6)	53% (8)	87% (3)
25-Neurology and Neuromuscular	63% (2)	63% (2)	61% (4)	56% (5)	39% (7)	39% (6)	33% (8)	65% (1)
26-CNS Assessment Tests	77% (3)	78% (2)	41% (8)	76% (4)	60% (6)	60% (5)	50% (7)	82% (1)
27-Chemotherapy Administration	83% (3)	83% (4)	90% (1)	76% (6)	57% (8)	57% (7)	78% (5)	85% (2)
28-Special Dermatological	72% (4)	72% (3)	93% (1)	78% (2)	46% (7)	71% (5)	28% (8)	57% (6)
29-Physical Medicine and Rehabilitation	87% (4)	87% (4)	103% (1)	88% (3)	70% (7)	70% (6)	54% (8)	93% (2)
30-Osteopathy, Chiropractic and Other Medicine	78% (4)	72% (6)	92% (2)	73% (5)	62% (8)	62% (7)	138% (1)	83% (3)

V. Trauma Center Payment Issues

In 2003, SB 479 (Chapter 385 of the Acts of 2003) created a Trauma and Emergency Medical Fund financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the fund. Based on the law, Maryland Medicaid is required to pay physicians 100 percent of the Medicare facility rates for the Baltimore area when they provide trauma care to Medicaid 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 for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fees were limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, HB 1164 (Chapter 484 of the Acts of 2006) extended the enhanced rates to any physician who provides trauma care to Medicaid beneficiaries, beginning July 1, 2006. MHCC and the HSCRC fully cover the additional outlay of general funds that the Maryland Medical Assistance program incurs due to enhanced trauma fees (i.e., the state's share of the difference between current Medicare rates and Medicaid rates). MHCC pays physicians directly for uncompensated care and on-call services.

VI. Reimbursement for Oral Health Services

Historically, the Maryland Medical Assistance program has had low dental fees. Unlike fees for physician services, there is no federal public program (such as Medicare) to serve as a benchmark for oral health service fees. The American Dental Association (ADA) used to publish a survey every two years, reporting the national and regional average charges for approximately 165 of the most common dental procedures, offering data for comparison. The latest published ADA survey pertains to 2013.

During the 2003 session, the Maryland General Assembly allocated $7.5 million through budgetary language to increase Medicaid fees for dental procedures. Effective March 1, 2004, managed care organizations 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 fee-for-service rates to the ADA's 50th percentile levels for the 12 restorative procedures.

In June 2007, the Department convened the Dental Action Committee to increase access to dental care services for Maryland children of low income families. The Dental Action Committee recommended increasing the dental reimbursement rates to the 50th percentile of the ADA's South Atlantic region charges for all dental procedures. Subsequently, SB 545 (Chapter 589 of the Acts of 2008) allocated $7 million in state funds ($14 million with matching federal funds) for increasing dental fees in FY09. The rate increase targeted preventive procedures and went into effect on July 1, 2008.

Based on the recommendations of the Dental Action Committee, an administrative service organization (ASO) to coordinate the provision of dental services for Medicaid beneficiaries in the fee-for-service program. The current ASO is Scion Dental. Fees for some of the dental

procedures were streamlined and adjusted, effective July 1, 2009, to coincide with the provision of all Medicaid dental services through the administrative service organization.

In FY15, the General Assembly allocated approximately $940,000 in state general funds (with matching federal funds, $2.15 million total funds), to increase fees for five dental procedures in January through June 2015. The annual equivalent amount of $4.3 million was allocated to the following five procedures: D1208 (Topical Application of Fluoride), D1330 (Oral Hygiene Instructions), D2940 (Protective Restoration), D3120 (Pulp Cap, Indirect), and D9941 (Athletic Mouth-guard). Table 8 presents Maryland Medicaid dental fees in 2014 and 2015 for the five selected dental procedures for which fees will increase in January 2015.

