Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

March 18, 2020

The Honorable Larry Hogan
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Bill Ferguson
President of the Senate
Maryland General Assembly
H-107 State House
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
Maryland General Assembly
H-101 State House
Annapolis, MD 21401-1991

Re: HB 70 (Ch. 656 of the Acts of 2009); Health – General § 15-103.5; and Insurance Article § 19-807(d)(2) — Annual Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates

Dear Governor Hogan, President Ferguson, and Speaker Jones:

Pursuant to Maryland Health-General §15-103.5 and Insurance Article §19-807(d)(2), the Maryland Department of Health is hereby submitting the required annual report that reviews the rates paid to providers under the federal Medicare fee schedule and compares the rates under the Medicare fee schedule to the fee-for-service rates paid to similar providers for the same services under the Maryland Medical Assistance Program and the rates paid to managed care organization providers for the same services under the Maryland Medical Assistance Program.

If you have any questions regarding this report, please contact me or my Chief of Staff Tom Andrews at 410-767-0136 or Thomas.Andrews@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Annual Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates

As required by HB 70 – MDH – Commissions, Programs, and Reports – Revision (Ch. 656 of the Acts of 2009); Health – General § 15-103.5; and Insurance Article § 19-807(d)(2)

Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates
January 2020

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I. Introduction

Pursuant to SB 481 (Chapter 464 of the Acts of 2002), the Maryland Department of Health (the Department) established an annual process to set the fee-for-service (FFS) 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 quality services and fair provider reimbursement. The law further stipulates that, in developing the rate-setting process, the Department should take into account community reimbursement rates and annual medical inflation, or utilize the Resource-Based Relative Value Scale (RBRVS) methodology and American Dental Association Current Dental Terminology (CDT-3) codes to set the Medicaid fee schedule. The RBRVS methodology is used by the Centers for Medicare & Medicaid Services (CMS) to establish the Medicare fee schedule. Appendix A includes a description of the RBRVS methodology.[1]

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

- 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
- The estimated costs of implementing the above schedule and proposed changes to the FFS reimbursement rates

In addition, Section 15 of HB 70 (Chapter 656 of the Acts of 2009) requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare them with the FFS rates for the same services paid to providers under the Maryland Medical Assistance program and within managed care organizations (MCOs). Furthermore, the Department requires MCOs to pay at least at the level of Medicaid FFS rates for evaluation and management (E&M) services. On or before January 1 of each year, the Department must report this information and determine whether the FFS rates and MCOs' provider rates will exceed the rates paid under the Medicare fee schedule. This report satisfies these requirements.

[1] The RBRVS methodology relates payments to resources that physicians use and the complexity of the services they provide. The Department used this methodology as a point of reference when it increased physician fees in fiscal years 2003 and 2006 –2009, and subsequently in fiscal years 2013 – 2019.

II. Background

In September 2001, in response to HB 1071 (Chapter 702 of the Acts of 2001), the Department prepared its first annual report analyzing the physician fees paid by Maryland Medicaid and CHIP. In 2002, SB 481 required the submission of this report on an annual basis. This is the 19th annual report.

The Department uses the Medicare fee schedule as a point of reference when it changes physician fees. The Department's first annual report showed that Maryland Medicaid's reimbursement rates in 2001 were, on average, approximately 36 percent of Medicare rates. Currently, Maryland Medicaid's overall reimbursement rates are approximately 87 percent of Medicare 2019 rates.

Furthermore, Senate Bill 836 of the 2005 General Assembly session created the Maryland Health Care Provider Rate Stabilization Fund (the Fund), which is administered by the Maryland Insurance Administration. The Fund was established in part to increase and maintain prior increases in physician fees within the Maryland Medical Assistance program. The Fund's primary revenues arise from a 2 percent tax imposed on MCO and health maintenance organization (HMO) revenues.

III. Physician Fee Changes in 2013 – 2019

Changes in Physician Fees due to ACA for CYs 2013 and 2014

There were no changes in Maryland Medicaid physician fees for the first six months of FY 2013. Under the Affordable Care Act (ACA), the federal government paid for increasing Medicaid payment rates in the Medicaid FFS program and MCOs for E&M and vaccine administration procedures provided by primary care physicians (PCPs) to 100 percent of the Medicare payment rates for calendar years (CYs) 2013 and 2014.

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

Federal Share of Fee Increases for Primary Care Physicians

For services provided between January 1, 2013, and December 31, 2014, the federal government provided 100 percent FMAP only for physicians who self-attested that they were PCPs.[2] The Department obtained self-attestations from approximately 3,600 physicians.

Claims and encounters data pertaining to PCPs and other physicians for E&M and vaccine administration procedures were analyzed. Base year utilization data and trend factors were used to estimate the costs of the fee increases in CYs 2013 and 2014, as shown in Table 1.

Table 1. Estimated Costs of E&M and Vaccine Administration Fee Increases to 100 Percent of Medicare Fees in CYs 2013 and 2014 (Million Dollars)

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

The estimated payments for E&M and vaccine administration claims and encounters data from self-attesting PCPs were divided by the estimated payments to all physicians for E&M and vaccine administration to calculate those payments that were subject to 100 percent FMAP. Table 2 shows the estimated cost of fee increases for E&M and vaccine administration procedures in CYs 2013 and 2014 that were subject to 100 percent federal financing.

Table 2. Estimated Amount of E&M and Vaccine Administration Cost Subject to 100 Percent FMAP in CYs 2013 – 2014 (Million Dollars)

Calendar Year	FFS	MCOs	Total
2013	$6.9	$57.9	$64.8
2014	$6.3	$61.6	$67.9

Maryland Health Care Provider Rate Stabilization Fund for Provider Rates

A total of $109 million was distributed to the Maryland Medical Assistance program from the Fund in FY 2013. With 50 percent FMAP for Medicaid and 65 percent for CHIP, the combined total amount of $222 million was used to maintain prior fee increases and increase provider reimbursement rates. The Fund contributed to increasing rates for non-PCPs, because their fee increases were not eligible for 100 percent FMAP.

2 The ACA specified that higher payment should be applied to primary care services delivered by physicians with the specialty designations of family medicine, general internal medicine, and pediatric medicine.

A total of $122 million was distributed to the Maryland Medical Assistance program from the Fund in FY 2014. With matching federal funds for Medicaid at 50 percent and CHIP at 65 percent, total federal matching funds reached approximately $125 million. The combined total amount of $247 million was allocated for maintaining provider reimbursement rates. Furthermore, $9.5 million in federal funds was allocated for physician services provided to Medicaid ACA expansion adult participants during the last six months of FY 2014.

Physician Fees for FYs 2015 – 2019

Following the expiration of 100 percent FMAP for E&M procedures provided by PCPs on January 1, 2015, Medicaid fees for these procedures were reduced to 87 percent of Medicare fees in April through June of 2015. Subsequently, with the support of the Governor, the Maryland legislature passed laws that increased Medicaid FY 2016 fees for E&M procedures to 92 percent of Medicare 2015 fees.

A total of $158.5 million was distributed to the Maryland Medical Assistance program from the Fund in FY 2015. With matching federal funds for Medicaid at 50 percent and 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 professional providers' reimbursement rates. The federal government paid approximately $31 million for physician services provided to Medicaid ACA expansion adult participants in FY 2015.

A total of $153 million was distributed to the Maryland Medical Assistance program from the Fund in FY 2016. With matching federal funds for Medicaid at 50 percent and CHIP at 88 percent,[3] total federal matching funds reached an estimated $214 million. The combined state and federal total amount of $367 million was allocated for maintaining provider reimbursement rates. Furthermore, $36 million in federal funds was assigned for physician services provided to Medicaid ACA expansion adult participants for FY 2016.

The Governor allocated approximately $5 million General Funds in FY 2017 for increasing Medicaid fees for E&M procedures to 94 percent of Medicare 2016 fees, effective October 1, 2016. Moreover, updates in relative value units (RVUs) led to decreases in Medicare fees for some procedures, resulting in Maryland Medicaid fees exceeding their corresponding Medicare fees. Therefore, effective January 1, 2017, the Department reduced any Medicaid fees that exceeded their corresponding Medicare fees and increased the lowest Medicaid fees for non-E&M procedures to approximately 72 percent of Medicare 2017 fees.

[3] Under the ACA, states received a 23 percent increase in FMAP for CHIP for federal fiscal years (FFYs) 2016 – 2019. Maryland's CHIP FMAP was 88 percent.

A total of $142.8 million was distributed to the Maryland Medicaid program from the Fund in FY 2017. The overall weighted average FMAP for FY 2017 was approximately 61 percent,[4] resulting in an overall state share of 39 percent. With the Fund allocation of $142.8 million, the total funds earmarked for maintaining physician reimbursement rates was $366.6 million in FY 2017, of which the federal share was $223.8 million.

A total of $130.1 million was distributed to the Maryland Medicaid program from the Fund in FY 2018. The overall weighted average FMAP for FY 2018 was approximately 61.6 percent, resulting in an overall state share of 38.4 percent. With the Fund allocation of $130.1 million, the total funds allocated for maintaining physician reimbursement rates was $338.8 million in FY 2018, of which the federal share was $208.7 million.

For FY 2019, approximately $4.5 million in total funds was allocated for increasing Medicaid fees for E&M procedures to a minimum of 93% of Medicare 2018 reimbursement rates. The new rates became effective on July 1, 2018.

A total of $151.4 million was distributed to the Maryland Medicaid program from the Fund in FY 2019. The overall weighted average FMAP for FY 2019 was approximately 61.2 percent, resulting in an overall state share of 38.8 percent. With the Fund allocation of $151.4 million, the total funds allocated for maintaining physician reimbursement rates was $390.5 million in FY 2019, of which the federal share was $239.1 million.

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

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

This section of the report compares Maryland's fees with other states' fees for E&M services and each group of specialty procedures. To compare Maryland's 2019 Medicaid fees with the corresponding Medicare 2019 reimbursement rates for the Baltimore region, as well as neighboring states' Medicaid fees, a sample of approximately 250 high-volume procedures in various specialty groups was selected. To select the codes for analysis, procedure codes were ordered by utilization within each specialty. The twelve codes with the highest utilization were included in the analysis. If the top twelve codes constituted higher than 90% of the total utilization for a specialty, the codes comprising 90% of the utilization were used, with a minimum of five codes per specialty included. Anesthesia procedures were not included in this comparison as the Medicare and Medicaid calculation for these codes differ (see Appendix B).

[4] The weighted average of various FMAPs includes regular Medicaid at 50 percent, enhanced CHIP funding at 88 percent, and ACA adult expansion participants at 95 percent, as well as administrative contracts that support provider services at approximately 61 percent. The FMAP for Medicaid expansion enrollees was 100 percent in federal fiscal year (FFY) 2014 through FFY 2016; it decreased to 95 percent in FFY 2017, 94 percent in FFY 2018, 93 percent in FFY 2019, and 90 percent in FFY 2020 and subsequent years.

The average percentages of Medicare fees were calculated using 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, West Virginia, and Delaware are compared with Medicare facility fees. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees.

Physician fees include three components: the physician's work, practice expenses (e.g., the costs of maintaining an office), and malpractice insurance expenses. 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.

The average Medicare fees in Maryland are approximately 7.9 percent higher than Delaware's Medicare fees, 5.6 percent higher than Pennsylvania's Medicare fees, 6.2 percent higher than Virginia's Medicare fees, and 7.6 percent higher than West Virginia's Medicare fees. Conversely, the average Medicare fees in Maryland are approximately 2.9 percent lower than the average Medicare fees in Washington, D.C.

Table 3 compares Maryland and its neighboring states' Medicaid reimbursement rates as percentages of Medicare rates for the Baltimore region by physician specialty in 2019. The numbers in parentheses indicate the rankings of the states and Washington, D.C. for each physician specialty (highest to lowest fees).

