STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

December 28, 2009

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

The Honorable Peter A. Hammen
Chairman
House Health and Government
Operations Committee
161 Lowe 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)

Dear Chairmen Middleton and Hammen:

The Department of Health and Mental Hygiene was required to annually submit a report pursuant to Section 1 of SB 481 – *Department of Health and Mental Hygiene – Reimbursement Rates*. The Department was required to provide information on the progress in establishing a process for annually setting the fee-for-service reimbursement rates for Medical Assistance and the Maryland Children's Health Program. It also provided analysis of other states' rates compared to Maryland; the schedule for raising rates; and an analysis of the estimated cost of implementing these changes. This report was due on September 1, 2008.

In addition, the Department incorporated into this report information required by HB 627 – *Community Health Care Access and Safety Net Act of 2005*. Section 11 of this Act required the Department to review the rates paid to providers under the federal Medicare fee schedule and compare 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. On or before January 1, the Department is to annually report this information and whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule.

In 2009, the General Assembly passed HB 70 – *Commissions, Programs and Reports – Revision* (Ch. 656 of the Acts of 2009), which consolidated these two physician fee reporting requirements so that the Department is now required to submit a single report on physician fee issues to the legislature by January 1 each year. The enclosed report satisfies this requirement.

If further information on this subject is required, please contact Shawn Cain, Assistant Director of the Office of Governmental Affairs, at (410) 767-6509.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Tricia Roddy
Audrey Richardson
Diane Herr
Shawn Cain

Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates January 2010

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Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Reimbursement Rates January 2010

I. Introduction

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

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

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

In addition, the Department has incorporated into this report information required by HB 70 from the 2009 session. Section 15 of this act requires the Department to review the rates paid to providers under the federal Medicare fee schedule and compare those rates with the fee-for-service rates for the same services paid to providers under: 1) the Medical Assistance program and 2) managed care organizations (MCOs). On or before January 1 of every year, the Department is required to report this information and state whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule.

II. Background

In September 2001, in response to Chapter 702 (HB 1071) of the 2001 session, the Department prepared the first annual report, analyzing the physician fees that are paid by the Maryland Medical Assistance and the Maryland Children's Health Programs. In 2002, SB 481 required the submission of this report on an annual basis. This is the ninth annual report.

The Department's first annual report showed that Maryland's Medicaid reimbursement rates in 2001 were, on average, approximately 36 percent of Medicare rates. The report also included the results of a survey conducted by the American Academy of Pediatrics in 1998/1999, which showed that Maryland's physician reimbursement rate for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the

Legislature allocated $50 million in additional total funds ($25 million state funds) to increase physician fees in the Medicaid program, beginning July 2002. The increase was targeted to evaluation and management (E&M) procedure codes that are primarily used by primary care and specialty care physicians.

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

SB 836 also required the Department to consult with the MCOs, the Maryland Hospital Association, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatricians, and the Maryland Chapter of the American College of Emergency Physicians to determine the new payment rates each year. These organizations are collectively referred to as stakeholders in this report. HB 1522 of the 2008 session modified provisions of the law enacted by SB 836 and included the Maryland State Dental Association and the Maryland Dental Society among entities with which the Department must consult to determine payment rates.

The Department used the Medicare physician payment methodology as a benchmark, or point of reference, when it increased physician fees in FYs 2003, 2006, 2007, and 2008. Medicare fees are based on the RBRVS methodology, which relates payments to the resources and skills that physicians use to provide services. The Centers for Medicare and Medicaid Services (CMS) annually updates the Medicare fee schedule. (See Appendix 1 for a description of RBRVS methodology).

For FY 2007, based on the stakeholders' recommendation, the Department increased fees for procedures that are primarily used for anesthesiology; general surgery; digestive surgery; ear, nose, and throat (ENT); allergy/immunology; dermatology; and radiation oncology procedures. For FY 2008, also based on the stakeholders' recommendation, the Department increased fees for E&M procedures, obstetric anesthesia, neonatology, radiology, psychiatry, and vaccine administration procedures. In addition, procedures with the lowest fees were raised to a minimum of 50 percent of Medicare fees.

