



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 26, 2014

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

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

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

Dear Chairmen Middleton and Hammen:

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

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

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

Sincerely,

Joshua M. Sharfstein, M.D.  
Secretary

Enclosure

cc: Chuck Lehman  
Tricia Roddy  
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Susan Tucker  
Allison Taylor  
Sarah Albert, MSAR #7893



**Report on the Maryland Medical Assistance Program and the  
Maryland Children’s Health Program – Reimbursement Rates  
January 2015**

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# **Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates January 2015**

## **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 (FFS) reimbursement rates for Maryland Medicaid and the Maryland Children's Health Program (MCHP) (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 (ADA) 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.<sup>1</sup>

The law also directed the Department to submit an annual report to the Governor and various 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 FFS 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 FFS rates for the same services paid to providers under the Maryland Medical Assistance program and within managed care organizations (MCOs). On or before January 1 of every year, the Department must report this information and determine whether the FFS rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule. This report satisfies these requirements.

## **II. Background**

In September 2001, in response to 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

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<sup>1</sup>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.

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

The Department’s first annual report showed that Maryland Medicaid’s reimbursement rates in 2001 were, on average, approximately 36 percent of Medicare rates. 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 (E&M) 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 FFS physician reimbursement rates and capitation payments to MCOs to enable these organizations to raise their physician fees.<sup>2</sup> 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 MCOs 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)**

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

Finally, SB 836 requires the Department to consult with the MCOs, the Maryland Hospital Association, the Maryland State Medical Society (MedChi), the Maryland Chapter of the American Academy of Pediatrics, the Maryland Chapter of the American College of Emergency Physicians, the Maryland State Dental Association, and the Maryland Dental Society to

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<sup>2</sup> 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.

determine the new payment rates each year. These organizations are collectively referred to as stakeholders in this report.

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 between 2006 and 2008. However, updates in relative value units (RVUs) led to decreases in Medicare fees for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for 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 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. *To this day, the Department continues to compare the Medicaid fee schedule with Medicare fees and reduces any Medicaid fees that exceed their corresponding Medicare facility or non-facility fees to the Medicare fee levels.*

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)**

<b>Fiscal Year</b>	<b>Procedure Code Group</b>	<b>Percent of Medicare Fees at Time of Fee Increase</b>
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 FY14*****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. Of the \$11.5 million total funds reduction in payments, about \$3.0 million was from fee-for-service payments and approximately \$8.5 million was from the reduction of HealthChoice MCOs' payments for physician services. 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 RVUs for procedures, which results in fee *increases* for some procedures and fee *decreases* for other procedures. The Department compared the Maryland Medicaid fee for each procedure with its corresponding Medicare fee and then reduced fees for procedures that exceeded Medicare fees to the Medicare fee levels. 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 (ACA), the federal government will pay for increasing Medicaid payment rates in FFS and MCOs for E&M and vaccine administration procedures provided by primary care physicians (PCPs) to 100 percent of the Medicare payment rates for calendar years (CYs) 2013 and 2014. For services provided between January 1, 2013, and December 31, 2014, states will receive 100 percent federal financing for increasing payment rates for physicians who self-attest that they are PCPs.

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

In the first quarters of CY13 and CY14, CMS released the corresponding average Medicare fees for 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 ACA, Medicaid fees that were effective on July 1, 2009, were used to estimate the costs of increasing PCP 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 must pay for increasing fees to their July 1, 2009 levels at the regular FMAP rate.

**Federal Share of Fee Increase for PCPs**

According to CMS, the federal government will provide 100 percent FFP only for physicians who self-attest that they are PCPs.<sup>3</sup> The Department has obtained self-attestations from approximately 3,600 physicians. Claims and encounter data from these physicians were identified, and payments for their 2013 E&M and vaccine administration procedures were projected. Then payments for these procedures for all physicians in CY13 and CY14 were estimated.

According to a CMS Technical Guide , base year utilization data for E&M and vaccine administration procedures and the trend factors (i.e., between the base years and implementation years) that were used for MCO 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)**

<b>Year</b>	<b>Increase in FFS Payments</b>	<b>Increase in MCO Payments</b>	<b>Total Increase in Payments</b>
<b>CY 2013</b>	<b>\$23.7</b>	<b>\$155.5</b>	<b>\$179.2</b>
<b>CY 2014</b>	<b>\$21.6</b>	<b>\$165.6</b>	<b>\$187.2</b>

CMS updated the practice expense RVUs for 2014 resulting in a decrease from the 2013 Medicare fees for E&M procedures. The decrease in estimated FFS payments in 2014 compared with 2013 in part reflects the decrease in 2014 fees. Enrollment growth due to the ACA Medicaid expansion resulted in an increase in the estimated payments to MCOs in 2014.

For the FFS system, actual claims data for services provided in 2013 and 2014 by self-attesting PCPs will be submitted to CMS to claim the 100 percent FFP. The estimated payments to MCOs shown in Table 3 were multiplied by the corresponding percentages pertaining to self-attesting

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<sup>3</sup> The federal statute specifies that higher payment applies to primary care services delivered by physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine.

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

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

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

The pertinent numbers in Tables 3 and 4 correspond to payments for MCOs, as federal payments for FFS will be based on actual claims in CY13 and CY14. Because claims and encounter data for self-attesting PCPs 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 PCPs is 36.3 percent of the total cost of the fee increase for these procedures.

To determine the portion of the MCOs' costs of the fee increase that is subject to 100 percent FFP, the estimated additional payments to MCOs (in Table 3) was multiplied by 37.2 percent. Table 5 shows the Department's estimated cost of fee increases for E&M and vaccine administration procedures in CY13 and CY14 that are subject to 100 percent federal financing.

**Table 5. Estimated Cost of Fee Increases for PCPs Subject to 100% FMAP (Million Dollars)<sup>4</sup>**

	<b>FFS</b>	<b>MCOs</b>	<b>Total</b>
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 percent FMAP for MCHP, the combined total amount of \$221.6 million was allocated to maintaining prior fee increases and increasing provider reimbursement rates. The amount of

<sup>4</sup> 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.

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 MCHP 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.

***Caveat:***

For physician services provided to dually eligible beneficiaries, Medicare pays physicians 80 percent of its reimbursement rate and Medicaid pays the remaining portion up to the Medicaid rate. There are three different Medicare fees in Maryland, based on the geographic location of physicians. The statewide average Medicaid fees are higher than Medicare fees in some counties and lower than Medicare fees for the Maryland suburbs of Washington, D.C. (Montgomery and Prince George's counties). In areas where the statewide average Medicaid reimbursement rates are higher than Medicare rates, the Medicaid copayment is 20 percent of Medicare rates, which is slightly less than 20 percent of the Medicaid reimbursement rate. In the Maryland suburbs of Washington, D.C., with higher Medicare rates, the copayment is 20 percent of Medicaid rates. Therefore, for Tables 3 through 5, it was assumed that the Medicaid costs of fee increases for dually eligible beneficiaries were 20 percent of the current Medicaid fees for each procedure.

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

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

Table 6 compares Maryland's FY14 Medicaid fees with the corresponding Medicare 2014 reimbursement rates for Baltimore region, and neighboring states' Medicaid fees for a sample of approximately 270 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; as such, these fees are compared with the corresponding Medicare facility and non-facility fees. 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, D.C.,<sup>5</sup> have separate facility and non-facility fees for some procedures, but they did not report facility fees for many of the procedures that are included in Table 6. Therefore, the table only compares Virginia and Washington, D.C., Medicaid's non-facility fees 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, D.C.

### ***Comparisons of E&M and Specialty Procedures***

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

#### **E&M Procedures**

As an average percentage of Medicare 2014 fees for Baltimore region, E&M facility and non-facility fees in Maryland are highest in the region. Virginia non-facility fees rank third; Pennsylvania fees rank fourth; Delaware fees rank fifth; Washington, D. C., fees rank sixth; and West Virginia facility fees and non-facility fees rank seventh and eighth, respectively.

All states and the District of Columbia were required by the ACA to increase fees for their E&M and vaccine administration procedures to their corresponding Medicare fees in 2013 and 2014. Therefore, Maryland established its fees for E&M and vaccine administration procedures as equal to their corresponding Medicare fees. The 2014 benchmark Medicare reimbursement rates were provided by CMS and represent the average of Medicare fees in Maryland counties, using Medicare's 2009 conversion factor, as required by the law.

#### **Surgery**

##### **Integumentary Procedures**

In addition to the integumentary<sup>6</sup> procedures included in last year's report, the following three high volume procedures were added: 10061 (drainage of skin abscess), 11056 (trim 2 to 4 skin lesions), and 11100 (biopsy of single skin lesion).

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<sup>5</sup> Washington, D.C., has very recently implemented site-of-service fee differentials for some procedures and was changing its fees at the time of this writing. Therefore, the fees included in this report are accurate as of September 2014.

<sup>6</sup> Integumentary procedures are related to the skin.

Adding these new procedures did not alter the state ranking order from last year: Delaware fees still rank first, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), Maryland facility fees (fourth), Maryland non-facility fees (fifth), West Virginia facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth).

### **Musculoskeletal System Procedures**

In addition to the musculoskeletal procedures in last year's report, the following two new high-volume procedures were added: 20553 (injections; single or multiple trigger points, 3 or more muscles) and 29540 (strapping of ankle and/or foot).

Similar to integumentary procedures, adding the fees for the two new procedures did not change the state ranking order from last year. Delaware fees for musculoskeletal system procedures still are the highest in the region. Maryland non-facility fees rank second; Maryland facility fees rank third; Washington, D.C., fees rank fourth; Virginia non-facility fees rank fifth; West Virginia facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank last. Washington D.C., data include one missing fee for procedure code 20552 (injection trigger point, 1 or 2 muscles), and Pennsylvania data are missing a value for procedure code 29130 (Application of finger splint).

### **Respiratory Procedures**

Two high-volume respiratory procedures were added for this report: 31237 (nasal/sinus endoscopy surgery) and 32551 (insertion of chest tube).

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

### **Cardiovascular Surgical Procedures**

Two new high-volume cardiovascular surgical procedures were added this year: 36558 (insert tunneled central venous catheter *without* port, > 5 years) and 36561 (insert tunneled central venous catheter *with* port, > 5 years).

Similar to last year's ranking order, Washington, D.C., has the highest fees for cardiovascular surgical procedures. Virginia non-facility fees rank second; Maryland non-facility fees rank third; West Virginia facility fees rank fourth; Maryland 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, the state's percentage of Medicare fees is lower than it would have been if fees for these procedures were included.

### **Hemic, Lymphatic, and Mediastinum Procedures**

For hemic, lymphatic, and mediastinum procedures, the following three high-volume procedures were added: 38500 (biopsy/removal lymph nodes), 38505 (needle biopsy lymph nodes), and 38900 (intra-operative identification of sentinel lymph nodes).

