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

January 22, 2013

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

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

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

Dear Chairmen Middleton and Hammen:

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

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

If further information on this subject is required, please contact Marie Grant, Director of the Office of Governmental Affairs, at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

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

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

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

I. Introduction

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

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

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

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

II. Background

In September 2001, in response to Chapter 702 (HB 1071) of the 2001 session, the Department prepared the first annual report, analyzing the physician fees that are paid by the Maryland Medicaid and MCHP programs. In 2002, SB 481 required the submission of this report on an annual basis. This is the twelfth annual report.

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

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

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

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

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

For FY 2007 and FY 2008, based on the stakeholders' recommendations, the Department increased fees for procedures of different specialties, as shown in Table 1. In addition, procedures with the lowest fees were raised to a minimum of 50 percent of Medicare fees in FY 2008. Subsequently, the Department implemented other fee changes for FY 2009. In previous years, fees for many procedures, including orthopedic, gynecology/obstetrics, neurosurgery, otorhinolaryngology (ENT), and emergency medicine were set at 100 percent of their corresponding Medicare fee. Medicare fees in general had not increased substantially during the 2006 to 2008 period. However, updates in relative value units (RVUs) led to Medicare fee decreases for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for many procedures were at 50 percent of Medicare fees. Therefore, based on the stakeholders' recommendations, the Department increased the lowest Medicaid fees and re-balanced any Medicaid fees that were higher than their corresponding Medicare fees. In addition, separate fees for different sites of

[1] Maryland Medicaid Assistance program includes both Medicaid and MCHP.

service were established so that Medicaid fees would have site of service differentials for facilities (e.g., hospitals) and non-facilities (e.g., offices).

Medicaid fees that were higher than Medicare fees were reduced to their corresponding Medicare fee levels by site of service, and the lowest fees were raised to 78.6 percent of their corresponding Medicare fees by site of service. The exceptions to this methodology were that fees for four obstetric procedures (normal and cesarean delivery procedures) were maintained at their original FY 2008 levels, which are higher than their corresponding Medicare fees.

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

Table 1 shows the percentage of Medicare fees for targeted groups of procedures at the times of fee increases in FYs 2003, 2006, 2007, 2008, and 2009.

Table 1. Prior Fee Increases to Percentage of Medicare Fees

Fiscal Year	Procedure Code Group	Percent of Medicare Fees at Time of Fee Increase
2003	Evaluation and management (99201-99499)	80%
2006	Four Specialties:	
	Orthopedic (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 and management (99201-99499)	80%
	Evaluation and management in hospital outpatient departments	50%
	Neonatology procedures (99294, 99296, 99299)	90%
	Radiology procedures (70010-79900, excluding 77261-77799)	53%
	Vaccine administration procedures	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%
	Orthopedic (20000-29999),	100%
	Gynecology/Obstetrics (56405-59899)	100%
	Neurosurgery (61000-64999)	100%
	Emergency Medicine (99281-99285)	100%

III. Physician Fee Changes in FY 2010 through FY 2013

The national economic recession reduced state revenues in FY 2010. Therefore, the Department implemented a reduction in physician fees for FY 2010. Effective July 1, 2009, physician fees were reduced to achieve an $11.5 million total reduction in payment for physician services for FY 2010. Some groups of procedure codes and specialties were excluded from the reduction in fees. Enrollment growth rates were set consistent with historical trends. Then, fees for remaining procedures were reduced across the board by 5.8 percent to achieve the required reduction of the $11.5 million in FY 2010 payments.

Physician Fees for FY 2011

The Medicare program regularly updates RVUs for procedures. This results in fee increases for some procedures and fee decreases for other procedures. The Department compared the Maryland Medicaid fee for each procedure with its corresponding Medicare fee and reduced fees for procedures that exceeded Medicare fees to the Medicare fee levels. Fees for the four obstetric delivery procedure codes (59409, 59410, 59514, and 59515) remained at their original levels. Aside from these minor adjustments, the Department kept FY 2011 physician fees at the same level as FY 2010 fees.

Physician Fee Reduction for FY 2012

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

1. The four specialties mentioned in SB 836 (Orthopedic, Obstetrics/Gynecology, Neurosurgery, and Emergency) were kept at a maximum of 100 percent of Medicare fees, without increasing their fees. In other words, if the current Medicaid fee for one of these procedures was greater than its corresponding Medicare fee, then it was set equal to the Medicare fee. However, if the Medicaid fee for one of these procedures was lower than its corresponding Medicare fee, then it was not changed.
2. There are 4 obstetric (delivery) procedures (59409, 59410, 59514, and 59515), 3 neonatal intensive care unit (NICU) procedures (99469, 99472, and 99479), and 22 procedure codes that are used by educational institutions (90801, 90804, 90806, 90808, 90847, 90853, 92506, 92507, 92508, 92557, 96101, 96152, 97001, 97002, 97003, 97004, 97110, 97150, 97530, 97802, 97803, and T1000) that were kept at their original FY 2011 levels.

Consistent with the recent trends in enrollment, we assumed a 10 percent annual increase in total enrollment, which resulted in an approximate 21 percent increase from the database year (FY 2010) to the implementation year (FY 2012). Then, an across-the-board 1.22 percent reduction in fees was applied for all remaining procedures to achieve the required reduction in FY 2012 payments. Overall, fees were reduced from an average of 75 percent to an average of 74 percent of Medicare 2011 fees. Of the $6.52 million total reduction in FY 2012 payments, about $1.06 million were from the reduction in FFS payments and about $5.46 million were from the reduction of HealthChoice MCOs' capitation payments for physician services.

Physician Fees for FY 2013

There were no changes in Maryland Medicaid physician fees for the first half of FY 2013. Under the Affordable Care Act, the federal government will pay for increasing Medicaid payment rates in FFS and managed care for evaluation and management (E&M) procedures provided by primary care physicians (PCPs) to 100 percent of the Medicare payment rates for calendar years (CYs) 2013 and 2014. For services provided on or after January 1, 2013, and before January 1, 2015, states will receive 100 percent federal financing for increasing PCPs' payment rates from the rates that were in effect on July 1, 2009.

However, the Maryland Medicaid physician specialty code data are not very accurate; therefore, primary care specialties cannot be precisely distinguished from other specialties. In addition, Maryland Medicaid allows patients to select a specialist as their PCP when they have a medically complex condition. Therefore, in order to ensure that payments to all physicians who provide primary care services are at 100 percent of Medicare fees, it is necessary to increase fees for E&M procedures rendered by all providers.