The Department implemented another fee increase for FY 2009. As indicated above, fees for many procedures, including orthopedic, obstetric/gynecology, neurosurgery, ENT, and emergency medicine were set in previous years at 100 percent of their corresponding Medicare fee. Medicare fees in general had not increased substantially during the 2006 to 2008 period.

However, updates in procedure relative value units (RVUs) led to Medicare fee decreases for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for many procedures were at 50 percent of Medicare fees. Therefore, the Department proposed, and the stakeholders agreed, to increase the lowest Medicaid fees and re-balance any Medicaid fees higher than Medicare. In addition, separate fees for different sites of service were established so that Medicaid fees would have site of service differentials for facilities (e.g., hospitals) and non-facilities (e.g., offices).

Medicaid fees that were higher than Medicare fees were reduced to their corresponding Medicare fee levels by site of service, and the lowest fees were raised to 78.6 percent of their corresponding Medicare fees by site of service. The exceptions to this methodology were that fees for procedures in four specialties (orthopedic, obstetric/gynecology, neurosurgery, and emergency medicine) were set equal to 100 percent of Medicare fees, and fees for four obstetric procedures (normal and cesarean delivery procedures) were maintained at their FY 2008 levels, which are higher than their corresponding Medicare fees.

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

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

Table 1. Prior Fee Increases to Percentage of Medicare Fees

Fiscal Year	Procedure Code Group	Percent of Medicare Fees at Time of Original Fee Increase
2003	Evaluation and management (99201-99499)	80%
2006	Four Specialties:	
	Orthopedic (20000-29999)	99.6%
	Obstetric/Gynecology (56405-59899)	99.6%
	Neurosurgery (61000-64999)	99.6%
	Emergency Medicine (99281-99285)	99.6%
2007	Anesthesia (00100-01999)	100%
	General Surgery (10000-19396)	80%
	Digestive System (40490-49905)	80%
	ENT (69000-69990, 92502-92700)	100%
	Radiation Oncology (77261-77799)	80%
	Allergy/Immunology (95004-95199)	80%
	Dermatology (96900-96999)	80%
2008	Evaluation and management (99201-99499)	80%
	Evaluation and management in hospital outpatient departments	50%
	Neonatology procedures (99294, 99296, 99299)	90%
	Radiology procedures (70010-79900, excluding 77261-77799)	53%
	Vaccine administration procedures	66%
	Psychiatry (90801-90911)	61%
	Procedures with the lowest fees	50%
2009	Set separate fees for facilities and non-facilities	
	Procedures with the lowest fees	78.6%
	Orthopedic (20000-29999),	100%
	Obstetric/Gynecology (56405-59899)	100%
	Neurosurgery (61000-64999)	100%
	Emergency Medicine (99281-99285)	100%

III. Physician Fee Reductions in FY 2009 and FY 2010

The national economic recession reduced state revenues in FY 2009 and FY 2010. Therefore, the Department implemented two reductions in physician fees during calendar year 2009: the first in January 2009, and the second in July 2009.

January-June 2009 Fee Reduction

In January 2009, the state reduced projected payments for physician services by $3.08 million in total funds for the six-month period of January through June 2009. From the total reduction in payments, $630,000 came from fee-for-service payments, and $2.45 million came from payments to HealthChoice MCOs. Payment reductions for procedures performed in facilities were nearly equal to the payment reductions for procedures performed in non-facilities. Fees for procedures performed by the four specialties (orthopedic, obstetric/gynecology, neurosurgery, and emergency medicine) were maintained at 100 percent of Medicare fees. Fees for the following specialties and procedures were maintained at their original FY 2009 amounts: ENT specialty codes, neonatal visit codes, and preventive medicine visit codes (99381-99397). Fees for the 146 codes with modifier 26 (professional component) that do not have Medicare base fees were also maintained at their original levels. Per CMS regulation, effective January 1, 2009, vaccine administration fees were reduced from $17 to $15.49, which is the maximum allowed vaccine administration fee in Maryland. Before the January fee reduction, fees for Medicaid procedures had a maximum limit of 100 percent of Medicare fees. Following the decrease, fees for all procedures except the four specialties were reduced across the board to a maximum of 82 percent of Medicare fees. However, the minimum percentage of Medicare fees for any procedure code remained the same at 78.6 percent.