Adding the new procedures did not change the state ranking order from last year. Delaware has the highest fees for hemic, lymphatic, and mediastinum procedures in the region followed by Washington, D.C., fees (second), Virginia non-facility fees (third), Maryland non-facility fees (fourth), West Virginia facility fees (fifth), Maryland facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth). Pennsylvania data have missing fees for procedure 38792 (identify sentinel node).

### **Digestive Procedures**

For selected digestive system procedures, similar to last year's report, Delaware fees rank the highest, followed by Washington, D.C., fees (second), Virginia non-facility fees (third), Maryland facility fees (fourth), West Virginia facility fees (fifth), Maryland non-facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth).

### **Urinary and Male Genital Procedures**

For urinary and male genital procedures, the following three high-volume procedures were added: 51700 (irrigation of bladder), 51741 (electro-uroflowmetry), 52332 (cystoscopy and treatment), and 54161 (circumcision 28 days or older).

Washington, D.C., fees for urinary and male genital procedures 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**

The following two high-volume gynecology and obstetrics procedures were added: 58100 (biopsy of uterus lining) and 58301 (remove intrauterine device).

Similar to last year's report, Pennsylvania has the highest fees for the selected gynecology and obstetrics procedures; although its data have missing values for procedure 59430 (care after delivery). Following Pennsylvania, in ranking order, are: West Virginia facility fees (second), Maryland non-facility fees (third), Maryland facility fees (fourth), West Virginia non-facility fees (fifth), Delaware fees (sixth), Washington, D.C., fees (seventh), and Virginia non-facility fees (eighth).

### **Endocrine System Procedures**

The following two high-volume endocrinology procedures were added: 60220 (partial removal of thyroid) and 60500 (explore parathyroid glands).

For the selected endocrine system procedures, similar to last year's report ranking, Delaware fees rank the highest. Washington, D.C., fees rank second; Virginia non-facility fees rank third; West Virginia facility fees rank fourth; West Virginia non-facility fees rank fifth; Maryland non-facility fees rank sixth; Maryland facility fees rank seventh; and Pennsylvania fees rank eighth.

### **Nervous System Procedures**

For nervous system procedures, code 61614 is no longer used, and the following three high-volume procedures were added: 64484 (injection(s), anesthetic agent/steroid, transforaminal epidural), 64494 (injection(s), diagnostic or therapeutic agent, paravertebral facet), and 64495 (injection(s), diagnostic or therapeutic agent, paravertebral facet, third and any additional level(s)).

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

### **Eye Surgery Procedures**

The following four high-volume eye surgery procedures were added: 65222 (remove foreign body from eye), 66821 (after cataract laser surgery), 66982 (cataract surgery complex), and 67800 (remove eyelid lesion).

Delaware fees for eye surgery procedures still rank first; Washington, D.C., fees rank second; Virginia non-facility fees rank third; Maryland non-facility fees rank fourth; Pennsylvania 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**

The following three high-volume ear surgery procedures were added: 69205 (clear outer ear canal), 69401 (inflate middle ear canal), and 69424 (remove ventilating tube).

Washington, D.C., 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 69401 (inflate middle ear canal), which reduce their percentage of Medicare fees.

### **Radiology Procedures**

The following seven high-volume procedures were added: 74177 (CT abdomen and pelvis, with contrast), 76816 (ultrasound, uterus, follow-up per fetus), 76817 (transvaginal ultrasound, pregnant uterus), 76819 (fetal biophysical profile, without non-stress testing), 76820 (umbilical artery echo), 76830 (transvaginal ultrasound), and 76856 (ultrasound exam, pelvic, complete).

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

## **Medicine**

### **Psychiatry Procedures**

For psychiatry procedures, high-volume procedure 90833 was added (psychotherapy, 30 minutes with patient and/or family member).

Last year's report indicated that there were major changes<sup>7</sup> to the codes in the Psychiatry section of the AMA's Current Procedural Terminology. Procedure 90801 is now divided into procedures 90791 and 90792. Procedure code 90791 is used for a psychiatric diagnostic evaluation. CPT code 90792 is used when additional medical services, such as physical examination and prescription of pharmaceuticals, are provided in addition to the diagnostic evaluation. The psychotherapy codes 90832, 90834, and 90837 replace codes 90804, 90805, and 90806, respectively.

For selected psychiatry procedures, Delaware fees rank first in the region; Maryland facility fees rank second; Maryland non-facility fees rank third; Virginia non-facility fees rank fourth; Washington, D.C. fees rank fifth; West Virginia facility and non-facility fees rank sixth and seventh, respectively. Pennsylvania fees rank last. Pennsylvania data have a missing value for procedure code 90833, which reduced its percentage of Medicare fees.

### **Dialysis Procedures**

Four high-volume procedures were added: 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+).

Delaware fees for dialysis procedures are highest in the region, followed, in ranking order, by Virginia non-facility, Washington, D.C., Pennsylvania, West Virginia, and Maryland fees. Pennsylvania data have missing fees for four newly added procedures.

### **Gastroenterology Procedures**

The following high-volume gastroenterology procedures were added: 91038 (esophageal function test, gastroesophageal reflux test with recording, analysis and interpretation, 1 hour+), 91065 (breath hydrogen/methane test), and 91122 (anal pressure record).

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<sup>7</sup> Current Procedural Terminology (CPT) code changes for 2013:  
<http://www.psychiatry.org/practice/managing-a-practice/cpt-changes-2013>

Similar to last year, Delaware's gastroenterology fees are highest in the region, followed, in ranking order, by Washington, D.C., Virginia, Maryland, West Virginia, and Pennsylvania fees. Pennsylvania data have missing fees for procedure code 91100 (GI tract capsule endoscopy).

### **Ophthalmology and Vision Care Procedures**

The following high-volume ophthalmology and vision care procedures were added: 92083 (visual field examination) and 92250 (eye exam with photos).

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

Pennsylvania data were missing fees for procedure codes 92083, 92250, and 92060.

### **Otorhinolaryngology Procedures**

For Ear, Nose, and Throat (ENT), or otorhinolaryngology procedures, three high-volume procedure codes were added: 92504 (ear microscopy examination), 92546 (sinusoidal rotational test), and 92547 (supplemental electrical test).

Similar to last year's report, Delaware fees are the highest for the selected ENT procedures in the region. Washington, D.C., fees rank second; Maryland facility and non-facility fees rank third and fourth, respectively; Virginia non-facility fees rank fifth; Pennsylvania fees rank sixth; and West Virginia facility and non-facility fees rank seventh and eighth, respectively.

Although Pennsylvania did not report a fee for one of the newly added procedures (92504), its percentage of Medicare fees is still higher than West Virginia facility and non-facility fees.

### **Cardiovascular Medicine Procedures**

The following three high-volume cardiovascular medicine procedures were added: 93015 (cardiovascular stress test, with supervision, interpretation and report), 93018 (cardiovascular stress test, only with interpretation and report), and 93306 (echocardiography, trans-thoracic, real-time with image documentation).

For the selected cardiovascular medicine procedures, Delaware fees rank first, followed in ranking order by Washington, D.C., Maryland, Virginia, Pennsylvania, and West Virginia fees. Pennsylvania data have missing fees for procedure code 93325 (Doppler color flow add-on).

### **Noninvasive Vascular Diagnostic Studies**

For noninvasive vascular diagnostic studies procedures, the following two high-volume procedures were added: 93922 (noninvasive physiologic studies of upper or lower extremity arteries) and 93975 (vascular study).

For the selected procedures, Delaware fees rank first, followed in ranking order by Washington, D.C. fees, Virginia non-facility fees, Maryland fees, Pennsylvania fees, and West Virginia 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, D.C., 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, similar to last year's report, Maryland facility fees rank first; Maryland non-facility fees rank second; Delaware fees rank third; Washington, D.C., fees rank fourth; Virginia non-facility fees rank fifth; West Virginia facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank eighth.

### **Neurology and Neuromuscular Procedures**

For neurology and neuromuscular procedures, the following high-volume procedures were added: 95810 (polysomnography, sleep staging with 4 or more additional parameters of sleep), 95886 (needle electromyography, each extremity, with nerve conduction), 95930 (visual evoked potential test), and 95951 (monitoring cerebral seizure, EEG monitoring, video recording, and interpretation).

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

### **Central Nervous System Assessment Tests**

For central nervous system (CNS) assessment procedures, the following three high-volume procedures were added: 96102 (psychological testing by technician), 96116 (neurobehavioral status exam), and 96118 (neuropsychological testing per hour of the psychologist's or physician's time).

For the selected CNS assessment procedures, similar to last year's ranking, Washington, D.C., fees rank first; Maryland facility and non-facility fees rank second and third; Virginia non-facility fees rank fourth; West Virginia facility fees rank fifth; West Virginia non-facility fees rank sixth; Pennsylvania fees rank seventh; and Delaware fees rank eighth.

Because Delaware's fee schedule lists \$0 for procedures 96102, 96111, and 96116, its ranking as a percentage of Medicare fees in Maryland is the lowest. Similarly, Pennsylvania's fees for the newly added procedure codes 96102 and 96118 are not available.

### **Chemotherapy Administration**

For chemotherapy administration procedures, Delaware fees rank first, followed by Maryland non-facility fees (second), Washington, D.C., 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 (eight).

### **Special Dermatological Procedures**

The following three high-volume dermatology procedures were added: 96920 (laser treatment for skin disease [psoriasis]; total area less than 250 sq cm), 96921 (laser treatment for skin disease; 250-500 sq cm), and 96922 (laser treatment for skin disease; over 500 sq cm).

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

Because Pennsylvanian and Washington, D.C., data have missing values for three newly added, surveyed procedures (96920, 96921, and 96922), their percentages of Medicare fees are lower than they would have been if these fees were included.

### **Physical Medicine and Rehabilitation Procedures**

Delaware fees rank highest for physical medicine and rehabilitation procedures followed in ranking order by Washington, D.C., Virginia, Maryland, West Virginia, and Pennsylvania fees.

### **Osteopathy, Chiropractic, and Other Medicine Procedures**

For the selected osteopathy, chiropractic, and other medicine procedures, Virginia non-facility fees are highest, followed in ranking order by Pennsylvania fees, Delaware fees, Washington D.C., fees, Maryland facility and non-facility fees, and West Virginia non-facility and facility fees.

Pennsylvania's fee schedule for two procedure codes, 98941 (chiropractic manipulation) and 99144 (moderate sedation by same physician, first 30 minutes, age 5 years or older) were not available. Also, Washington, D.C., data have a missing fee for 99144 (chiropractic manipulation). Interestingly, Virginia's non-facility fee for procedure code 99173 (visual acuity screening) is nearly 21 times the Medicare fee for this procedure.