Table 8. Maryland 2014 and 2015 Medicaid Dental Fees

Procedure Code	Description	Median ADA fees in 2013	Medicaid 2014 Fees	Medicaid 2015 Fees
D1208	Topical Application of Fluoride	$33.00	$21.60	$23.00
D1330	Oral Hygiene Instructions	$16.00	$0.00	$6.00
D2940	Protective Restoration	$100.00	$18.00	$50.00
D3120	Pulp Cap, Indirect	$70.00	$15.00	$35.00
D9941	Athletic Mouth-guard	$206.00	$40.00	$103.00

Table 9 shows Maryland Medicaid weighted average dental fees by specialty groups of procedures, before and after the fee increase, as percentages of the ADA's 50th percentile of charges in 2013.

Table 9. Average of Maryland Medicaid Dental Fees as a Percentage of the ADA's 50th Percentile of Charges

Procedure Group	CY14 Average Medicaid Fees	CY15 Average Medicaid Fees
D0100-D1999 Diagnostic & Preventive Procedures	57%	59%
D2000-D2999 Restorative Procedures	56%	57%
D3000-D3999 Endodontics	62%	64%
D4210-D6999 Periodontics & Prosthodontics	51%	51%
D7000-D7999 Oral and Maxillofacial Surgery	59%	59%
D8000-D9999 Orthodontics & Adjunctive General Services	32%	32%
All Procedures Combined	**54%**	**55%**

Table 10 compares Maryland Medicaid dental fees for selected high-volume procedures with the corresponding fees in Delaware, Virginia, West Virginia, Pennsylvania, and Washington, DC. Numbers of claims in Maryland were used to calculate the weighted average rank of Maryland and its neighboring states' fees.

The ranking of states' weighted average fees are: Delaware (first), Washington, DC (second), Maryland (third), West Virginia (fourth), Virginia (fifth), and Pennsylvania (sixth). ADA fees correspond to CY 2013, and the states' fees correspond to 2015.

Table 10. Maryland Medicaid and Neighboring States' 2015 Dental Fees

Procedure Code	Procedure Description	ADA CY13	MD	DE	VA	WV	PA	DC
D0120	Periodic oral evaluation	$45	$29	$46	$20	$25	$20	$35
D0140	Limited oral evaluation, problem focus	$65	$43	$69	$25	$35	N/A	$50
D0145	Oral evaluation, pt < 3yrs	$55	$40	$63	$20	$25	$20	$40
D0150	Comprehensive oral evaluation	$73	$52	$81	$31	$35	$20	$78
D1110	Prophylaxis – adult (12 years of age and older)	$82	$58	$83	$47	$55	$36	$78
D1120	Dental prophylaxis child	$61	$42	$63	$34	$40	$30	$47
D1206	Topical fluoride varnish	$35	$25	$39	$21	$20	$18	$29
D1351	Dental sealant per tooth	$48	$33	$50	$32	$30	$25	$38
D7140	Extraction erupted tooth	$155	$103	$164	$69	$80	$65	$110
D9248	Nonintravenous conscious sedation	$170	$187	$295	$110	0	$184	0
Ranking			3	1	5	4	6	2

VII. Physician Participation in the Maryland Medicaid Program

Physician claims and encounter data pertaining to FY02 (the year before the July 2002 fee increase) and FY13 through FY16 were analyzed to determine the number of physicians who had partial or full participation in the Medicaid program.

Because of incurred but not reported (IBNR) claims, FY16 fee-for-service claims and managed care organizations' encounter data were not complete. Hence, they showed an insignificant decrease in the total number of participating physicians in FY16 compared with FY15. This phenomenon was also observed in previous years. Therefore, FY15 data were used as the last year for comparison in Tables 11, 12, and 13.

Tables 11, 12, and 13 show the percentage changes in the numbers of participating physicians from all specialties (including primary care) who participated in the fee-for-service program, managed care organizations networks, and the total Medicaid program. Physicians with fewer than 25 claims during each fiscal year are included in the data for all physicians, but are not shown separately. Physicians who submitted more than 25 claims, but treated fewer than 50 Medicaid patients were considered partial participants in the Medicaid program. Physicians with at least 50 Medicaid patients during the year were considered full participants in the Medicaid program.