FY 2010 Fee Reduction

The state reduced physician fees effective July 1, 2009, to achieve an $11.5 million total funds ($4.5 million state funds) reduction in payments for physician services in FY 2010. Again, some groups of specialties and procedure codes were excluded from the reduction in fees:

- Fees for procedures performed by the four specialties (orthopedic, obstetric/gynecology, neurosurgery, and emergency medicine) were maintained at a maximum of 100 percent of Medicare fees. Also, fees for four obstetric delivery procedures were maintained at their original FY 2008 levels, which are higher than their corresponding Medicare fees.
- Fees for E&M procedure codes (99201-99215) and preventive medicine procedure codes (99381-99397) that are used by primary care physicians and specialists were held at their FY 2009 levels.

To consistently pay the same fee for the same procedure performed in different facilities, fees for E&M procedures performed in outpatient hospitals were set equal to their corresponding facility fees. Also, any fees that were higher than their corresponding Medicare fees were lowered to equal the Medicare fees, by site of service. Then, fees for all remaining procedures were reduced across the board by 5.8 percent to achieve the required reduction of $11.5 million in FY 2010 payments.

Fees for procedures performed in non-facilities (e.g., offices) were reduced from an average of 80 percent to an average of 79 percent of Medicare fees. Fees for procedures performed in facilities (e.g., hospitals) were reduced from an average of 86 percent to an average of 83 percent of Medicare fees. Before the fee decrease, Medicaid fees were on average 83 percent of Medicare 2009 fees. After the fee decrease, they were reduced to an average of 81 percent of

Medicare 2009 fees. Approximately 24 percent of the total reduction in payments comes from E&M procedures, as they account for approximately 49 percent of the total payments for procedures that are subject to fee reduction. From the $11.5 million total funds reduction in payments, approximately $3 million comes from fee-for-service payments, and approximately $8.5 million come from the reduction of HealthChoice MCOs payments for physician services.

IV. Maryland Medicaid Fees Compared with Medicare Fees

Table 2 shows the average percentage of Medicare 2009 fees for all specialty groups of procedures before and after the July 1, 2009, fee decrease. The average percentages reported in Table 2 are weighted averages of Maryland fees as percentages of Medicare fees for all procedures in each specialty group.

Table 2 also shows the number of procedures in each specialty group that had a fee decrease in FY 2009. Note that the numbers of procedures that had fee changes do not include changes in fees for modifier components of procedures. That is, a procedure code that has a base fee and payment modifiers that increase the fee under various circumstances is counted as one procedure. However, procedures that had fee changes in both facilities and non-facilities are counted twice: once for the change in the facility fee, and once for the change in the non-facility fee.

Table 2. Average Percentage of Medicare 2009 Fees by Procedure Specialty Group (Sum of Facilities and Non-Facilities)

Specialty Group	CPT Codes	Pre-Decrease % of Medicare	Post-Decrease % of Medicare	Procedures with Fee Decrease
Anesthesia	00100-01999	90%	85%	All
Integumentary / General Surgery	10000-19396	80%	75%	499
Musculoskeletal System	20000-29999	100%	99%	605
Respiratory	30000-32999	79%	74%	253
Cardiovascular System Surgery	33010-37790	79%	74%	483
Hemic and Lymphatic Systems	38100-38794	77%	73%	52
Mediastinum	39000-39561	77%	72%	13
Digestive System	40490-49905	79%	74%	687
Urinary and Male Genital	50010-55999	77%	72%	326
Gynecology-Obstetric	56405-59899	104%	104%	49
Endocrine System	60000-60699	76%	72%	24
Neurosurgery	61000-64999	101%	98%	74
Eye Surgery	65091-68899	78%	74%	223
ENT Surgery	69000-69990	101%	96%	75
Radiology	70010-79900	80%	75%	832
Laboratory	80048- 89356	78%	73%	1,262
Psychiatry	90801-90911	77%	73%	38
Dialysis	90918-90999	77%	73%	8
Gastroenterology	91000-91299	86%	81%	21
Ophthalmology and Vision Care	92002-92499	80%	75%	67
ENT (Otorhinolaryngology)	92502-92700	101%	89%	71
Cardiovascular Medicine	92950-93798	88%	81%	155
Noninvasive Vascular Diagnostic Tests	93875-93990	78%	74%	44
Pulmonary	94010-94799	80%	76%	59
Allergy and Immunology	95004-95199	94%	88%	32
Neurology and Neuromuscular	95805-96004	82%	77%	118
CNS Assessment Tests	96100-96155	79%	74%	22
Chemotherapy Administration	96400-96571	86%	81%	22
Special Dermatological Procedures	96900-96999	74%	70%	7
Physical Medicine and Rehabilitation	97001-97804	77%	72%	69
Osteopathy, Chiropractic, and Other Medicine	97810-99195	81%	76%	36
Evaluation and Management	99201-99499	79%	77%	142
Emergency Medicine	99281-99285	95%	95%	0
Outpatient Departments Evaluation and Management		74%	88%	6
All Procedures		**83%**	**81%**	**6,374**