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV F	PA	DC
	<b>1-Evaluation &amp; Management</b>										
99203	Office/outpatient visit, new	115	81	114	80	108	83	74	55	106	98
99204	Office/outpatient visit, new	177	139	174	137	166	128	115	94	163	149
99212	Office/outpatient visit, est	47	27	46	26	44	34	29	18	42	40
99213	Office/outpatient visit, est	78	54	77	54	73	56	50	37	71	66
99214	Office/outpatient visit, est	115	83	113	82	108	83	74	56	106	97
99223	Initial hospital care	N/A	215	N/A	212	203	157	N/A	145	203	180
99232	Subsequent hospital care	N/A	76	N/A	75	72	56	N/A	51	72	64
99238	Hospital discharge day	N/A	77	N/A	76	72	56	N/A	51	72	N/A
99244	Office consultation	197	165	194	163	0	143	129	112	183	166
99283	Emergency dept visit	N/A	65	N/A	64	61	44	N/A	45	62	54
99284	Emergency dept visit	N/A	124	N/A	122	117	83	N/A	86	118	103
99285	Emergency dept visit	N/A	182	N/A	180	172	122	N/A	126	174	151
99291	Critical care, first hour	291	236	287	233	274	212	192	161	271	245
99308	Nursing fac care, subseq	73	73	72	72	69	53	48	48	68	61
99381	Init pm e/m, new pat, inf	118	82	117	81	111	81	76	56	109	100
99391	Per pm reeval, est pat, inf	106	75	105	74	100	73	68	51	98	90
99392	Prev visit, est, age 1-4	114	82	112	81	107	78	73	56	104	96
99393	Prev visit, est, age 5-11	113	82	112	81	106	78	73	56	104	96
99394	Prev visit, est, age 12-17	124	92	122	91	116	85	80	63	114	105
99469	Neonate crit care, subsq	N/A	417	N/A	413	395	306	N/A	283	395	347
99472	Ped critical care, subsq	N/A	424	N/A	419	401	311	N/A	288	401	353
99479	Ic lbw inf 1500-2500 g subsq	N/A	132	N/A	130	124	97	N/A	90	125	110
<b>Weighted Average % of Medicare Fees</b>				99%	99%	91%	96%	64%	68%	92%	85%
<b>Ranking</b>				2	1	5	3	8	7	4	6

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

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>2-Integumentary and General Surgery</b>										
10060	Drainage of skin abscess	125	104	74	66	117	101	78	66	24	107
10061	Drainage of skin abscess	222	194	131	117	207	179	141	125	53	188
11042	Debride skin/tissue	126	67	54	35	118	101	78	44	33	108
11056	Trim skin lesions 2 to 4	63	24	40	24	59	50	39	17	30	54
11100	Biopsy skin lesion	111	53	67	34	103	88	68	35	35	95
11721	Debride nail, 6 or more	48	27	31	21	45	39	31	18	20	41
12001	Repair superficial wound(s)	97	49	102	58	90	78	60	33	25	83
12011	Repair superficial wound(s)	119	61	113	69	110	95	74	42	32	101
17110	Destruct b9 lesion, 1-14	118	75	70	43	110	94	71	47	49	102
17250	Chemical cautery, tissue	86	41	54	26	80	69	52	26	26	74
<b>Weighted Average % of Medicare Fees</b>				67%	71%	146%	80%	62%	65%	29%	86%
<b>Ranking</b>				5	4	1	3	7	6	8	2

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

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>3-Musculoskeletal System</b>										
20550	Inj tendon sheath/ligament	63	45	56	39	59	51	40	30	32	54
20552	Inj trigger point, 1/2 muscl	60	41	50	33	56	48	38	28	31	N/A
20553	Inject trigger points 3/>	69	47	55	37	65	56	44	31	34	59
20610	Drain/inject, joint/bursa	65	50	72	48	61	53	42	34	24	55
25600	Treat fracture radius/ulna	358	339	259	232	332	286	221	210	115	307
29075	Application of forearm cast	95	68	80	58	88	76	59	44	46	81
29125	Apply forearm splint	71	43	61	39	66	57	43	28	26	61
29130	Application of finger splint	45	31	37	27	42	36	29	21	N/A	38
29515	Application lower leg splint	79	55	65	47	73	63	49	36	35	67
29540	Strapping of ankle and/or ft	40	28	35	25	38	32	25	18	20	34
<b>Weighted Average % of Medicare Fees</b>				90%	85%	93%	80%	63%	65%	38%	81%
<b>Ranking</b>				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.*

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV F	PA	DC
	<b>4-Respiratory</b>										
30300	Remove nasal foreign body	257	140	161	88	238	204	151	85	23	222
31231	Nasal endoscopy, dx	230	70	134	57	214	183	136	47	59	199
31237	Nasal/sinus endoscopy surg	283	177	232	136	264	227	176	117	160	242
31500	Insert emergency airway	120	120	77	77	112	98	84	84	72	99
31575	Diagnostic laryngoscopy	125	83	83	57	116	100	77	54	69	107
31622	Dx bronchoscope/wash	341	160	236	108	150	273	210	109	134	292
31624	Dx bronchoscope/lavage	339	161	241	108	151	272	208	109	135	290
32551	Insertion of chest tube	196	196	128	128	180	159	135	135	133	162
<b>Weighted Average % of Medicare Fees</b>				64%	69%	84%	80%	62%	67%	40%	85%
<b>Ranking</b>				6	4	2	3	7	5	8	1
	<b>5-Cardiovascular System Surgery</b>										
36400	Bl draw < 3 yrs fem/jugular	33	22	18	13	31	27	21	15	N/A	28
36406	Bl draw < 3 yrs other vein	21	10	13	7	19	17	13	7	N/A	18
36410	Non-routine bl draw > 3 yrs	19	11	14	7	17	15	12	7	N/A	16
36556	Insert non-tunnel cv cath	255	133	194	90	124	205	160	92	113	218
36558	Insert tunneled cv cath	864	307	670	217	286	688	517	206	266	745
36561	Insert tunneled cv cath	1,303	393	938	259	364	1,034	772	264	319	1,126
36569	Insert PICC cath	273	100	226	72	94	218	165	68	87	235
36620	Insertion catheter, artery	55	55	36	36	52	45	39	39	48	46
<b>Weighted Average % of Medicare Fees</b>				75%	68%	43%	80%	61%	68%	33%	86%
<b>Ranking</b>				3	5	7	2	6	4	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.*



**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>6-Hemic, Lymphatic, and Mediastinum</b>										
38220	Bone marrow aspiration	175	66	123	44	163	140	105	44	55	151
38221	Bone marrow biopsy	181	81	136	56	169	145	110	54	70	155
38500	Biopsy/removal lymph nodes	361	277	218	168	334	290	231	184	114	306
38505	Needle biopsy lymph nodes	139	78	93	56	129	111	85	51	67	119
38525	Biopsy/removal, lymph nodes	474	474	281	281	438	383	315	315	156	399
38792	Identify sentinel node	45	45	30	30	41	36	29	29	N/A	38
38900	Intraoperative identification of sentinel lymph node	150	150	113	113	138	122	103	103	110	125
<b>Weighted Average % of Medicare Fees</b>				67%	64%	93%	80%	63%	67%	36%	85%
<b>Ranking</b>				4	6	1	3	7	5	8	2
	<b>7-Digestive System</b>										
42820	Remove tonsils and adenoids	321	321	212	212	300	260	209	209	184	271
42830	Removal of adenoids	231	231	151	151	215	186	148	148	134	196
43235	Upper GI endoscopy, diagnosis	344	145	229	104	319	274	208	97	125	296
43239	Upper GI endoscopy, biopsy	440	162	263	123	408	350	263	108	149	379
45378	Diagnostic colonoscopy	426	236	299	155	395	341	264	158	221	364
45380	Colonoscopy and biopsy	507	281	357	186	471	406	315	189	225	433
45385	Lesion removal colonoscopy	571	334	400	221	531	458	357	225	268	487
47562	Laparoscopic cholecystectomy	715	715	502	502	660	578	480	480	589	598
49082	Abd paracentesis	209	80	141	59	195	167	125	53	55	180
<b>Weighted Average % of Medicare Fees</b>				66%	69%	93%	80%	62%	67%	48%	85%
<b>Ranking</b>				6	4	1	3	7	5	8	2

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

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV F	PA	DC
	<b>8-Urinary and Male Genital</b>										
51600	Injection for bladder x-ray	199	48	162	34	45	158	117	33	32	172
51700	Irrigation of bladder	89	48	70	34	83	72	56	33	29	76
51701	Insert bladder catheter	59	30	53	21	55	47	36	20	25	51
51741	Electro-uroflowmetry first	17	17	46	46	16	14	11	11	24	14
51798	Ultrasound urine capacity measurement	21	21	16	16	19	16	12	12	14	0
52000	Cystoscopy	218	136	163	94	128	175	137	91	75	186
52332	Cystoscopy and treatment	527	168	346	120	157	420	314	113	144	456
54150	Circumcision w/regional block	167	106	145	73	99	135	107	73	79	142
54161	Circum 28 days or older	212	212	144	144	198	173	141	141	128	178
<b>Weighted Average % of Medicare Fees</b>				81%	71%	34%	80%	60%	68%	25%	86%
<b>Ranking</b>				2	4	7	3	6	5	8	1
	<b>9-Gynecology and Obstetrics</b>										
57452	Exam of cervix w/scope	120	101	108	88	111	97	78	68	40	101
57454	Bx/curett of cervix w/scope	169	150	152	133	157	137	111	101	106	142
58100	Biopsy of uterus lining	120	98	109	85	112	98	78	66	51	102
58300	Insert intrauterine device	75	55	76	52	0	62	49	37	17	64
58301	Remove intrauterine device	105	75	95	66	98	85	68	51	17	89
59025	Fetal non-stress test	52	52	46	46	48	42	33	33	18	45
59409	Obstetrical care	918	918	860	860	839	744	900	900	1,200	763
59410	Obstetrical care	1,169	1,169	942	942	1,069	948	1,143	1,143	1,200	973
59430	Care after delivery	206	157	139	125	189	166	193	154	N/A	173
59514	Cesarean delivery only	1,033	1,033	993	993	839	837	1,014	1,014	1,200	858
59515	Cesarean delivery w/ postpartum	1,417	1,417	1,124	1,124	1,069	1,147	1,383	1,383	2,050	1,179
<b>Weighted Average % of Medicare Fees</b>				90%	90%	85%	81%	89%	90%	92%	84%
<b>Ranking</b>				3	4	6	8	5	2	1	7

