STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

January 15, 2016

The Honorable Thomas M. Middleton
Chairman
Senate Finance Committee
3 East Miller Senate Office Bld.
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,

Van T. Mitchell
Secretary

Enclosure

cc: Shannon McMahon
Tricia Roddy
Audrey Parham-Stewart
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 2016

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Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates January 2016

I. Introduction

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

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

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

In addition, Section 15 of HB 70 (Chapter 656 of the Acts of 2009) requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare them with the fee-for-service rates for the same services paid to providers under the Maryland Medical Assistance program and within managed care organizations. On or before January 1 of every year, the Department must report this information and determine whether the fee-for-service rates and managed care organization provider rates will exceed the rates paid under the Medicare fee schedule. This report satisfies these requirements.

II. Background

In September 2001, in response to HB 1071 (Chapter 702 of the Acts of 2001), the Department prepared the first annual report analyzing the physician fees that are paid by Maryland Medicaid

[1]The Department used the resource-based relative value scale 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 CHIP. In 2002, SB 481 required the submission of this report on an annual basis. This is the fifteenth 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 procedure codes, which are used by both primary care and specialty care physicians.

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

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

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

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

Finally, SB 836 requires the Department to consult with the managed care organizations, 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

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

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.

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 led to decreases in Medicare fees for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for other procedures remained at 50 percent of Medicare fees. Therefore, based on stakeholders' recommendations, the Department increased the lowest Medicaid fees and re-balanced any Medicaid fees that were higher than their corresponding Medicare fees.

Furthermore, separate fees for different sites of service were established in FY09 so that Medicaid fees would have site-of-service differentials for facilities and non-facilities. "Facilities" include inpatient hospitals, nursing homes, and other medical care facilities, whereas "non-facilities" include physician offices and homes of patients. Medicaid fees higher than the Medicare fees were reduced to their corresponding Medicare fee levels by site of service, and the lowest fees were raised to 78.6 percent of their corresponding Medicare fees by site of service.

The Department used the resource-based relative value scale methodology as a benchmark, or point of reference, when it increased physician fees in fiscal years 2003, 2006, 2007, 2008, and 2009. Table 2 shows the percentage of Medicare fees for targeted groups of procedures at the times of fee increases in FYs 2003, 2006, 2007, 2008, and 2009.

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

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

III. Physician Fee Changes in FY10 through FY16

Physician Fees for FY10

The national economic recession reduced state revenues in FY10 necessitating an $11.5 million reduction in FY10 physician fee payments. Customized reductions were made to some codes, while most other procedures were subject to a 5.8 percent cut. Certain procedure codes and orthopedics, gynecology/obstetrics, neurosurgery, and emergency medicine procedure codes were excluded from the reduction in fees. 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 managed care organizations' 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 relative value units for procedures, which results in fee *increases* for some procedures and fee *decreases* for other procedures. The Department compared the Maryland Medicaid fee for each procedure with its corresponding Medicare fee and then reduced fees for procedures that exceeded Medicare fees to the Medicare fee levels. Aside from these adjustments, the Department maintained FY11 physician fees at the same level as FY10 fees. $117.7 million from the Rate Stabilization Fund ($238.8 million with matching federal funds) was allocated to maintaining prior fee increases.

Physician Fees for FY12

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

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

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

Physician Fees for CY13 and CY14

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

However, Maryland Medicaid allows patients who have medically complex conditions to select specialists as their primary care physicians. In order to improve access to primary care and specialists, the fees for evaluation and management and vaccine administration procedures were

increased for *all* providers, not just primary care physicians. The costs for the fee increase for physicians who did not self-attest as primary care physicians were financed at the regular federal medical assistance percentage (FMAP).

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

Federal Share of Fee Increase for Primary Care Physicians

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician Fees for FY15 and FY16

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

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

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

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

Table 6 compares Maryland's FY15 Medicaid fees with the corresponding Medicare 2015 reimbursement rates for Baltimore region, and neighboring states' Medicaid fees for a sample of approximately 250 high-volume procedures in various specialty groups. In this table, procedure fees are rounded to the nearest dollar amount, and the last row of each section shows each state's weighted average Medicaid fees for the surveyed procedures as a percentage of Medicare fees in the Baltimore region. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percentages of Medicare fees reported in this table correspond to the appropriate Medicare non-facility and facility fees. More specifically, Medicaid non-facility fees are compared with Medicare non-facility fees, and Medicaid facility fees, reported for Maryland and West Virginia, are compared with Medicare facility fees.

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

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

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

Comparisons of Evaluation and Management and Specialty Procedures

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

Evaluation and Management Procedures

As an average percentage of Medicare 2015 fees for Baltimore region, evaluation and management fees in Delaware are highest in the region. Maryland non-facility and facility fees rank second and third, respectively; Washington DC fees rank fourth; West Virginia facility fees rank fifth; Virginia non-facility fees rank sixth; West Virginia non-facility fees rank seventh; and Pennsylvania fees rank eighth. Pennsylvania has missing fees for two procedures, 99469 (neonatal critical care, subsequent) and 99479 (Intensive Care for Low Birth-Weight Infant 1500-2500 grams).

Surgery

Integumentary Procedures

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

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

Cardiovascular Surgical Procedures
Similar to last year's ranking order, Washington, DC 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 these procedures were covered.

Hemic, Lymphatic, and Mediastinum Procedures
For selected hemic, lymphatic, and mediastinum procedures, Delaware has the highest fees in the region followed by Washington, DC fees (second), Virginia non-facility fees (third), West Virginia facility fees (fourth), Maryland non-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, DC 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
Washington, DC 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
Maryland non-facility fees for the selected gynecology and obstetrics procedures rank highest in the region. Maryland facility fees rank second; West Virginia facility fees rank third; West

Virginia non-facility fees rank fourth; Delaware fees rank fifth; Washington, D.C., fees rank sixth; Virginia non-facility fees rank seventh; and Pennsylvania fees rank eighth. Pennsylvania data have missing fees for two procedures, 59430 (care after delivery) and 59514 (cesarean delivery only).

Endocrine System Procedures
For the selected endocrine system procedures, similar to last year's ranking, Delaware fees rank the highest. Washington, DC 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
Maryland non-facility fees for nervous system procedures are the highest in the region, followed, in ranking order, by Maryland facility fees, Delaware fees, Virginia non-facility fees, West Virginia facility fees, Washington, DC fees, West Virginia non-facility fees, and Pennsylvania fees.

Eye Surgery Procedures
Similar to last year's ranking order, Delaware fees for eye surgery procedures still rank first; Washington, DC 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
Washington, DC has the highest fees for ear surgery procedures in the region, followed by Maryland non-facility fees (second), Maryland facility fees (third), Virginia non-facility fees (fourth), West Virginia facility fees (fifth), West Virginia non-facility fees (sixth), Delaware fees (seventh), and Pennsylvania fees (eighth).

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

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

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, DC fees.

Medicine

Psychiatry Procedures

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

Dialysis Procedures

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

Gastroenterology Procedures

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

Ophthalmology and Vision Care Procedures

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

Otorhinolaryngology Procedures

Delaware fees are the highest for the selected Otorhinolaryngology (Ear, Nose, Throat) procedures in the region. Washington, DC 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. Pennsylvania did not report a fee for procedure 92504 (ear microscopy examination).

Cardiovascular Medicine Procedures

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

Noninvasive Vascular Diagnostic Studies

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

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

Neurology and Neuromuscular Procedures
Washington, DC 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 the selected CNS assessment procedures, Virginia non-facility fees rank first; Washington, DC fees rank second; Maryland facility and non-facility fees rank third and fourth; Pennsylvania fees rank fifth; Delaware fees rank sixth; West Virginia non-facility fees rank seventh; and West Virginia facility fees rank eighth.