At the time of this writing, Medicare physician fees for 2013 have not yet been published by CMS. However, CMS "issued a final rule with comment period on November 1, 2012 for Medicare's payments for physician fees for 2013…The changes in the rule are expected to increase payment to family practitioners by seven percent — and other primary care practitioners between three and five percent — if Congress averts the statutorily required reduction in Medicare's physician fee schedule."[2] Since it is unlikely the Department will have the 2013 Medicare physician fees by January 1, 2013, the Department will be communicating how it plans on paying the correct rate when the new Medicare rates become available.

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

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

Table 2 compares Maryland's FY 2013 Medicaid fees with the corresponding Medicare 2012 reimbursement rates and neighboring states' Medicaid fees for a sample of high-volume procedures in each specialty group. In this table, procedure fees are rounded to the nearest dollar amount and the last row of each section shows each state's weighted average fees for surveyed procedures as a percentage of Medicare fees in Maryland. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percentage of Medicare fees reported in this table corresponds to the appropriate Medicare non-facility and facility fees.

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

Maryland and West Virginia have separate facility and non-facility fees. Therefore, their facility and non-facility fees are compared with the corresponding Medicare fees. However, for Washington, D.C., Delaware, and Pennsylvania, which have one fee for each procedure, fees are compared with Medicare non-facility fees. Hence, for Washington, D.C., Delaware, and Pennsylvania, the percentages of Medicare fees reported in the table underestimate the percentage of Medicare fees for procedures performed in facilities. In 2009, Washington, D.C. set its Medicaid fees to 100 percent of its Medicare non-facility fees. Therefore, for many

[2] Source: Center for Medicaid and CHIP Services information bulletin dated November 2, 2012.

procedure groups, it has the highest or second highest physician reimbursement rates in the region. Virginia has separate facility and non-facility fees for some procedures. However, it did not report facility fees for many procedures that are included in Table 2. Therefore, we only reported Virginia's Medicaid non-facility fees.

For this report, we have compared Maryland's and other states' Medicaid rates with the Medicare fee schedule for Maryland. Average Medicare fees in Maryland are approximately 3 percent higher than Medicare fees in Pennsylvania, approximately 4 percent higher than Medicare fees in Virginia, 5 percent higher than Medicare fees in Delaware, and 7 percent higher than Medicare fees in West Virginia. Average Medicare fees in Washington, D.C. are approximately 6 percent higher than average Medicare fees in Maryland.

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

In the following paragraphs, we compare Maryland's fees with other states' fees for E&M and each group of specialty procedures, as shown in Table 2.

E&M Procedures

As an average percentage of Medicare 2012 fees in Maryland, Delaware has the highest fees in the region for the selected E&M procedures. Washington, D.C. ranks second; Maryland facility fees rank third; Virginia non-facility fees rank forth; Maryland non-facility fees rank fifth; West Virginia facility fees and non-facility fees rank sixth and seventh, respectively; and Pennsylvania ranks eight. As mentioned above, Maryland will increase fees for E&M procedures to 100 percent of Medicare 2013 fees.

Surgery

Integumentary Procedures

For integumentary[3] procedures, Delaware fees rank first, followed by Washington, D.C. fees (second), Virginia non-facility fees (third), Maryland facility fees (fourth), Maryland non-facility fees (fifth), West Virginia facility fees (sixth), West Virginia non-facility fees (seventh), and Pennsylvania fees (eighth).

Musculoskeletal System Procedures

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

Respiratory Procedures

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

[3] Integumentary procedures are related to skin.

Cardiovascular System Surgery Procedures
For selected cardiovascular system surgery procedures, Washington, D.C. has the highest fees. Virginia non-facility fees rank second, Maryland non-facility fees rank third, Maryland facility fees rank fourth, West Virginia facility fees rank fifth, West Virginia non-facility fees rank sixth, Delaware fees rank seventh, and Pennsylvania fees rank eighth. Because Pennsylvania has missing fees for three surveyed procedures, its percentage of Medicare fees is lower than it would have been had it covered these procedures. Also, please note that for ranking purposes, non-facility fees for Maryland and West Virginia are compared with Medicare non-facility fees.

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

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

Urinary and Male Genital Procedures
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
Pennsylvania has the highest fees for the selected gynecology and obstetrics procedures, followed, in ranking order, by West Virginia facility fees, West Virginia non-facility fees, Maryland facility fees, Maryland non-facility fees, Delaware fees, Virginia non-facility fees, and Washington, D.C. fees.

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

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

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

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

Radiology Procedures
For the selected radiology procedures, Delaware fees rank first, Washington, D.C. fees rank second, Maryland facility and non-facility fees rank third, Virginia non-facility fees rank fifth, West Virginia facility and non-facility fees rank sixth, and Pennsylvania fees have the last ranking.

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

Medicine

Psychiatry Procedures
For psychiatry procedures, Delaware fees rank first in the region. Maryland facility fees rank second, Maryland non-facility fees rank third, Washington, D.C. fees rank fourth, Virginia non-facility fees rank fifth, West Virginia facility fees rank sixth, and West Virginia non-facility fees rank seventh. Pennsylvania fees rank last in the region.

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

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

Ophthalmology and Vision Care Procedures
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), Maryland non-facility fees (fifth), West Virginia non-facility fees (sixth), Maryland facility fees (seventh), and Pennsylvania fees (eighth).

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

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

Non-Invasive Vascular Diagnostic Studies
For the selected non-invasive vascular diagnostic studies procedures, Washington, D.C. fees rank first, Virginia non-facility fees rank second, Delaware fees rank third, West Virginia facility and non-facility fees rank fourth and fifth, Maryland facility and non-facility fees rank sixth and seventh, and Pennsylvania fees rank last.

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

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

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

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

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

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

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

Osteopathy, Chiropractic, and Other Medicine Procedure
Virginia non-facility fees rank highest for osteopathy, chiropractic, and other medicine procedures, followed, in ranking order, by Pennsylvania fees, Delaware fees, Washington, D.C. fees, Maryland facility fees, Maryland non-facility fees, West Virginia non-facility fees, and West Virginia facility fees. The Virginia non-facility fee for procedure code 99173 (visual acuity screening) is 21 times the Medicare fee for this procedure.