The data in Table 11 demonstrate significant increases in physician participation in the fee-for-service program, managed care organization networks, and the total Medicaid program between FY02 and FY15.

Table 11. Percentage Change in the Number of Participating Physicians of All Specialties, FY02-FY15

	FFS	MCO Networks	Total Medicaid
Partial Participation	66.2%	56.7%	96.4%
Full Participation	128.7%	208.3%	189.9%
All Physicians	59.4%	68.4%	106.4%

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

Because some physicians participate in both fee-for-service and managed care organizations networks, the percentages of total physicians participating in the Medicaid program do not equal the sum of fee-for-service and managed care organization network physicians. Notice the significant increases in numbers of physicians that fully participate in the Medicaid fee-for-service program and HealthChoice managed care organizations.

Similarly, examination of the data in Table 12 shows that, following the increase in evaluation and management fees in CYs 2013 and 2014, physician participation increased significantly between FY13 and FY15.

Table 12. Percentage Change in the Number of Participating Physicians of All Specialties, FY13-FY15

	FFS	MCO Networks	Total Medicaid
Partial Participation	10.2%	11.5%	12.5%
Full Participation	42.3%	35.8%	35.9%
All Physicians	8.9%	15.7%	15.2%

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

The data in Table 12 show that physician participation in the fee-for-service program and managed care organization networks increased significantly between FY13 and FY 15. Furthermore, the numbers of physicians who had full participation in both fee-for-service program and managed care organization networks had substantial increases. Table 13 shows that the increasing trend in total physician participation in the Medicaid program continued between FY14 and FY15, especially among physicians who are full participant, and care for 50 or more patients. The 1.8 percent decrease among partial participants in MCOs networks is because many of previous partial participants decided to fully participate in the Medicaid program.

Table 13. Percentage Change in the Number of Participating Physicians of All Specialties, FY14-FY15

	FFS	MCO Networks	Total Medicaid
Partial Participation	9.8%	-1.8%	2.5%
Full Participation	24.9%	13.2%	14.6%
All Physicians	4.5%	4.2%	4.8%

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

Although national data pertaining to previous years have shown that fewer physicians provide services to higher numbers of Medicaid beneficiaries, the increase in Medicaid fees for evaluation and management procedures to Medicare fee levels in CYs 2013 and 2014 provided financial incentives for physicians to participate in Maryland Medicaid program, resulting in significant increases in numbers of physicians with full participation in Medicaid. However, the increase in the number of participating physicians following Medicaid expansion under the Affordable Care Act is partly the result of substantial increase in number of Medicaid beneficiaries.

Therefore, to separate the effects of increase in fees from the effects of the increase in Medicaid enrollment on physician participation, we conducted an additional analysis in which we calculated the number of claims per enrollee for each year, beginning in FY02 (see Table 14). For this analysis, we excluded radiology and laboratory procedures for all years, because they may not be representative of patient access to physician services.

Table 14. 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
2002	617,929	3,903,991	6.3	N/A
2003	652,414	4,274,666	6.6	3.7%
2004	669,021	4,758,155	7.1	8.5%
2005	687,269	4,816,418	7.0	-1.5%
2006	690,227	5,159,342	7.5	6.7%
2007	700,930	5,422,073	7.7	3.5%
2008	709,832	5,912,029	8.3	7.7%
2009	772,582	6,620,713	8.6	2.9%
2010	834,285	7,765,486	9.3	8.6%
2011	923,937	8,733,375	9.5	1.6%
2012	987,133	9,256,308	9.4	-0.8%
2013	1,042,038	9,770,955	9.4	0.0%
2014	1,154,192	10,724,760	9.3	-0.9%
2015	1,275,915	12,261,460	9.6	3.4%

N/A: Not Applicable

The continued increase in the average number of claims per enrollee shows that, as physician reimbursement rates increased in FY03, and subsequently during the FY06 to FY09 period, Medicaid enrollees' utilization of physician services increased steadily, from an average of 6.3 claims per enrollee in FY02 to an average of 9.6 claims per enrollee in FY15. This is a 52 percent increase in utilization of physician services by Medicaid enrollees, which is a proxy for increase in the participation of physicians in the Maryland Medicaid program and may be interpreted as an increase in the access of Medicaid enrollees to physician services. The average number of claims per enrollee has fluctuated between 9.3 and 9.6 since FY10.