Because Delaware's fee schedule lists $0 for 96102, 96111, and 96116, and West Virginia lists $0 for 96102 and 96110, their rankings as a percentage of Medicare fees are the lowest. Similarly, Pennsylvania's fees for the procedure codes 96102 are not available.

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

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

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

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

Osteopathy, Chiropractic, and Other Medicine Procedures
For the selected osteopathy, chiropractic, and other medicine procedures, Pennsylvania fees are highest, followed in ranking order by Virginia non-facility fees, Washington, DC fees, Maryland non-facility fees, Delaware fees, Maryland 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, DC data have a zero fee for 98941 and 99144.

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 FA	PA	DC
	1-Evaluation & Management										
99203	Office/outpatient visit, new	117	82	107	75	110	73	75	55	54	98
99204	Office/outpatient visit, new	177	139	162	127	166	112	115	93	90	149
99212	Office/outpatient visit, est	47	27	43	25	44	30	29	18	26	40
99213	Office/outpatient visit, est	78	54	71	49	73	49	50	36	35	66
99214	Office/outpatient visit, est	116	83	106	76	109	73	74	56	54	97
99223	Initial hospital care	217	217	198	198	205	138	145	145	42	180
99232	Subsequent hospital care	77	77	70	70	73	49	52	52	17	64
99238	Hospital discharge day	78	78	71	71	74	50	51	51	17	0
99244	Office consultation	197	165	181	151	0	125	0	0	121	166
99283	Emergency dept visit	66	66	60	60	63	44	45	45	35	54
99284	Emergency dept visit	125	125	115	115	119	83	87	87	50	103
99285	Emergency dept visit	185	185	170	170	176	123	128	128	50	151
99291	Critical care, first hour	296	239	271	219	278	187	194	163	152	245
99308	Nursing fac care, subseq	73	73	67	67	69	46	48	48	37	61
99381	Init pm e/m, new pat, inf	119	82	109	75	112	75	76	55	20	95
99391	Per pm reeval, est pat, inf	107	75	98	68	100	67	68	50	20	86
99392	Prev visit, est, age 1-4	114	82	105	75	107	72	73	55	20	91
99393	Prev visit, est, age 5-11	114	82	104	75	107	72	73	55	20	91
99394	Prev visit, est, age 12-17	125	93	114	85	117	79	80	63	20	105
99469	Neonate crit care, subsq	422	422	386	386	401	309	286	286	N/A	347
99472	Ped critical care, subsq	434	434	398	398	412	317	293	293	240	353
99479	Ic lbw inf 1500-2500 g subsq	132	132	121	121	125	97	90	90	N/A	110
Weighted Average % of Medicare Fees				92%	92%	92%	64%	64%	66%	40%	82%
Ranking				2	3	1	6	7	5	8	4

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

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 FA	PA	DC
	2-Integumentary and General Surgery										
10060	Drainage of skin abscess	128	106	74	66	119	102	79	67	24	107
10061	Drainage of skin abscess	225	197	131	117	210	180	142	126	53	188
11042	Debride skin/tissue	128	67	54	35	119	102	78	44	33	108
11056	Trim skin lesions 2 to 4	64	24	40	24	59	51	39	17	30	54
11100	Biopsy skin lesion	113	53	67	34	105	90	68	35	35	95
11721	Debride nail, 6 or more	48	26	31	21	45	39	31	18	20	41
12001	Repair superficial wound(s)	98	48	102	58	91	78	60	33	25	83
12011	Repair superficial wound(s)	120	60	113	69	112	95	74	41	32	101
17110	Destruct b9 lesion, 1-14	121	76	70	43	112	96	72	47	49	102
17250	Chemical cautery, tissue	87	40	54	26	81	69	52	26	26	74
Weighted Average % of Medicare Fees				66%	71%	93%	79%	61%	65%	29%	84%
Ranking				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)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	3-Musculoskeletal System										
20550	Inj tendon sheath/ligament	65	46	56	39	60	52	40	30	32	54
20552	Inj trigger point, 1/2 muscl	60	41	50	33	56	48	38	28	31	0
20553	Inject trigger points 3/>	70	47	55	37	65	56	44	31	34	59
20610	Drain/inject, joint/bursa	66	50	72	48	61	53	42	34	24	55
25600	Treat fracture radius/ulna	362	342	259	232	336	286	223	212	115	307
29075	Application of forearm cast	97	69	80	58	90	76	59	44	46	81
29125	Apply forearm splint	71	43	61	39	66	56	43	28	26	61
29130	Application of finger splint	45	31	37	27	42	36	28	21	N/A	38
29515	Application lower leg splint	79	54	65	47	74	63	49	35	35	67
29540	Strapping of ankle and/or ft	28	19	35	25	26	22	18	13	20	34
Weighted Average % of Medicare Fees				90%	85%	93%	80%	63%	65%	39%	82%
Ranking				2	3	1	5	7	6	8	4

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

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 FA	PA	DC
	4-Respiratory										
30300	Remove nasal foreign body	257	140	161	88	237	202	150	85	23	222
31231	Nasal endoscopy, dx	233	72	134	57	215	183	138	48	59	199
31237	Nasal/sinus endoscopy surg	285	177	232	136	265	226	177	117	160	242
31500	Insert emergency airway	120	120	77	77	113	97	82	82	72	99
31575	Diagnostic laryngoscopy	126	85	83	57	118	100	78	55	69	107
31622	Dx bronchoscope/wash	345	159	236	108	150	274	211	107	134	292
31624	Dx bronchoscope/lavage	345	161	241	108	153	274	211	109	135	290
32551	Insertion of chest tube	187	187	128	128	177	151	128	128	133	162
Weighted Average % of Medicare Fees				64%	69%	84%	79%	62%	67%	40%	85%
Ranking				6	4	2	3	7	5	8	1
	5-Cardiovascular System Surgery										
36400	Bl draw < 3 yrs fem/jugular	31	21	18	13	29	25	19	14	N/A	28
36406	Bl draw < 3 yrs other vein	22	11	13	7	21	18	14	8	N/A	18
36410	Non-routine bl draw > 3 yrs	19	10	14	7	17	15	12	7	N/A	16
36556	Insert non-tunnel cv cath	256	132	194	90	125	204	161	91	113	218
36558	Insert tunneled cv cath	869	307	670	217	290	685	518	205	266	745
36561	Insert tunneled cv cath	1,308	392	938	259	369	1,029	774	264	319	1,126
36569	Insert PICC cath	276	101	226	72	95	219	166	68	87	235
36620	Insertion catheter, artery	55	55	36	36	53	45	38	38	48	46
Weighted Average % of Medicare Fees				74%	68%	43%	79%	61%	68%	33%	85%
Ranking				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)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	6-Hemic, Lymphatic, and Mediastinum										
38220	Bone marrow aspiration	182	67	123	44	168	143	109	45	55	151
38221	Bone marrow biopsy	184	82	136	56	171	146	111	54	70	155
38500	Biopsy/removal lymph nodes	367	282	218	168	342	291	234	186	114	306
38505	Needle biopsy lymph nodes	140	79	93	56	131	111	85	51	67	119
38525	Biopsy/removal, lymph nodes	483	483	281	281	453	386	320	320	156	399
38792	Identify sentinel node	44	44	30	30	41	35	28	28	N/A	38
38900	Intraoperative identification of sentinel lymph node	152	152	113	113	144	123	105	105	110	125
Weighted Average % of Medicare Fees				66%	63%	93%	79%	63%	66%	36%	83%
Ranking				5	6	1	3	7	4	8	2
	7-Digestive System										
42820	Remove tonsils and adenoids	322	322	212	212	302	258	210	210	184	271
42830	Removal of adenoids	231	231	151	151	216	185	147	147	134	196
43235	Upper GI endoscopy, diagnosis	350	146	229	104	324	276	210	96	125	296
43239	Upper GI endoscopy, biopsy	447	164	263	123	414	352	266	108	149	379
45378	Diagnostic colonoscopy	428	236	299	155	398	340	265	158	221	364
45380	Colonoscopy and biopsy	510	282	357	186	474	405	315	188	225	433
45385	Lesion removal colonoscopy	575	334	400	221	535	457	358	224	268	487
47562	Laparoscopic cholecystectomy	728	728	502	502	684	583	488	488	589	598
49082	Abd paracentesis	214	83	141	59	199	169	129	55	55	180
Weighted Average % of Medicare Fees				66%	69%	93%	79%	62%	66%	48%	84%
Ranking				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 FA	PA	DC
	8-Urinary and Male Genital										
51600	Injection for bladder x-ray	203	49	162	34	46	160	119	33	32	172
51700	Irrigation of bladder	91	49	70	34	85	72	56	33	29	76
51701	Insert bladder catheter	60	30	53	21	55	47	37	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	223	138	163	94	130	178	140	92	75	186
52332	Cystoscopy and treatment	537	170	346	120	161	423	318	113	144	456
54150	Circumcision w/regional block	169	106	145	73	101	135	107	72	79	142
54161	Circum 28 days or older	215	215	144	144	202	173	142	142	128	178
Weighted Average % of Medicare Fees				80%	70%	34%	79%	60%	67%	25%	84%
Ranking				2	4	7	3	6	5	8	1
	9-Gynecology and Obstetrics										
57452	Exam of cervix w/scope	119	101	108	88	111	97	77	67	40	101
57454	Bx/curett of cervix w/scope	166	148	152	133	156	136	109	99	106	142
58100	Biopsy of uterus lining	118	95	109	85	111	97	77	64	51	102
58300	Insert intrauterine device	76	55	76	52	0	62	49	37	17	64
58301	Remove intrauterine device	103	73	95	66	97	84	66	50	17	89
59025	Fetal non-stress test	53	53	46	46	50	43	34	34	18	45
59409	Obstetrical care	909	909	860	860	855	744	895	895	1,200	763
59410	Obstetrical care	1,160	1,160	942	942	1,091	949	1,139	1,139	1,200	973
59430	Care after delivery	206	156	139	125	193	168	194	153	N/A	173
59514	Cesarean delivery only	1,021	1,021	993	993	855	835	1,007	1,007	N/A	858
59515	Cesarean delivery w/ postpartum	1,405	1,405	1,124	1,124	1,091	1,148	1,376	1,376	2,050	1,179
Weighted Average % of Medicare Fees				91%	91%	87%	82%	89%	90%	67%	84%
Ranking				1	2	5	7	4	3	8	6