Table 3. Comparison of Maryland and Neighboring States' Medicaid Reimbursement Rates as Percentages of Medicare Rates, by Specialty, in 2019

Specialty	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
1-Evaluation & Management	93% (4)	93% (3)	94% (2)	94% (1)	70% (6)	65% (8)	67% (7)	42% (9)	84% (5)
2-Integumentary System / General Surgery	74% (6)	78% (4)	93% (2)	98% (1)	75% (5)	62% (8)	65% (7)	29% (9)	86% (3)
3-Musculoskeletal System	93% (2)	92% (4)	93% (3)	94% (1)	75% (6)	63% (8)	66% (7)	41% (9)	81% (5)
4-Respiratory System	76% (4)	75% (5)	93% (2)	94% (1)	75% (6)	62% (8)	66% (7)	40% (9)	85% (3)
5-Cardiovascular System – Surgical	85% (4)	82% (5)	92% (2)	94% (1)	75% (6)	60% (8)	67% (7)	35% (9)	86% (3)
6-Hemic, Lymphatic System, and Mediastinum	73% (5)	73% (6)	93% (2)	93% (1)	75% (4)	64% (8)	66% (7)	42% (9)	84% (3)
7-Digestive System	75% (5)	76% (4)	92% (2)	93% (1)	75% (6)	62% (8)	66% (7)	51% (9)	85% (3)
8-Urinary System and Male Genital	79% (5)	79% (4)	93% (2)	94% (1)	75% (6)	62% (8)	66% (7)	46% (9)	83% (3)
9-Gynecology and Obstetrics	82% (6)	83% (4)	60% (9)	63% (8)	81% (7)	91% (3)	93% (2)	102% (1)	83% (5)
10-Endocrine System	72% (5)	72% (6)	93% (2)	93% (1)	75% (4)	66% (8)	66% (7)	57% (9)	83% (3)
11-Nervous System	92% (3)	92% (4)	93% (2)	94% (1)	75% (5)	61% (8)	66% (7)	36% (9)	70% (6)
12-Eye Surgery	76% (6)	92% (5)	92% (2)	93% (1)	94% (7)	75% (9)	61% (8)	66% (4)	36% (3)
13-Ear Surgery	85% (3)	82% (5)	93% (2)	93% (1)	75% (6)	63% (9)	65% (8)	68% (7)	85% (4)
14-Radiology	79% (4)	79% (4)	92% (1)	92% (1)	78% (6)	60% (8)	60% (8)	71% (7)	86% (3)
15-Laboratory	76% (7)	76% (7)	89% (2)	89% (2)	89% (1)	84% (4)	84% (4)	79% (6)	72% (9)
16-Psychiatry	93% (4)	100% (1)	95% (3)	95% (2)	93% (5)	68% (8)	69% (7)	33% (9)	83% (6)
17-Dialysis	72% (5)	72% (6)	94% (1)	94% (2)	77% (4)	66% (7)	66% (8)	15% (9)	83% (3)
18-Gastroenterology	74% (4)	74% (4)	92% (1)	92% (1)	75% (3)	58% (8)	58% (8)	59% (7)	73% (6)
19-Ophthalmology and Vision Care	73% (6)	74% (5)	92% (2)	93% (1)	74% (4)	62% (8)	65% (7)	37% (9)	85% (3)
20-Otorhinolaryngology	98% (1)	97% (2)	92% (4)	92% (3)	74% (6)	58% (9)	58% (8)	60% (7)	87% (5)
21-Cardiovascular System – Medical	87% (3)	87% (4)	93% (1)	93% (2)	75% (6)	61% (7)	61% (8)	42% (9)	86% (5)
22-Noninvasive Vascular Diagnostic Studies	80% (4)	80% (4)	92% (1)	92% (1)	76% (6)	59% (8)	59% (8)	68% (7)	89% (3)
23-Pulmonary System	75% (4)	75% (4)	92% (1)	92% (1)	74% (6)	58% (7)	58% (7)	35% (9)	87% (3)
24-Allergy and Immunology	84% (2)	87% (2)	91% (4)	91% (4)	74% (6)	57% (8)	57% (7)	49% (9)	87% (1)
25-Neurology and Neuromuscular System	57% (2)	57% (2)	51% (4)	51% (4)	47% (6)	33% (8)	33% (7)	29% (9)	58% (1)
26-Central Nervous System Assessment Tests	79% (5)	79% (4)	87% (2)	88% (1)	76% (6)	57% (9)	57% (8)	64% (7)	87% (3)
27-Chemotherapy Administration	80% (4)	80% (5)	92% (2)	92% (1)	74% (7)	58% (9)	58% (8)	75% (6)	87% (3)
28-Special Dermatology	56% (7)	53% (8)	92% (2)	92% (1)	74% (3)	58% (5)	58% (4)	21% (9)	56% (6)
29-Physical Medicine and Rehabilitation	77% (6)	79% (5)	83% (4)	83% (3)	89% (1)	63% (8)	64% (7)	42% (9)	85% (2)
30-Osteopathy, Chiropractic, and Other Medicine	84% (4)	86% (3)	86% (2)	84% (5)	75% (6)	57% (8)	58% (7)	122% (1)	52% (9)

Delaware's rates are consistently highest as compared to neighboring states for most specialties. Pennsylvania ranks near the bottom for most specialties, but reimburses at the highest rates as compared to neighboring states for both gynecology and obstetrics and osteopathy, chiropractic, and other medicine. Maryland facility rates for psychiatry and non-facility rates for otorhinolaryngology rank highest among the states.

Maryland rates for evaluation and management, musculoskeletal system, nervous system, psychiatry, otorhinolaryngology specialties are all above 90 percent of Medicare rates. Maryland rates for the neurology and neuromuscular system specialty rank second among the states, although rates are 57 percent of the Medicare rate. Maryland ranks near the bottom for special dermatology, and rates are 56 percent of Medicare for non-facility and 53 percent of Medicare for facility. For all other specialties, Maryland rates are reimbursed at between 72 percent and 87 percent of the Medicare rate.

Table 4 shows the codes included in the analysis for each specialty, as well as the total percentage of Medicare and ranking from Table 3 above. 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.

Delaware, Maryland, and West Virginia have separate facility and non-facility fees. Pennsylvania does not separate facility and non-facility fees, so its fees are compared with Medicare non-facility fees. Hence, for Pennsylvania, the percentages of Medicare fees reported in Table 4 underestimate the percentages of Medicare fees for procedures performed in facilities. Virginia and Washington, D.C., have separate facility and non-facility fees for some procedures, but they did not report facility fees for some of the procedures included in Table 4. Therefore, the table only compares the Medicaid non-facility fees of Virginia and Washington, D.C., with the corresponding Medicare non-facility fees for the Baltimore region. In some cases the fee schedule for a state would omit the procedure, in these cases the table below is marked with "N/A". For the calculation of the state's weighted average, the fees for missing procedures were set to zero.

Table 4. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, FY 2019

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

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Evaluation & Management												
99203	Office/outpatient visit new	$118	$82	$109	$77	$110	$77	$83	$75	$55	$54	$100
99204	Office/outpatient visit new	$178	$139	$166	$130	$166	$131	$126	$114	$92	$90	$150
99212	Office/outpatient visit est	$49	$27	$46	$26	$46	$26	$34	$30	$18	$26	$42
99213	Office/outpatient visit estblishd	$80	$55	$75	$51	$75	$52	$57	$51	$36	$40	$68
99214	Office/outpatient visit estblishd	$118	$84	$109	$79	$110	$80	$83	$75	$56	$54	$100
99232	Subsequent hospital care	$78	$78	$73	$73	$74	$74	$56	$52	$52	$17	$65
99233	Subsequent hospital care	$111	$111	$104	$104	$105	$105	$79	$74	$74	$17	$93
99283	Emergency Department visit	$66	$66	$62	$62	$63	$63	$44	$45	$45	$35	$55
99284	Emergency Department visit	$126	$126	$117	$117	$119	$119	$84	$86	$86	$50	$104
99285	Emergency Department visit	$186	$186	$173	$173	$176	$176	$123	$127	$127	$50	$153
99391	Per pm reeval establsh pat infant	$108	$75	$101	$70	$101	$71	$72	$69	$50	$20	$92
99392	Preventive visit establs age 1-4	$116	$82	$107	$77	$108	$78	$77	$74	$55	$20	$98
Weighted Average % of Medicare Fees				**93%**	**93%**	**94%**	**94%**	**70%**	**65%**	**67%**	**42%**	**84%**
Ranking				**4**	**3**	**2**	**1**	**6**	**8**	**7**	**9**	**5**
Integumentary System / General Surgery												
10060	Drainage of skin abscess	$131	$109	$93	$77	$121	$101	$98	$81	$69	$24	$112
10061	Drainage of skin abscess	$227	$199	$163	$143	$211	$186	$171	$143	$127	$53	$193
11042	Deb subq tissue 20 sq cm/<	$135	$68	$93	$49	$125	$63	$101	$82	$44	$33	$116
11043	Deb musc/fascia 20 sq cm/<	$255	$171	$187	$129	$237	$160	$192	$161	$114	$33	$216
11056	Trim skin lesions 2 to 4	$74	$25	$46	$24	$68	$23	$55	$44	$17	$30	$64
11720	Debride nail 1-5	$36	$16	$25	$12	$34	$15	$27	$22	$11	$16	$31
11721	Debride nail 6 or more	$50	$27	$35	$21	$46	$25	$38	$31	$18	$20	$42

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
11981	Insert drug implant device	$158	$93	$112	$66	$146	$146	$118	$99	$62	$76	$134
12001	Rpr s/n/ax/gen/trnk 2.5cm/<	$98	$49	$88	$43	$91	$46	$74	$60	$32	$25	$84
12011	Rpr f/e/e/n/l/m 2.5 cm/<	$120	$60	$113	$74	$111	$57	$90	$74	$40	$32	$103
17110	Destruct b9 lesion 1-14	$122	$76	$89	$56	$113	$71	$91	$73	$47	$49	$106
17250	Chem caut of granltj tissue	$90	$41	$63	$30	$83	$38	$67	$54	$26	$26	$78
Weighted Average % of Medicare Fees				**74%**	**78%**	**93%**	**98%**	**75%**	**62%**	**65%**	**29%**	**86%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
Musculoskeletal System												
20550	Inj tendon sheath/ligament	$58	$43	$56	$39	$54	$41	$44	$37	$29	$32	$49
20552	Inj trigger point 1/2 muscl	$61	$42	$50	$33	$56	$39	$46	$38	$28	$31	N/A
20553	Inject trigger points 3/>	$70	$48	$55	$37	$65	$45	$53	$44	$31	$34	$60
20600	Drain/inj joint/bursa w/o us	$53	$40	$52	$39	$50	$37	$40	$34	$26	$18	$45
20605	Drain/inj joint/bursa w/o us	$56	$41	$55	$40	$52	$39	$42	$35	$27	$22	$47
20610	Drain/inj joint/bursa w/o us	$66	$51	$66	$48	$62	$48	$50	$43	$34	$24	$56
20611	Drain/inj joint/bursa w/us	$101	$67	$98	$65	$94	$63	$76	$64	$45	$50	$86
29075	Application of forearm cast	$96	$69	$80	$58	$89	$64	$72	$59	$44	$46	$82
29125	Apply forearm splint	$71	$44	$61	$39	$66	$41	$53	$43	$28	$26	$61
29130	Application of finger splint	$45	$32	$37	$27	$42	$30	$34	$29	$21	N/A	$38
29515	Application lower leg splint	$79	$55	$65	$47	$73	$51	$59	$49	$35	$35	$67
29540	Strapping of ankle and/or ft	$32	$20	$28	$20	$29	$19	$24	$20	$13	$20	$27
Weighted Average % of Medicare Fees				**93%**	**92%**	**93%**	**94%**	**75%**	**63%**	**66%**	**41%**	**81%**
Ranking				**2**	**4**	**3**	**1**	**6**	**8**	**7**	**9**	**5**
Respiratory System												
30300	Remove nasal foreign body	$206	$122	$161	$88	$189	$113	$153	$123	$76	$23	$178
30901	Control of nosebleed	$153	$62	$75	$45	$141	$58	$114	$93	$42	$27	$131
31231	Nasal endoscopy dx	$223	$72	$167	$57	$205	$67	$166	$133	$47	$59	$193
31237	Nasal/sinus endoscopy surg	$282	$177	$232	$136	$261	$165	$212	$175	$116	$160	$241
31500	Insert emergency airway	$155	$155	$112	$112	$146	$146	$119	$106	$106	$72	$128