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>10-Endocrine System</b>										
60100	Biopsy of thyroid	123	86	82	57	115	99	79	59	66	104
60220	Partial removal of thyroid	777	777	518	518	720	629	517	517	521	652
60240	Removal of thyroid	1,006	1,006	662	662	932	815	674	674	591	843
60500	Explore parathyroid glands	1,055	1,055	683	683	976	854	707	707	705	884
<b>Weighted Average % of Medicare Fees</b>				66%	66%	93%	81%	67%	67%	62%	84%
<b>Ranking</b>				6	7	1	3	5	4	8	2
	<b>11-Neurosurgery</b>										
62270	Spinal fluid tap, diagnostic	175	86	150	73	163	140	108	59	42	150
62311	Inject spine l/s (cd)	117	77	183	79	109	94	73	51	75	100
64450	N block, other peripheral	87	50	99	68	81	70	54	33	21	75
64483	Inj foramen epidural l/s	243	123	257	101	227	195	148	81	95	208
64484	Inj foramen epidural add-on	96	57	113	55	90	77	60	39	60	82
64494	Inj paravert f jnt l/s 2 lev	95	57	87	54	53	76	60	38	42	81
64495	Inj paravert f jnt l/s 3 lev	95	57	88	55	54	77	60	39	42	81
<b>Weighted Average % of Medicare Fees</b>				106%	93%	86%	80%	55%	78%	41%	86%
<b>Ranking</b>				1	2	4	5	7	6	8	3

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

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>12-Eye Surgery</b>										
65222	Remove foreign body from eye	75	60	49	36	70	61	48	39	26	64
65855	Laser surgery of eye	379	336	227	195	352	305	240	216	237	322
66821	After cataract laser surgery	369	349	203	190	342	296	230	220	217	314
66982	Cataract surgery complex	896	896	678	678	833	723	581	581	697	758
66984	Cataract surg w/iol, 1 stage	721	721	494	494	670	581	464	464	603	610
67028	Injection eye drug	114	112	136	111	106	92	74	73	106	96
67210	Treatment of retinal lesion	580	561	430	413	539	467	369	359	375	493
67228	Treatment of retinal lesion	1,125	1,068	731	636	1,046	908	728	696	491	951
67311	Revise eye muscle	678	678	370	370	629	545	435	435	468	574
67800	Remove eyelid lesion	143	118	81	65	133	115	90	76	41	122
<b>Weighted Average % of Medicare Fees</b>				70%	68%	93%	81%	64%	65%	69%	85%
<b>Ranking</b>				4	6	1	3	8	7	5	2
	<b>13-Ear Surgery</b>										
69200	Clear outer ear canal	136	64	113	49	126	108	81	41	30	117
69205	Clear outer ear canal	112	112	91	91	104	90	71	71	89	95
69210	Remove impacted ear wax	54	36	44	29	N/A	43	34	24	20	46
69401	Inflate middle ear canal	98	55	72	45	91	78	59	35	N/A	84
69424	Remove ventilating tube	142	69	115	55	132	113	85	44	54	122
69436	Create eardrum opening	177	177	149	149	165	143	113	113	99	150
69990	Microsurgery add-on	239	239	199	199	217	192	164	164	201	199
<b>Weighted Average % of Medicare Fees</b>				82%	81%	51%	80%	62%	67%	42%	85%
<b>Ranking</b>				2	3	7	4	6	5	8	1

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>14-Radiology</b>										
70450	CT head/brain w/o dye	135	135	177	177	126	108	81	81	117	117
71010	Chest x-ray	26	26	20	20	24	21	16	16	19	22
71020	Chest x-ray	34	34	26	26	31	27	20	20	25	29
72193	CT pelvis w/dye	258	258	259	259	240	205	152	152	140	224
73610	X-ray exam of ankle	37	37	24	24	35	30	22	22	27	32
73630	X-ray exam of foot	35	35	24	24	33	28	21	21	19	30
74000	X-ray exam of abdomen	27	27	21	21	25	22	17	17	18	23
74160	CT abdomen w/dye	263	263	263	263	245	209	155	155	149	228
74177	CT abd & pelv w/contrast	355	355	287	287	331	283	210	210	263	307
76805	Ob ultrasound /= 14 wks, sngl fetus	160	160	110	110	149	128	95	95	78	138
76815	Ob ultrasound, limited, fetus(s)	99	99	70	70	92	79	59	59	64	85
76816	Ob ultrasound follow-up per fetus	127	127	78	78	119	102	76	76	72	110
76817	Transvaginal ultrasound obstetric	111	111	74	74	104	89	67	67	88	96
76819	Fetal biophys profil w/o nst	98	98	78	78	91	79	59	59	86	84
76820	Umbilical artery echo	53	53	50	50	50	43	33	33	46	45
76830	Transvaginal ultrasound non-ob	139	139	88	88	129	111	82	82	77	120
76856	Ultrasound exam pelvic complete	136	136	88	88	127	109	80	80	77	118
<b>Weighted Average % of Medicare Fees</b>				79%	79%	93%	80%	60%	60%	68%	86%
<b>Ranking</b>				5	4	1	3	8	7	6	2

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC</b>	<b>MD</b>	<b>DE</b>	<b>VA</b>	<b>WV</b>	<b>PA</b>	<b>DC</b>
	<b>15- Laboratory</b>							
80053	Comprehen metabolic panel	14	11	14	12	13	12	12
80061	Lipid panel	17	13	18	15	16	14	17
81002	Urinalysis nonauto w/o scope	3	3	3	3	3	4	2
83655	Assay of lead	17	12	16	14	15	10	8
85025	Complete CBC w/auto diff wbc	11	8	10	9	10	6	5
86592	Blood serology, qualitative	5	4	6	4	5	4	3
87081	Culture screen only	9	7	9	8	8	5	4
87086	Urine culture/colony count	11	9	11	8	10	8	6
87491	Chylmd trach, dna, amp probe	42	33	47	38	43	23	23
87880	Strep a assay w/optic	16	13	15	14	15	6	7
<b>Weighted Average % of Medicare Fees</b>			77%	102%	86%	95%	62%	61%
<b>Ranking</b>			4	1	3	2	5	6

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>16-Psychiatry</b>										
90791	Psy dx evaluation (no medical)	140	135	147	147	133	116	97	94	26	116
90792	Psy dx evaluation (w/ medical)	150	146	147	147	143	125	104	102	75	125
90832	Psytx, pt &/ family 30 minutes	67	67	48	48	64	56	47	47	26	56
90833	Psytx pt &/fam w/ E&M 30 min	69	69	48	48	66	57	48	48	N/A	57
90834	Psytx, pt &/ family 45 minutes	89	89	88	88	85	74	63	62	39	74
90837	Psytx, pt &/ family 60 minutes	134	133	98	98	127	111	93	93	52	111
90847	Family psytx w/ patient	112	111	92	87	107	93	78	77	13	92
90853	Group psychotherapy	28	27	24	24	26	23	19	19	4	23
<b>Weighted Average % of Medicare Fees</b>				91%	92%	95%	83%	70%	70%	30%	83%
<b>Ranking</b>				3	2	1	4	7	6	8	5

**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV F	PA	DC
	<b>17-Dialysis</b>										
90935	Hemodialysis, one evaluation	77	77	49	49	73	63	52	52	165	64
90937	Hemodialysis, repeated eval	110	110	80	80	105	138	75	75	165	92
90945	Dialysis, one evaluation	91	91	51	51	86	138	61	61	165	77
90960	ESRD srv 4 visits p mo 20+	302	302	207	207	285	248	202	202	N/A	253
90961	ESRD srv 2-3 visits p mo 20+	255	255	170	170	240	208	170	170	N/A	214
90962	ESRD serv 1 visit p mo 20+	197	197	133	133	186	161	130	130	N/A	165
90970	ESRD home pt serv p day 20+	8	8	6	6	8	7	6	6	N/A	7
<b>Weighted Average % of Medicare Fees</b>				66%	66%	94%	87%	67%	67%	82%	84%
<b>Ranking</b>				6	6	1	2	5	5	4	3
	<b>18-Gastroenterology</b>										
91034	Gastroesophageal reflux test	208	208	167	167	193	165	122	122	172	180
91038	Esoph impeded funct test > 1hr	498	498	106	106	463	394	285	285	98	434
91065	Breath hydrogen/methane test	91	91	48	48	84	72	52	52	17	79
91110	GI tract capsule endoscopy	978	978	733	733	911	777	569	569	N/A	849
91122	Anal pressure record	241	241	190	190	226	193	146	146	69	208
<b>Weighted Average % of Medicare Fees</b>				73%	73%	93%	79%	58%	58%	8%	87%
<b>Ranking</b>				4	4	1	3	5	5	6	2

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<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>19-Ophthalmology and Vision Care</b>										
92004	Eye exam, new patient	162	108	95	65	152	130	102	72	59	137
92012	Eye exam, established pat	93	58	53	32	87	75	58	39	29	80
92014	Eye exam & treatment	135	87	77	50	126	109	85	58	45	115
92015	Refraction	22	21	28	14	20	18	15	14	5	18
92060	Special eye evaluation	71	71	40	40	67	57	44	44	34	61
92081	Visual field examination(s)	37	37	38	38	35	30	23	23	28	32
92083	Visual field examination(s)	70	70	57	57	66	56	42	42	63	61
92250	Eye exam with photos	86	86	54	54	80	68	51	51	53	74
<b>Weighted Average % of Medicare Fees</b>				62%	60%	94%	81%	63%	66%	39%	85%
<b>Ranking</b>				6	7	1	3	5	4	8	2

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>20-ENT (Otorhinolaryngology)</b>										
92504	Ear microscopy examination	33	10	26	9	31	26	20	7	N/A	29
92546	Sinusoidal rotational test	113	113	82	82	105	89	65	65	22	98
92547	Supplemental electrical test	7	7	5	5	6	5	4	4	4	6
92551	Pure tone hearing test, air	13	13	8	8	12	10	7	7	8	11
92552	Pure tone audiometry, air	34	34	18	18	31	27	19	19	8	30
92557	Comprehensive hearing test	40	35	47	44	38	33	26	23	29	34
92567	Tympanometry	16	12	16	13	15	13	10	8	12	13
92568	Acoustic refl threshold tst	17	17	16	16	16	14	11	11	10	14
92585	Auditory evoked potentials (ABR comprehensive)	143	143	101	101	133	113	83	83	27	124
92587	Evoked auditory (otoacoustic emission) testing	24	24	40	40	22	19	16	16	34	20
<b>Weighted Average % of Medicare Fees</b>				83%	83%	93%	79%	58%	60%	62%	87%
<b>Ranking</b>				4	3	1	5	8	7	6	2