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 FA	PA	DC
	10-Endocrine System										
60100	Biopsy of thyroid	124	87	82	57	116	99	80	59	66	104
60220	Partial removal of thyroid	780	780	518	518	733	626	518	518	521	652
60240	Removal of thyroid	1,015	1,015	662	662	954	815	679	679	591	843
60500	Explore parathyroid glands	1,066	1,066	683	683	1,002	855	713	713	705	884
Weighted Average % of Medicare Fees				65%	65%	94%	80%	67%	67%	61%	83%
Ranking				6	7	1	3	5	4	8	2
	11- Nervous System										
62270	Spinal fluid tap, diagnostic	177	86	150	73	164	140	108	58	42	150
62311	Inject spine l/s (cd)	244	98	183	79	226	193	147	65	75	100
64450	N block, other peripheral	88	50	99	68	82	70	54	33	21	75
64483	Inj foramen epidural l/s	241	124	257	101	224	191	147	81	95	208
64484	Inj foramen epidural add-on	95	56	113	55	89	76	60	38	60	82
64494	Inj paravert f jnt l/s 2 lev	95	57	87	54	54	76	59	38	42	81
64495	Inj paravert f jnt l/s 3 lev	95	58	88	55	54	76	59	38	42	81
Weighted Average % of Medicare Fees				94%	90%	86%	79%	56%	78%	36%	76%
Ranking				1	2	3	4	7	5	8	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)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	12-Eye Surgery										
65222	Remove foreign body from eye	72	56	49	36	68	58	46	37	26	64
65855	Laser surgery of eye	367	322	227	195	343	293	230	205	237	322
66821	After cataract laser surgery	359	339	203	190	335	286	222	211	217	314
66982	Cataract surgery complex	859	859	678	678	807	691	551	551	697	758
66984	Cataract surg w/iol, 1 stage	693	693	494	494	649	556	441	441	603	610
67028	Injection eye drug	110	108	136	111	103	88	70	69	106	96
67210	Treatment of retinal lesion	562	543	430	413	526	450	354	344	375	493
67228	Treatment of retinal lesion	1,081	1,022	731	636	1,014	868	693	660	491	951
67311	Revise eye muscle	648	648	370	370	607	519	412	412	468	574
67800	Remove eyelid lesion	138	112	81	65	129	110	86	71	41	122
Weighted Average % of Medicare Fees				73%	70%	96%	80%	64%	64%	72%	88%
Ranking				4	6	1	3	8	7	5	2
	13-Ear Surgery										
69200	Clear outer ear canal	136	64	113	49	126	107	81	41	30	117
69205	Clear outer ear canal	112	112	91	91	105	90	71	71	89	95
69210	Remove impacted ear wax	54	36	44	29	NA	43	34	24	20	46
69424	Remove ventilating tube	142	68	115	55	132	112	85	44	54	122
69436	Create eardrum opening	178	178	149	149	166	142	113	113	54	150
69990	Microsurgery add-on	252	252	199	199	235	200	172	172	N/A	199
Weighted Average % of Medicare Fees				82%	81%	50%	80%	62%	66%	31%	85%
Ranking				2	3	7	4	6	5	8	1

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

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 FA	PA	DC
	14-Radiology										
70450	CT head/brain w/o dye	126	126	177	177	117	100	75	75	117	117
71010	Chest x-ray	24	24	20	20	23	19	15	15	19	22
71020	Chest x-ray	30	30	26	26	28	24	18	18	25	29
72193	CT pelvis w/dye	246	246	259	259	228	194	145	145	140	224
73610	X-ray exam of ankle	34	34	24	24	32	27	20	20	27	32
73630	X-ray exam of foot	32	32	24	24	29	25	19	19	19	30
74000	X-ray exam of abdomen	26	26	21	21	24	20	16	16	18	23
74160	CT abdomen w/dye	251	251	263	263	233	198	148	148	149	228
74177	CT abd & pelv w/contrast	340	340	287	287	315	268	201	201	263	307
76805	Ob ultrasound /= 14 wks, sngl fetus	157	157	110	110	145	126	94	94	78	138
76815	Ob ultrasound, limited, fetus(s)	93	93	70	70	86	75	56	56	64	85
76816	Ob ultrasound follow-up per fetus	126	126	78	78	117	102	76	76	72	110
76817	Transvaginal ultrasound obstetric	107	107	74	74	99	86	65	65	88	96
76819	Fetal biophys profil w/o nst	98	98	78	78	91	79	59	59	86	84
76820	Umbilical artery echo	52	52	50	50	48	42	32	32	46	45
76830	Transvaginal ultrasound non-ob	135	135	88	88	125	108	80	80	77	120
76856	Ultrasound exam pelvic complete	120	120	88	88	112	97	71	71	77	118
Weighted Average % of Medicare Fees				83%	83%	93%	80%	60%	60%	71%	91%
Ranking				3	3	1	5	7	7	6	2

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

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

Procedure Code	Procedure Description	MC	MD	DE	VA	WV	PA	DC
	15- Laboratory							
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	16	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	5	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
Weighted Average % of Medicare Fees			78%	102%	87%	95%	63%	61%
Ranking			4	1	3	2	5	6