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
31575	Diagnostic laryngoscopy	$129	$74	$91	$57	$119	$69	$97	$79	$48	$69	$111
31579	Laryngoscopy telescopic	$203	$132	$167	$104	$188	$123	$153	$126	$86	$75	$173
31615	Visualization of windpipe	$188	$127	$134	$92	$174	$119	$141	$117	$83	$115	$160
31622	Dx bronchoscope/wash	$265	$145	$236	$108	$246	$136	$200	$165	$97	$134	$226
31624	Dx bronchoscope/lavage	$275	$147	$241	$108	$255	$139	$207	$170	$98	$135	$235
32551	Insertion of chest tube	$174	$174	$128	$128	$164	$164	$132	$118	$118	$133	$144
32555	Aspirate pleura w/ imaging	$331	$123	$287	$94	$306	$116	$248	$200	$82	$89	$285
Weighted Average % of Medicare Fees				**76%**	**75%**	**93%**	**94%**	**75%**	**62%**	**66%**	**40%**	**85%**
Ranking				**4**	**5**	**2**	**1**	**6**	**8**	**7**	**9**	**3**
Cardiovascular System Surgery												
33948	Ecmo/ecls daily mgmt-venous	$266	$266	$210	$210	$249	$249	$202	$180	$180	$200	$219
36000	Place needle in vein	$30	$10	$21	$7	$28	$10	$22	$18	$7	$8	$26
36406	Bl draw <3 yrs other vein	$18	$9	$15	$15	$17	$9	$14	$11	$6	N/A	$16
36410	Non-routine bl draw 3/> yrs	$19	$10	$14	$7	$18	$10	$14	$12	$7	N/A	$16
36471	Njx sclrsnt mlt incmptnt vn	$214	$85	$140	$81	$197	$80	$160	$130	$58	$91	$184
36475	Endovenous rf 1st vein	$1,596	$314	$1,476	$253	$1,463	$293	$1,185	$935	$212	$290	$1,388
36556	Insert non-tunnel cv cath	$233	$94	$194	$96	$216	$88	$175	$142	$63	$113	$200
36558	Insert tunneled cv cath	$849	$290	$670	$217	$781	$272	$633	$506	$191	$266	$734
36561	Insert tunneled cv cath	$1,200	$376	$938	$273	$1,103	$351	$893	$713	$249	$319	$1,038
36569	Insj picc 5 yr+ w/o imaging	$104	$104	$226	$73	$98	$98	$79	$70	$70	$87	$86
36589	Removal tunneled cv cath	$182	$153	$131	$110	$170	$143	$137	$117	$100	$130	$154
36620	Insertion catheter artery	$48	$49	$40	$40	$46	$46	$37	$33	$33	$48	$40
Weighted Average % of Medicare Fees				**85%**	**82%**	**92%**	**94%**	**75%**	**60%**	**67%**	**35%**	**86%**
Ranking				**4**	**5**	**2**	**1**	**6**	**8**	**7**	**9**	**3**
Hemic, Lymphatic System, and Mediastinum												
38100	Removal of spleen total	$1,302	$1,302	$932	$932	$1,212	$1,212	$976	$868	$868	$563	$1,079
38220	Dx bone marrow aspirations	$184	$77	$134	$49	$170	$72	$137	$111	$51	$55	$158
38221	Dx bone marrow biopsies	$171	$76	$136	$59	$158	$72	$128	$104	$50	$70	$147

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
38500	Biopsy/removal lymph nodes	$374	$287	$266	$205	$346	$266	$280	$237	$188	$114	$317
38505	Needle biopsy lymph nodes	$138	$78	$101	$57	$128	$73	$104	$85	$50	$67	$119
38510	Biopsy/removal lymph nodes	$582	$468	$416	$337	$540	$436	$436	$372	$308	$136	$490
38525	Biopsy/removal lymph nodes	$493	$493	$353	$353	$458	$458	$369	$322	$322	$156	$412
38571	Laparoscopy lymphadenectomy	$735	$735	$582	$582	$689	$689	$559	$486	$486	$633	$613
38724	Removal of lymph nodes neck	$1,609	$1,609	$1,160	$1,160	$1,502	$1,502	$1,216	$1,058	$1,058	$844	$1,343
38746	Remove thoracic lymph nodes	$242	$242	$194	$194	$226	$226	$182	$165	$165	$237	$199
38792	Ra tracer id of sentinl node	$91	$37	$32	$32	$84	$35	$68	$55	$25	N/A	$78
38900	Io map of sent lymph node	$156	$156	$113	$113	$145	$145	$117	$105	$105	$110	$128
Weighted Average % of Medicare Fees				**73%**	**73%**	**93%**	**93%**	**75%**	**64%**	**66%**	**42%**	**84%**
Ranking				**5**	**6**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Digestive System												
42820	Remove tonsils and adenoids	$321	$321	$231	$231	$299	$299	$242	$207	$207	$184	$270
43235	Egd diagnostic brush wash	$297	$138	$229	$104	$274	$129	$222	$180	$91	$125	$255
43239	Egd biopsy single/multiple	$398	$156	$274	$123	$367	$146	$297	$239	$103	$149	$344
43775	Lap sleeve gastrectomy	$1,258	$1,258	$969	$969	$1,173	$1,173	$944	$850	$850	$1,034	$1,038
44970	Laparoscopy appendectomy	$679	$679	$486	$486	$631	$631	$508	$448	$448	$444	$565
45378	Diagnostic colonoscopy	$357	$208	$299	$155	$331	$195	$268	$222	$138	$181	$305
45380	Colonoscopy and biopsy	$459	$226	$357	$186	$424	$211	$344	$281	$149	$225	$394
45385	Colonoscopy w/lesion removal	$481	$287	$400	$221	$446	$268	$361	$299	$190	$268	$410
46221	Ligation of hemorrhoid(s)	$303	$214	$215	$153	$280	$199	$227	$186	$136	$46	$260
46600	Diagnostic anoscopy spx	$107	$46	$71	$33	$98	$43	$79	$64	$29	$20	$92
47562	Laparoscopic cholecystectomy	$743	$743	$532	$532	$691	$691	$556	$491	$491	$589	$618
49083	Abd paracentesis w/imaging	$329	$119	$267	$91	$304	$112	$246	$197	$79	$84	$284
Weighted Average % of Medicare Fees				**75%**	**76%**	**92%**	**93%**	**75%**	**62%**	**66%**	**51%**	**85%**
Ranking				**5**	**4**	**2**	**1**	**6**	**8**	**7**	**9**	**3**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Urinary System and Male Genital												
51700	Irrigation of bladder	$83	$33	$70	$34	$76	$31	$62	$50	$22	$29	$71
51701	Insert bladder catheter	$49	$28	$47	$47	$46	$26	$37	$31	$18	$25	$42
51741	Electro-uroflowmetry first	$16	$16	$16	$16	$15	$15	$12	$10	$10	$24	$14
51784	Anal/urinary muscle study	$75	$75	$68	$68	$69	$69	$56	$46	$46	$96	$64
51797	Intraabdominal pressure test	$154	$154	$111	$111	$142	$142	$115	$92	$92	$35	$134
51798	Us urine capacity measure	$14	$14	$16	$16	$13	$13	$11	$8	$8	$14	$0
52000	Cystoscopy	$210	$90	$144	$89	$194	$84	$157	$127	$60	$75	$180
52310	Cystoscopy and treatment	$298	$168	$205	$121	$276	$158	$224	$185	$111	$129	$254
52332	Cystoscopy and treatment	$529	$173	$393	$124	$487	$162	$395	$315	$114	$144	$458
52356	Cysto/uretero w/lithotripsy	$461	$461	$337	$337	$433	$433	$352	$308	$308	$333	$383
54150	Circumcision w/regionl block	$171	$108	$145	$78	$159	$102	$129	$108	$73	$79	$145
54161	Circum 28 days or older	$219	$219	$157	$157	$205	$205	$166	$143	$143	$128	$183
Weighted Average % of Medicare Fees				**79%**	**79%**	**93%**	**94%**	**75%**	**62%**	**66%**	**46%**	**83%**
Ranking				**5**	**4**	**2**	**1**	**6**	**8**	**7**	**9**	**3**
Gynecology and Obstetrics												
57454	Bx/curett of cervix w/scope	$172	$146	$152	$133	$160	$137	$140	$111	$97	$106	$144
58100	Biopsy of uterus lining	$102	$77	$109	$85	$95	$72	$83	$65	$51	$51	$86
58300	Insert intrauterine device	$88	$59	$76	$52	$82	$82	$72	$56	$39	$17	$75
58301	Remove intrauterine device	$104	$73	$95	$66	$97	$69	$85	$66	$49	$17	$88
58558	Hysteroscopy biopsy	$1,526	$255	$1,092	$256	$847	$847	$1,222	$886	$169	$239	$1,332
59025	Fetal non-stress test	$54	$54	$46	$46	$50	$50	$43	$34	$34	$18	$45
59400	Obstetrical care	$2,357	$2,357	N/A	N/A	$1,085	$1,085	$1,900	$2,212	$2,212	$1,786	$1,963
59409	Obstetrical care	$909	$909	$860	$860	$847	$847	$735	$873	$873	$1,200	$751
59410	Obstetrical care	$1,166	$1,166	$942	$942	$1,085	$1,085	$941	$1,114	$1,114	$1,200	$964
59430	Care after delivery	$217	$154	$149	$125	$82	$82	$175	$199	$148	N/A	$183
59514	Cesarean delivery only	$1,026	$1,026	$993	$993	N/A	N/A	$828	$985	$985	$1,200	$847
59515	Cesarean delivery	$1,420	$1,420	$1,124	$1,124	$847	$847	$1,144	$1,357	$1,357	$2,050	$1,174