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Evaluation & Management										
99203	Office/outpatient visit, new	$113	$79	$76	$65	$104	$82	$73	$53	$54	$95
99204	Office/outpatient visit, new	$171	$134	$112	$108	$159	$125	$112	$91	$90	$144
99212	Office/outpatient visit, establish	$46	$27	$31	$22	$43	$33	$29	$18	$26	$39
99213	Office/outpatient visit, establish	$75	$52	$48	$41	$70	$55	$48	$35	$35	$63
99214	Office/outpatient visit, establish	$111	$80	$72	$65	$104	$81	$72	$54	$54	$94
99223	Initial hospital care	$206	$206	$133	$133	$192	$152	$140	$140	$42	$171
99232	Subsequent hospital care	$74	$74	$49	$49	$69	$54	$49	$49	$17	$61
99238	Hospital discharge day	$74	$74	$51	$51	$69	$54	$49	$49	$17	$0
99244	Office consultation	$188	$157	$139	$114	$0	$137	$125	$107	$121	$157
99283	Emergency dept visit	$63	$63	$60	$60	$59	$44	$44	$44	$35	$52
99284	Emergency dept visit	$121	$121	$111	$111	$112	$83	$84	$84	$50	$99
99285	Emergency dept visit	$177	$177	$166	$166	$164	$122	$122	$122	$50	$145
99291	Critical care, first hour	$284	$229	$197	$159	$264	$208	$188	$156	$152	$237
99308	Nursing fac care, subseq	$70	$70	$44	$44	$65	$51	$46	$46	$37	$58
99381	Init pm e/m, new pat, infant	$115	$78	$85	$56	$108	$82	$74	$53	$20	$97
99391	Per pm reeval, est pat, infant	$102	$71	$64	$48	$96	$73	$66	$48	$20	$86
99392	Prev visit, est, age 1-4	$110	$78	$72	$56	$102	$78	$71	$53	$20	$92
99393	Prev visit, est, age 5-11	$109	$78	$71	$56	$102	$78	$71	$53	$20	$92
99394	Prev visit, est, age 12-17	$119	$88	$78	$64	$112	$85	$78	$60	$20	$100
99469	Neonate crit care, subsequent	$427	$427	$325	$325	$401	$339	$288	$288	$240	$355
99472	Ped critical care, subsequent	$412	$412	$325	$325	$386	$327	$280	$280	$240	$342
99479	Ic lbw inf 1500-2500 g Subseqnt	$131	$131	$107	$107	$122	$104	$88	$88	$76	$108
	Average % of Medicare Fees			**70%**	**79%**	**91%**	**72%**	**66%**	**68%**	**41%**	**83%**