V. Comparisons of Maryland Medicaid Fees with Other States' Fees

Like Maryland, the neighboring states have their own Medicaid fee schedules. For this report, we collected data on Medicaid physician fees of the neighboring states of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, D.C. We obtained the most current physician fee schedules of Delaware, Pennsylvania, Virginia, and West Virginia from their websites. Washington, D.C. provided its fee schedule information directly. We compiled data on each state's current Medicaid fees for a sample of approximately 210 high-volume procedures in various specialties.

Table 3 compares Maryland's FY 2009 and FY 2010 Medicaid fees with the corresponding Medicare and neighboring states' Medicaid fees for a sample of high-volume procedures in each specialty group. In Table 3, procedure fees are rounded to the nearest dollar amount. In this table, the last row of each section shows the weighted average of each state's fees for surveyed procedures as a percent of Medicare fees in Maryland. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. It should be noted that the average percent of Medicare fees reported in this table corresponds to the appropriate Medicare non-facility and facility fees. Fees for Maryland, Virginia, and West Virginia, which have separate facility and non-facility fees, are compared with the corresponding Medicare fees. However, for Washington, D.C., Delaware, and Pennsylvania, which have one fee for each procedure, fees are compared with Medicare non-facility fees. Hence, for D.C., Delaware, and Pennsylvania, the percentage of Medicare fees reported in the table is an under-estimate of the percent of Medicare fees for procedures performed in facilities.

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

Comparisons of E&M and Specialty Procedures

In the following paragraphs, we compare Maryland fees with other states' fees for evaluation and management and each group of specialty procedures.

Evaluation and Management Procedures

As the data in Table 3 indicate, as an average percentage of Medicare fees in Maryland, Washington, D.C. has the highest fees in the region for the selected E&M procedures. Delaware holds the second rank. Maryland, Virginia, and West Virginia's facility fees rank third, fourth, and fifth. Maryland, Virginia, and West Virginia's non-facility fees rank sixth, seventh, and eighth, and Pennsylvania fees hold the ninth ranking.

Integumentary and General Surgery Procedures
For integumentary procedures, Washington, D.C. fees rank first, Delaware fees rank second, Virginia facility fees rank third, and Maryland non-facility fees rank fourth, Virginia non-facility fees rank fifth, Maryland facility fees rank sixth, West Virginia facility and non-facility fees rank seventh and eighth and Pennsylvania fees rank ninth in the region.

Musculoskeletal System Procedures
Maryland non-facility fees for musculoskeletal system procedures are set at 100 percent of their corresponding Medicare fees. Washington, D.C. fees are the highest in the region, followed in order by Maryland non-facility fees, Maryland facility fees, Delaware, Virginia facility fees, Virginia non-facility fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees.

Respiratory Procedures
Washington, D.C. fees for respiratory procedures rank highest in the region, followed by Virginia facility fees and Delaware fees. The other neighboring states are ranked as follows from highest to lowest: Maryland non-facility, Virginia non-facility, Maryland facility, West Virginia facility, West Virginia non-facility, and Pennsylvania.

Cardiovascular System Surgery Procedures
Virginia facility fees for selected cardiovascular system surgery procedures are the highest in the region, followed by Washington, D.C. fees, Maryland non-facility fees, Virginia non-facility fees, Maryland facility fees, West Virginia facility fees, West Virginia non-facility fees, Delaware fees, and Pennsylvania fees.