Comparison of Access to Medical Care for Medicaid and Private Coverage

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

The GAO found that:

> Beneficiaries covered by Medicaid for a full year reported low rates of difficulty obtaining necessary medical care and prescription medicine, similar to those with private

> insurance coverage for a full year. In calendar years 2008 and 2009, approximately 3.7 percent of Medicaid beneficiaries enrolled for a full year and 3 percent of individuals enrolled in private insurance for a full year reported difficulties obtaining needed medical care; the difference between these two groups was not statistically significant. In addition, 2.7 percent of full-year Medicaid beneficiaries reported difficulty obtaining needed prescription medicines and about 2.4 percent of individuals with full-year private insurance reported the same issue—also not statistically significant (United States Government Accountability Office, November 2012).

However, 5.4 percent of full-year Medicaid beneficiaries, compared with 3.7 percent with full year private insurance coverage, reported experiencing difficulty obtaining necessary dental care. (United States Government Accountability Office, November 2012).

A study in the Journal of General Internal Medicine, using descriptive and multivariate analysis of Medical Expenditure Panel Survey data from 2005–2008, indicates that Medicaid actually does a better job of providing access to affordable health care coverage than either private coverage or Medicare. Given the fact that more than one-third of low-income adults nationally were underinsured, the results of this study show the importance of safety net programs such as Medicaid. Magge, Cabral, Kazis, and Sommers indicate that, in a comparison of different insurance groups, Medicaid beneficiaries were less likely to be underinsured than privately insured adults (2013).

VIII. Plan for the Future

The Department remains dedicated to ensuring physicians are reimbursed equitably for their services. The provision of the Affordable Care Act requiring parity of reimbursement rates for evaluation and management services and vaccine administration procedures with the rates paid by Medicare expired at the end of the 2014.

Although Maryland Medicaid reimbursement rates for evaluation and management services have decreased compared to the Medicare rates, the state has allocated funds to maintain them at 94 percent of Medicare reimbursement rates. Furthermore, the Department will continue to monitor provider network adequacy to ensure that patient access to care is not compromised.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate formula that was used for annual update of Medicare physician fees under the resource-based relative value scale system. Furthermore, MACRA will replace Medicare's multiple quality of care reporting programs with a Merit-Based Incentive Payment System program that rewards physicians for providing high-quality, high-value health care; and for participating in new payment and delivery models to improve the efficiency of care while preserving the fee-for-service system. Beginning in 2019, MACRA will provide bonuses for physicians who score well in the Merit-Based Incentive Payment System quality reporting program (American Medical Association, May 2015). The Department strongly supports federal efforts to enhance the payment system and will be monitoring them closely.

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 methodology relates payments to the resources and skills that physicians use to provide services. There are three components that determine the relative weight of each procedure: physician work, practice expense, and malpractice expense. A geographic cost index and conversion factor are used to convert the weights to fees.

For approximately 10,000 physician procedures, the Centers for Medicare & Medicaid Services (CMS) determines the associated relative value units and various payment policy indicators needed for payment adjustment. The relative value unit weights reflect the resource requirements of each procedure performed by physicians. Medicare fees are adjusted depending on the site in which each procedure is performed. For example, Medicare fees for some procedures are lower if they are performed in facilities (e.g., hospitals and skilled nursing facilities) than if they are performed in non-facilities (e.g., offices), where physicians must pay for practice expenses. The implementation of the resource-based relative value scale in 1992 resulted in increased payments for office-based (non-facility) procedures and reduced payments for hospital-based procedures.