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Weighted Average % of Medicare Fees				**82%**	**83%**	**60%**	**63%**	**81%**	**91%**	**93%**	**102%**	**83%**
Ranking				**6**	**4**	**9**	**8**	**7**	**3**	**2**	**1**	**5**
Endocrine System												
60100	Biopsy of thyroid	$123	$87	$89	$63	$115	$82	$93	$79	$58	$66	$104
60220	Partial removal of thyroid	$788	$788	$565	$565	$734	$734	$593	$517	$517	$521	$658
60240	Removal of thyroid	$1,027	$1,027	$737	$737	$957	$957	$772	$678	$678	$591	$855
60252	Removal of thyroid	$1,474	$1,474	$1,059	$1,059	$1,374	$1,374	$1,109	$976	$976	$826	$1,226
60260	Repeat thyroid surgery	$1,218	$1,218	$875	$875	$1,136	$1,136	$918	$806	$806	$375	$1,014
60271	Removal of thyroid	$1,180	$1,180	$847	$847	$1,100	$1,100	$889	$780	$780	$925	$982
60280	Remove thyroid duct lesion	$491	$491	$354	$354	$457	$457	$370	$316	$316	$304	$414
60500	Explore parathyroid glands	$1,083	$1,083	$775	$775	$1,008	$1,008	$813	$715	$715	$705	$901
60512	Autotransplant parathyroid	$272	$272	$195	$195	$254	$254	$205	$183	$183	$217	$225
60650	Laparoscopy adrenalectomy	$1,337	$1,337	$960	$960	$1,248	$1,248	$1,007	$891	$891	N/A	$1,110
Weighted Average % of Medicare Fees				**72%**	**72%**	**93%**	**93%**	**75%**	**66%**	**66%**	**57%**	**83%**
Ranking				**5**	**6**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Nervous System Surgery												
62270	Spinal fluid tap diagnostic	$164	$86	$150	$73	$152	$80	$123	$101	$57	$42	$141
62321	Njx interlaminar crv/thrc	$280	$117	$246	$109	$259	$110	$210	$169	$77	$89	$241
62323	Njx interlaminar lmbr/sac	$277	$109	$242	$99	$256	$102	$207	$167	$72	$81	$239
64447	N block inj fem single	$134	$72	$94	$67	$124	$69	$101	$84	$50	$61	$111
64450	N block other peripheral	$85	$49	$88	$50	$79	$46	$64	$52	$32	$21	$73
64483	Inj foramen epidural l/s	$250	$122	$238	$101	$232	$115	$188	$152	$80	$95	$215
64484	Inj foramen epidural add-on	$108	$57	$95	$55	$100	$53	$81	$67	$38	$60	$92
64493	Inj paravert f jnt l/s 1 lev	$191	$99	$170	$94	$177	$93	$143	$116	$65	$72	$164
64494	Inj paravert f jnt l/s 2 lev	$96	$57	$87	$54	$90	$54	$73	$60	$38	$42	$82
64495	Inj paravert f jnt l/s 3 lev	$96	$58	$88	$55	$90	$54	$73	$60	$38	$42	$82
64635	Destroy lumb/sac facet jnt	$456	$243	$453	$243	$423	$228	$343	$279	$159	$179	N/A
64636	Destroy l/s facet jnt addl	$189	$65	$188	$65	$174	$61	$142	$113	$43	$48	N/A

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Weighted Average % of Medicare Fees				**92%**	**92%**	**93%**	**94%**	**75%**	**61%**	**66%**	**36%**	**70%**
Ranking				**3**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**6**
Eye Surgery												
65855	Trabeculoplasty laser surg	$270	$227	$227	$453	$252	$212	$205	$170	$145	$237	$230
66761	Revision of iris	$329	$259	$285	$88	$305	$241	$248	$203	$163	$181	$282
66821	After cataract laser surgery	$365	$342	$260	$246	$338	$318	$275	$225	$212	$217	$312
66982	Cataract surgery complex	$867	$867	$678	$242	$810	$810	$658	$552	$552	$697	$734
66984	Cataract surg w/iol 1 stage	$699	$699	$503	$95	$652	$652	$530	$443	$443	$603	$593
67028	Injection eye drug	$111	$109	$99	$238	$104	$102	$84	$71	$70	$106	$94
67113	Repair retinal detach cplx	$1,462	$1,462	$1,062	$94	$1,367	$1,367	$1,111	$933	$933	$1,086	$1,237
67210	Treatment of retinal lesion	$568	$548	$430	$150	$529	$510	$430	$356	$345	$375	$483
67228	Treatment x10sv retinopathy	$375	$335	$333	$170	$349	$313	$284	$236	$214	$491	$318
67311	Revise eye muscle	$653	$653	$470	$88	$609	$609	$495	$413	$413	$468	$554
67800	Remove eyelid lesion	$141	$113	$100	$188	$131	$105	$106	$87	$72	$41	$120
68761	Close tear duct opening	$164	$130	$117	$87	$152	$121	$123	$100	$81	$63	$140
Weighted Average % of Medicare Fees				**76%**	**92%**	**92%**	**93%**	**94%**	**75%**	**61%**	**66%**	**36%**
Ranking				**6**	**5**	**2**	**1**	**7**	**9**	**8**	**4**	**3**
Ear Surgery												
69200	Clear outer ear canal	$90	$52	$82	$49	$84	$49	$68	$56	$34	$30	$77
69209	Remove impacted ear wax uni	$16	$16	$11	$11	$14	$14	$12	$9	$9	$10	$14
69210	Remove impacted ear wax uni	$52	$36	$44	$29	$48	$34	$39	$33	$24	$50	$44
69220	Clean out mastoid cavity	$89	$57	$89	$55	$82	$53	$67	$56	$37	$49	$76
69436	Create eardrum opening	$175	$175	$149	$149	$162	$162	$132	$111	$111	$99	$148
69990	Microsurgery add-on	$253	$253	$199	$199	$234	$234	$187	$171	$171	N/A	$209
Weighted Average % of Medicare Fees				**85%**	**82%**	**93%**	**93%**	**75%**	**63%**	**65%**	**68%**	**85%**
Ranking				**3**	**5**	**2**	**1**	**6**	**9**	**8**	**7**	**4**
Radiology												
70450	Ct head/brain w/o dye	$127	$127	$114	$114	$117	$117	$95	$76	$76	$117	$109

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
73610	X-ray exam of ankle	$37	$37	$25	$25	$34	$34	$27	$22	$22	$19	$32
73630	X-ray exam of foot	$34	$34	$24	$24	$32	$32	$26	$21	$21	$12	$30
74177	Ct abd & pelv w/contrast	$351	$351	$287	$287	$323	$323	$262	$208	$208	$263	$304
76805	Ob us >/= 14 wks sngl fetus	$155	$155	$114	$114	$143	$143	$125	$93	$93	$78	$133
76815	Ob us limited fetus(s)	$93	$93	$70	$70	$86	$86	$75	$56	$56	$64	$80
76816	Ob us follow-up per fetus	$126	$126	$93	$93	$116	$116	$102	$76	$76	$72	$108
76817	Transvaginal us obstetric	$106	$106	$78	$78	$98	$98	$86	$64	$64	$88	$91
76819	Fetal biophys profil w/o nst	$98	$98	$78	$78	$91	$91	$79	$60	$60	$86	$84
76820	Umbilical artery echo	$52	$52	$50	$50	$49	$49	$42	$32	$32	$46	$45
76830	Transvaginal us non-ob	$134	$134	$98	$98	$124	$124	$108	$79	$79	$77	$116
76856	Us exam pelvic complete	$121	$121	$88	$88	$111	$111	$97	$72	$72	$77	$104
Weighted Average % of Medicare Fees				**79%**	**79%**	**92%**	**92%**	**78%**	**60%**	**60%**	**71%**	**86%**
Ranking				**4**	**4**	**1**	**1**	**6**	**8**	**8**	**7**	**3**
Laboratory												
80053	Comprehen metabolic panel	$13	$13	$10	$10	$12	$12	$12	$11	$11	$12	$9
80061	Lipid panel	$17	$17	$13	$13	$15	$15	$15	$13	$13	$14	$12
80307	Drug test prsmv chem anlyzr	$72	$72	$51	$51	$63	$63	$65	$58	$58	$64	$52
81002	Urinalysis nonauto w/o scope	$3	$3	$3	$3	$3	$3	$3	$3	$3	$4	$3
82306	Vitamin d 25 hydroxy	$37	$37	$29	$29	$32	$32	$31	$30	$30	$41	$26
83036	Glycosylated hemoglobin test	$12	$12	$10	$10	$11	$11	$11	$10	$10	$7	$9
84443	Assay thyroid stim hormone	$21	$21	$17	$17	$18	$18	$19	$17	$17	$23	$15
85025	Complete cbc w/auto diff wbc	$10	$10	$8	$8	$8	$8	$9	$8	$8	$6	$7
87086	Urine culture/colony count	$10	$10	$8	$8	$9	$9	$8	$9	$9	$8	$7
87491	Chylmd trach dna amp probe	$43	$43	$34	$34	$38	$38	$38	$39	$39	$23	$31
87591	N.gonorrhoeae dna amp prob	$43	$43	$34	$34	$38	$38	$38	$39	$39	$23	$31
87880	Strep a assay w/optic	$17	$17	$13	$13	$16	$16	$14	$15	$15	$6	$13
Weighted Average % of Medicare Fees				**76%**	**76%**	**89%**	**89%**	**89%**	**84%**	**84%**	**79%**	**72%**
Ranking				**7**	**7**	**2**	**2**	**1**	**4**	**4**	**6**	**9**

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Psychiatry												
90791	Psych diagnostic evaluation	$147	$133	$147	$147	$139	$127	$136	$99	$91	$26	$121
90832	Psytx w pt 30 minutes	$71	$66	$67	$67	$68	$63	$66	$48	$45	$26	$59
90834	Psytx w pt 45 minutes	$95	$88	$88	$88	$90	$84	$88	$64	$60	$39	$79
90847	Family psytx w/pt 50 min	$120	$111	$111	$107	$114	$106	$111	$81	$76	$13	$99
90853	Group psychotherapy	$29	$26	$24	$24	$27	$25	$27	$19	$18	$4	$24
Weighted Average % of Medicare Fees				**93%**	**100%**	**95%**	**95%**	**93%**	**68%**	**69%**	**33%**	**83%**
Ranking				**4**	**1**	**3**	**2**	**5**	**8**	**7**	**9**	**6**
Dialysis												
90935	Hemodialysis one evaluation	$79	$78	$56	$56	$74	$74	$60	$53	$53	$35	$65
90945	Dialysis one evaluation	$92	$92	$66	$66	$87	$87	$71	$61	$61	$35	$77
90960	Esrd srv 4 visits p mo 20+	$305	$305	$219	$219	$288	$288	$234	$201	$201	N/A	$255
90961	Esrd srv 2-3 vsts p mo 20+	$257	$257	$184	$184	$242	$242	$197	$168	$168	N/A	$215
90970	Esrd svc pr day pt 20+	$8	$8	$6	$6	$8	$8	$6	$5	$5	N/A	$7
Weighted Average % of Medicare Fees				**72%**	**72%**	**94%**	**94%**	**77%**	**66%**	**66%**	**15%**	**83%**
Ranking				**5**	**6**	**1**	**2**	**4**	**7**	**8**	**9**	**3**
Gastroenterology												
91010	Esophagus motility study	$210	$210	$155	$155	$193	$193	$157	$126	$126	$28	$181
91037	Esoph imped function test	$182	$182	$127	$127	$168	$168	$136	$108	$108	$114	$158
91065	Breath hydrogen/methane test	$84	$84	$60	$60	$77	$77	$62	$49	$49	$17	$73
91110	Gi tract capsule endoscopy	$973	$973	$733	$733	$892	$892	$729	$563	$563	$680	$857
91120	Rectal sensation test	$508	$508	$341	$341	$465	$465	$378	$292	$292	$337	N/A
91122	Anal pressure record	$267	$267	$190	$190	$246	$246	$200	$160	$160	$69	$230
91200	Liver elastography	$43	$43	$31	$31	$40	$40	$32	$26	$26	$30	N/A
Weighted Average % of Medicare Fees				**74%**	**74%**	**92%**	**92%**	**75%**	**58%**	**58%**	**59%**	**73%**
Ranking				**4**	**4**	**1**	**1**	**3**	**8**	**8**	**7**	**6**
Ophthalmology/Vision Care												
92002	Eye exam new patient	$91	$52	$64	$37	$85	$49	$69	$56	$34	$28	$78