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 FA	PA	DC
	16-Psychiatry										
90791	Psy dx evaluation (no medical)	137	133	147	147	131	113	94	91	26	116
90792	Psy dx evaluation (w/ medical)	154	149	147	147	147	126	104	101	75	125
90832	Psytx, pt &/ family 30 minutes	67	66	48	48	64	55	47	47	26	56
90833	Psytx pt &/fam w/ E&M 30 min	69	68	48	48	66	56	48	48	N/A	57
90834	Psytx, pt &/ family 45 minutes	88	88	88	88	84	73	62	61	39	74
90837	Psytx, pt &/ family 60 minutes	133	132	98	98	127	109	91	91	52	111
90847	Family psytx w/ patient	111	111	92	87	107	92	77	77	13	92
Weighted Average % of Medicare Fees				91%	92%	95%	82%	69%	69%	31%	83%
Ranking				3	2	1	5	7	6	8	4

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 FA	PA	DC
	17-Dialysis										
90935	Hemodialysis, one evaluation	77	77	49	49	73	63	52	52	35	64
90937	Hemodialysis, repeated eval	111	111	80	80	105	90	75	75	35	92
90945	Dialysis, one evaluation	92	92	51	51	87	74	60	60	35	77
90960	ESRD srv 4 visits p mo 20+	303	303	207	207	286	246	201	201	N/A	253
90961	ESRD srv 2-3 visits p mo 20+	255	255	170	170	241	207	169	169	N/A	214
90962	ESRD serv 1 visit p mo 20+	197	197	133	133	186	159	130	130	N/A	165
90970	ESRD home pt serv p day 20+	8	8	6	6	8	7	6	6	N/A	7
Weighted Average % of Medicare Fees				66%	66%	95%	81%	67%	67%	17%	84%
Ranking				6	6	1	3	4	4	8	2
	18-Gastroenterology										
91034	Gastroesophageal reflux test	207	207	167	167	192	163	122	122	172	180
91038	Esoph imped funct test > 1hr	505	505	106	106	465	396	289	289	98	434
91065	Breath hydrogen/methane test	90	90	48	48	83	71	52	52	17	79
91110	GI tract capsule endoscopy	989	989	733	733	912	777	574	574	680	849
91122	Anal pressure record	247	247	190	190	230	196	149	149	69	208
Weighted Average % of Medicare Fees				72%	72%	92%	79%	58%	58%	61%	86%
Ranking				4	4	1	3	7	7	6	2

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

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 FA	PA	DC
	19-Ophthalmology and Vision Care										
92004	Eye exam, new patient	160	106	95	65	150	128	100	70	59	137
92012	Eye exam, established pat	92	56	53	32	86	74	57	37	29	80
92014	Eye exam & treatment	133	85	77	50	125	107	83	56	45	115
92015	Refraction	21	21	28	14	20	17	14	14	5	18
92060	Special eye evaluation	70	70	40	40	66	56	44	44	34	61
92081	Visual field examination(s)	37	37	38	38	35	29	23	23	28	32
92083	Visual field examination(s)	70	70	57	57	65	56	42	42	63	61
92250	Eye exam with photos	86	86	54	54	80	68	51	51	53	74
Weighted Average % of Medicare Fees				63%	62%	94%	80%	63%	66%	37%	86%
Ranking				5	7	1	3	6	4	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 FA	PA	DC
	20-ENT (Otorhinolaryngology)										
92504	Ear microscopy examination	33	10	26	9	31	26	19	7	N/A	29
92546	Sinusoidal rotational test	114	114	82	82	105	89	65	65	22	98
92547	Supplemental electrical test	7	7	5	5	7	6	4	4	4	6
92551	Pure tone hearing test, air	13	13	8	8	12	10	8	8	8	11
92552	Pure tone audiometry, air	35	35	18	18	32	27	19	19	8	30
92557	Comprehensive hearing test	40	34	47	44	38	32	26	23	29	34
92567	Tympanometry	16	12	16	13	15	13	10	8	12	13
92568	Acoustic refl threshold tst	17	16	16	16	16	14	11	11	10	14
92585	Auditory evoked potentials (ABR comprehensive)	149	149	101	101	137	117	86	86	27	124
92587	Evoked auditory (otoacoustic emission) testing	23	23	40	40	22	19	15	15	34	20
Weighted Average % of Medicare Fees				81%	82%	92%	79%	58%	59%	61%	85%
Ranking				4	3	1	5	8	7	6	2

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

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 FA	PA	DC
	21 - Cardiovascular Medicine Procedures										
93000	Electrocardiogram, complete	19	19	18	18	17	15	12	12	19	15
93010	Electrocardiogram report	9	9	6	6	9	7	6	6	8	8
93015	Cardiovascular stress test	83	83	80	80	77	66	51	51	90	70
93016	Cardiovascular stress test	24	24	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)	260	260	171	171	241	205	153	153	157	224
93306	Echo TT w/doppler complete	249	249	206	206	230	197	147	147	141	215
93307	Ech TT w/o doppler, complete	142	142	148	148	132	113	85	85	140	123
93320	Doppler echo exam, heart	60	60	66	66	55	47	36	36	61	51
93325	Doppler color flow add-on	29	29	39	39	27	23	17	17	N/A	25
Weighted Average % of Medicare Fees				83%	83%	92%	79%	60%	60%	65%	86%
Ranking				3	3	1	5	7	7	6	2
	22-Noninvasive Vascular Tests										
93880	Extracranial study	223	223	140	140	206	175	130	130	148	182
93922	Upr/l extremity art 2 levels	99	99	97	97	91	78	57	57	49	85
93970	Extremity study	218	218	143	143	201	171	127	127	147	179
93971	Extremity study	134	134	91	91	124	105	77	77	100	108
93975	Vascular study	311	311	185	185	250	245	182	182	182	340
93976	Vascular study	180	180	162	162	166	142	106	106	131	200
Weighted Average % of Medicare Fees				75%	75%	91%	79%	58%	58%	69%	97%
Ranking				4	4	2	3	7	7	6	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)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	23-Pulmonary										
94010	Breathing capacity test	40	40	26	26	37	31	23	23	15	34
94060	Evaluation of wheezing	67	67	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	21	21	11	11	19	16	12	12	N/A	18
94664	Evaluate pt use of inhaler	19	19	12	12	18	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
Weighted Average % of Medicare Fees				62%	62%	92%	78%	58%	58%	34%	86%
Ranking				4	4	1	3	6	6	8	2
	24-Allergy and Immunology										
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
Weighted Average % of Medicare Fees				99%	100%	92%	78%	56%	56%	53%	87%
Ranking				2	1	3	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 FA	PA	DC
	25-Neurology and Neuromuscular										
95810	Polysomnography, 4 or more	684	684	628	628	631	537	397	397	347	586
95811	Polysom 6/>yrs cpap 4/> parm	718	718	691	691	663	564	417	417	648	615
95816	EEG, awake and drowsy	396	396	165	165	365	310	228	228	23	336
95819	EEG, awake and asleep	452	452	167	167	416	354	259	259	23	385
95860	Muscle test, one limb	134	134	64	64	125	107	81	81	30	113
95886	Musc test done w/n test comp	99	99	48	48	92	79	89	89	66	85
95926	Somatosensory testing	159	159	78	78	146	125	92	92	58	138
95930	Visual evoked potential test	142	142	83	83	131	111	81	81	74	127
95951	EEG monitoring/videorecord	2,028	2,028	244	244	0	255	0	0	228	449
95957	EEG digital analysis	347	347	181	181	321	274	206	206	138	417
Weighted Average % of Medicare Fees				51%	51%	61%	56%	39%	39%	34%	65%
Ranking				4	4	2	3	6	6	8	1
	26-CNS Assessment Tests										
96102	Psycho testing by technician	69	24	28	0	0	55	0	0	N/A	62
96110	Developmental test, lim	11	11	9	9	10	8	0	0	7	8
96111	Developmental test, extend	136	128	96	94	0	111	91	87	50	114
96116	Neurobehavioral status exam	99	92	72	70	0	80	66	63	53	83
96118	Neuropsych test by psych/phys	103	82	84	68	98	84	69	57	40	87
Weighted Average % of Medicare Fees				76%	78%	44%	80%	35%	35%	50%	79%
Ranking				4	3	6	1	7	8	5	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 FA	PA	DC
	27-Chemotherapy Administration										
96411	Chemo, IV push, addl drug	68	68	53	53	63	53	39	39	53	58
96413	Chemo, IV infusion, 1 hr	149	149	126	126	137	117	85	85	125	127
96415	Chemo, IV infusion, addl hr	31	31	28	28	28	24	18	18	28	26
96417	Chemo IV infus each addl seq	69	69	62	62	63	54	40	40	62	59
96450	Chemotherapy, into CNS	199	87	212	75	185	158	120	58	77	168
96523	Irrig drug delivery device	28	28	21	21	25	21	0	0	19	24
Weighted Average % of Medicare Fees				86%	85%	92%	78%	53%	53%	80%	85%
Ranking				2	4	1	6	7	8	5	3
	28-Special Dermatological Procedures										
96910	Photochemotherapy with UV-B	79	79	46	46	73	62	44	44	20	67
96912	Photochemotherapy with UV-A	102	102	59	59	93	79	57	57	20	86
96920	Laser tx skin < 250 sq cm	169	72	120	48	157	134	101	47	59	N/A
96921	Laser tx skin 250-500 sq cm	187	81	118	48	174	148	112	53	59	N/A
96922	Laser tx skin >500 sq cm	258	131	174	81	240	205	157	86	98	N/A
Weighted Average % of Medicare Fees				62%	59%	92%	78%	46%	71%	28%	55%
Ranking				4	5	1	2	7	3	8	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)