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

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Integumentary										
10060	Drainage of skin abscess	$122	$101	$74	$66	$113	$94	$76	$65	$24	$103
11042	Debride skin/tissue	$117	$63	$54	$35	$108	$90	$73	$42	$33	$99
11721	Debride nail, 6 or more	$47	$26	$31	$21	$44	$36	$29	$18	$20	$39
12001	Repair superficial wound(s)	$101	$53	$102	$58	$93	$78	$63	$35	$25	$86
12011	Repair superficial wound(s)	$121	$65	$113	$69	$111	$94	$76	$44	$32	$103
17110	Destruct b9 lesion, 1-14	$120	$75	$70	$43	$112	$93	$73	$47	$49	$103
17250	Chemical cautery, tissue	$85	$39	$54	$26	$78	$65	$52	$25	$26	$73
	Average % of Medicare Fees			**71%**	**76%**	**93%**	**77%**	**62%**	**65%**	**29%**	**85%**
	Musculoskeletal System										
20550	Inj tendon sheath/ligament	$61	$43	$56	$39	$57	$48	$39	$29	$32	$52
20552	Inj trigger point, 1/2 muscl	$58	$39	$50	$33	$53	$45	$37	$26	$31	$0
20610	Drain/inject, joint/bursa	$75	$53	$72	$48	$69	$58	$48	$35	$24	$63
25600	Treat fracture radius/ulna	$342	$320	$259	$232	$314	$264	$215	$202	$115	$291
29075	Application of forearm cast	$97	$67	$80	$58	$89	$75	$61	$43	$46	$82
29125	Apply forearm splint	$69	$42	$61	$39	$64	$53	$43	$27	$26	$59
29130	Application of finger splint	$43	$30	$37	$27	$40	$34	$28	$20	N/A	$36
29515	Application lower leg splint	$76	$53	$65	$47	$70	$59	$48	$35	$35	$64
	Average % of Medicare Fees			**87%**	**84%**	**92%**	**77%**	**63%**	**65%**	**37%**	**80%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Respiratory										
30300	Remove nasal foreign body	$257	$139	$161	$88	$239	$198	$155	$86	$23	$222
31231	Nasal endoscopy, dx	$214	$83	$134	$57	$199	$165	$129	$54	$59	$184
31500	Insert emergency airway	$117	$117	$77	$77	$107	$92	$81	$81	$72	$96
31575	Diagnostic laryngoscopy	$126	$83	$83	$57	$117	$98	$79	$54	$69	$108
31622	Dx bronchoscope/wash	$345	$157	$236	$108	$144	$267	$215	$106	$134	$294
31624	Dx bronchoscope/lavage	$343	$157	$241	$108	$145	$266	$214	$106	$135	$293
	Average % of Medicare Fees			**66%**	**67%**	**77%**	**78%**	**63%**	**67%**	**40%**	**85%**
	Cardiovascular System Surgery										
36400	Bl draw < 3 yrs fem/jugular	$30	$21	$18	$13	$28	$24	$20	$14	N/A	$25
36406	Bl draw < 3 yrs other vein	$19	$9	$13	$7	$17	$15	$11	$6	N/A	$16
36410	Non-routine bl draw > 3 yrs	$19	$10	$14	$7	$18	$15	$12	$7	N/A	$16
36556	Insert non-tunnel cv cath	$257	$130	$194	$90	$119	$199	$162	$89	$113	$218
36569	Insert picc cath	$272	$98	$226	$72	$90	$210	$167	$66	$87	$233
36620	Insertion catheter, artery	$54	$54	$36	$36	$50	$43	$37	$37	$48	$44
	Average % of Medicare Fees			**76%**	**69%**	**52%**	**78%**	**63%**	**68%**	**39%**	**85%**
	Hemic, Lymphatic, and Mediastinum										
38220	Bone marrow aspiration	$173	$64	$123	$44	$161	$133	$106	$43	$55	$148
38221	Bone marrow biopsy	$179	$79	$136	$56	$167	$139	$110	$52	$70	$153
38525	Biopsy/removal, lymph nodes	$463	$463	$281	$281	$418	$361	$310	$310	$156	$385
38792	Identify sentinel node	$44	$44	$30	$30	$40	$34	$28	$28	N/A	$37
	Average % of Medicare Fees			**70%**	**65%**	**92%**	**78%**	**63%**	**67%**	**34%**	**85%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Digestive System										
42820	Remove tonsils and adenoids	$319	$319	$212	$212	$294	$249	$209	$209	$184	$268
42830	Removal of adenoids	$230	$230	$151	$151	$212	$179	$148	$148	$134	$194
43235	Upper GI endoscopy, diagnosis	$330	$158	$229	$104	$305	$255	$205	$106	$125	$282
43239	Upper GI endoscopy, biopsy	$380	$186	$263	$123	$351	$294	$237	$125	$149	$325
45378	Diagnostic colonoscopy	$435	$235	$299	$155	$401	$337	$274	$158	$181	$370
45380	Colonoscopy and biopsy	$519	$281	$357	$186	$479	$402	$326	$189	$225	$441
45385	Lesion removal colonoscopy	$584	$333	$400	$221	$538	$452	$369	$225	$268	$495
47562	Laparoscopic cholecystectomy	$797	$797	$502	$502	$718	$622	$538	$538	$589	$660
49080	Puncture, peritoneal cavity	N/A	N/A	N/A	N/A	N/A	$134	N/A	N/A	$64	$152
	Average % of Medicare Fees			**68%**	**65%**	**92%**	**80%**	**64%**	**67%**	**49%**	**87%**
	Urinary and Male Genital										
51600	Injection for bladder x-ray	$209	$47	$162	$34	$43	$161	$125	$31	$32	$181
51701	Insert bladder catheter	$62	$29	$53	$21	$57	$48	$38	$20	$25	$69
51798	Us urine capacity measure	$21	$21	$16	$16	$20	$16	$12	$12	$14	$0
52000	Cystoscopy	$223	$135	$163	$94	$125	$173	$141	$90	$75	$189
54150	Circumcision w/ regional block	$175	$105	$145	$73	$97	$136	$112	$72	$79	$148
	Average % of Medicare Fees			**81%**	**70%**	**54%**	**78%**	**63%**	**68%**	**42%**	**85%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Gynecology/Obstetric										
57452	Exam of cervix w/ scope	$118	$99	$108	$88	$108	$97	$77	$66	$40	$99
57454	Bx/curett of cervix w/ scope	$167	$147	$152	$133	$152	$137	$110	$99	$106	$139
58300	Insert intrauterine device	$76	$54	$76	$52	$0	$63	$49	$36	$17	$64
59025	Fetal non-stress test	$52	$52	$46	$46	$47	$43	$33	$33	$18	$44
59409	Obstetrical care	$895	$895	$860	$860	$788	$737	$896	$896	$1,200	$734
59410	Obstetrical care	$1,138	$1,138	$942	$942	$1,003	$937	$1,136	$1,136	$1,200	$934
59430	Care after delivery	$195	$154	$139	$125	$174	$160	$188	$153	N/A	$162
59514	Cesarean delivery only	$1,012	$1,012	$993	$993	$788	$832	$1,012	$1,012	$1,200	$829
59515	Cesarean delivery with postpartum	$1,380	$1,380	$1,124	$1,124	$1,003	$1,134	$1,375	$1,375	$1,200	$1,132
	Average % of Medicare Fees			**88%**	**89%**	**84%**	**82%**	**98%**	**98%**	**104%**	**82%**
	Endocrine System										
60100	Biopsy of thyroid	$119	$84	$82	$57	$110	$93	$77	$57	$66	$100
60240	Removal of thyroid	$989	$989	$662	$662	$896	$773	$667	$667	$591	$821
	Average % of Medicare Fees			**67%**	**67%**	**91%**	**78%**	**67%**	**67%**	**59%**	**83%**
	Nervous System										
62270	Spinal fluid tap, diagnostic	$170	$83	$150	$73	$156	$131	$106	$56	$42	$144
62311	Inject spine l/s (cd)	$226	$93	$183	$79	$211	$175	$138	$62	$75	$194
64450	N block, other peripheral	$113	$73	$99	$68	$105	$88	$72	$49	$21	$96
64483	Inj foramen epidural l/s	$262	$119	$257	$101	$244	$202	$161	$79	$95	$224
64614	Destroy nerve, extrem muscle	$191	$168	$161	$132	$174	$149	$124	$111	$123	$161
	Average % of Medicare Fees			**87%**	**86%**	**93%**	**91%**	**62%**	**67%**	**32%**	**85%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Eye Surgery										
65855	Laser surgery of eye	$363	$319	$227	$195	$333	$282	$234	$209	$237	$306
66984	Cataract surg w/ iol, 1 stage	$816	$816	$494	$494	$747	$636	$535	$535	$603	$683
67028	Injection eye drug	$124	$112	$136	$111	$114	$97	$80	$73	$106	$105
67210	Treatment of retinal lesion	$563	$541	$430	$413	$518	$438	$363	$351	$375	$475
67228	Treatment of retinal lesion	$1,118	$1,036	$731	$636	$1,025	$871	$730	$683	$491	$939
67311	Revise eye muscle	$643	$643	$370	$370	$588	$500	$420	$420	$468	$540
	Average % of Medicare Fees			**65%**	**64%**	**92%**	**78%**	**65%**	**65%**	**66%**	**84%**
	Ear Surgery										
69200	Clear outer ear canal	$138	$63	$113	$49	$128	$106	$84	$41	$30	$119
69210	Remove impacted ear wax	$55	$35	$44	$29	N/A	$43	$35	$23	$20	$47
69436	Create eardrum opening	$178	$178	$149	$149	$164	$139	$114	$114	$99	$150
69990	Microsurgery add-on	$237	$237	$199	$199	$206	$183	$162	$162	$201	$194
	Average % of Medicare Fees			**82%**	**83%**	**54%**	**78%**	**64%**	**65%**	**45%**	**84%**
	Radiology										
70450	Ct head/brain w/o dye	$201	$201	$177	$177	$187	$154	$120	$120	$117	$173
71010	Chest x-ray	$26	$26	$20	$20	$24	$20	$16	$16	$19	$22
71020	Chest x-ray	$34	$34	$26	$26	$31	$26	$20	$20	$25	$29
72193	Ct pelvis w/ dye	$301	$301	$259	$259	$281	$232	$180	$180	$140	$261
73610	X-ray exam of ankle	$37	$37	$24	$24	$34	$28	$22	$22	$27	$32
73630	X-ray exam of foot	$35	$35	$24	$24	$33	$27	$21	$21	$19	$30
74000	X-ray exam of abdomen	$27	$27	$21	$21	$25	$21	$16	$16	$18	$23
74160	Ct abdomen w/ dye	$345	$345	$263	$263	$322	$265	$205	$205	$149	$298
76805	Ob us >/= 14 wks, sngl fetus	$156	$156	$110	$110	$146	$135	$100	$100	$78	$142
76815	Ob us, limited, fetus(s)	$101	$101	$70	$70	$94	$82	$61	$61	$64	$87
	Average % of Medicare Fees			**79%**	**79%**	**93%**	**78%**	**60%**	**60%**	**56%**	**87%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Laboratory										
80053	Comprehen metabolic panel	$15	$15	$11	$11	$15	$14	$15	$15	$12	$12
80061	Lipid panel	$17	$17	$13	$13	$18	$18	$19	$19	$14	$17
81002	Urinalysis nonauto w/o scope	$4	$4	$3	$3	$4	$3	$3	$3	$4	$2
83655	Assay of lead	$17	$17	$12	$12	$17	$16	$17	$17	$10	$8
85025	Complete cbc w/ auto diff wbc	$11	$11	$8	$8	$11	$10	$11	$11	$6	$5
86592	Blood serology, qualitative	$5	$5	$4	$4	$6	$5	$6	$6	$4	$3
87081	Culture screen only	$9	$9	$7	$7	$9	$9	$9	$9	$5	$4
87086	Urine culture/colony count	$11	$11	$9	$9	$11	$10	$11	$11	$8	$6
87491	Chylmd trach, dna, amp probe	$44	$44	$33	$33	$48	$43	$50	$50	$23	$23
87880	Strep a assay w/ optic	$17	$17	$13	$13	$15	$16	$17	$17	$6	$7
	Average % of Medicare Fees			**75%**	**75%**	**101%**	**94%**	**104%**	**104%**	**60%**	**57%**
	Psychiatry										
90801	Psy dx interview	$161	$125	$147	$122	$152	$127	$107	$86	$26	$135
90804	Psytx, office, 20-30 min	$65	$51	$48	$43	$64	$51	$43	$35	$26	$54
90805	Psytx, off, 20-30 min w/ E&M	$76	$60	$53	$47	$75	$60	$50	$41	$26	$63
90806	Psytx, off, 45-50 min	$86	$78	$88	$82	$85	$69	$59	$54	$39	$71
90847	Family psytx w/ patient	$107	$98	$92	$87	$101	$85	$73	$67	$13	$89
90853	Group psychotherapy	$33	$30	$24	$23	$31	$26	$22	$20	$4	$28
90862	Medication management	$62	$46	$41	$34	$58	$49	$40	$31	$15	$52
	Average % of Medicare Fees			**88%**	**92%**	**96%**	**79%**	**67%**	**69%**	**27%**	**83%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Dialysis										
90935	Hemodialysis, one evaluation	$77	$77	$49	$49	$72	$61	$52	$52	$50	$64
90937	Hemodialysis, repeated eval	$109	$109	$80	$80	$103	$87	$74	$74	$50	$91
90945	Dialysis, one evaluation	$88	$88	$51	$51	$83	$70	$59	$59	$35	$73
	Average % of Medicare Fees			**65%**	**65%**	**94%**	**79%**	**67%**	**67%**	**63%**	**83%**
	Gastroenterology										
91034	Gastroesophageal reflux test	$217	$217	$167	$167	$203	$167	$130	$130	$172	$187
91110	Gi tract capsule endoscopy	$1,023	$1,023	$733	$733	$956	$786	$609	$609	N/A	$886
	Average % of Medicare Fees			**73%**	**73%**	**93%**	**82%**	**60%**	**60%**	**21%**	**87%**
	Ophthalmology/Vision Care										
92004	Eye exam, new patient	$155	$104	$95	$65	$145	$121	$99	$69	$59	$131
92012	Eye exam established pat	$89	$54	$53	$32	$83	$69	$56	$36	$29	$75
92014	Eye exam & treatment	$128	$83	$77	$50	$120	$100	$81	$55	$45	$109
92015	Refraction	$25	$20	$28	$14	$23	$19	$16	$14	$5	$21
92060	Special eye evaluation	$67	$67	$40	$40	$63	$52	$42	$42	$34	$57
92081	Visual field examination(s)	$53	$53	$38	$38	$49	$41	$32	$32	$28	$46
	Average % of Medicare Fees			**64%**	**62%**	**93%**	**78%**	**64%**	**66%**	**37%**	**85%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	ENT (Otorhinolaryngology)										
92551	Pure tone hearing test, air	$13	$13	$8	$8	$12	$10	$8	$8	$8	$11
92552	Pure tone audiometry, air	$33	$33	$18	$18	$30	$25	$19	$19	$8	$28
92557	Comprehensive hearing test	$42	$36	$47	$44	$39	$33	$27	$24	$29	$35
92567	Tympanometry	$16	$12	$16	$13	$15	$13	$10	$8	$12	$14
92568	Acoustic refl threshold tst	$17	$17	$16	$16	$16	$13	$11	$11	$10	$14
92585	Auditory evoked potentials (ABR comprehensive)	$135	$135	$101	$101	$126	$104	$80	$80	$27	$117
92587	Evoked auditory testing	$30	$30	$40	$40	$28	$24	$19	$19	$34	$26
	Average % of Medicare Fees			**84%**	**85%**	**93%**	**77%**	**61%**	**60%**	**62%**	**86%**
	Cardiovascular Medicine										
93000	Electrocardiogram, complete	$21	$21	$18	$18	$19	$16	$12	$12	$19	$18
93010	Electrocardiogram report	$9	$9	$6	$6	$8	$7	$6	$6	$8	$7
93016	Cardiovascular stress test	$23	$23	$18	$18	$0	$18	$15	$15	$22	$19
93042	Rhythm ECG, report	$8	$8	$6	$6	$7	$6	$5	$5	$7	$6
93303	Echo transthoracic	$225	$225	$171	$171	$211	$174	$137	$137	$157	$194
93307	Tte w/o doppler, complete	$143	$143	$148	$148	$134	$111	$87	$87	$140	$123
93320	Doppler echo exam, heart	$59	$59	$66	$66	$55	$45	$35	$35	$61	$50
93325	Doppler color flow add-on	$31	$31	$39	$39	$29	$24	$18	$18	N/A	$27
	Average % of Medicare Fees			**97%**	**97%**	**92%**	**77%**	**61%**	**61%**	**81%**	**86%**
	Non-Invasive Vascular Diagnostic Studies										
93880	Extracranial study	$198	$198	$140	$140	$185	$211	$162	$162	$148	$239
93970	Extremity study	$203	$203	$143	$143	$188	$218	$168	$168	$147	$247
93971	Extremity study	$129	$129	$91	$91	$120	$130	$100	$100	$100	$147
93976	Vascular study	$229	$229	$162	$162	$214	$182	$143	$143	$131	$204
	Average % of Medicare Fees			**71%**	**71%**	**93%**	**96%**	**74%**	**74%**	**68%**	**109%**