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 relative value unit (i.e., physician work, practice expense, and malpractice expense). Each locality's GPCIs are used to calculate fees by multiplying the relative value unit 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.

Previously, CMS updated the conversion factor based on the sustainable growth rate system, which tied the updates to growth in the national economy. The "Medicare Access and CHIP Reauthorization Act of 2015" (MACRA) repealed the sustainable growth rate formula. According to MACRA, the annual update of the conversion factor for physician fee schedule will be 0.5 percent for July 2015 through 2019; and 0 percent for 2020 through 2025. MACRA requires use of two separate conversion factors for each year beginning with 2026: one for services provided by physicians participating in an alternative payment model (APM conversion factor), and another one for services provided by other physicians. The annual update for 2026 and subsequent years will be 0.75 percent for physicians who participate in the alternative payment model and 0.25 percent for all others physicians.

Payment for Anesthesia Procedures

Prior to December 1, 2003, the Maryland Medicaid program reimbursed anesthesia services based on a percentage of the surgical fee. The program in general did not use the anesthesia CPT codes, but rather the surgical CPT codes with a modifier. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that national standard code sets be used. In late

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

Medicare payments for anesthesia services represent a departure from the resource-based relative value scale methodology. Medicare's methodology recognizes anesthesia time as the key element for determining the payment rate. The anesthesia time for any additional procedures performed during the same operative session is added to the time for the primary procedure. This time is then converted to units, with 15 minutes equal to 1 unit.

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

Appendix B: Number of Physicians and Dentists in Each State, and per 10,000 Population in 2014

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

Annual Estimates of the Resident Population for the United States in 2014 are from the Census Bureau, US Department of Commerce:
https://www.census.gov/popest/data/state/totals/2014/

Table B.1. Number of Physicians by State in 2015, Ranked by Number per 10,000 Population

Rank	Geographic Area	Primary Care Physicians	Specialist Physicians	Total Physicians	Active Physicians Per 10,000
	United States	434,840	473,668	908,508	28.3
1	District of Columbia	2,785	3,601	6,386	95.0
2	Massachusetts	14,239	17,891	32,130	47.3
3	Rhode Island	2,178	2,313	4,491	42.5
4	New York	36,128	43,674	79,802	40.3
5	Connecticut	6,235	7,800	14,035	39.1
6	**Maryland**	**10,079**	**12,123**	**22,202**	**37.0**
7	Pennsylvania	21,627	24,074	45,701	35.7
8	Michigan	16,683	18,332	35,015	35.3
9	Vermont	1,041	1,077	2,118	33.8
10	Ohio	17,649	20,440	38,089	32.8
11	Maine	2,229	2,077	4,306	32.4
12	New Jersey	13,471	14,355	27,826	31.1
13	Illinois	19,912	19,497	39,409	30.6
14	Minnesota	8,013	8,532	16,545	30.1
15	Delaware	1,367	1,472	2,839	30.0
16	Missouri	8,528	9,601	18,129	29.8
17	New Hampshire	1,886	2,073	3,959	29.8
18	Washington	9,784	10,186	19,970	27.9
19	West Virginia	2,603	2,531	5,134	27.8
20	Wisconsin	7,676	8,343	16,019	27.8
21	Oregon	5,437	5,613	11,050	27.4
22	Tennessee	8,334	9,418	17,752	26.9
23	Louisiana	5,668	6,651	12,319	26.4
24	California	49,164	52,815	101,979	26.1
25	Hawaii	1,791	1,866	3,657	25.5
26	Virginia	10,629	10,724	21,353	25.5
27	Florida	24,772	26,299	51,071	25.2
28	North Carolina	12,064	13,111	25,175	25.1
29	Nebraska	2,421	2,325	4,746	25.0
30	Colorado	6,694	6,856	13,550	24.8

Table B.1. Number of Physicians by State in 2015, Ranked by Number per 10,000 Population (Continued)