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>21 - Cardiovascular Medicine Procedures</b>										
93000	Electrocardiogram, complete	18	18	18	18	17	15	11	11	19	15
93010	Electrocardiogram report	9	9	6	6	9	7	6	6	8	8
93015	Cardiovascular stress test	81	81	80	80	76	66	50	50	90	70
93016	Cardiovascular stress test	23	23	18	18	0	19	16	16	22	19
93018	Cardiovascular stress test	15	15	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 (TT)	259	259	171	171	242	207	153	153	157	224
93306	Echo TT w/doppler complete	248	248	206	206	232	198	147	147	141	215
93307	Ech TT w/o doppler, complete	143	143	148	148	134	114	86	86	140	123
93320	Doppler echo exam, heart	59	59	66	66	55	47	36	36	61	51
93325	Doppler color flow add-on	29	29	39	39	26	23	17	17	N/A	25
<b>Weighted Average % of Medicare Fees</b>				84%	84%	93%	80%	60%	60%	65%	86%
<b>Ranking</b>				3	3	1	4	6	6	5	2
	<b>22-Noninvasive Vascular Tests</b>										
93880	Extracranial study	209	209	140	140	194	166	121	121	148	182
93922	Upr/l extremity art 2 levels	97	97	97	97	90	77	56	56	49	85
93970	Extremity study	206	206	143	143	191	163	120	120	147	179
93971	Extremity study	125	125	91	91	116	99	73	73	100	108
93975	Vascular study	305	305	185	185	284	312	231	231	182	340
93976	Vascular study	231	231	162	162	216	184	137	137	131	200
<b>Weighted Average % of Medicare Fees</b>				70%	70%	93%	82%	61%	61%	64%	89%
<b>Ranking</b>				4	4	1	3	6	6	5	2

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>23-Pulmonary</b>										
94010	Breathing capacity test	39	39	26	26	37	31	23	23	15	34
94060	Evaluation of wheezing	66	66	45	45	62	53	39	39	19	57
94375	Respiratory flow volume loop	43	43	28	28	40	34	26	26	31	37
94640	Airway inhalation treatment	20	20	11	11	19	16	11	11	N/A	18
94664	Evaluate pt use of inhaler	19	19	12	12	17	15	11	11	12	17
94760	Measure blood oxygen level	4	4	2	2	3	3	2	2	2	3
94761	Measure blood oxygen level	6	6	5	5	5	4	3	3	4	5
<b>Weighted Average % of Medicare Fees</b>				63%	63%	92%	79%	58%	58%	34%	87%
<b>Ranking</b>				4	4	1	3	5	5	6	2
	<b>24-Allergy and Immunology</b>										
95004	Percut allergy skin tests	7	7	4	4	7	6	4	4	2	6
95024	Id allergy test, drug/bug	9	1	5	5	8	7	5	1	5	8
95115	Immunotherapy, one injection	10	10	10	10	9	8	6	6	4	9
95117	Immunotherapy injections	11	11	13	13	11	9	6	6	7	10
95165	Antigen therapy services	14	3	9	2	13	11	8	2	8	12
<b>Weighted Average % of Medicare Fees</b>				99%	105%	92%	79%	56%	56%	53%	87%
<b>Ranking</b>				2	1	3	5	7	6	8	4

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>25-Neurology and Neuromuscular</b>										
95810	Polysomnography, 4 or more	676	676	628	628	628	536	394	394	347	586
95811	Polysom 6/>yrs cpap 4/> parm	709	709	691	691	659	562	413	413	648	615
95816	EEG, awake and drowsy	387	387	165	165	359	306	223	223	23	336
95819	EEG, awake and asleep	442	442	167	167	410	349	253	253	23	385
95860	Muscle test, one limb	131	131	64	64	123	105	79	79	30	113
95886	Musc test done w/n test comp	99	99	48	48	93	79	61	61	66	85
95926	Somatosensory testing	159	159	78	78	148	126	92	92	58	138
95930	Visual evoked potential test	146	146	83	83	136	116	84	84	74	127
95951	EEG monitoring/videorecord	2018	2018	244	244	0	247	234	234	228	449
95957	EEG digital analysis	481	481	181	181	448	382	281	281	138	417
<b>Weighted Average % of Medicare Fees</b>				52%	52%	62%	57%	42%	42%	34%	65%
<b>Ranking</b>				4	4	2	3	5	5	6	1
	<b>26-CNS Assessment Tests</b>										
96102	Psycho testing by technician	72	25	0	0	0	57	43	17	N/A	62
96110	Developmental test, lim	9	9	9	9	8	7	5	5	7	8
96111	Developmental test, extend	136	129	96	94	0	112	93	89	50	114
96116	Neurobehavioral status exam	100	93	72	70	0	82	68	64	53	83
96118	Neuropsych test by psych/phys	104	83	84	68	99	86	70	58	N/A	87
<b>Weighted Average % of Medicare Fees</b>				82%	84%	40%	81%	63%	63%	54%	85%
<b>Ranking</b>				3	2	8	4	6	5	7	1

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>MC NF</b>	<b>MC FA</b>	<b>MD NF</b>	<b>MD FA</b>	<b>DE</b>	<b>VA NF</b>	<b>WV NF</b>	<b>WV F</b>	<b>PA</b>	<b>DC</b>
	<b>27-Chemotherapy Administration</b>										
96411	Chemo, IV push, addl drug	67	67	53	53	62	53	39	39	53	58
96413	Chemo, IV infusion, 1 hr	146	146	126	126	135	115	83	83	125	127
96415	Chemo, IV infusion, addl hr	30	30	28	28	28	24	18	18	28	26
96417	Chemo IV infus each addl seq	68	68	62	62	63	54	39	39	62	59
96450	Chemotherapy, into CNS	196	86	212	75	183	157	119	58	77	168
96523	Irrig drug delivery device	27	27	21	21	25	21	15	15	19	24
<b>Weighted Average % of Medicare Fees</b>				88%	86%	93%	79%	58%	58%	82%	87%
<b>Ranking</b>				2	4	1	6	8	7	5	3
	<b>28-Special Dermatological Procedures</b>										
96910	Photochemotherapy with UV-B	76	76	46	46	71	60	43	43	20	67
96912	Photochemotherapy with UV-A	98	98	59	59	91	77	55	55	20	86
96920	Laser tx skin < 250 sq cm	165	71	120	48	155	132	99	47	N/A	N/A
96921	Laser tx skin 250-500 sq cm	182	80	118	48	171	146	110	52	N/A	N/A
96922	Laser tx skin >500 sq cm	252	130	174	81	236	203	154	85	N/A	N/A
<b>Weighted Average % of Medicare Fees</b>				64%	61%	93%	79%	47%	71%	16%	57%
<b>Ranking</b>				4	5	1	2	7	3	8	6

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**Table 6. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, in FY 2015 (Continued)**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV F	PA	DC
	<b>29-Physical Medicine and Rehabilitation</b>										
97001	Pt evaluation	80	80	72	72	76	66	52	52	45	68
97010	Hot or cold packs therapy	7	7	4	4	6	5	4	4	17	6
97014	Electric stimulation therapy	17	17	10	10	16	14	11	11	17	15
97035	Ultrasound therapy	14	14	9	9	13	11	9	9	10	11
97110	Therapeutic exercises	34	34	29	29	32	28	22	22	8	29
97112	Neuromuscular reeducation	36	36	21	21	34	29	23	23	17	30
97140	Manual therapy	32	32	19	19	30	26	20	20	21	27
97530	Therapeutic activities	37	37	31	31	35	30	23	23	13	32
<b>Weighted Average % of Medicare Fees</b>				73%	73%	94%	81%	64%	64%	49%	85%
<b>Ranking</b>				4	4	1	3	5	5	6	2
	<b>30-Osteopathy, Chiropractic, and Other Medicine</b>										
98941	Chiropractic manipulation	44	37	25	21	0	36	29	25	N/A	0
99144	Mod sedation by same phys, 5 yrs +	45	45	28	28	0	66	0	0	N/A	N/A
99173	Visual acuity screen	3	3	2	2	3	64	2	2	6	3
99183	Hyperbaric oxygen therapy	231	130	150	85	215	186	145	89	107	197
<b>Weighted Average % of Medicare Fees</b>				67%	68%	78%	872%	53%	52%	97%	73%
<b>Ranking</b>				6	5	3	1	7	8	2	4

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

For each of the 30 specialty groups that were presented in Table 6, the last two rows are shown in Table 7.

**Table 7. Comparison of Maryland and Neighboring States' Medicaid Reimbursement Rates  
as Percentages of Medicare Rates (Region Rank), by Specialty, in FY 2015**