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Pulmonary										
94010	Breathing capacity test	$39	$39	$26	$26	$36	$30	$23	$23	$15	$34
94060	Evaluation of wheezing	$66	$66	$45	$45	$62	$51	$40	$40	$19	$57
94375	Respiratory flow volume loop	$42	$42	$28	$28	$39	$33	$25	$25	$31	$36
94640	Airway inhalation treatment	$19	$19	$11	$11	$18	$15	$11	$11	N/A	$17
94664	Evaluate pt use of inhaler	$19	$19	$12	$12	$17	$14	$11	$11	$12	$16
94760	Measure blood oxygen level	$3	$3	$2	$2	$3	$3	$2	$2	$2	$3
94761	Measure blood oxygen level	$5	$5	$5	$5	$5	$4	$3	$3	$4	$5
	Average % of Medicare Fees			**63%**	**63%**	**92%**	**76%**	**58%**	**58%**	**33%**	**87%**
	Allergy/Immunology										
95004	Percut allergy skin tests	$7	$7	$4	$4	$6	$5	$4	$4	$2	$6
95024	Id allergy test, drug/bug	$9	$1	$5	$5	$8	$7	$5	$0	$5	$7
95115	Immunotherapy, one injection	$11	$11	$10	$10	$10	$8	$6	$6	$4	$9
95117	Immunotherapy injections	$13	$13	$13	$13	$12	$10	$8	$8	$7	$11
95165	Antigen therapy services	$14	$4	$9	$2	$13	$11	$8	$2	$8	$12
	Average % of Medicare Fees			**88%**	**94%**	**92%**	**76%**	**57%**	**57%**	**46%**	**87%**
	Neurology/Neuromuscular										
95810	Polysomnography, 4 or more	$722	$722	$628	$628	$673	$554	$430	$430	$347	$625
95816	Eeg, awake and drowsy	$367	$367	$165	$165	$343	$282	$218	$218	$23	$318
95819	Eeg, awake and asleep	$417	$417	$167	$167	$389	$320	$246	$246	$23	$362
95860	Muscle test, one limb	$103	$103	$64	$64	$97	$80	$64	$64	$30	$88
95903	Motor nerve conduction test	$81	$81	$49	$49	$76	$63	$49	$49	$38	$70
95904	Sense nerve conduction test	$62	$62	$38	$38	$58	$48	$37	$37	$22	$53
95926	Somatosensory testing	$176	$176	$78	$78	$164	$135	$104	$104	$58	$152
95934	H-reflex test	$66	$66	$33	$33	$62	$51	$41	$41	$30	$57
95957	EEG digital analysis	$420	$420	$181	$181	$392	$323	$252	$252	$138	$362
	Average % of Medicare Fees			**63%**	**63%**	**93%**	**77%**	**59%**	**59%**	**28%**	**87%**