Rank	Geographic Area	Primary Care Physicians	Specialist Physicians	Total Physicians	Active Physicians Per 10,000
31	New Mexico	2,652	2,508	5,160	24.8
32	Kansas	3,742	3,441	7,183	24.7
33	Kentucky	5,046	5,868	10,914	24.7
34	Iowa	3,964	3,616	7,580	24.3
35	Arizona	7,906	8,636	16,542	24.2
36	North Dakota	997	826	1,823	24.1
37	Indiana	7,657	8,080	15,737	23.8
38	South Carolina	5,792	5,793	11,585	23.7
39	Alaska	939	804	1,743	23.6
40	Alabama	5,372	5,776	11,148	22.9
41	Georgia	11,387	11,674	23,061	22.6
42	Oklahoma	4,374	4,364	8,738	22.3
43	Arkansas	3,209	3,324	6,533	21.9
44	South Dakota	968	891	1,859	21.7
45	Texas	28,113	30,221	58,334	21.2
46	Montana	1,066	1,084	2,150	20.8
47	Utah	2,735	3,354	6,089	20.3
48	Mississippi	2,951	3,041	5,992	20.0
49	Nevada	2,796	2,807	5,603	19.4
50	Wyoming	593	538	1,131	19.3
51	Idaho	1,494	1,352	2,846	17.2

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

Table B.2. Primary Care Physicians by Field, 2015

Geographic Area	Internal Medicine	Family Medicine/ General Practice	Pediatrics	Obstetrics and Gynecology	Geriatrics	Total Primary Care
United States	178,497	127,662	78,662	48,761	1,258	434,840
Alabama	2,108	1,708	932	616	8	5,372
Alaska	198	532	124	85	0	939
Arizona	3,106	2,526	1,330	900	44	7,906
Arkansas	803	1,557	555	285	9	3,209
California	20,119	13,938	9,491	5,503	113	49,164
Colorado	2,299	2,538	1,065	774	18	6,694
Connecticut	3,432	715	1,207	874	7	6,235
Delaware	469	360	383	152	3	1,367
District of Columbia	1,393	316	731	338	7	2,785
Florida	10,293	7,554	4,302	2,531	92	24,772
Georgia	4,489	3,118	2,238	1,521	21	11,387
Hawaii	752	468	313	256	2	1,791
Idaho	354	834	153	150	3	1,494
Illinois	8,685	5,493	3,494	2,206	34	19,912
Indiana	2,479	3,161	1,166	831	20	7,657
Iowa	1,074	2,020	550	308	12	3,964
Kansas	1,073	1,673	611	378	7	3,742
Kentucky	1,799	1,752	882	600	13	5,046
Louisiana	2,199	1,607	1,090	765	7	5,668
Maine	749	967	304	192	17	2,229
Maryland	**5,221**	**1,633**	**2,021**	**1,175**	**29**	**10,079**
Massachusetts	8,271	1,803	2,864	1,276	25	14,239
Michigan	6,785	5,472	2,323	2,050	53	16,683
Minnesota	2,942	3,260	1,082	708	21	8,013

Table B.2. Primary Care Physicians by Field, 2015 (Continued)

Geographic Area	Internal Medicine	Family Medicine/ General Practice	Pediatrics	Obstetrics and Gynecology	Geriatrics	Total Primary Care
Mississippi	1,047	1,047	465	390	2	2,951
Missouri	3,433	2,547	1,549	961	38	8,528
Montana	307	534	106	117	2	1,066
Nebraska	710	1,093	399	218	1	2,421
Nevada	1,252	844	388	306	6	2,796
New Hampshire	806	561	312	202	5	1,886
New Jersey	6,438	2,464	2,914	1,598	57	13,471
New Mexico	896	1,017	480	256	3	2,652
New York	18,622	5,633	7,610	4,190	73	36,128
North Carolina	4,621	3,641	2,269	1,478	55	12,064
North Dakota	302	540	100	52	3	997
Ohio	7,143	4,997	3,514	1,915	80	17,649
Oklahoma	1,178	2,082	673	428	13	4,374
Oregon	2,273	1,850	728	570	16	5,437
Pennsylvania	9,309	6,469	3,387	2,324	138	21,627
Rhode Island	1,200	251	477	247	3	2,178
South Carolina	1,926	2,145	982	722	17	5,792
South Dakota	315	466	108	77	2	968
Tennessee	3,342	2,382	1,605	994	11	8,334
Texas	9,999	8,913	5,510	3,599	92	28,113
Utah	838	946	598	349	4	2,735
Vermont	390	342	204	104	1	1,041
Virginia	3,901	3,434	2,003	1,262	29	10,629
Washington	3,364	4,027	1,486	884	23	9,784
West Virginia	877	1,116	353	249	8	2,603
Wisconsin	2,777	2,980	1,176	732	11	7,676
Wyoming	139	336	55	63	0	593