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
92004	Eye exam new patient	$164	$107	$117	$77	$153	$101	$124	$102	$70	$59	$140
92012	Eye exam establish patient	$96	$57	$67	$41	$89	$53	$73	$59	$37	$29	$82
92014	Eye exam&tx estab pt 1/>vst	$138	$86	$97	$62	$128	$81	$104	$85	$56	$45	$118
92015	Determine refractive state	$21	$21	$19	$15	$20	$20	$16	$14	$14	$5	$18
92060	Special eye evaluation	$70	$70	$51	$51	$65	$65	$53	$43	$43	$34	$60
92083	Visual field examination(s)	$70	$70	$57	$57	$65	$65	$53	$43	$43	$63	$61
92133	Cmptr ophth img optic nerve	$41	$41	$37	$37	$38	$38	$31	$25	$25	$35	$35
92134	Cptr ophth dx img post segmt	$45	$45	$37	$37	$42	$42	$34	$28	$28	$35	$38
92250	Eye exam with photos	$56	$56	$54	$54	$51	$51	$42	$34	$34	$53	$48
92340	Fit spectacles monofocal	$38	$20	$28	$14	N/A	N/A	N/A	$24	$13	N/A	$33
Weighted Average % of Medicare Fees				**73%**	**74%**	**92%**	**93%**	**74%**	**62%**	**65%**	**37%**	**85%**
Ranking				**6**	**5**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Otorhinolaryngology												
92550	Tympanometry & reflex thresh	$24	$24	$35	$35	$22	$22	$18	$15	$15	$16	$20
92551	Pure tone hearing test air	$13	$13	$10	$10	$12	$12	$10	$7	$7	$8	$11
92552	Pure tone audiometry air	$35	$35	$25	$25	$32	$32	$26	$20	$20	$8	$31
92567	Tympanometry	$17	$12	$20	$15	$15	$11	$13	$10	$8	$12	$14
92587	Evoked auditory test limited	$24	$24	$50	$50	$22	$22	$18	$15	$15	$34	$20
Weighted Average % of Medicare Fees				**98%**	**97%**	**92%**	**92%**	**74%**	**58%**	**58%**	**60%**	**87%**
Ranking				**1**	**2**	**4**	**3**	**6**	**9**	**8**	**7**	**5**
Cardiovascular System Medical												
93000	Electrocardiogram complete	$19	$19	$18	$18	$17	$17	$14	$12	$12	$19	$16
93010	Electrocardiogram report	$9	$9	$7	$7	$9	$9	$7	$6	$6	$8	$8
93015	Cardiovascular stress test	$78	$78	$80	$80	$72	$72	$59	$48	$48	$90	$66
93018	Cardiovascular stress test	$16	$16	$12	$12	$15	$15	$12	$10	$10	$15	$13
93042	Rhythm ecg report	$8	$8	$6	$6	$7	$7	$6	$5	$5	$7	$6
93303	Echo transthoracic	$260	$260	$188	$188	$239	$239	$194	$153	$153	$62	$225

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
93306	Tte w/doppler complete	$227	$227	$206	$206	$210	$210	$170	$136	$136	$43	$196
93320	Doppler echo exam heart	$59	$59	$53	$53	$54	$54	$44	$35	$35	$61	$51
93325	Doppler color flow add-on	$28	$28	$25	$25	$26	$26	$21	$16	$16	N/A	$24
Weighted Average % of Medicare Fees				**87%**	**87%**	**93%**	**93%**	**75%**	**61%**	**61%**	**42%**	**86%**
Ranking				**3**	**4**	**1**	**2**	**6**	**7**	**8**	**9**	**5**
Noninvasive Vascular Diagnostic Studies												
93880	Extracranial bilat study	$224	$224	$162	$162	$205	$205	$166	$131	$131	$148	$194
93922	Upr/l xtremity art 2 levels	$96	$96	$97	$97	$88	$88	$71	$56	$56	$49	$84
93923	Upr/lxtr art stdy 3+ lvls	$149	$149	$148	$148	$136	$136	$110	$86	$86	$92	$129
93925	Lower extremity study	$285	$285	$208	$208	$261	$261	$212	$165	$165	$147	$248
93970	Extremity study	$217	$217	$158	$158	$199	$199	$161	$126	$126	$147	$189
93971	Extremity study	$134	$134	$96	$96	$123	$123	$100	$78	$78	$100	$117
93975	Vascular study	$309	$309	$225	$225	$284	$284	$230	$181	$181	$182	$269
93976	Vascular study	$166	$166	$162	$162	$153	$153	$135	$98	$98	$131	$158
Weighted Average % of Medicare Fees				**80%**	**80%**	**92%**	**92%**	**76%**	**59%**	**59%**	**68%**	**89%**
Ranking				**4**	**4**	**1**	**1**	**6**	**8**	**8**	**7**	**3**
Pulmonary System												
94010	Breathing capacity test	$39	$39	$29	$29	$36	$36	$29	$23	$23	$15	$34
94060	Evaluation of wheezing	$66	$66	$49	$49	$60	$60	$49	$39	$39	$19	$57
94150	Vital capacity test	$28	$28	$20	$20	$26	$26	$21	$17	$17	$4	$25
94640	Airway inhalation treatment	$20	$20	$15	$15	$18	$18	$15	$11	$11	N/A	$18
94664	Evaluate pt use of inhaler	$19	$19	$14	$14	$17	$17	$14	$11	$11	$12	$17
94729	Co/membane diffuse capacity	$61	$61	$46	$46	$56	$56	$46	$36	$36	$40	$53
94760	Measure blood oxygen level	$3	$3	$3	$3	$3	$3	$2	$2	$2	$2	$2
94761	Measure blood oxygen level	$5	$5	$5	$5	$4	$4	$4	$3	$3	$4	$4
Weighted Average % of Medicare Fees				**75%**	**75%**	**92%**	**92%**	**74%**	**58%**	**58%**	**35%**	**87%**
Ranking				**4**	**4**	**1**	**1**	**6**	**7**	**7**	**9**	**3**
Allergy and Immunology												

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
95004	Percut allergy skin tests	$5	$5	$5	$5	$4	$4	$4	$3	$3	$2	$4
95012	Exhaled nitric oxide meas	$23	$23	$15	$15	$21	$21	$17	$13	$13	N/A	$20
95115	Immunotherapy one injection	$10	$10	$9	$9	$9	$9	$8	$6	$6	$4	$9
95117	Immunotherapy injections	$12	$12	$10	$10	$11	$11	$9	$7	$7	$7	$10
95165	Antigen therapy services	$16	$3	$10	$2	$14	$3	$12	$9	$2	$8	$14
Weighted Average % of Medicare Fees				**84%**	**87%**	**91%**	**91%**	**74%**	**57%**	**57%**	**49%**	**87%**
Ranking				**5**	**4**	**1**	**2**	**6**	**8**	**7**	**9**	**3**
Neurology and Neuromuscular System												
95806	Sleep study unatt&resp efft	$152	$152	$161	$161	$140	$140	$114	$91	$91	N/A	$131
95810	Polysom 6/> yrs 4/> param	$680	$680	$628	$628	$624	$624	$506	$398	$398	$347	$592
95811	Polysom 6/>yrs cpap 4/> parm	$713	$713	$691	$691	$654	$654	$531	$417	$417	$648	$620
95816	Eeg awake and drowsy	$403	$403	$289	$289	$369	$369	$300	$234	$234	$23	$352
95819	Eeg awake and asleep	$475	$475	$333	$333	$435	$435	$353	$274	$274	$23	$415
95885	Musc tst done w/nerv tst lim	$68	$68	$48	$48	$62	$62	$50	$40	$40	$42	$59
95886	Musc test done w/n test comp	$104	$104	$72	$72	$96	$96	$78	$63	$63	$66	$89
95910	Nrv cndj test 7-8 studies	$213	$213	$157	$157	$198	$198	$161	$131	$131	$140	$182
95911	Nrv cndj test 9-10 studies	$256	$256	$186	$186	$238	$238	$193	$158	$158	$170	$219
95923	Autonomic nrv syst funj test	$142	$142	$112	$112	$131	$131	$106	$85	$85	N/A	$122
95930	Visual ep test cns w/i&r	$76	$76	$104	$104	$70	$70	$57	$45	$45	$74	$66
95951	Eeg monitoring/videorecord	$2,054	$2,054	$450	$450	N/A	N/A	$266	N/A	N/A	$228	$449
Weighted Average % of Medicare Fees				**57%**	**57%**	**51%**	**51%**	**47%**	**33%**	**33%**	**29%**	**58%**
Ranking				**2**	**2**	**4**	**4**	**6**	**8**	**7**	**9**	**1**
Central Nervous System Assessment Tests												
96110	Developmental screen w/score	$11	$11	$9	$9	$10	$10	$8	$6	$6	$7	$10
96116	Nubhvl xm phys/qhp 1st hr	$102	$91	$72	$70	N/A	N/A	$94	$68	$62	$69	$85
96127	Brief emotional/behav assmt	$6	$6	$5	$5	$5	$5	$5	$3	$3	$4	$5
96150	Assess hlth/behave init	$25	$23	$29	$28	$23	$21	$19	$17	$16	$20	N/A
96152	Intervene hlth/behave indiv	$22	$21	$6	$6	$21	$20	$17	$15	$14	$20	$18

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Weighted Average % of Medicare Fees				**79%**	**79%**	**87%**	**88%**	**76%**	**57%**	**57%**	**64%**	**87%**
Ranking				**5**	**4**	**2**	**1**	**6**	**9**	**8**	**7**	**3**
Chemotherapy Administration												
96401	Chemo anti-neopl sq/im	$88	$88	$60	$60	$81	$81	$65	$51	$51	$50	$77
96411	Chemo iv push addl drug	$65	$65	$53	$53	$59	$59	$48	$38	$38	$53	$56
96413	Chemo iv infusion 1 hr	$157	$157	$126	$126	$143	$143	$116	$90	$90	$125	$137
96415	Chemo iv infusion addl hr	$34	$34	$28	$28	$31	$31	$25	$20	$20	$28	$29
96416	Chemo prolong infuse w/pump	$157	$157	$137	$137	$143	$143	$116	$90	$90	$135	$137
96417	Chemo iv infus each addl seq	$76	$76	$62	$62	$69	$69	$56	$44	$44	$62	$66
96450	Chemotherapy into cns	$199	$86	$179	$75	$184	$81	$150	$121	$58	$77	$171
96523	Irrig drug delivery device	$30	$30	$21	$21	$28	$28	$22	$18	$18	$19	$27
Weighted Average % of Medicare Fees				**80%**	**80%**	**92%**	**92%**	**74%**	**58%**	**58%**	**75%**	**87%**
Ranking				**4**	**5**	**2**	**1**	**7**	**9**	**8**	**6**	**3**
Special Dermatology Procedures												
96900	Ultraviolet light therapy	$24	$24	$17	$17	$22	$22	$18	$13	$13	N/A	$21
96910	Photochemotherapy with uv-b	$128	$128	$57	$57	$117	$117	$95	$72	$72	$20	$113
96912	Photochemotherapy with uv-a	$109	$109	$74	$74	$99	$99	$80	$62	$62	$20	$96
96920	Laser tx skin < 250 sq cm	$181	$72	$124	$53	$167	$68	$135	$108	$47	$59	N/A
96921	Laser tx skin 250-500 sq cm	$198	$82	$136	$60	$183	$77	$149	$119	$53	$59	N/A
Weighted Average % of Medicare Fees				**56%**	**53%**	**92%**	**92%**	**74%**	**58%**	**58%**	**21%**	**56%**
Ranking				**7**	**8**	**2**	**1**	**3**	**5**	**4**	**9**	**6**
Physical Medicine and Rehabilitation												
97010	Hot or cold packs therapy	$7	$7	$5	$5	$6	$6	$5	$4	$4	$17	$6
97012	Mechanical traction therapy	$16	$16	$13	$13	$15	$15	$12	$10	$10	$13	$13
97014	Electric stimulation therapy	$16	$16	$13	$13	$15	$15	$12	$10	$10	$17	$14
97035	Ultrasound therapy	$15	$15	$10	$10	$14	$14	$11	$10	$10	$10	$13
97110	Therapeutic exercises	$33	$33	$29	$29	$31	$31	$28	$21	$21	$8	$28
97112	Neuromuscular reeducation	$38	$38	$27	$27	$35	$35	$29	$24	$24	$17	$32