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

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	CNS Assessment Tests										
96110	Developmental test, lim	$11	$11	$9	$9	$10	$8	$0	$0	$7	$9
96111	Developmental test, extend	$131	$125	$96	$94	$0	$104	$89	$86	$50	$108
	Average % of Medicare Fees			**75%**	**77%**	**23%**	**79%**	**51%**	**51%**	**45%**	**84%**
	Chemotherapy Administration										
96411	Chemo, iv push, addl drug	$68	$68	$53	$53	$63	$52	$40	$40	$53	$59
96413	Chemo, iv infusion, 1 hr	$151	$151	$126	$126	$141	$116	$89	$89	$125	$132
96415	Chemo, iv infusion, addl hr	$33	$33	$28	$28	$31	$26	$20	$20	$28	$29
96417	Chemo iv infus each addl seq	$78	$78	$62	$62	$72	$59	$46	$46	$62	$67
96450	Chemotherapy, into CNS	$202	$86	$212	$75	$189	$156	$125	$58	$77	$173
96523	Irrig drug delivery device	$28	$28	$21	$21	$26	$21	$16	$16	$19	$24
	Average % of Medicare Fees			**83%**	**82%**	**93%**	**77%**	**59%**	**59%**	**78%**	**87%**
	Dermatology										
96910	Photochemotherapy with UV-B	$79	$79	$46	$46	$74	$60	$46	$46	$20	$69
96912	Photochemotherapy with UV-A	$102	$102	$59	$59	$95	$77	$59	$59	$20	$89
	Average % of Medicare Fees			**58%**	**58%**	**93%**	**76%**	**58%**	**58%**	**22%**	**87%**

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

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	Phys Medicine/Rehab Therapy										
97001	Physical therapy evaluation	$78	$78	$72	$72	$73	$61	$51	$51	$45	$66
97010	Hot or cold packs therapy	$6	$6	$4	$4	$6	$5	$4	$4	$17	$5
97014	Electric stimulation therapy	$16	$16	$10	$10	$15	$13	$10	$10	$17	$14
97035	Ultrasound therapy	$13	$13	$9	$9	$12	$10	$8	$8	$10	$11
97110	Therapeutic exercises	$33	$33	$29	$29	$31	$26	$21	$21	$8	$28
97112	Neuromuscular reeducation	$34	$34	$21	$21	$32	$27	$22	$22	$17	$29
97140	Manual therapy	$30	$30	$19	$19	$29	$24	$20	$20	$21	$26
97530	Therapeutic activities	$36	$36	$31	$31	$34	$28	$23	$23	$13	$30
	Average % of Medicare Fees			**78%**	**78%**	**94%**	**79%**	**64%**	**64%**	**54%**	**84%**
	Osteopathy, Chiropractic and Other Medicine										
98941	Chiropractic manipulation	$37	$32	$25	$21	$0	$30	$25	$22	$13	$32
99144	Mod sedation by same phys, age 5 years or older	$44	$44	$28	$28	$0	$61	$0	$0	N/A	$0
99173	Visual acuity screen	$3	$3	$2	$2	$3	$64	$2	$2	$6	$3
99183	Hyperbaric oxygen therapy	$232	$126	$150	$85	$215	$181	$147	$86	$107	$197
	Average % of Medicare Fees			**64%**	**65%**	**74%**	**828%**	**49%**	**48%**	**92%**	**72%**