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE	VA NF	WV NF	WV FA	PA	DC
	29-Physical Medicine and Rehabilitation										
97001	Pt evaluation	80	80	72	72	76	65	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	35	35	29	29	33	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
Weighted Average % of Medicare Fees				73%	73%	94%	80%	64%	64%	49%	84%
Ranking				4	4	1	3	6	6	8	2
	30-Osteopathy, Chiropractic, and Other Medicine										
98941	Chiropractic manipulation	44	37	25	21	41	35	29	25	13	0
99144	Mod sedation by same phys, 5 yrs +	0	0	28	28	0	68	0	0	N/A	0
99173	Visual acuity screen	4	4	2	2	3	2	2	2	6	3
99183	Hyperbaric oxygen therapy	119	119	150	85	113	97	138	81	107	197
Weighted Average % of Medicare Fees				95%	77%	92%	106%	77%	62%	138%	103%
Ranking				4	6	5	2	7	8	1	3

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 FA	PA	DC
1-Evaluation & Management	92% (2)	92% (3)	92% (1)	64%(6)	64%(7)	66%(5)	40%(8)	82%(4)
2-Integumentary and General Surgery	66%(5)	71%(4)	93%(1)	79%(3)	61%(7)	65%(6)	29%(8)	84%(2)
3-Musculoskeletal System	90%(2)	85%(3)	93%(1)	80%(5)	63%(7)	65%(6)	39%(8)	82%(4)
4-Respiratory	64%(6)	69%(4)	84%(2)	79%(3)	62%(7)	67%(5)	40%(8)	85%(1)
5-Cardiovascular System Surgery	74%(3)	68%(5)	43%(7)	79%(2)	61%(6)	68%(4)	33%(8)	85%(1)
6-Hemic, Lymphatic, and Mediastinum	66%(5)	63%(6)	93%(1)	79%(3)	63%(7)	66%(4)	36%(8)	83%(2)
7-Digestive System	66%(6)	69%(4)	93%(1)	79%(3)	62%(7)	66%(5)	48%(8)	84%(2)
8-Urinary and Male Genital	80%(2)	70%(4)	34%(7)	79%(3)	60%(6)	67%(5)	25%(8)	84%(1)
9-Gynecology and Obstetrics	91%(1)	91%(2)	87%(5)	82%(7)	89%(4)	90%(3)	67%(8)	84%(6)
10-Endocrine System	65%(6)	65%(7)	94%(1)	80%(3)	67%(5)	67%(4)	61%(8)	83%(2)
11-Neurosurgery	94%(1)	90%(2)	86%(3)	79%(4)	56%(7)	78%(5)	36%(8)	76%(6)
12-Eye Surgery	73%(4)	70%(6)	96%(1)	80%(3)	64%(8)	64%(7)	72%(5)	88%(2)
13-Ear Surgery	82%(2)	81%(3)	50%(7)	80%(4)	62%(6)	66%(5)	31%(8)	85%(1)
14-Radiology	83%(3)	83%(3)	93%(1)	80%(5)	60%(7)	60%(7)	71%(6)	91%(2)
15-Laboratory	78%(5)	78%(5)	102%(1)	87%(4)	95%(2)	95%(2)	63%(7)	61%(8)
16-Psychiatry	91%(3)	92%(2)	95%(1)	82%(5)	69%(7)	69%(6)	31%(8)	83%(4)
17-Dialysis	66%(5)	66%(6)	95%(1)	81%(3)	67%(4)	67%(4)	17%(8)	84%(2)
18-Gastroenterology	72%(4)	72%(4)	92%(1)	79%(3)	58%(7)	58%(7)	61%(6)	86%(2)
19-Ophthalmology and Vision Care	63%(5)	62%(7)	94%(1)	80%(3)	63%(6)	66%(4)	37%(8)	86%(2)
20-ENT (Otorhinolaryngology)	81%(4)	82%(3)	92%(1)	79%(5)	58%(8)	59%(7)	61%(6)	85%(2)
21-Cardiovascular Medicine Procedures	83%(3)	83%(3)	92%(1)	79%(5)	60%(7)	60%(7)	65%(6)	86%(2)
22-Noninvasive Vascular Tests	75%(4)	75%(4)	91%(1)	79%(3)	58%(7)	58%(7)	69%(6)	97%(1)
23-Pulmonary	62%(4)	62%(4)	92%(1)	78%(3)	58%(6)	58%(6)	34%(8)	86%(2)
24-Allergy and Immunology	99%(2)	105%(1)	92%(3)	78%(5)	56%(7)	56%(6)	53%(8)	87%(4)
25-Neurology and Neuromuscular	51%(4)	51%(4)	61%(2)	56%(3)	39%(6)	39%(6)	34%(8)	65%(1)
26-CNS Assessment Tests	76%(4)	78%(3)	44%(6)	80%(1)	35%(7)	35%(8)	50%(5)	79%(2)
27-Chemotherapy Administration	86%(2)	85%(4)	92%(1)	78%(6)	53%(7)	53%(8)	80%(5)	85%(3)
28-Special Dermatological	62%(4)	59%(5)	92%(1)	78%(2)	46%(7)	71%(3)	28%(8)	55%(6)
29-Physical Medicine and Rehabilitation	73%(4)	73%(4)	94%(1)	80%(3)	64%(6)	64%(6)	49%(8)	84%(2)
30-Osteopathy, Chiropractic and Other Medicine	95%(4)	77%(6)	92%(5)	106%(2)	77%(7)	62%(8)	138%(1)	103%(3)

V. Trauma Center Payment Issues

In 2003, SB 479 (Chapter 385 of the Acts of 2003) created a Trauma and Emergency Medical Fund financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the fund. Based on the law, Maryland Medicaid is required to pay physicians 100 percent of the Medicare facility rates for the Baltimore area when they provide trauma care to Medicaid 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, managed care organizations were required to reimburse their contracted providers at the ADA's then-current 50th percentile of charges for 12 restorative procedures. At the same time, Medicaid increased fee-for-service rates to the ADA's 50th percentile levels for the 12 restorative procedures.