Hemic and Lymphatic Systems Procedures
Washington, D.C. fees for hemic and lymphatic systems procedures are the highest in the region, followed by Virginia facility fees, Delaware fees, Maryland non-facility fees, Virginia non-facility fees, Maryland facility fees, West Virginia facility fees, West Virginia non-facility fees, and Pennsylvania fees.

Digestive System Procedures
Washington, D.C. fees for selected digestive system procedures are the highest in the region, followed by Virginia facility fees. The rank orders of the other neighboring states are: Delaware, Maryland non-facility, Virginia non-facility, Maryland facility, West Virginia facility, West Virginia non-facility, and Pennsylvania.

Urinary and Male Genital Procedures
Washington, D.C. fees for urinary and male genital procedures rank highest in the region, followed by Virginia facility fees, Maryland non-facility fees, Virginia non-facility fees, West Virginia facility fees, Maryland facility fees, West Virginia non-facility fees, Delaware fees, and Pennsylvania.

Gynecology and Obstetric Procedures
Most of the neighboring states have relatively high fees for gynecology and obstetric procedures. Pennsylvania has the highest fees, followed by West Virginia facility, West Virginia non-facility, Maryland non-facility, Maryland facility, Washington, D.C., Virginia facility, Virginia non-facility, and Delaware.

Endocrine System Procedures
Washington, D.C. has the highest fees for the selected endocrine system procedures, followed by Delaware, Virginia facility, Virginia non-facility, West Virginia facility, Maryland non-facility, Maryland facility, West Virginia facility, and Pennsylvania.

Neurosurgery Procedures
Virginia facility fees are the highest for the selected nervous system procedures, followed by Washington, D.C., Maryland non-facility, Maryland facility, Delaware, Virginia non-facility, West Virginia facility, West Virginia non-facility, and Pennsylvania.

Eye Surgery Procedures
Washington, D.C. has the highest fees for the selected eye surgery procedures, followed by Delaware, Virginia facility, Virginia non-facility, Pennsylvania, Maryland non-facility, Maryland facility, West Virginia facility and West Virginia non-facility.

Ear Surgery Procedures
Washington, D.C. has the highest fees for the selected ear surgery procedures, followed by Maryland non-facility, Maryland facility, Virginia facility, Virginia non-facility, West Virginia facility, West Virginia non-facility, Delaware and Pennsylvania. Because Delaware does not cover one of the selected procedures, its ranking was lowered among the neighboring states.

Radiology Procedures
Washington, D.C. has the highest fees for the selected radiology procedures, followed by Delaware, Virginia non-facility, Virginia facility, Maryland non-facility and facility, West Virginia non-facility and facility, and Pennsylvania.

Laboratory Procedures
Delaware has the highest fees for the selected laboratory procedures, followed by Virginia non-facility and facility, Maryland non-facility and facility, Pennsylvania, and Washington, D.C.. West Virginia fees for the selected procedures were not reported in their fee schedule.

Psychiatry Procedures
Washington, D.C. has the highest fees for the selected psychiatry procedures, followed by Delaware, Virginia facility, Maryland facility, Virginia non-facility, Maryland non-facility, West Virginia facility, West Virginia non-facility, and Pennsylvania.

Dialysis Procedures
Washington, D.C. fees for selected dialysis procedures are highest in the region, followed by Delaware, Virginia non-facility and facility, Maryland non-facility and facility, West Virginia non-facility and facility, and Pennsylvania fees.

Gastroenterology Procedures
Washington, D.C. has the highest fees for the selected gastroenterology procedures, followed by Delaware, Maryland facility, Virginia facility, Maryland non-facility, Virginia non-facility, West Virginia facility, West Virginia non-facility, and Pennsylvania.

Ophthalmology and Vision Care Procedures
Washington D.C. has the highest fees for the selected ophthalmology and Vision Care procedures, followed by Delaware, Virginia facility, Virginia non-facility, Maryland non-facility, Maryland facility, West Virginia facility, West Virginia non-facility and Pennsylvania.

ENT (Otorhinolaryngology) Procedures
Washington, D.C. fees for Otorhinolaryngology procedures hold the first rank in the region, followed by Delaware, Maryland non-facility, Maryland facility, Virginia facility, Virginia non-facility, Pennsylvania, West Virginia facility, and West Virginia non-facility.