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

V. Trauma Center Payment Issues

During the 2003 legislative session, the Maryland General Assembly passed, and the Governor signed into law, SB 479 (Chapter 395), which created a Trauma and Emergency Medical Fund that is financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the fund. Based on the legislation, Maryland Medicaid is required to pay physicians 100 percent of the Medicare facility rates for the Baltimore area when they provide trauma care to Medicaid's fee-for-service and HealthChoice program enrollees. The enhanced Medicaid fees apply only to services rendered in trauma centers designated by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fees were limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, HB 1164 (Chapter 484) of the 2006 legislative session extended the enhanced rate to any physician who provides trauma care to Medicaid beneficiaries beginning July 1, 2006. MHCC and the HSCRC fully cover the additional outlay of general funds that the Maryland Medical Assistance program incurs due to enhanced trauma fees (the state's share of the difference between current Medicare rates and Medicaid rates). MHCC pays physicians directly for uncompensated care and on-call services.

VI. Reimbursement for Oral Health Services

Historically, the Maryland Medical Assistance program has had low dental fees. Unlike fees for physician service, 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 publishes a survey reporting the national and regional average charges for approximately 165 of the most common dental procedures, offering data for comparison. Also, a book entitled the National Dental Advisory Service (NDAS) contains the percentile of charges for approximately 520 (of a total of approximately 580) dental procedures.

During the 2003 session of the Maryland General Assembly, the legislature included budgetary language in HB 40 (Chapter 202) that stated, "It is also the intent of the General Assembly that $7.5 million of the funds included in the CY 2004 Managed Care rates for dental services be restricted to increasing fees for restorative procedures." The $7.5 million funding increase was based on a University of Maryland Dental School analysis of the impact of increasing certain restorative procedure fees to the 50th percentile levels of the ADA survey. In compliance with the budgetary language, effective March 1, 2004, MCOs were required to reimburse their contracted providers at the ADA's then-current 50^{th} percentile of charges for 12 restorative procedures. At the same time, Medicaid increased FFS rates to the ADA's 50^{th} percentile levels for the corresponding restorative procedures.

In June 2007, the Secretary of the Maryland Department of Health and Mental Hygiene convened the Dental Action Committee to increase access to dental care services for Maryland children whose families have low incomes. The Dental Action Committee recommended increasing the dental reimbursement rates to the 50^{th} percentile of the ADA's South Atlantic region charges for all dental procedures. Subsequently, SB 545 (Chapter 589) of the 2008 session

of the Maryland General Assembly allocated $7 million in state funds ($14 million total funds) for increasing dental fees in FY 2009. The rate increase targeted preventive procedures and went into effect on July 1, 2008.

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

Table 3 shows Maryland Medicaid FY 2013 weighted average dental fees by groups of procedures as percentages of the ADA's 50th percentile of charges in 2011.

Table 3. Average of Maryland Medicaid Dental Fees as a Percentage of the ADA's 50th Percentile of Charges in 2011

Procedure Groups	**Medicaid FY 2013 Fees**
D0100-D1999 Diagnostic & Preventive Procedures	62%
D2000-D2999 Restorative Procedures	59%
D3000-D3999 Endodontic Procedures	34%
D4210-D6999 Periodontics and Prosthodontics	49%
D7000-D7999 Oral and Maxillofacial Surgery	51%
D8000-D9999 Orthodontics & Adjunctive General Services	30%
All Procedures Combined	**54%**

Table 4 compares Maryland Medicaid dental fee for some of the high-volume procedures, with the corresponding fees in Delaware, Virginia, and Washington, D.C. Because Pennsylvania and West Virginia had some missing fees, their fees are not included in the table. We used Maryland's number of claims for these dental procedures to determine the weighted average rank of Maryland and neighboring states' fees. The ranking of states' fees are: Delaware (first), Washington, D.C. (second), Maryland (third), and Virginia (fourth).

Table 4. Maryland Medicaid and Neighboring States' FY 2013 Dental Fees

Procedure Code	Procedure Description	MD	DE	VA	DC
D0120	Periodic Oral Examination	$29	$42	$20	$35
D0140	Oral Evaluation-Limited-Problem Focused	$43	$64	$25	$50
D0145	Oral Evaluation, Patient < 3 Yrs Old	$40	$0	$20	$0
D0150	Comprehensive Oral Evaluation	$52	$76	$31	$78
D1110	Prophylaxis Adult 14 and Over	$58	$77	$47	$78
D1120	Prophylaxis Child Up to Age 14	$42	$57	$34	$47
D1203	Topic Appl of Fluor Exclud Proph-	$22	$32	$21	$29
D1204	Topical Appl of Fluoride (No Prophylaxis)	$23	$32	$21	$26
D1206	Topical Fluoride Varnish	$25	$38	$21	$0
D1351	Top Appl Seal Per Tooth Max 4 Per Quad	$33	$46	$32	$38
D7140	Extraction, Erupted Tooth or Exposed	$103	$148	$69	$110
D9248	Non-Intravenous Conscious Sedation	$187	$277	$110	$0
	State Rank	**3**	**1**	**4**	**2**

VII. Physician Participation in the Maryland Medicaid Program

Physicians' claims and encounter data pertaining to FY 2002 (the year before the July 2002 fee increase), FY 2009, FY 2010, and FY 2011 were analyzed for the number of physicians who had either partial or full participation in the Medicaid program.[4] In Tables 5, 6, and 7, physicians who had fewer than 25 claims during the fiscal year are included in the data for all physicians but are not shown separately. Physicians who submitted more than 25 claims but had fewer than 50 Medicaid patients were considered partial participants in the Medicaid program. Physicians who had at least 50 Medicaid patients during the year were considered full participants in the Medicaid program.

Tables 5, 6, and 7 show the percentage changes in the numbers of participating physicians from all specialties (including primary care) who participated in FFS programs, MCO networks, and the total Medicaid program. The data in Table 5 demonstrate that there were significant increases in physician participation in the FFS program, MCO networks, and the total Medicaid program between FY 2002 and FY 2011. Comparable figures for the FY 2002 to FY 2010 period for "All Physicians" in the FFS program, MCO networks, and total Medicaid program were 33.2, 57.8, and 92.8 percent, respectively.

[4] The data in these tables pertain to FY 2002 through FY 2011. Therefore, to some extent, these tables include the impact of fee changes in FY 2010 on physician participation in the Medicaid program.