	MD NF	MD FA	DE	VA NF	WV NF	WV F	PA	DC
<b>1-Evaluation &amp; Management</b>	99% (2)	99% (1)	91% (5)	96%(3)	64%(8)	68%(7)	92%(4)	85%(6)
<b>2-Integumentary and General Surgery</b>	67%(5)	71%(4)	146%(1)	80%(3)	62%(7)	65%(6)	29%(8)	86%(2)
<b>3-Musculoskeletal System</b>	90%(2)	85%(3)	93%(1)	80%(5)	63%(7)	65%(6)	38%(8)	81%(4)
<b>4-Respiratory</b>	64%(6)	69%(4)	84%(2)	80%(3)	62%(7)	67%(5)	40%(8)	85%(1)
<b>5-Cardiovascular System Surgery</b>	75%(3)	68%(5)	43%(7)	80%(2)	61%(6)	68%(4)	33%(8)	86%(1)
<b>6-Hemic, Lymphatic, and Mediastinum</b>	67%(4)	64%(6)	93%(1)	80%(3)	63%(7)	67%(5)	36%(8)	85%(2)
<b>7-Digestive System</b>	66%(6)	69%(4)	93%(1)	80%(3)	62%(7)	67%(5)	48%(8)	85%(2)
<b>8-Urinary and Male Genital</b>	81%(2)	71%(4)	34%(7)	80%(3)	60%(6)	68%(5)	25%(8)	86%(1)
<b>9-Gynecology and Obstetrics</b>	90%(3)	90%(4)	85%(6)	81%(8)	89%(5)	90%(2)	92%(1)	84%(7)
<b>10-Endocrine System</b>	66%(6)	66%(7)	93%(1)	81%(3)	67%(5)	67%(4)	62%(8)	84%(2)
<b>11-Neurosurgery</b>	106%(1)	93%(2)	86%(4)	80%(5)	55%(7)	78%(6)	41%(8)	86%(3)
<b>12-Eye Surgery</b>	70%(4)	68%(6)	93%(1)	81%(3)	64%(8)	65%(7)	69%(5)	85%(2)
<b>13-Ear Surgery</b>	82%(2)	81%(3)	51%(7)	80%(4)	62%(6)	67%(5)	42%(8)	85%(1)
<b>14-Radiology</b>	79%(4)	79%(4)	93%(1)	80%(3)	60%(7)	60%(7)	68%(6)	86%(2)
<b>15-Laboratory</b>	77%(5)	77%(5)	102%(1)	86%(4)	95%(2)	95%(2)	62%(7)	61%(8)
<b>16-Psychiatry</b>	91%(3)	92%(2)	95%(1)	83%(4)	70%(7)	70%(6)	30%(8)	83%(5)
<b>17-Dialysis</b>	66%(6)	66%(7)	94%(1)	87%(2)	67%(5)	67%(5)	82%(4)	84%(3)
<b>18-Gastroenterology</b>	73%(4)	73%(4)	93%(1)	79%(3)	58%(6)	58%(6)	8%(8)	87%(2)
<b>19-Ophthalmology and Vision Care</b>	62%(6)	60%(7)	94%(1)	81%(3)	63%(5)	66%(4)	39%(8)	85%(2)
<b>20-ENT (Otorhinolaryngology)</b>	83%(4)	83%(3)	93%(1)	79%(5)	58%(8)	60%(7)	62%(6)	87%(2)
<b>21-Cardiovascular Medicine Procedures</b>	84%(3)	84%(3)	93%(1)	80%(5)	60%(7)	60%(7)	65%(6)	86%(2)
<b>22-Noninvasive Vascular Tests</b>	70%(4)	70%(4)	93%(1)	82%(3)	61%(7)	61%(7)	64%(6)	89%(2)
<b>23-Pulmonary</b>	63%(4)	63%(4)	92%(1)	79%(3)	58%(6)	58%(6)	34%(8)	87%(2)
<b>24-Allergy and Immunology</b>	99%(2)	105%(1)	92%(3)	79%(5)	56%(7)	56%(6)	53%(8)	87%(4)
<b>25-Neurology and Neuromuscular</b>	52%(4)	52%(4)	62%(2)	57%(3)	42%(6)	42%(6)	34%(8)	65%(1)
<b>26-CNS Assessment Tests</b>	82%(3)	84%(2)	40%(8)	81%(4)	63%(6)	63%(5)	54%(7)	85%(1)
<b>27-Chemotherapy Administration</b>	88%(2)	86%(4)	93%(1)	79%(6)	58%(8)	58%(7)	82%(5)	87%(3)
<b>28-Special Dermatological</b>	64%(4)	61%(5)	93%(1)	79%(2)	47%(7)	71%(3)	16%(8)	57%(6)
<b>29-Physical Medicine and Rehabilitation</b>	73%(4)	73%(4)	94%(2)	168%(1)	64%(6)	64%(6)	49%(8)	85%(3)
<b>30-Osteopathy, Chiropractic and Other Medicine</b>	67%(6)	68%(5)	78%(3)	872%(1)	53%(7)	52%(8)	97%(2)	73%(4)



## **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 FFS and HealthChoice program enrollees. The enhanced Medicaid fees apply only to services rendered in trauma centers designated by the Maryland Institute for Emergency Medical Services Systems for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fees were limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, HB 1164 (Chapter 484 of the 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. However, every two years, the American Dental Association (ADA) publishes a survey, reporting the national and regional average charges for approximately 165 of the most common dental procedures, offering data for comparison. Also, a book entitled the National Dental Advisory Service (NDAS) contains the percentile of charges for approximately 550 (of a total of approximately 580) dental procedures.

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, MCOs were required to reimburse their contracted providers at the ADA's then-current 50<sup>th</sup> percentile of charges for 12 restorative procedures. At the same time, Medicaid increased FFS rates to the ADA's 50<sup>th</sup> percentile levels for the 12 restorative procedures.

In June 2007, the Secretary of 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 50<sup>th</sup> 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, effective July 1, 2009, an administrative service organization (ASO)—DentaQuest, formerly Doral Dental—coordinates the provision of dental services for Medicaid beneficiaries in the FFS program. Fees for some of

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

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**

<b>Procedure Code</b>	<b>Description</b>	<b>Median ADA fees in 2013</b>	<b>Medicaid 2014 Fees</b>	<b>Medicaid 2015 Fees</b>
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 50<sup>th</sup> percentile of charges in 2013.

**Table 9. Average of Maryland Medicaid Dental Fees as a Percentage of the ADA's 50th Percentile of Charges in 2013**

<b>Procedure Group</b>	<b>CY14 Average Medicaid Fees</b>	<b>CY15 Average Medicaid Fees</b>
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%
<b>All Procedures Combined</b>	<b>54%</b>	<b>55%</b>

Table 10 compares Maryland Medicaid dental fees for selected high-volume procedures with the corresponding fees in Delaware, Virginia, West Virginia, Pennsylvania, and Washington, D.C. 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, D.C., (second), Maryland (third), West Virginia (fourth), Virginia (fifth), and Pennsylvania (sixth). ADA fees correspond to CY 2013, and the states' fees correspond to FY 2014.

**Table 10. Maryland Medicaid and Neighboring States' FY 2014 Dental Fees**

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>ADA CY13</b>	<b>MD</b>	<b>DE</b>	<b>VA</b>	<b>WV</b>	<b>PA</b>	<b>DC</b>
D0120	Periodic oral evaluation	\$45	\$29	\$45	\$20	\$25	\$20	\$35
D0140	Limited oral evaluation, problem focus	\$65	\$43	\$68	\$25	\$35	N/A	\$50
D0145	Oral evaluation, pt < 3yrs	\$55	\$40	\$60	\$20	\$25	N/A	\$40
D0150	Comprehensive oral evaluation	\$73	\$52	\$80	\$31	\$35	\$20	\$78
D1110	Prophylaxis – adult (12 years of age and older)	\$82	\$58	\$82	\$47	N/A	\$36	\$78
D1120	Dental prophylaxis child	\$61	\$42	\$60	\$34	\$40	\$30	\$47
D1206	Topical fluoride varnish	\$35	\$25	\$38	\$21	\$20	\$18	\$29
D1351	Dental sealant per tooth	\$48	\$33	\$50	\$32	\$30	\$25	\$38
D7140	Extraction erupted tooth	\$155	\$103	\$160	N/A	\$80	\$65	\$110
D7286	Biopsy of oral tissue soft	\$289	\$231	0	\$82	\$130	N/A	0
D7451	Remove odontogen cyst > 1.25 cm	N/A	\$125	0	\$161	\$840	\$80	\$593
D9248	Nonintravenous conscious sedation	\$170	\$187	\$294	N/A	0	\$184	0
<b>Ranking</b>			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 FY10 through FY14 were analyzed to determine the number of physicians who had partial or full participation in the Medicaid program.

Because FY14 claims data, in particular the MCOs' encounter data, were not complete (i.e., claims were incurred but not reported [IBNR]), data for FY14 showed an insignificant decrease in the total number of participating physicians in FY14 compared with FY13. Therefore, FY13 data were used as the last year for comparison in Tables 11, 12, and 13.<sup>8</sup>

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 FFS program, MCO networks, and the total Medicaid program. Physicians with fewer than 25 claims during the fiscal year are included in the data for all physicians, but are not shown separately. Physicians who submitted more than 25 claims, but 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 FFS program, MCO networks, and the total Medicaid program between FY02 and FY13. Comparable figures (from January 2014 report) for the FY02 through FY12 period for "All Physicians" in the FFS program, MCO networks, and total Medicaid program were 41.7 percent, 86.4 percent, and 125.2 percent, respectively.

**Table 11. Percentage Change in the Number of Participating Physicians of All Specialties, FY02-FY13**

	<b>FFS</b>	<b>MCO Networks</b>	<b>Total Medicaid</b>
Partial Participation	50.8%	82.8%	136.5%
Full Participation	59.3%	178.0%	155.8%
All Physicians	46.1%	107.3%	145.9%

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

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

Similarly, examination of the data in Table 12 shows that, following the FY08 and FY09 fee increases, with the exception of full participation in the FFS program, physician participation increased significantly between FY11 and FY13.

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<sup>8</sup> The data in these tables pertain to FY02 through FY13. Therefore, to some extent, these tables reflect the impact of fee changes in FY10 through FY13 on physician participation in the Medicaid program.

**Table 12. Percentage Change in the Number of Participating Physicians of All Specialties, FY11-FY13**

	<b>FFS</b>	<b>MCO Networks</b>	<b>Total Medicaid</b>
Partial Participation	3%	20.5%	13.2%
Full Participation	-13%	17.1%	11.4%
All Physicians	7%	23.4%	18.5%

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

The increase in “All Physician” participation within the FFS program (particularly the increase in partial participation among physicians) compensates for the physicians who reduced their level of participation in the FFS program. Furthermore, there was 23.4 percent increase in the number of physicians who participated in MCO networks, both partial and full participants. Table 12 shows that, between FY11 and FY13, the total number of partial and full participating physicians increased by 13.2 percent and 11.4 percent, respectively. Moreover, participation of all physicians in the Medicaid program increased by 18.5 percent in FY13, compared with FY11.

Table 13 shows that the increasing trend in total physician participation in the Medicaid program continued between FY12 and FY13.

**Table 13. Percentage Change in the Number of Participating Physicians of All Specialties, FY12-FY13**

	<b>FFS</b>	<b>MCO Networks</b>	<b>Total Medicaid</b>
Partial Participation	0.3%	9.7%	6.1%
Full Participation	-4.2%	5.5%	4.1%
All Physicians	3.0%	9.2%	7.8%

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

It is likely that, with the reductions in Medicaid physician fees in FY11 and FY12, as well as increasing costs, some physicians decided to reduce their level of participation in the Medicaid FFS program. However, the 4.2 percent decrease in the number of FFS physicians with full participation between FY12 and FY13 should not pose a problem for access of FFS Medicaid beneficiaries to physician services. National data have shown similar trends, indicating that fewer physicians provide services to higher percentages of Medicaid beneficiaries; in other words, Medicaid beneficiaries constitute an increasing share of some physicians’ practices.

The increase in the number of participating physicians is, to some extent, the result of pre-ACA Medicaid expansion and increased enrollment. Therefore, to separate the effects of the 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**

<b>Fiscal Year</b>	<b>Average Monthly Medicaid Enrollment</b>	<b>Number of Physician Claims and Encounters</b>	<b>Average Number of Claims Per Enrollee</b>	<b>Annual % Increase in Claims Per Enrollee</b>	<b>Increase in Claims Per Enrollee From Each Year to 2013</b>
2002	617,929	3,919,805	6.3	N/A	51.5%
2003	652,414	4,281,928	6.6	3.5%	46.4%
2004	669,021	4,789,248	7.2	9.1%	34.2%
2005	687,269	4,891,558	7.1	-0.6%	35.0%
2006	690,227	5,253,246	7.6	6.9%	26.3%
2007	700,930	5,527,421	7.9	3.6%	21.9%
2008	709,832	6,079,603	8.6	8.6%	12.2%
2009	772,582	6,933,686	9.0	4.8%	7.1%
2010	867,788	8,168,426	9.4	4.9%	2.1%
2011	951,716	9,185,576	9.7	2.5%	-0.4%
2012	1,013,543	9,708,887	9.6	-0.8%	0.3%
2013	1,066,380	10,247,847	9.6	0.3%	N/A

*N/A: Not Applicable*

The continued increase in the average number of claims per enrollee shows that, as physician reimbursement rates increased during the FY06 to FY09 period, Medicaid enrollees' utilization of physician services also increased steadily, from an average of 6.3 claims per enrollee in FY02 to an average of 9.6 claims per enrollee in FY13. This is approximately 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.