In June 2007, the 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 50th percentile of the ADA's South Atlantic region charges for all dental procedures. Subsequently, SB 545 (Chapter 589 of the Acts of 2008) allocated $7 million in state funds ($14 million with matching federal funds) for increasing dental fees in FY09. The rate increase targeted preventive procedures and went into effect on July 1, 2008.

Based on the recommendations of the Dental Action Committee, effective July 1, 2009, an administrative service organization—DentaQuest—coordinates the provision of dental services

for Medicaid beneficiaries in the fee-for-service program. Fees for some of the dental procedures were streamlined and adjusted, effective July 1, 2009, to coincide with the provision of all Medicaid dental services through the administrative service organization.

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

Table 8. Maryland 2014 and 2015 Medicaid Dental Fees

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

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

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

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

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

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

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

Procedure Code	Procedure Description	ADA CY13	MD	DE	VA	WV	PA	DC
D0120	Periodic oral evaluation	$45	$29	$46	$20	$25	$20	$35
D0140	Limited oral evaluation, problem focus	$65	$43	$69	$25	$35	N/A	$50
D0145	Oral evaluation, pt < 3yrs	$55	$40	$63	$20	$25	$20	$40
D0150	Comprehensive oral evaluation	$73	$52	$81	$31	$35	$20	$78
D1110	Prophylaxis – adult (12 years of age and older)	$82	$58	$83	$47	$55	$36	$78
D1120	Dental prophylaxis child	$61	$42	$63	$34	$40	$30	$47
D1206	Topical fluoride varnish	$35	$25	$39	$21	$20	$18	$29
D1351	Dental sealant per tooth	$48	$33	$50	$32	$30	$25	$38
D7140	Extraction erupted tooth	$155	$103	$164	$69	$80	$65	$110
D7286	Biopsy of oral tissue soft	$289	$231	0	$82	$130	N/A	$201
D7451	Remove odontogen cyst > 1.25 cm	N/A	$125	0	$161	$840	$80	$593
D9248	Nonintravenous conscious sedation	$170	$187	$295	$110	0	$184	0
Ranking			3	1	5	4	6	2

VII. Physician Participation in the Maryland Medicaid Program

Physician claims and encounter data pertaining to FY02 (the year before the July 2002 fee increase) and FY12 through FY15 were analyzed to determine the number of physicians who had partial or full participation in the Medicaid program.

Because of incurred but not reported (IBNR) claims, FY15 fee-for-service claims and managed care organizations' encounter data were not complete. Hence, they showed an insignificant decrease in the total number of participating physicians in FY15 compared with FY14. Therefore, FY14 data were used as the last year for comparison in Tables 11, 12, and 13.[5]

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

The data in Table 11 demonstrate significant increases in physician participation in the fee-for-service program, managed care organization networks, and the total Medicaid program between FY02 and FY14.

Table 11. Percentage Change in the Number of Participating Physicians of All Specialties, FY02-FY14

	FFS	MCO Networks	Total Medicaid
Partial Participation	51.7%	59.4%	92.0%
Full Participation	82.7%	172.1%	152.4%
All Physicians	52.4%	61.1%	96.5%

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

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

Similarly, examination of the data in Table 12 shows that, following the FY08 and FY09 fee increases, and increase in evaluation and management fees in CYs 2013 and 2014, physician participation increased significantly between FY12 and FY14.

[5] The data in these tables pertain to various fiscal years to FY14. As fees for E&M procedures were increased to Medicare fee levels in April 2013 (retroactive to January 2013), to some extent these tables reflect the impact of the fee increase on physician participation in the Medicaid program.

Table 12. Percentage Change in the Number of Participating Physicians of All Specialties, FY12-FY14

	FFS	MCO Networks	Total Medicaid
Partial Participation	0.8%	29.4%	19.4%
Full Participation	9.9%	27.4%	24.1%
All Physicians	7.4%	27.6%	22.9%

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

The data in Table 12 shows that physician participation in the fee-for-service program and managed care organization networks increased significantly between FY12 and FY 14. Furthermore, the number of physicians who had full participation in both fee-for-service program and managed care organization networks had a substantial increase. Table 13 shows that the increasing trend in total physician participation in the Medicaid program continued between FY13 and FY14.

Table 13. Percentage Change in the Number of Participating Physicians of All Specialties, FY13-FY14

	FFS	MCO Networks	Total Medicaid
Partial Participation	0.6%	13.4%	9.8%
Full Participation	13.6%	19.9%	18.4%
All Physicians	4.1%	10.8%	9.7%

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

Although national data pertaining to previous years have shown that fewer physicians provide services to higher numbers of Medicaid beneficiaries, the increase in Medicaid evaluation and management fees to Medicare fee levels in CYs 2013 and 2014 provided financial incentives for physicians to participate in Maryland Medicaid program, resulting in significant increases in numbers of physicians with full participation in Medicaid.

The increase in the number of participating physicians is, to some extent, the result of the Medicaid expansion under the Affordable Care Act, and increase in Medicaid 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

Fiscal Year	Average Monthly Medicaid Enrollment	Number of Physician Claims and Encounters	Average Number of Claims Per Enrollee	Annual % Increase in Claims Per Enrollee
2002	617,929	3,903,991	6.3	N/A
2003	652,414	4,274,666	6.6	3.7%
2004	669,021	4,758,155	7.1	8.5%
2005	687,269	4,816,418	7.0	-1.5%
2006	690,227	5,159,342	7.5	6.7%
2007	700,930	5,422,073	7.7	3.5%
2008	709,832	5,912,029	8.3	7.7%
2009	772,582	6,620,713	8.6	2.9%
2010	867,788	7,765,486	8.9	4.4%
2011	951,716	8,733,375	9.2	2.5%
2012	1,013,543	9,256,298	9.1	-0.5%
2013	1,066,815	9,770,347	9.2	0.3%
2014	1,180,725	10,721,531	9.1	-0.5%

N/A: Not Applicable

The continued increase in the average number of claims per enrollee shows that, as physician reimbursement rates increased in FY03, and subsequently during the FY06 to FY09 period, Medicaid enrollees' utilization of physician services increased steadily, from an average of 6.3 claims per enrollee in FY02 to an average of 9.1 claims per enrollee in FY14. This is approximately a 45 percent increase in utilization of physician services by Medicaid enrollees, which is a proxy for increase in the participation of physicians in the Maryland Medicaid program and may be interpreted as an increase in the access of Medicaid enrollees to physician services. The average number of claims per enrollee has become stable, and has fluctuated between 9.1 and 9.2 claims per enrollees since FY11.

Comparison of Access to Medical Care for Medicaid and Private Coverage

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

The GAO found that,

> Beneficiaries covered by Medicaid for a full year reported low rates of difficulty obtaining necessary medical care and prescription medicine, similar to those with private insurance coverage for a full year. In calendar years 2008 and 2009, approximately 3.7 percent of Medicaid beneficiaries enrolled for a full year and 3 percent of individuals

enrolled in private insurance for a full year reported difficulties obtaining needed medical care; the difference between these two groups was not statistically significant. In addition, 2.7 percent of full-year Medicaid beneficiaries reported difficulty obtaining needed prescription medicines and about 2.4 percent of individuals with full-year private insurance reported the same issue—also not statistically significant.

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 Medical Expenditure Panel Survey data from 2005–2008, indicates that Medicaid actually does a better job of providing access to affordable health care coverage than either private coverage or Medicare. Given the fact that more than one-third of low-income adults nationally were underinsured, the results of this study show the importance of safety net programs such as Medicaid. Magge et al. (2013) indicate that, in a comparison of different insurance groups, Medicaid beneficiaries were less likely to be underinsured than privately insured adults, indicating potential benefits of Medicaid expansion under the Affordable Care Act.