Table 5. FY 2002-2011 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	47.2%	51.8%	109.3%
Full Participation	81.9%	137.4%	129.3%
All Physicians	37.0%	66.3%	106.1%

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

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

Similarly, examination of the data in Table 6 shows that, following the FY 2008 and FY 2009 fee increases, except for full participation in the FFS program, physician participation increased significantly between FY 2009 and FY 2011. During this period, total physicians participating in the FFS program increased from approximately 15,300 in FY 2009 to 15,900 in FY 2010 and 16,350 in FY 2011.

Table 6. FY 2009-2011 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	11.6%	4.1%	10.5%
Full Participation	-2.4%	29.2%	21.5%
All Physicians	6.7%	3.6%	9.6%

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

Data in Table 7 show that the increasing trend in total physician participation in the Medicaid program continued between FY 2010 and FY 2011.

Table 7. FY 2010-2011 Percentage Change in the Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	2.4%	1.3%	3.5%
Full Participation	-6.4%	11.3%	6.8%
All Physicians	2.8%	3.9%	5.8%

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

It is likely that with the 5.8 percent reduction in Medicaid physician fees in FY 2010, some physicians have decided to reduce their levels of participation in the Medicaid FFS program. However, the increase in the number of physicians with full participation from 2,160 in FY 2009 to 2,250 in FY 2010, and subsequent reduction to approximately 2,100 full-participation physicians in FY 2011 should not pose a problem for access of FFS Medicaid beneficiaries to

physician services. Also, the increases in total physician participation within the FFS program (particularly the increase in partial participation among physicians) compensates for the 150 physicians who have reduced their levels of participation in the FFS program. Furthermore, there was an increase in the number of physicians who were participating in MCO networks. The increase resulted from an increase in both the number of partial and full participants.

Between FY 2010 and FY 2011, the number of physicians who had fewer than 25 claims increased by 5.5 percent (figure not presented in the table). Moreover, the number of partially and fully participating physicians who had more than 25 claims increased by 3.5 percent and 6.8 percent, respectively. After taking into account these increases, the data show that 2,552 additional physicians participated in the Medicaid program in FY 2011 compared to FY 2010. This indicates that some of the partial- and full-participation physicians did not previously participate in the Medicaid program.

As mentioned above, the increase in the number of participating physicians is, to some extent, the result of Medicaid expansion and increased enrollment. Therefore, to separate the effects of the increase in physician fees from the effects of the increase in Medicaid enrollment, we conducted an additional analysis in which we calculated the number of claims per enrollee for each year, beginning in FY 2002 (see Table 8). For this analysis, we excluded radiology and laboratory procedures for all years, as they may not be representative of patients' access to physician services.

Table 8. Number of Claims per Medicaid Enrollee

Fiscal Year	Average Monthly Medicaid Enrollment	Number of Physician Claims and Encounters	Average Number of Claims Per Enrollee	Annual % Change in Claims Per Enrollee	Increase in Claims Per Enrollee From Each Year to 2011
2002	617,929	3,919,805	6.3	N/A	52%
2003	652,414	4,281,928	6.6	3.5%	47%
2004	669,021	4,789,248	7.2	9.1%	35%
2005	687,269	4,891,558	7.1	-0.6%	36%
2006	690,227	5,253,246	7.6	6.9%	27%
2007	700,930	5,527,421	7.9	3.6%	22%
2008	709,832	6,079,603	8.6	8.6%	13%
2009	772,582	6,933,686	9.0	4.8%	8%
2010	867,788	8,167,816	9.4	4.9%	3%
2011	951,464	9,183,685	9.7	2.5%	N/A

N/A: Not Applicable

The continued increase in the average number of claims per enrollee shows that, as physician reimbursement rates increased during the FY 2006 to FY 2009 period, Medicaid enrollees' utilization of physician services increased steadily, from an average of 6.3 claims per enrollee in FY 2002 to an average of 9.7 claims per enrollee in FY 2011. This is a 52 percent increase in Medicaid enrollees' utilization of physician services, which is a proxy for an increase in the

participation of physicians in the Maryland Medicaid program and may be interpreted as an increase in Medicaid enrollees' access 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 that Medicaid beneficiaries reported difficulties obtaining medical care. These national surveys rely on information reported by individuals who voluntarily participated in the surveys. The GAO also compared the results for Medicaid with private/commercial insurance coverage.

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

VIII. Plan for Future

One of the Department's goals remains to reimburse physicians at 100 percent of Medicare reimbursement rates. The Affordable Care Act provides temporary enhanced federal funding for Maryland to achieve this goal for some procedures. Specifically, the Affordable Care Act requires states to pay 100 percent of Medicare rates for certain evaluation and management services provided by primary care physicians during calendar years 2013 and 2014. The federal government will pay 100 percent of the increase in reimbursement rates for these two years. Maryland will be paying non-primary care physicians for these services at the Medicare rate as well. The federal government will match the cost of the services provided by non-primary care providers at Maryland's normal matching rate of 50 percent. Since it is unlikely the Department will have the 2013 Medicare physician fees by January 1, 2013, the Department will be communicating how it plans on paying the correct rate when the new Medicare rates become available. Lastly, another goal of the Department continues to be increasing the dental reimbursement rates to the 50th percentile of the ADA's South Atlantic region charges for all dental procedures.

Appendix A

Medicare Resource-Based Relative Value Scale and Anesthesia Reimbursement

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

For approximately 11,000 physician procedures, the Centers for Medicare and 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 (such as hospitals and skilled nursing facilities) than if they are performed in non-facilities (offices), where physicians must pay for practice expenses. The implementation of RBRVS resulted in increased payments to office-based (non-facility) procedures and reduced payments for hospital-based procedures.

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

CMS updates the conversion factor based on the Sustainable Growth Rate (SGR) system, which ties the updates to growth in the national economy. The SGR system is based on formulas designed to control overall spending while accounting for factors that affect the costs of providing care.

Medicare rates are adjusted annually. In 2002, overall Medicare rates actually decreased. However, following federal legislative mandates, Medicare physician fees increased by small percentages in subsequent years.

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

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

added to the time for the primary procedure. This time is then converted to units, with 15 minutes equal to 1 unit.

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

Appendix B

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

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

Table B.1. Number of Physicians by State

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

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

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

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

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

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

Note: Physician data include allopathic and osteopathic physicians.

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

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

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

Note: Physician data include allopathic and osteopathic physicians.

Table B.4. Dentists per 10,000 Population, 2012

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

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

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

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

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