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
97140	Manual therapy 1/> regions	$30	$30	$23	$23	$28	$28	$23	$19	$19	$21	$25
97150	Group therapeutic procedures	$20	$20	$18	$18	$19	$19	$15	$13	$13	$7	$17
97530	Therapeutic activities	$44	$44	$31	$31	$41	$41	$71	$27	$27	$13	$37
97597	Rmvl devital tis 20 cm/<	$98	$26	$60	$22	$91	$24	$74	$58	$17	$32	$85
97802	Medical nutrition indiv in	$40	$37	$30	$30	N/A	N/A	$31	$26	$24	N/A	$34
97803	Med nutrition indiv subseq	$35	$31	$26	$26	N/A	N/A	$27	$22	$20	N/A	$30
Weighted Average % of Medicare Fees				**77%**	**79%**	**83%**	**83%**	**89%**	**63%**	**64%**	**42%**	**85%**
Ranking				**6**	**5**	**4**	**3**	**1**	**8**	**7**	**9**	**2**
Osteopathy, Chiropractic, and Other Medicine												
99152	Mod sed same phys/qhp 5/>yrs	$56	$13	$45	$11	$52	$13	$42	$33	$9	$10	N/A
99153	Mod sed same phys/qhp ea	$12	$12	$10	$10	$11	$11	$9	$7	$7	$8	N/A
99173	Visual acuity screen	$3	$3	$3	$3	$3	$3	$2	$2	$2	$6	$3
99174	Ocular instrumnt screen bil	$6	$6	$7	$7	$6	$6	$5	$4	$4	$8	$6
99177	Ocular instrumnt screen bil	$5	$5	$7	$7	N/A	N/A	$4	$3	$3	$15	$5
Weighted Average % of Medicare Fees				**84%**	**86%**	**86%**	**84%**	**75%**	**57%**	**58%**	**122%**	**52%**
Ranking				**4**	**3**	**2**	**5**	**6**	**8**	**7**	**1**	**9**

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

The states' average reimbursement rates as percentages of Medicare rates have remained relatively stable over the past three years. Tables C.1 – C.3 in Appendix C depict the numbers of primary care and specialty physicians per 10,000 population in the United States and by state in 2019. Maryland has the sixth highest number of PCPs and specialty physicians per 10,000 population in the nation.

V. Reimbursement for Oral Health Services

The Maryland Medicaid program includes dental benefits for children, pregnant women, and Rare and Expensive Case Management (REM) adult populations. In addition, individuals who were formerly in foster care continue to receive dental benefits until they are 26 years of age, a benefit that took effect in January 2017. In 2019, Medicaid implemented a statewide dental pilot program that serves individuals between the ages of 21 and 64 who are dually eligible for both Medicare and Medicaid. The Department does not reimburse for adult dental services outside of these categories; however, some MCOs provide a limited adult dental benefit from their own funds.[5]

In FY 2015, the General Assembly allocated approximately $940,000 in state general funds ($2.15 million with matching federal funds) to increase fees for five dental procedures in January through June 2015. The annual equivalent of $4.3 million was earmarked for the five procedures included in Table 5. This table presents Maryland Medicaid dental fees in 2014 and 2015, compared with median ADA charges in 2018[6] for the five selected dental procedures for which fees increased in January 2015. The 2019 Medicaid fees for these dental procedures remain at the same level as the 2015 fees.

Table 5. Maryland Medicaid Dental Fees Compared with Median ADA Charges in 2018

Procedure Code	Description	2018 Median ADA Charges	2014 Medicaid Fees	2015-2019 Medicaid Fees
D1208	Topical Application of Fluoride	$37.00	$21.60	$23.00
D1330	Oral Hygiene Instructions	$30.00	$0.00	$6.00
D2940	Protective Restoration	$130.00	$18.00	$50.00
D3120	Pulp Cap, Indirect	$85.00	$15.00	$35.00
D9941	Athletic Mouth-guard	$257.00	$40.00	$103.00

Table 6 compares Maryland Medicaid dental fees for selected high-volume procedures with the corresponding fees in Delaware, Virginia, West Virginia, Pennsylvania, and Washington, D.C. Numbers of claims in Maryland were used to calculate the weighted average rank of Maryland and its neighboring states' fees.

The ranking of states' weighted average fees for these procedures are: Delaware (first), Washington, D.C. (second), Maryland (third), West Virginia (fourth), Virginia (fifth), and

[5] The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) package of benefits is required for all Medicaid participants under the age of 21 years. Although EPSDT mandates dental care coverage for children, federal law does not mandate minimum requirements for adult dental coverage through Medicaid.
[6] These figures were published in the ADA 2019 Survey of Dental Fees, which can be found at https://success.ada.org/en/practice-management/finances/survey-of-dental-fees.

Pennsylvania (sixth). ADA fees correspond to CY 2018, and the states' fees correspond to CY 2019.

Table 6. Comparison of Maryland Medicaid and Neighboring States' 2019 Dental Fees with Median ADA Charges in 2018

Procedure Code	Procedure Description	ADA	MD	DE	VA	WV	PA	DC
D0120	Periodic oral evaluation	$55	$29	$44	$20	$25	$20	$35
D0140	Limited oral evaluation, problem focus	$79	$43	$65	$25	$35	N/A	$50
D0145	Oral evaluation, pt < 3yrs	$70	$40	$58	$20	$25	$20	$40
D0150	Comprehensive oral evaluation	$87	$52	$76	$31	$35	$20	$78
D1110	Prophylaxis – adult (12 years of age and older)	$96	$58	$78	$47	$55	$36	$78
D1120	Dental prophylaxis child	$73	$42	$59	$34	$40	$30	$47
D1206	Topical fluoride varnish	$40	$25	$36	$21	$20	$18	$29
D1351	Dental sealant per tooth	$58	$33	$48	$32	$30	$25	$38
D7140	Extraction erupted tooth	$188	$103	$158	$69	$80	$65	$110
D9248	Non-intravenous conscious sedation	$289	$187	$265	$110	$0	$184	$0
Ranking		**N/A**	**3**	**1**	**5**	**4**	**6**	**2**

Table C.4 in Appendix C depicts the number of dentists by state per 10,000 population in CY 2019. Maryland has the seventh highest number of dentists per 10,000 population in the nation. By comparison, the District of Columbia is first and Delaware is 48th.

VI. Trauma Center Payments

In 2003, SB 479 (Chapter 385 of the Acts of 2003) created a Trauma and Emergency Medical Fund, which is financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the fund. This law requires Maryland Medicaid to pay physicians 100 percent of the Medicare facility rates for the Baltimore region when they provide trauma care to Medicaid FFS and HealthChoice program participants. The enhanced Medicaid fees apply only to services rendered in trauma centers designated by the Maryland Institute for Emergency Medical Services Systems to 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. The Fund fully covers the additional outlay of general funds that the Maryland Medical Assistance program pays 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.

VII. Physician Participation in the Maryland Medicaid Program

Physician claims and encounters data pertaining to FY 2002 (the year before the July 2002 fee increase) and FYs 2015 – 2019 were analyzed to determine the number of physicians who partially and fully participated in the Medicaid program. Because of incurred but not reported (IBNR) claims, FY 2019 FFS claims and MCO encounter data were not complete. Therefore, FY 2018 data were used as the last year for comparison in Tables 7 through 9.

Tables 7 through 9 show the percentage changes in the numbers of participating physicians from all specialties (including primary care) from 2002-2018, 2015-2018, and 2017-2018. 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, are considered partial participants in the Medicaid program. Physicians who treated at least 50 Medicaid patients during the year are considered full participants in the Medicaid program.

Because some physicians participate in both FFS and MCO networks, the percentages of all physicians participating in the Total Medicaid column do not equal the sum of FFS and MCO network physicians. Table 7 shows physician participation in the FFS program, MCO networks, and the Medicaid program overall between FYs 2002 and 2018. Participation increased significantly over this time period, particularly for physicians participating fully in Medicaid.

Table 7. Percentage Increase in the Numbers of Participating Physicians of All Specialties, FYs 2002 – 2018

Physician Participation Level	FFS	MCO Networks	Total Medicaid
Partial Participation	65.8%	45.4%	64.8%
Full Participation	76.5%	239.8%	198.1%
All Physicians	78.5%	81.5%	109.5%

Table 8 shows physician participation between FYs 2015 and 2018. After the ACA mandated increase in reimbursement rates for E&M procedures in CYs 2013 and 2014, their rates were maintained at a minimum of 93 percent of Medicare fees. The data shows an overall increase in participation by 19.3 percent. Furthermore, the numbers of physicians who fully participated in MCO networks increased substantially. There was a decrease in the number of physicians who fully or partially participated in the Medicaid FFS program, which could be due to physicians accepting fewer Medicaid patients. The number of physicians with less than 25 claims per month increased by 19.7% between FYs 2015 – 2018 (data are not shown separately, but are included in All Physicians).

Table 8. Percentage Change in the Numbers of Participating Physicians of All Specialties, FYs 2015 – 2018

Physician Participation Level	FFS	MCO Networks	Total Medicaid
Partial Participation	-0.5%	15.9%	13.6%
Full Participation	-21.5%	18.4%	14.0%
All Physicians	10.9%	19.6%	19.3%

Table 9 shows that the increasing trend in total physician participation in the Maryland Medicaid program continued throughout FYs 2017 and 2018. The number of partial participants increased 1.9 percent, along with a 6.8 percent decrease among full participants in the FFS program. As additional physicians began participating in the FFS program, other physicians reduced their levels of participation in the program.

Table 9. Percentage Change in the Numbers of Participating Physicians of All Specialties, FYs 2017 – 2018

Physician Participation Level	FFS	MCO Networks	Total Medicaid
Partial Participation	1.9%	7.3%	5.4%
Full Participation	-6.8%	5.8%	5.2%
All Physicians	3.2%	8.1%	7.2%

The increase in Medicaid fees for E&M procedures to the Medicare fee levels in CYs 2013 and 2014, and maintenance of the E&M reimbursement rates above 92% of Medicare rates offer financial incentives for Maryland physicians to participate in the Medicaid program. Indeed, there has been a significant increase in the number of physicians who fully participate in Medicaid over time. MCOs are given the flexibility to negotiate rates with physicians, and the most significant increases have been seen for physicians participating in MCO networks.

To separate the effects of fee increases on physician participation from the effects of the increase in Medicaid enrollment, an additional analysis was conducted, in which the number of claims per participant for each year was calculated beginning in FY 2002 (Table 10). Note that this analysis excludes radiology and laboratory procedures for all years, because they may not be representative of patient access to physician services.