Note: Physician data include all allopathic and osteopathic physicians.

Table B.3. Non-Primary Care Physicians by Specialty, 2015

Geographic Area	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology (Cancer)	Endocrinology, Diabetes, and Metabolism	All Other Specialties	Total
United States	50,862	48,691	46,453	47,065	44,615	29,649	17,257	6,995	182,081	473,668
Alabama	471	697	546	405	608	377	200	58	2,414	5,776
Alaska	105	78	75	120	64	35	12	6	309	804
Arizona	810	911	1,014	954	810	489	226	95	3,327	8,636
Arkansas	319	345	316	286	341	191	124	37	1,365	3,324
California	6,717	4,876	5,624	5,167	4,615	2,937	1,609	728	20,542	52,815
Colorado	758	650	825	843	589	324	208	92	2,567	6,856
Connecticut	1,141	733	644	684	746	562	281	192	2,817	7,800
Delaware	156	164	94	196	182	104	55	11	510	1,472
District of Columbia	520	373	256	288	266	254	161	73	1,410	3,601
Florida	2,066	2,617	2,625	2,505	2,522	1,976	954	376	10,658	26,299
Georgia	1,162	1,350	1,157	1,225	1,114	757	402	148	4,359	11,674
Hawaii	303	173	185	203	165	68	36	23	710	1,866
Idaho	105	151	111	164	199	48	27	10	537	1,352
Illinois	1,942	1,935	1,931	2,246	1,897	1,300	693	324	7,229	19,497
Indiana	627	812	1,133	833	818	532	304	123	2,898	8,080
Iowa	303	451	428	283	374	241	122	30	1,384	3,616
Kansas	418	423	356	248	323	197	113	38	1,325	3,441
Kentucky	544	714	585	600	525	353	176	65	2,306	5,868
Louisiana	569	736	544	670	554	435	215	84	2,844	6,651
Maine	310	259	203	276	184	119	63	15	648	2,077
Maryland	**1,589**	**1,130**	**1,069**	**850**	**1,011**	**731**	**571**	**228**	**4,944**	**12,123**
Massachusetts	2,639	1,684	1,634	1,455	1,840	1,364	963	412	5,900	17,891
Michigan	1,455	2,043	1,471	2,755	1,909	976	594	199	6,930	18,332
Minnesota	747	900	637	801	904	624	349	165	3,405	8,532

Table B.3. Non-Primary Care Physicians by Specialty, 2015 (Continued)