***Comparison of Access to Medical Care for Medicaid and Private Coverage***

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

The GAO found that,

Beneficiaries covered by Medicaid for a full year reported low rates of difficulty obtaining necessary medical care and prescription medicine, similar to those with private insurance coverage for a full year. In calendar years 2008 and 2009, approximately 3.7 percent of Medicaid beneficiaries enrolled for a full year and 3 percent of individuals enrolled in private insurance for a full year reported difficulties obtaining needed medical care; the difference between these two groups was not statistically significant. In addition, 2.7 percent of full-year Medicaid beneficiaries reported difficulty obtaining

needed prescription medicines and about 2.4 percent of individuals with full-year private insurance reported the same issue—also not statistically significant.

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

A recent study in the *Journal of General Internal Medicine*, using descriptive and multivariate analysis of data from the 2005–2008 MEPS, indicates that Medicaid actually does a better job delivering access and affordable 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 et al. (2013) indicate that, in a comparison of different insurance groups, Medicaid recipients were less likely to be underinsured than privately insured adults, indicating potential benefits of Medicaid Expansion under the ACA.

### **VIII. Plan for the Future**

The Department remains dedicated to ensuring physicians are reimbursed equitably for their services. The provision of the ACA requiring parity with the rates paid by Medicare for E&M services and vaccine administration provided by Medicaid PCPs expires at the end of the current calendar year. While the Department’s goal remains to reimburse PCPs and specialists at 100 percent of the Medicare rate, this may not be feasible given the current budget challenges facing the State. Nonetheless, the Department will continue to monitor provider network adequacy to ensure patient access to care is not compromised. The Department notes that several bills before Congress seek to extend the enhanced payment mandate for PCPs, *see, e.g. Medicaid Parity Act of 2014, H.R. 5353, 113<sup>th</sup> Cong. (2014)*. The Department strongly supports these federal efforts to extend the enhanced payment 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 (RBRVS) methodology relates payments to the resources and skills that physicians use to provide services. There are three components that determine the relative weight of each procedure: physician work, malpractice expense, and practice expense. A geographic cost index and conversion factor are used to convert the weights to fees.

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

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

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

Currently, a proposal is under consideration in the U.S. Congress that would permanently repeal the SGR update mechanism, reform the FFS payment system through greater focus on value over volume, and encourage participation in alternative payment models.

### **Payment for Anesthesia Procedures**

Prior to December 1, 2003, the Maryland Medicaid program reimbursed anesthesia services based on a percentage of the surgical fee. The program in general did not use the anesthesia CPT codes, but rather the surgical CPT codes with a modifier. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that national standard code sets be used. In late 2003, the Medicaid program complied with the federal standards and began transitioning from a fixed anesthesia rate for each surgical procedure to Medicare's national methodology.



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

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

## **Appendix B: Number of Physicians and Dentists in Each State, and per 10,000 Population in 2013**

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 2013 are from the Census Bureau, US Department of Commerce:  
<https://www.census.gov/popest/data/state/totals/2013/index.html>

**Table B.1. Number of Physicians by State in 2013,  
Ranked by Number per 10,000 Population**

<b>Rank</b>	<b>Geographic Area</b>	<b>Primary Care Physicians</b>	<b>Specialist Physicians</b>	<b>Total Physicians</b>	<b>Physicians in Patient Care Per 10,000</b>
	<b>United States</b>	<b>425,032</b>	<b>468,819</b>	<b>893,851</b>	<b>28.27</b>
1	District of Columbia	2,685	3,466	6,151	95.15
2	Massachusetts	13,971	17,392	31,363	46.86
3	Rhode Island	2,154	2,254	4,408	41.92
4	New York	34,578	42,754	77,332	39.35
5	Connecticut	6,061	7,642	13,703	38.11
<b>6</b>	<b>Maryland</b>	<b>9,886</b>	<b>12,187</b>	<b>22,073</b>	<b>37.23</b>
7	Pennsylvania	21,066	24,101	45,167	35.36
8	Michigan	16,214	17,962	34,176	34.54
9	Vermont	1,035	1,080	2,115	33.75
10	Maine	2,207	2,117	4,324	32.55
11	Ohio	17,216	20,181	37,397	32.32
12	Delaware	1,329	1,486	2,815	30.41
13	Missouri	8,603	9,712	18,315	30.30
14	New Jersey	12,856	14,070	26,926	30.26
15	Minnesota	7,795	8,374	16,169	29.83
16	Illinois	19,321	19,076	38,397	29.81
17	New Hampshire	1,830	2,011	3,841	29.02
18	Washington	9,530	10,068	19,598	28.11
19	Wisconsin	7,630	8,293	15,923	27.73
20	Oregon	5,291	5,599	10,890	27.71
21	West Virginia	2,533	2,520	5,053	27.25
22	Tennessee	8,167	9,302	17,469	26.89
23	California	48,472	52,760	101,232	26.41
24	Virginia	10,568	11,223	21,791	26.38
25	Louisiana	5,553	6,582	12,135	26.24
26	Nebraska	2,513	2,367	4,880	26.12
27	Hawaii	1,764	1,881	3,645	25.96
28	Florida	24,172	25,859	50,031	25.59
29	Colorado	6,546	6,752	13,298	25.24
30	North Carolina	11,707	12,769	24,476	24.85
31	North Dakota	957	822	1,779	24.59
32	Arizona	7,829	8,452	16,281	24.57
33	Kentucky	4,958	5,799	10,757	24.47
34	New Mexico	2,546	2,529	5,075	24.34
35	Iowa	3,920	3,565	7,485	24.22

**Table B.1. Number of Physicians by State in 2013,  
Ranked by Number per 10,000 Population, Continued**

<b>Rank</b>	<b>Geographic Area</b>	<b>Primary Care Physicians</b>	<b>Specialist Physicians</b>	<b>Total Physicians</b>	<b>Physicians in Patient Care Per 10,000</b>
36	Indiana	7,528	8,126	15,654	23.82
37	South Carolina	5,677	5,617	11,294	23.65
38	Kansas	3,523	3,252	6,775	23.41
39	Alaska	920	790	1,710	23.26
40	Georgia	11,201	11,512	22,713	22.73
41	Alabama	5,251	5,684	10,935	22.62
42	Oklahoma	4,248	4,249	8,497	22.07
43	Arkansas	3,177	3,339	6,516	22.02
44	South Dakota	953	901	1,854	21.94
45	Texas	27,615	30,200	57,815	21.86
46	Montana	1,033	1,109	2,142	21.10
47	Utah	2,701	3,352	6,053	20.87
48	Mississippi	2,963	3,024	5,987	20.02
49	Nevada	2,721	2,753	5,474	19.62
50	Wyoming	581	537	1,118	19.19
51	Idaho	1,477	1,367	2,844	17.64

**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, 2013**

<b>Geographic Area</b>	<b>Internal Medicine</b>	<b>Family Medicine/ General Practice</b>	<b>Pediatrics</b>	<b>Obstetrics and Gynecology</b>	<b>Total Primary Care</b>
United States	175,888	124,529	76,590	48,025	425,032
Alabama	2,094	1,645	905	607	5,251
Alaska	196	517	119	88	920
Arizona	3,114	2,486	1,332	897	7,829
Arkansas	828	1,522	537	290	3,177
California	20,021	13,618	9,360	5,473	48,472
Colorado	2,294	2,446	1,059	747	6,546
Connecticut	3,368	689	1,173	831	6,061
Delaware	465	345	368	151	1,329
District of Columbia	1,352	298	712	323	2,685
Florida	10,060	7,390	4,199	2,523	24,172
Georgia	4,430	3,064	2,175	1,532	11,201
Hawaii	746	459	303	256	1,764
Idaho	351	823	150	153	1,477
Illinois	8,610	5,285	3,247	2,179	19,321
Indiana	2,441	3,092	1,164	831	7,528
Iowa	1,086	1,976	554	304	3,920
Kansas	1,063	1,647	447	366	3,523
Kentucky	1,778	1,742	834	604	4,958
Louisiana	2,186	1,569	1,045	753	5,553
Maine	739	974	303	191	2,207
Maryland	5,162	1,559	1,974	1,191	9,886
Massachusetts	8,205	1,739	2,785	1,242	13,971
Michigan	6,619	5,329	2,294	1,972	16,214
Minnesota	2,880	3,170	1,059	686	7,795
Mississippi	1,057	1,056	456	394	2,963
Missouri	3,374	2,469	1,811	949	8,603
Montana	304	511	104	114	1,033
Nebraska	800	1,087	383	243	2,513
Nevada	1,206	832	378	305	2,721
New Hampshire	780	551	306	193	1,830
New Jersey	6,167	2,366	2,776	1,547	12,856
New Mexico	854	1,000	443	249	2,546
New York	17,949	5,328	7,252	4,049	34,578
North Carolina	4,549	3,527	2,191	1,440	11,707

**Table B.2. Primary Care Physicians by Field, 2013, Continued**

<b>Geographic Area</b>	<b>Internal Medicine</b>	<b>Family Medicine/ General Practice</b>	<b>Pediatrics</b>	<b>Obstetrics and Gynecology</b>	<b>Total Primary Care</b>
North Dakota	290	515	97	55	957
Ohio	7,024	4,930	3,401	1,861	17,216
Oklahoma	1,157	2,003	663	425	4,248
Oregon	2,215	1,810	704	562	5,291
Pennsylvania	9,214	6,286	3,311	2,255	21,066
Rhode Island	1,195	241	469	249	2,154
South Carolina	1,893	2,114	953	717	5,677
South Dakota	310	472	103	68	953
Tennessee	3,310	2,348	1,541	968	8,167
Texas	9,908	8,785	5,350	3,572	27,615
Utah	842	924	580	355	2,701
Vermont	386	343	204	102	1,035
Virginia	3,944	3,346	2,015	1,263	10,568
Washington	3,308	3,894	1,453	875	9,530
West Virginia	854	1,098	344	237	2,533
Wisconsin	2,776	2,978	1,151	725	7,630
Wyoming	134	331	53	63	581