Table 10. Number of Claims per Medicaid Participant, FYs 2002 – 2018[7]

Fiscal Year	Average Monthly Medicaid Enrollment	Number of Physician Claims and Encounters	Average Number of Claims Per Participant	Annual Percentage Increase in Claims Per Participant
2002	617,929	4,022,098	6.5	N/A
2003	652,414	4,412,558	6.8	3.9%
2004	669,021	4,888,690	7.3	8.0%
2005	687,269	5,009,629	7.3	-0.2%
2006	690,227	5,393,091	7.8	7.2%
2007	676,522	5,750,599	8.5	8.8%
2008	678,584	6,239,473	9.2	8.2%
2009	741,772	7,158,616	9.7	5.0%
2010	826,599	8,465,703	10.2	6.1%
2011	894,681	9,522,361	10.6	3.9%
2012	948,177	10,023,803	10.6	-0.7%
2013	987,857	10,573,565	10.7	1.2%
2014	1,136,525	11,775,727	10.4	-3.2%
2015	1,309,861	13,039,307	10.0	-3.9%
2016	1,279,359	12,551,868	9.8	-1.4%
2017	1,370,258	13,159,214	9.6	-2.1%
2018	1,409,408	13,436,590	9.5	-0.7%

N/A: Not Applicable

The continued increase in the average number of claims per participant shows that, as physician reimbursement rates increased in FY 2003 and subsequently during the FYs 2006 – 2013 period, the utilization of physician services by Medicaid participants increased steadily, from an average of 6.5 claims per participant in FY 2002 to an average of 10.7 claims per participant in FY 2013. The utilization of physician services by Medicaid participants is a proxy for the physician participation in the Maryland Medicaid program and this increase may be interpreted as an increase in the access to physician services for Medicaid participants. The average number of claims per participant has gradually decreased, in tandem with the downward trend in Maryland Medicaid reimbursement rates for E&M procedures that are used by most physicians. In 2013, the Medicaid reimbursement rates for E&M procedures were equal to Medicare rates in Maryland, but declined to 87 percent of Medicare rates in 2015. However, as noted above, Maryland Medicaid reimbursement rates for E&M procedures are currently at a minimum of 93 percent of corresponding Medicare rates.

[7] The source of Average Monthly Medicaid Enrollment data used for this table is the Medicaid enrollment data maintained in the Decision Support System (DSS) at The Hilltop Institute at the University of Maryland, Baltimore County (UMBC).

Comparison of Access to Medical Care for Medicaid and Private Coverage

The U.S. Government Accountability Office (GAO) analyzed national surveys to evaluate the extent to which Medicaid beneficiaries reported difficulties obtaining medical care. The GAO compared the results for Medicaid with private/commercial insurance coverage and found that beneficiaries covered by Medicaid for a full year reported low rates of difficulty obtaining necessary medical care and prescription medicine, similar to individuals with private insurance coverage for a full year (Government Accountability Office, November 2012).

Howell, Decker, Hogan, Yemane, & Foster (2010) analyzed childhood mortality using the National Center for Health Statistics' death records to examine the effects of expanding Medicaid and CHIP program eligibility on national childhood mortality. They found that childhood mortality continued to decline significantly in the United States, and Medicaid and CHIP eligibility expansion was a significant contributor to this decline.

A study sponsored by America's Health Insurance Plans (AHIP), titled "The Value of Medicaid: Providing Access to Care and Preventive Health Services," found that adults and children enrolled in Medicaid health plans had significantly better access to care and preventive services than people with no health care coverage (2018). For example:

- Adult Medicaid participants were almost five times more likely to have a usual source of care, and children were four times more likely to have a usual source of care than people with no health coverage.
- Adults were four times more likely to receive certain preventive care services, and children were two to three times more likely to receive certain preventive care services than people with no health insurance.
- Greater proportions of commercial health plan and Medicaid health plan participants have access to care and preventive services relative to uninsured adults.[8]

VIII. Plan for the Future

The Department remains dedicated to ensuring that physicians are reimbursed equitably for their services. While the provision of the ACA that required parity of reimbursement rates for E&M procedures with the rates paid by Medicare expired at the end of 2014, the state has allocated funds to maintain rates at a minimum of 93 percent of Medicare reimbursement rates. In addition, the Department is analyzing reimbursement for other specialties and

[8] For this study, MEPS data pertaining to 2013 – 2015 were used. To control for confounding factors, including demographics, geographic location, and general health status, and to isolate the effect of insurance coverage, multivariate statistical models were constructed that tested the relationships between insurance status and measures of access to care and provision of preventive services. Controlling for these potentially influential patient factors allowed for an accurate comparison among commercially insured, Medicaid insured, and uninsured patients.

continuing to identify needs for adjustment in reimbursement rates to ensure physician participation and maintain network adequacy.

Federal legislation in recent years has addressed issues with the current payment system. For example, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate formula used for the annual update of Medicare physician fees and implemented a Merit-Based Incentive Payment System (MIPS) program that rewards physicians for providing high-quality, high-value health care. Appendix D of this report briefly describes the MIPS program. The Department strongly supports federal efforts to enhance the payment system and will continue to monitor them closely.

Appendix A: Medicare Resource-Based Relative Value Scale

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

CMS determines the associated relative value units (RVUs) and various payment policy indicators needed for payment adjustment of approximately 10,000 physician procedures. The RVU 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 when they are performed in non-facilities (e.g., offices), where physicians must pay for practice expenses. The implementation of RBRVS methodology in 1992 resulted in increased payments for office-based (non-facility) procedures and reduced payments for hospital-based procedures.

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

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

Appendix B: Anesthesia Reimbursement Calculations

Prior to December 1, 2003, reimbursement for anesthesia services in the Maryland Medicaid program was based on a percentage of the surgical fee. In general, the program used the surgical CPT codes with a modifier, rather than the anesthesia CPT codes. 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 RBRVS methodology. Medicare's methodology recognizes anesthesia time as the key element for determining the payment rate. The anesthesia time for any additional procedures performed during the same operative session is added to the time for the primary procedure. This time is then converted to units, with 15 minutes equal to one unit.

More than 5,000 surgical procedure codes exist, but there are fewer than 300 anesthesia codes. Each anesthesia CPT code has a non-variable (fixed) number of "Base Units." Like RBRVS, the Base Units represent the difficulty associated with a given group of procedures. The Base Units of time for the selected anesthesia procedure are added to the (actual) units of time related to anesthesia procedure, 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 C: Number of Physicians and Dentists in Each State and per 10,000 Population in CY 2018

Source: All data for the numbers of physicians and dentists in this appendix were downloaded from the website of the Kaiser Family Foundation, State Health Facts on October 16, 2019: https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Annual Estimates of the Resident Population for the United States in 2018 are from the Census Bureau, U.S. Department of Commerce. They were downloaded from the following website on October 16, 2019: https://www.census.gov/search-results.html?q=population+by+states&page=1&stateGeo=none&searchtype=web&cssp=SERP&_charset_=UTF-8

Physician data include all active allopathic and osteopathic physicians. Data in the last column of Table C.1 are based on the numbers of physicians in patient care per 10,000 population. Maryland ranks sixth in the number of physicians per 10,000 population among all states and the District of Columbia.

Dentist data include all professionally active dentists. Maryland has the seventh highest number of dentists per 10,000 people among all states.

Table C.1. Number of Physicians by State in CY 2019, Ranked by Number per 10,000 Population

Rank	Geographic Location	Primary Care Physicians	Specialist Physicians	Total Physicians	Active Physicians Per 10,000 Population
	United States	**479,856**	**525,439**	**1,005,295**	**30.7**
1	Dist. of Columbia	3,176	4,170	7,346	104.6
2	Massachusetts	15,784	20,722	36,506	52.9
3	Rhode Island	2,407	2,581	4,988	47.2
4	New York	40,592	48,908	89,500	45.8
5	Connecticut	6,990	8,615	15,605	43.7
6	**Maryland**	**10,944**	**13,732**	**24,676**	**40.8**
7	Pennsylvania	24,302	26,767	51,069	39.9
8	Michigan	18,516	20,303	38,819	38.8
9	Vermont	1,128	1,210	2,338	37.3
10	Ohio	19,591	22,782	42,373	36.2
11	Maine	2,477	2,244	4,721	35.3
12	New Jersey	14,834	15,668	30,502	34.2
13	Illinois	21,993	21,384	43,377	34.0
14	Missouri	9,410	10,865	20,275	33.1
15	Delaware	1,564	1,584	3,148	32.5
16	Minnesota	8,788	9,383	18,171	32.4
17	West Virginia	2,882	2,803	5,685	31.5
18	New Hampshire	2,002	2,238	4,240	31.3
19	Wisconsin	8,498	9,197	17,695	30.4
20	Louisiana	6,328	7,493	13,821	29.7
21	Washington	10,919	11,117	22,036	29.2
22	Nebraska	2,882	2,745	5,627	29.2
23	Oregon	5,987	6,162	12,149	29.0
24	California	54,135	58,771	112,906	28.5
25	Tennessee	8,876	10,103	18,979	28.0
26	New Mexico	2,936	2,894	5,830	27.8
27	Virginia	11,555	11,752	23,307	27.4
28	North Carolina	13,400	14,979	28,379	27.3
29	Kansas	4,113	3,813	7,926	27.2
30	Iowa	4,424	4,087	8,511	27.0
31	Kentucky	5,481	6,456	11,937	26.7
32	Florida	27,396	29,103	56,499	26.5

Rank	Geographic Location	Primary Care Physicians	Specialist Physicians	Total Physicians	Active Physicians Per 10,000 Population
33	North Dakota	1,112	903	2,015	26.5
34	Hawaii	1,856	1,804	3,660	25.8
35	Alaska	1,054	846	1,900	25.8
36	Colorado	7,220	7,289	14,509	25.5
37	South Carolina	6,395	6,452	12,847	25.3
38	Indiana	8,110	8,706	16,816	25.1
39	Alabama	5,863	6,342	12,205	25.0
40	Arizona	8,537	9,269	17,806	24.8
41	Georgia	12,524	12,788	25,312	24.1
42	Oklahoma	4,810	4,662	9,472	24.0
43	Arkansas	3,513	3,637	7,150	23.7
44	South Dakota	1,083	958	2,041	23.1
45	Texas	30,704	33,898	64,602	22.5
46	Mississippi	3,216	3,381	6,597	22.1
47	Montana	1,174	1,152	2,326	21.9
48	Utah	3,065	3,696	6,761	21.4
49	Wyoming	628	544	1,172	20.3
50	Nevada	3,065	3,086	6,151	20.3
51	Idaho	1,617	1,395	3,012	17.2

Table C.2. Primary Care Physicians by Field, CY 2019

Geographic Location	Internal Medicine	Family Medicine/ General Practice	Pediatrics	Obstetrics and Gynecology	Geriatrics	Total Primary Care
United States	197,506	139,407	87,637	53,913	1,393	479,856
Alabama	2,285	1,868	1,030	671	9	5,863
Alaska	218	592	146	98	N/A	1,054
Arizona	3,325	2,689	1,489	991	43	8,537
Arkansas	899	1,685	619	301	9	3,513
California	22,363	15,198	10,500	5,956	118	54,135
Colorado	2,503	2,723	1,166	811	17	7,220
Connecticut	3,889	783	1,325	984	9	6,990
Delaware	493	411	474	182	4	1,564
Dist. of Columbia	1,623	332	809	405	7	3,176
Florida	11,595	8,280	4,683	2,733	105	27,396
Georgia	4,978	3,411	2,446	1,662	27	12,524
Hawaii	755	490	320	289	2	1,856
Idaho	389	922	154	148	4	1,617
Illinois	9,651	6,054	3,830	2,424	34	21,993
Iowa	1,278	2,161	639	331	15	4,424
Indiana	2,631	3,323	1,301	831	24	8,110
Kansas	1,205	1,789	695	418	6	4,113
Kentucky	1,975	1,900	930	662	14	5,481
Louisiana	2,507	1,792	1,178	842	9	6,328
Maine	805	1,118	334	203	17	2,477
Maryland	**5,688**	**1,715**	**2,204**	**1,308**	**29**	**10,944**
Massachusetts	9,193	1,971	3,163	1,430	27	15,784
Michigan	7,415	6,023	2,640	2,384	54	18,516
Minnesota	3,215	3,506	1,265	778	24	8,788
Mississippi	1,179	1,097	525	412	3	3,216
Missouri	3,811	2,736	1,739	1,083	41	9,410
Montana	344	587	125	116	2	1,174
Nebraska	894	1,260	441	284	3	2,882
Nevada	1,411	901	424	323	6	3,065
New Hampshire	869	581	328	218	6	2,002
New Jersey	7,070	2,708	3,164	1,831	61	14,834
New Mexico	979	1,135	531	285	6	2,936
New York	20,720	6,480	8,600	4,720	72	40,592