VIII. Plan for the Future

The Department remains dedicated to ensuring physicians are reimbursed equitably for their services. The provision of the Affordable Care Act requiring parity with the rates paid by Medicare for evaluation and management services and vaccine administration provided by Medicaid primary care physicians expired at the end of the 2014. Maintaining primary and specialist care physicians at 100 percent of the Medicare rate may not be feasible given the current budget challenges facing the State. Nonetheless, the Department will continue to monitor provider network adequacy to ensure that patient access to care is not compromised.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate formula that was used for annual update of Medicare physician fees under the resource-based relative value scale system. Furthermore, MACRA will replace Medicare's multiple quality of care reporting programs with a Merit-Based Incentive Payment System program that rewards physicians for providing high-quality, high-value health care; and for participating in new payment and delivery models to improve the efficiency of care while preserving the fee-for-service system. Beginning in 2019, MACRA will provide bonuses for physicians who score well in the Merit-Based Incentive Payment System quality reporting program.[6] The Department strongly supports these federal efforts to enhance the payment system and will be monitoring them closely.

[6] Source: American Medical Association section-by-section summary of "Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. Law 114-10"

Appendix A:
Medicare Resource-Based Relative Value Scale and Anesthesia Reimbursement

Medicare payments for physician services are made according to a fee schedule. The Medicare resource-based relative value scale methodology relates payments to the resources and skills that physicians use to provide services. There are three components that determine the relative weight of each procedure: physician work, practice expense, and malpractice expense. A geographic cost index and conversion factor are used to convert the weights to fees.

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

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

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

Payment for Anesthesia Procedures

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

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

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

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

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

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

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

Table B.1. Number of Physicians by State in 2014, Ranked by Number per 10,000 Population

Rank	Geographic Area	Primary Care Physicians	Specialist Physicians	Total Physicians	Physicians in Patient Care Per 10,000
	United States	435,084	479,636	914,720	28.7
1	District of Columbia	2,786	3,640	6,426	97.5
2	Massachusetts	14,369	17,955	32,324	47.9
3	Rhode Island	2,220	2,319	4,539	43.0
4	New York	35,839	44,563	80,402	40.7
5	Connecticut	6,136	8,038	14,174	39.4
6	**Maryland**	**10,063**	**12,280**	**22,343**	**37.4**
7	Pennsylvania	21,727	24,332	46,059	36.0
8	Michigan	16,663	18,579	35,242	35.6
9	Vermont	1,055	1,088	2,143	34.2
10	Ohio	17,619	20,805	38,424	33.1
11	Maine	2,228	2,126	4,354	32.7
12	New Jersey	13,392	14,566	27,958	31.3
13	Illinois	19,886	19,566	39,452	30.6
14	Delaware	1,376	1,481	2,857	30.5
15	Minnesota	7,999	8,571	16,570	30.4
16	Missouri	8,607	9,716	18,323	30.2
17	New Hampshire	1,866	2,086	3,952	29.8
18	Washington	9,769	10,266	20,035	28.4
19	Wisconsin	7,699	8,467	16,166	28.1
20	Oregon	5,443	5,664	11,107	28.0
21	West Virginia	2,581	2,560	5,141	27.8
22	Tennessee	8,342	9,617	17,959	27.4
23	Louisiana	5,674	6,742	12,416	26.7
24	California	49,140	53,493	102,633	26.5
25	Hawaii	1,791	1,889	3,680	25.9
26	Florida	24,865	26,688	51,553	25.9
27	Virginia	10,620	10,792	21,412	25.7
28	Nebraska	2,435	2,350	4,785	25.4
29	North Carolina	12,076	13,176	25,252	25.4
30	Colorado	6,673	6,868	13,541	25.3
31	Kentucky	5,091	5,961	11,052	25.0
32	New Mexico	2,647	2,574	5,221	25.0
33	North Dakota	1,000	850	1,850	25.0
34	Kansas	3,801	3,448	7,249	25.0
35	Arizona	7,943	8,735	16,678	24.8

Table B.1. Number of Physicians by State in 2014, Ranked by Number per 10,000 Population (Continued)

Rank	Geographic Area	Primary Care Physicians	Specialist Physicians	Total Physicians	Physicians in Patient Care Per 10,000
36	Iowa	4,006	3,660	7,666	24.7
37	South Carolina	5,818	5,852	11,670	24.1
38	Indiana	7,726	8,153	15,879	24.1
39	Alaska	942	798	1,740	23.6
40	Alabama	5,348	5,850	11,198	23.1
41	Georgia	11,434	11,793	23,227	23.0
42	Oklahoma	4,397	4,427	8,824	22.8
43	Arkansas	3,198	3,373	6,571	22.2
44	South Dakota	960	907	1,867	21.9
45	Texas	28,197	30,600	58,797	21.8
46	Montana	1,065	1,123	2,188	21.4
47	Utah	2,747	3,409	6,156	20.9
48	Mississippi	2,959	3,099	6,058	20.2
49	Nevada	2,773	2,818	5,591	19.7
50	Wyoming	589	551	1,140	19.5
51	Idaho	1,504	1,372	2,876	17.6

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, 2014

Geographic Area	Internal Medicine	Family Medicine/ General Practice	Pediatrics	Obstetrics and Gynecology	Total Primary Care
United States	179,040	127,756	78,243	48,857	435,084
Alabama	2,091	1,701	926	623	5,348
Alaska	199	533	121	88	942
Arizona	3,125	2,545	1,326	904	7,943
Arkansas	797	1,552	552	286	3,198
California	20,161	13,920	9,436	5,519	49,140
Colorado	2,313	2,507	1,070	767	6,673
Connecticut	3,369	707	1,194	861	6,136
Delaware	474	362	382	155	1,376
District of Columbia	1,418	308	723	330	2,786
Florida	10,315	7,643	4,263	2,557	24,865
Georgia	4,506	3,135	2,233	1,540	11,434
Hawaii	758	469	306	257	1,791
Idaho	347	844	155	155	1,504
Illinois	8,797	5,472	3,360	2,226	19,886
Indiana	2,497	3,187	1,178	844	7,726
Iowa	1,107	2,035	548	304	4,006
Kansas	1,087	1,696	631	380	3,801
Kentucky	1,812	1,781	879	606	5,091
Louisiana	2,204	1,621	1,079	764	5,674
Maine	754	961	304	192	2,228
Maryland	5,243	1,617	1,998	1,181	10,063
Massachusetts	8,424	1,792	2,856	1,275	14,369
Michigan	6,775	5,454	2,326	2,058	16,663
Minnesota	2,953	3,229	1,082	714	7,999
Mississippi	1,045	1,058	460	394	2,959
Missouri	3,486	2,542	1,567	972	8,607
Montana	318	523	105	117	1,065
Nebraska	717	1,100	396	221	2,435
Nevada	1,239	841	388	299	2,773
New Hampshire	794	558	310	199	1,866
New Jersey	6,396	2,466	2,886	1,591	13,392
New Mexico	897	1,015	477	255	2,647
New York	18,515	5,520	7,564	4,169	35,839
North Carolina	4,653	3,643	2,259	1,472	12,076

Table B.2. Primary Care Physicians by Field, 2014 (Continued)

Geographic Area	Internal Medicine	Family Medicine/ General Practice	Pediatrics	Obstetrics and Gynecology	Total Primary Care
North Dakota	298	544	100	56	1,000
Ohio	7,157	5,010	3,475	1,901	17,619
Oklahoma	1,197	2,084	675	428	4,397
Oregon	2,278	1,846	734	571	5,443
Pennsylvania	9,366	6,516	3,406	2,309	21,727
Rhode Island	1,231	249	483	254	2,220
South Carolina	1,930	2,161	981	730	5,818
South Dakota	312	466	108	72	960
Tennessee	3,350	2,398	1,583	1,001	8,342
Texas	10,030	8,966	5,493	3,619	28,197
Utah	841	952	598	352	2,747
Vermont	399	346	207	102	1,055
Virginia	3,891	3,443	2,006	1,255	10,620
Washington	3,373	3,991	1,489	895	9,769
West Virginia	868	1,116	349	241	2,581
Wisconsin	2,796	2,996	1,162	733	7,699
Wyoming	137	335	54	63	589

Note: Physician data include all allopathic and osteopathic physicians.