Geographic Area	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology (Cancer)	Endocrinology, Diabetes, and Metabolism	All Other Specialties	Total
Mississippi	259	362	281	320	291	178	103	40	1,207	3,041
Missouri	915	994	1,002	931	994	589	346	158	3,672	9,601
Montana	98	130	138	115	112	53	28	7	403	1,084
Nebraska	216	266	282	184	233	155	83	28	878	2,325
Nevada	253	274	353	344	256	170	75	34	1,048	2,807
New Hampshire	248	237	204	203	175	137	77	28	764	2,073
New Jersey	1,558	1,384	1,578	1,223	1,190	1,131	508	265	5,518	14,355
New Mexico	348	233	246	319	205	126	71	36	924	2,508
New York	6,344	3,877	3,874	3,549	3,701	2,783	1,779	750	17,017	43,674
North Carolina	1,443	1,362	1,031	1,429	1,241	847	520	179	5,059	13,111
North Dakota	116	120	71	67	95	35	29	10	283	826
Ohio	1,632	2,223	1,820	2,344	1,816	1,290	725	271	8,319	20,440
Oklahoma	397	451	480	502	409	223	133	37	1,732	4,364
Oregon	603	629	628	652	470	249	180	78	2,124	5,613
Pennsylvania	2,476	2,773	2,146	2,672	2,366	1,748	981	353	8,559	24,074
Rhode Island	249	264	121	320	197	153	113	50	846	2,313
South Carolina	659	750	524	595	530	320	168	77	2,170	5,793
South Dakota	94	115	65	49	103	53	27	8	377	891
Tennessee	730	1,120	832	733	943	587	399	130	3,944	9,418
Texas	2,743	3,257	3,492	2,684	2,871	1,905	1,175	410	11,684	30,221
Utah	271	288	412	382	307	159	86	30	1,419	3,354
Vermont	178	123	100	83	102	63	36	14	378	1,077
Virginia	1,226	1,091	980	1,159	1,084	636	321	192	4,035	10,724
Washington	973	966	1,159	1,021	1,054	485	444	117	3,967	10,186
West Virginia	232	306	195	292	240	133	81	40	1,012	2,531
Wisconsin	769	821	917	764	1,022	429	303	117	3,201	8,343
Wyoming	56	70	59	72	48	18	8	4	203	538

Table B.4. Number of Dentists by State in 2015, Ranked by Number per 10,000 Population

Rank	Geographic Area	Total Dentists	Dentists Per 10,000 Population
	United States	210,030	6.5
1	District of Columbia	739	11.0
2	Massachusetts	6,301	9.3
3	New Jersey	7,772	8.7
4	California	33,247	8.5
5	New York	16,336	8.3
6	Alaska	605	8.2
7	Connecticut	2,922	8.1
8	**Maryland**	**4,764**	**7.9**
9	Hawaii	1,129	7.9
10	Washington	5,541	7.7
11	Colorado	4,059	7.4
12	Illinois	9,127	7.1
13	Nebraska	1,309	6.9
14	Pennsylvania	8,758	6.8
15	Virginia	5,720	6.8
16	New Hampshire	883	6.6
17	Utah	1,941	6.5
18	Michigan	6,358	6.4
19	Montana	657	6.4
20	Minnesota	3,458	6.3
21	Kentucky	2,723	6.2
22	Arizona	4,003	5.9
23	Wisconsin	3,380	5.9
24	North Dakota	431	5.7
25	Florida	11,487	5.7
26	Iowa	1,749	5.6
27	Nevada	1,612	5.6
28	Ohio	6,460	5.6
29	Wyoming	323	5.5
30	Rhode Island	580	5.5
31	Texas	15,050	5.5
32	Tennessee	3,573	5.4
33	Kansas	1,576	5.4
34	New Mexico	1,128	5.4
35	South Dakota	460	5.4
36	Maine	708	5.3

Table B.4. Number of Dentists by State in 2015,
Ranked by Number per 10,000 Population (Continued)

Rank	Geographic Area	Total Dentists	Dentists Per 10,000 Population
37	North Carolina	5,319	5.3
38	West Virginia	966	5.2
39	Oklahoma	2,034	5.2
40	Missouri	3,138	5.2
41	South Carolina	2,517	5.1
42	Louisiana	2,377	5.1
43	Indiana	3,342	5.0
44	Idaho	835	5.0
45	Georgia	5,088	5.0
46	Vermont	302	4.8
47	Oregon	1,904	4.7
48	Delaware	446	4.7
49	Alabama	2,290	4.7
50	Mississippi	1,333	4.5
51	Arkansas	1,270	4.3

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

Note: Data include all professionally-active dentists. Source: Census, 2015 and Kaiser Family Foundation web-sites: http://kff.org/other/state-indicator/total-dentists/#

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