Table C.2. Primary Care Physicians by Field, CY 2018, continued

Geographic Location	Internal Medicine	Family Medicine/ General Practice	Pediatrics	Obstetrics and Gynecology	Geriatrics	Total Primary Care
North Carolina	5,055	4,024	2,568	1,691	62	13,400
North Dakota	351	587	110	60	4	1,112
Ohio	7,906	5,406	3,993	2,192	94	19,591
Oklahoma	1,319	2,260	704	514	13	4,810
Oregon	2,569	1,978	811	613	16	5,987
Pennsylvania	10,376	7,204	3,896	2,666	160	24,302
Rhode Island	1,308	283	535	275	6	2,407
South Carolina	2,137	2,341	1,122	776	19	6,395
South Dakota	339	541	121	80	2	1,083
Tennessee	3,587	2,486	1,729	1,064	10	8,876
Texas	10,860	9,612	6,169	3,953	110	30,704
Utah	971	1,052	669	369	4	3,065
Vermont	417	373	215	122	1	1,128
Virginia	4,248	3,729	2,198	1,347	33	11,555
Washington	3,748	4,417	1,786	939	29	10,919
West Virginia	976	1,241	393	264	8	2,882
Wisconsin	3,052	3,276	1,343	812	15	8,498
Wyoming	132	376	58	62	N/A	628

Note: Physician data include all allopathic and osteopathic physicians.

Table C.3. Specialist Physicians by Field, CY 2019

Geographic Location	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology	Endocrine, Metabolism	All Other Specialties	Total
United States	54,935	53,002	50,121	55,671	47,828	32,640	20,473	8,046	202,723	525,439
Alabama	506	754	602	465	674	410	241	71	2,619	6,342
Alaska	106	85	81	126	68	36	15	8	321	846
Arizona	875	979	1,023	1,093	876	530	264	102	3,527	9,269
Arkansas	352	370	333	327	364	202	139	43	1,507	3,637
California	7,288	5,367	6,098	6,050	5,012	3,235	1,898	822	23,001	58,771
Colorado	769	684	835	949	621	346	233	90	2,762	7,289
Connecticut	1,233	814	677	766	818	614	358	222	3,113	8,615
Delaware	161	173	108	232	186	115	57	13	539	1,584
Dist. of Columbia	565	425	300	374	298	287	192	94	1,635	4,170
Florida	2,303	2,818	2,806	2,928	2,684	2,107	1,099	422	11,936	29,103
Georgia	1,219	1,465	1,199	1,385	1,201	828	467	166	4,858	12,788
Hawaii	283	166	178	211	160	73	43	19	671	1,804
Idaho	109	149	112	171	207	48	31	14	554	1,395
Illinois	2,027	2,053	2,088	2,646	1,978	1,425	842	385	7,940	21,384
Iowa	340	528	465	349	400	271	144	42	1,548	4,087
Indiana	659	828	1,187	915	874	550	336	136	3,221	8,706
Kansas	455	465	407	294	338	222	129	43	1,460	3,813
Kentucky	593	787	623	696	560	362	200	69	2,566	6,456
Louisiana	641	811	603	784	604	459	244	97	3,250	7,493
Maine	313	276	214	317	193	127	70	19	715	2,244
Maryland	**1,693**	**1,268**	**1,204**	**985**	**1,113**	**829**	**671**	**255**	**5,714**	**13,732**
Massachusetts	2,878	1,903	1,783	1,735	2,010	1,637	1,176	497	7,103	20,722
Michigan	1,567	2,099	1,585	3,339	1,929	1,095	685	239	7,765	20,303
Minnesota	854	993	689	939	999	682	425	167	3,635	9,383

Table C.3. Specialist Physicians by Field, CY 2019, continued

Geographic Location	Psychiatry	Surgery	Anesthesiology	Emergency Medicine	Radiology	Cardiology	Oncology	Endocrine, Metabolism	All Other Specialties	Total
Mississippi	267	400	282	376	314	188	120	48	1,386	3,381
Missouri	1,030	1,115	1,114	1,092	1,099	674	422	181	4,138	10,865
Montana	104	129	146	124	110	56	31	7	445	1,152
Nebraska	270	326	325	214	264	163	102	35	1,046	2,745
Nevada	283	289	388	386	262	185	86	36	1,171	3,086
New Hampshire	280	245	224	234	182	149	91	31	802	2,238
New Jersey	1,661	1,471	1,605	1,533	1,252	1,232	588	325	6,001	15,668
New Mexico	383	259	263	390	228	143	88	46	1,094	2,894
New York	6,759	4,293	4,262	4,560	3,999	3,149	2,213	902	18,771	48,908
North Carolina	1,576	1,589	1,133	1,661	1,310	940	606	213	5,951	14,979
North Dakota	134	149	74	66	104	35	31	14	296	903
Ohio	1,770	2,444	1,987	2,878	1,942	1,484	878	303	9,096	22,782
Oklahoma	435	448	526	582	417	232	145	46	1,831	4,662
Oregon	653	717	688	726	515	275	208	84	2,296	6,162
Pennsylvania	2,641	2,998	2,306	3,163	2,551	1,923	1,204	429	9,552	26,767
Rhode Island	267	290	129	396	217	174	156	55	897	2,581
South Carolina	739	804	578	728	574	343	198	78	2,410	6,452
South Dakota	103	123	68	58	102	53	32	9	410	958
Tennessee	798	1,173	853	832	995	649	442	145	4,216	10,103
Texas	3,026	3,477	3,788	3,259	3,128	2,041	1,411	467	13,301	33,898
Utah	304	316	439	426	311	174	106	33	1,587	3,696
Vermont	192	137	113	90	108	64	39	14	453	1,210
Virginia	1,303	1,167	1,058	1,334	1,160	680	362	197	4,491	11,752
Washington	1,048	1,086	1,300	1,156	1,162	521	489	127	4,228	11,117
West Virginia	245	325	228	368	243	148	100	50	1,096	2,803
Wisconsin	818	905	986	889	1,066	459	359	133	3,582	9,197
Wyoming	57	67	58	74	46	16	7	3	216	544

Table C.4. Number of Dentists by State, Ranked by Number per 10,000 Population, CY 2019

Rank	Geographic Location	Total Dentists	Dentists Per 10,000 Population
	United States	**186,209**	**5.8**
1	Dist. of Columbia	608	8.7
2	Massachusetts	5,437	7.9
3	New Jersey	6,942	7.8
4	California	29,548	7.5
5	New York	14,368	7.4
6	Alaska	505	6.8
7	**Maryland**	**4,116**	**6.8**
8	Connecticut	2,424	6.8
9	Hawaii	962	6.8
10	Colorado	3,739	6.6
11	Washington	4,941	6.6
12	Illinois	8,034	6.3
13	Virginia	5,157	6.1
14	Nebraska	1,158	6.0
15	Pennsylvania	7,464	5.8
16	Utah	1,817	5.7
17	New Hampshire	769	5.7
18	Michigan	5,538	5.5
19	Kentucky	2,472	5.5
20	Vermont	345	5.5
21	Montana	577	5.4
22	Minnesota	2,976	5.3
23	Wisconsin	3,033	5.2
24	Arizona	3,705	5.2
25	Nevada	1,560	5.1
26	Texas	14,573	5.1
27	North Carolina	5,141	5.0
28	Florida	10,518	4.9
29	Ohio	5,721	4.9
30	North Dakota	369	4.9
31	Idaho	850	4.8
32	Iowa	1,525	4.8
33	Kansas	1,392	4.8
34	Rhode Island	505	4.8
35	Maine	638	4.8
36	Wyoming	273	4.7

Table C.4. Number of Dentists by State, Ranked by Number per 10,000 Population, CY 2019, continued

Rank	Geographic Location	Total Dentists	Dentists Per 10,000 Population
37	Tennessee	3,193	4.7
38	New Mexico	984	4.7
39	Missouri	2,862	4.7
40	Oklahoma	1,822	4.6
41	South Dakota	405	4.6
42	Louisiana	2,118	4.5
43	Indiana	3,000	4.5
44	Oregon	1,877	4.5
45	West Virginia	800	4.4
46	South Carolina	2,242	4.4
47	Georgia	4,556	4.3
48	Delaware	398	4.1
49	Mississippi	1,174	3.9
50	Alabama	1,919	3.9
51	Arkansas	1,159	3.8

Appendix D: The Merit-Based Incentive Payment System

The Merit-based Incentive Payment System (MIPS) was designed to link payments to high-quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care. In this system, physician performance is measured through the data clinicians report in four categories: quality, promoting interoperability, improvement activities, and cost.

Quality

The quality of care that physicians deliver is evaluated based on performance measures created by CMS, medical professionals, and stakeholder groups.

Promoting Interoperability

The promoting interoperability (PI) category addresses patient engagement and the electronic exchange of health information. Physicians promote interoperability by proactively sharing information with other clinicians in a comprehensive manner, such as sharing test results, visit summaries, and therapeutic plans with the patient and other facilities to coordinate care.

Improvement Activities

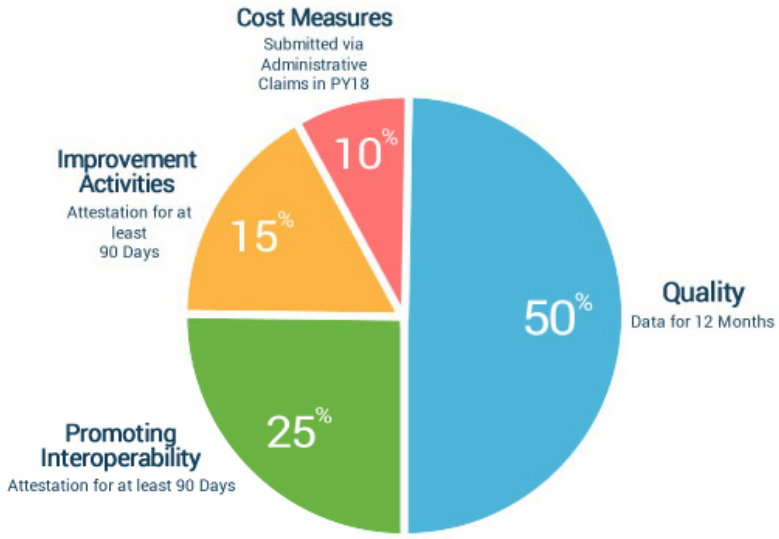
The improvement activities performance category includes an inventory of activities that assess how physicians improve care processes, enhance patient engagement in care, and increase access to care.

Cost

The cost of the care physicians provide is calculated by CMS based on their Medicare claims. MIPS uses cost measures to gauge the total cost of care during the year and during a specific hospital stay. Beginning in 2018, this performance category was included in the MIPS final score.

A single MIPS composite score factors in performance in the four weighted performance categories on a 0 – 100 point scale. The figure below illustrates the Summary of MIPS Performance Categories and the weights that are used for each performance category to calculate the MIPS score for each physician and multi-physician practices.

MIPS Performance Category Scoring: Summary of MIPS Performance Categories



Source: The Merit-based Incentive Payment System: MIPS Scoring Methodology Overview. CMS, US HHS

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