**Note:** Physician data include all allopathic and osteopathic physicians.

**Table B.3. Non-Primary Care Physicians by Specialty, 2013**

<b>Geographic Area</b>	<b>Psychiatry</b>	<b>Surgery</b>	<b>Anesthesiology</b>	<b>Emergency Medicine</b>	<b>Radiology</b>	<b>Cardiology</b>	<b>Oncology (Cancer)</b>	<b>Endocrinology, Diabetes, and Metabolism</b>	<b>All Other Specialties</b>	<b>Total</b>
United States	50,416	48,806	46,089	45,140	43,822	28,700	16,217	6,546	183,083	468,819
Alabama	457	702	535	387	602	364	182	53	2,402	5,684
Alaska	106	79	76	115	65	35	12	5	297	790
Arizona	836	912	990	928	808	483	210	88	3,197	8,452
Arkansas	308	350	324	269	338	188	110	34	1,418	3,339
California	6,706	4,991	5,609	5,000	4,586	2,908	1,544	703	20,713	52,760
Colorado	748	656	818	815	583	309	202	89	2,532	6,752
Connecticut	1,133	733	619	636	701	522	252	163	2,883	7,642
Delaware	148	156	94	194	180	102	55	11	546	1,486
District of Columbia	504	361	246	275	246	222	146	63	1,403	3,466
Florida	2,062	2,607	2,614	2,441	2,500	1,938	903	370	10,424	25,859
Georgia	1,157	1,328	1,151	1,185	1,082	727	386	142	4,354	11,512
Hawaii	307	174	178	196	163	69	38	22	734	1,881
Idaho	101	152	112	172	205	48	27	10	540	1,367
Illinois	1,901	1,908	1,933	2,114	1,852	1,206	635	292	7,235	19,076
Indiana	617	805	1,112	812	823	535	297	116	3,009	8,126
Iowa	301	448	418	279	364	231	111	29	1,384	3,565
Kansas	406	416	358	222	301	179	98	36	1,236	3,252
Kentucky	526	745	572	573	509	331	166	65	2,312	5,799
Louisiana	571	755	542	645	561	429	202	77	2,800	6,582
Maine	303	254	202	269	192	112	61	14	710	2,117
Maryland	1,581	1,149	1,058	854	970	714	545	222	5,094	12,187
Massachusetts	2,630	1,697	1,582	1,405	1,738	1,303	875	370	5,792	17,392

**Table B.3. Non-Primary Care Physicians by Specialty, 2013, Continued**

<b>Geographic Area</b>	<b>Psychiatry</b>	<b>Surgery</b>	<b>Anesthesiology</b>	<b>Emergency Medicine</b>	<b>Radiology</b>	<b>Cardiology</b>	<b>Oncology (Cancer)</b>	<b>Endocrinology, Diabetes, and Metabolism</b>	<b>All Other Specialties</b>	<b>Total</b>
Michigan	1,440	2,008	1,460	2,584	1,851	941	543	181	6,954	17,962
Minnesota	731	880	637	772	871	594	333	151	3,405	8,374
Mississippi	263	366	282	311	294	171	98	35	1,204	3,024
Missouri	894	1,012	1,013	928	1,013	580	345	153	3,774	9,712
Montana	102	133	141	112	112	48	29	6	426	1,109
Nebraska	229	289	285	182	251	163	87	27	854	2,367
Nevada	246	270	334	335	250	166	69	32	1,051	2,753
New Hampshire	232	229	206	196	172	134	66	25	751	2,011
New Jersey	1,540	1,376	1,531	1,153	1,163	1,108	462	237	5,500	14,070
New Mexico	351	235	256	297	209	129	66	34	952	2,529
New York	6,300	3,838	3,792	3,285	3,542	2,669	1,654	677	16,997	42,754
North Carolina	1,405	1,340	999	1,372	1,201	819	485	167	4,981	12,769
North Dakota	117	122	69	67	89	33	27	10	288	822
Ohio	1,591	2,197	1,812	2,198	1,754	1,241	672	252	8,464	20,181
Oklahoma	382	458	464	468	409	218	133	35	1,682	4,249
Oregon	599	632	610	634	457	250	183	77	2,157	5,599
Pennsylvania	2,509	2,774	2,158	2,575	2,353	1,692	929	337	8,774	24,101
Rhode Island	250	263	123	302	191	142	106	44	833	2,254
South Carolina	636	738	517	581	507	320	157	71	2,090	5,617
South Dakota	86	124	65	49	104	51	26	9	387	901
Tennessee	710	1,120	836	716	945	579	373	122	3,901	9,302
Texas	2,716	3,325	3,489	2,536	2,829	1,822	1,108	389	11,986	30,200
Utah	273	285	411	377	300	158	83	32	1,433	3,352



**Table B.3. Non-Primary Care Physicians by Specialty, 2013, Continued**

<b>Geographic Area</b>	<b>Psychiatry</b>	<b>Surgery</b>	<b>Anesthesiology</b>	<b>Emergency Medicine</b>	<b>Radiology</b>	<b>Cardiology</b>	<b>Oncology (Cancer)</b>	<b>Endocrinology, Diabetes, and Metabolism</b>	<b>All Other Specialties</b>	<b>Total</b>
Vermont	174	126	102	78	106	52	35	14	393	1,080
Virginia	1,253	1,148	1,021	1,142	1,147	627	320	185	4,380	11,223
Washington	945	955	1,158	1,001	1,050	477	404	119	3,959	10,068
West Virginia	213	310	201	276	232	129	71	34	1,054	2,520
Wisconsin	767	807	915	756	1,007	412	287	113	3,229	8,293
Wyoming	53	68	59	71	44	20	9	4	209	537

**Note:** Physician data include all allopathic and osteopathic physicians.

**Table B.4. Number of Dentists by State in 2013,  
Ranked by Number per 10,000 Population**

<b>Rank</b>	<b>Geographic Area</b>	<b>Total Dentists</b>	<b>Dentists Per 10,000 Population</b>	<b>Total Population</b>
	<b>United States</b>	<b>200,946</b>	<b>6.36</b>	<b>316,128,839</b>
1	District of Columbia	691	10.69	646,449
2	Massachusetts	5,759	8.60	6,692,824
3	New Jersey	7,475	8.40	8,899,339
4	California	31,640	8.25	38,332,521
5	New York	15,642	7.96	19,651,127
6	Connecticut	2,855	7.94	3,596,080
7	Alaska	570	7.75	735,132
<b>8</b>	<b>Maryland</b>	<b>4,583</b>	<b>7.73</b>	<b>5,928,814</b>
9	Hawaii	1,079	7.68	1,404,054
10	Washington	5,222	7.49	6,971,406
11	Colorado	3,821	7.25	5,268,367
12	Illinois	8,846	6.87	12,882,135
13	Nebraska	1,267	6.78	1,868,516
14	Virginia	5,493	6.65	8,260,405
15	New Hampshire	867	6.55	1,323,459
16	Utah	1,886	6.50	2,900,872
17	Pennsylvania	8,273	6.48	12,773,801
18	Michigan	6,291	6.36	9,895,622
19	Minnesota	3,411	6.29	5,420,380
20	Montana	631	6.22	1,015,165
21	Kentucky	2,647	6.02	4,395,295
22	Vermont	374	5.97	626,630
23	Wisconsin	3,321	5.78	5,742,713
24	North Dakota	413	5.71	723,393
25	Arizona	3,767	5.68	6,626,624
26	Idaho	913	5.66	1,612,136
27	Iowa	1,715	5.55	3,090,416
28	Florida	10,848	5.55	19,552,860
29	Nevada	1,504	5.39	2,790,136
30	Wyoming	314	5.39	582,658
31	Ohio	6,219	5.37	11,570,808
32	Texas	14,164	5.36	26,448,193
33	Tennessee	3,455	5.32	6,495,978
34	South Dakota	448	5.30	844,877
35	Rhode Island	556	5.29	1,051,511
36	New Mexico	1,095	5.25	2,085,287

**Table B.4. Number of Dentists by State in 2013,  
Ranked by Number per 10,000 Population Continued**

<b>Rank</b>	<b>Geographic Area</b>	<b>Total Dentists</b>	<b>Dentists Per 10,000 Population</b>	<b>Total Population</b>
37	Maine	693	5.22	1,328,302
38	Kansas	1,502	5.19	2,893,957
39	Oklahoma	1,980	5.14	3,850,568
40	North Carolina	4,990	5.07	9,848,060
41	West Virginia	936	5.05	1,854,304
42	Missouri	3,050	5.05	6,044,171
43	Louisiana	2,326	5.03	4,625,470
44	South Carolina	2,353	4.93	4,774,839
45	Indiana	3,232	4.92	6,570,902
46	Georgia	4,845	4.85	9,992,167
47	Delaware	433	4.68	925,749
48	Alabama	2,233	4.62	4,833,722
49	Oregon	1,780	4.53	3,930,065
50	Mississippi	1,304	4.36	2,991,207
51	Arkansas	1,234	4.17	2,959,373

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

**Note:** Data include all professionally active dentists.

Source: Census, 2013 and Kaiser Family Foundation web-sites:

<http://kff.org/other/state-indicator/total-dentists/#>

**Census Bureau, Annual Estimates of the Resident Population for the United States in 2013**

<https://www.census.gov/popest/data/state/totals/2013/index.html>

## References

American Academy of Pediatrics. (1999). *Medicaid Reimbursement Survey Fixed Fee Schedule 1998/1999*. Retrieved from [http://www.aap.org/en-us/professional-resources/Research/Medicaid%20Reimbursement%20Reports/1998-1999\\_MedicaidReimbursement\\_FixedFeeSchedule.PDF](http://www.aap.org/en-us/professional-resources/Research/Medicaid%20Reimbursement%20Reports/1998-1999_MedicaidReimbursement_FixedFeeSchedule.PDF)

American Dental Association. (2004, October). *State and Community Models for Improving Access to Dental Care for the Underserved— Executive Summary*. Retrieved from [http://www.ada.org/~media/ADA/Advocacy/Files/topics\\_access\\_whitepaper\\_execsumm.ashx](http://www.ada.org/~media/ADA/Advocacy/Files/topics_access_whitepaper_execsumm.ashx)

United States Government Accountability Office. (2012, November). *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*. Retrieved from <http://www.gao.gov/assets/650/649788.pdf>

United States Census Bureau. (2013). Retrieved on November 12, 2014 from <https://www.census.gov/popest/data/state/totals/2013/index.html>

Kaiser Family Foundation, State Health Facts. Retrieved on November 12, 2014 from <http://www.statehealthfacts.org>

Magge, H., Cabral, H. J., Kazis, L. E., & Sommers, B. D. (2013). Prevalence and predictors of underinsurance among low-income adults. *Journal of General Internal Medicine*, 9(28), 1136-1142.