Table B.3. Non-Primary Care Physicians by Specialty, 2014

Geographic Area	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology (Cancer)	Endocrinology, Diabetes, and Metabolism	All Other Specialties	Total
United States	51,277	49,049	46,658	46,708	44,494	29,270	16,808	6,817	188,555	479,636
Alabama	474	699	548	397	603	368	192	55	2,514	5,850
Alaska	105	77	73	119	64	34	12	6	308	798
Arizona	821	918	1,012	964	826	489	219	92	3,394	8,735
Arkansas	317	349	318	283	338	192	119	36	1,421	3,373
California	6,782	4,920	5,615	5,130	4,630	2,916	1,574	714	21,212	53,493
Colorado	762	653	833	853	593	319	206	90	2,559	6,868
Connecticut	1,142	730	642	654	734	549	273	184	3,130	8,038
Delaware	154	161	94	193	184	103	55	11	526	1,481
District of Columbia	523	380	249	288	258	250	155	69	1,468	3,640
Florida	2,094	2,647	2,649	2,511	2,538	1,964	935	380	10,970	26,688
Georgia	1,180	1,352	1,169	1,220	1,105	742	392	146	4,487	11,793
Hawaii	309	176	184	205	164	70	38	22	721	1,889
Idaho	106	153	113	164	203	49	27	10	547	1,372
Illinois	1,954	1,935	1,943	2,226	1,886	1,257	663	309	7,393	19,566
Indiana	634	807	1,131	821	818	533	293	122	2,994	8,153
Iowa	309	461	430	285	377	243	122	29	1,404	3,660
Kansas	428	426	360	244	319	193	112	37	1,329	3,448
Kentucky	543	719	592	600	520	340	174	66	2,407	5,961
Louisiana	581	742	542	653	556	429	211	84	2,944	6,742
Maine	312	256	201	270	183	114	61	14	715	2,126
Maryland	1,618	1,147	1,093	852	994	711	556	226	5,083	12,280
Massachusetts	2,664	1,728	1,630	1,457	1,815	1,336	924	397	6,004	17,955

Table B.3. Non-Primary Care Physicians by Specialty, 2014 (Continued)

Geographic Area	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology (Cancer)	Endocrinology, Diabetes, and Metabolism	All Other Specialties	Total
Michigan	1,480	2,055	1,497	2,750	1,897	969	570	189	7,172	18,579
Minnesota	740	893	642	793	863	603	342	158	3,537	8,571
Mississippi	267	367	287	311	289	173	99	37	1,269	3,099
Missouri	925	1,006	1,016	928	991	582	337	157	3,774	9,716
Montana	105	133	140	115	112	52	29	7	430	1,123
Nebraska	216	273	284	188	233	154	84	27	891	2,350
Nevada	254	274	354	338	256	169	67	35	1,071	2,818
New Hampshire	239	238	200	202	179	136	73	26	793	2,086
New Jersey	1,566	1,395	1,583	1,201	1,197	1,122	488	257	5,757	14,566
New Mexico	355	236	257	316	210	127	70	35	968	2,574
New York	6,404	3,860	3,858	3,465	3,662	2,742	1,714	717	18,141	44,563
North Carolina	1,437	1,369	1,024	1,428	1,216	842	505	176	5,179	13,176
North Dakota	119	123	72	67	98	36	27	10	298	850
Ohio	1,631	2,220	1,830	2,320	1,796	1,274	703	263	8,768	20,805
Oklahoma	401	459	487	494	421	218	135	37	1,775	4,427
Oregon	606	634	626	648	466	245	182	77	2,180	5,664
Pennsylvania	2,511	2,810	2,166	2,649	2,364	1,740	960	349	8,783	24,332
Rhode Island	252	270	124	320	195	150	105	49	854	2,319
South Carolina	671	769	531	595	532	324	168	73	2,189	5,852
South Dakota	91	114	66	49	103	52	27	8	397	907
Tennessee	736	1,127	845	736	961	584	398	128	4,102	9,617
Texas	2,760	3,317	3,484	2,653	2,869	1,871	1,153	399	12,094	30,600
Utah	274	290	420	377	306	161	86	31	1,464	3,409

Table B.3. Non-Primary Care Physicians by Specialty, 2014 (Continued)

Geographic Area	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology (Cancer)	Endocrinology, Diabetes, and Metabolism	All Other Specialties	Total
Vermont	178	127	102	80	106	58	37	14	386	1,088
Virginia	1,230	1,095	986	1,148	1,090	629	316	186	4,112	10,792
Washington	961	968	1,176	1,022	1,060	479	431	117	4,052	10,266
West Virginia	233	310	196	290	235	134	79	36	1,047	2,560
Wisconsin	769	814	925	765	1,031	424	301	116	3,322	8,467
Wyoming	54	67	59	71	48	19	9	4	220	551

Note: Physician data include all allopathic and osteopathic physicians.

Table B.4. Number of Dentists by State in 2014, Ranked by Number per 10,000 Population

Rank	Geographic Area	Total Dentists	Dentists Per 10,000 Population
	United States	210,187	6.6
1	District of Columbia	750	11.4
2	Massachusetts	6,343	9.4
3	New Jersey	7,776	8.7
4	California	33,242	8.6
5	New York	16,396	8.3
6	Alaska	606	8.2
7	Connecticut	2,925	8.1
8	**Maryland**	**4,745**	**7.9**
9	Hawaii	1,117	7.9
10	Washington	5,494	7.8
11	Colorado	4,064	7.6
12	Illinois	9,122	7.1
13	Nebraska	1,315	7.0
14	Virginia	5,708	6.9
15	Pennsylvania	8,748	6.8
16	New Hampshire	890	6.7
17	Utah	1,956	6.6
18	Michigan	6,398	6.5
19	Minnesota	3,466	6.4
20	Montana	650	6.4
21	Kentucky	2,731	6.2
22	Arizona	3,999	5.9
23	Wisconsin	3,393	5.9
24	North Dakota	429	5.8
25	Florida	11,535	5.8
26	Nevada	1,615	5.7
27	Iowa	1,750	5.6
28	Ohio	6,480	5.6
29	Texas	15,039	5.6
30	Wyoming	324	5.5
31	Rhode Island	576	5.5
32	Tennessee	3,575	5.5
33	Kansas	1,579	5.4
34	New Mexico	1,125	5.4
35	South Dakota	457	5.4
36	North Carolina	5,312	5.3

Table B.4. Number of Dentists by State in 2014, Ranked by Number per 10,000 Population (Continued)

Rank	Geographic Area	Total Dentists	Dentists Per 10,000 Population
37	Maine	706	5.3
38	West Virginia	980	5.3
39	Oklahoma	2,038	5.3
40	Missouri	3,146	5.2
41	South Carolina	2,488	5.1
42	Louisiana	2,387	5.1
43	Idaho	832	5.1
44	Indiana	3,339	5.1
45	Georgia	5,087	5.0
46	Oregon	1,914	4.8
47	Delaware	450	4.8
48	Vermont	297	4.7
49	Alabama	2,292	4.7
50	Mississippi	1,333	4.5
51	Arkansas	1,268	4.3

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

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

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

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