Cardiovascular Medicine Procedures
Washington, D.C. has the highest fees for the selected cardiovascular medicine procedures, followed by Delaware, Maryland non-facility and facility, Virginia non-facility and facility, West Virginia non-facility and facility, and Pennsylvania.

Noninvasive Vascular Diagnostic Studies
Washington, D.C. has the highest fees for the selected noninvasive vascular test procedures, followed by Delaware, Virginia non-facility and facility, West Virginia non-facility, West Virginia facility, Maryland non-facility and facility, and Pennsylvania.

Pulmonary Procedures
Washington, D.C. has the highest fees for the selected pulmonary procedures, followed by Delaware, Maryland non-facility and facility, Virginia non-facility and facility, West Virginia non-facility and facility, and Pennsylvania.

Allergy and Immunology Procedures
Washington, D.C. has the highest fees for the selected allergy and immunology procedures, followed by Delaware, Maryland facility, Maryland non-facility, Virginia facility, Virginia non-facility, West Virginia facility, West Virginia non-facility, and Pennsylvania.

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

CNS Assessment Tests
Washington, D.C. has the highest fees in the region for selected CNS assessment procedures, followed by Virginia facility, West Virginia facility, Virginia non-facility, West Virginia non-facility, Maryland facility, Maryland non-facility, Pennsylvanian, and Delaware.

Chemotherapy Administration
Washington, D.C. has the highest fees in the region for the selected chemotherapy administration, followed by Delaware, Maryland non-facility, Pennsylvania, Virginia facility, Virginia non-facility, Maryland facility, West Virginia facility, and West Virginia non-facility fees.

Special Dermatology Procedures
Washington, D.C. has the highest fees in the region for the selected dermatology procedures, followed by Delaware, Virginia non-facility and facility, Maryland non-facility, West Virginia non-facility and facility, Pennsylvania, and Maryland facility fees.

Physical Medicine and Rehabilitation Procedures
Washington, D.C. fees for selected physical medicine and rehabilitation procedures are highest in the region, followed by Delaware, Virginia non-facility and facility, Maryland non-facility and facility, West Virginia non-facility and facility, and Pennsylvania fees.

Osteopathy, Chiropractic and Other Medicine Procedure
Virginia facility fees are the highest in the region for the selected chiropractic and other medicine procedures, followed by Virginia non-facility, Pennsylvania, Washington, D.C., Maryland non-facility, Delaware, Maryland facility, West Virginia non-facility, and West Virginia facility fees.

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Evaluation and Management													
99203	Office/outpatient visit, new	$95	$70	$77	$66	$77	$66	$103	$91	$54	$74	$64	$65	$50
99204	Office/outpatient visit, new	$146	$117	$113	$109	$113	$109	$158	$141	$90	$114	$103	$102	$84
99212	Office/outpatient visit, estab	$39	$24	$31	$22	$31	$22	$42	$37	$26	$30	$24	$26	$17
99213	Office/outpatient visit, estab	$63	$46	$48	$42	$48	$42	$69	$61	$35	$49	$43	$68	$52
99214	Office/outpatient visit, estab	$95	$71	$73	$65	$73	$65	$103	$92	$54	$74	$65	$65	$51
99223	Initial hospital care	$185	$185	$142	$142	$134	$134	$196	$178	$42	$145	$145	$133	$133
99232	Subsequent hospital care	$68	$68	$52	$52	$49	$49	$73	$66	$17	$54	$54	$49	$49
99238	Hospital discharge day	$68	$68	$55	$55	$51	$51	N/A	$66	$17	$53	$53	$48	$48
99244	Office consultation	$190	$158	$149	$122	$140	$115	$205	$183	$121	$148	$136	$132	$113
99283	Emergency dept visit	$63	$63	$60	$60	$60	$60	$66	$60	$35	$49	$49	$46	$46
99284	Emergency dept visit	$117	$117	$111	$111	$111	$111	$123	$112	$50	$92	$92	$86	$86
99285	Emergency dept visit	$174	$174	$166	$166	$166	$166	$182	$167	$50	$136	$136	$128	$128
99291	Critical care, first hour	$261	$217	$212	$171	$200	$161	$280	$252	$152	$204	$187	$184	$157
99308	Nursing facility care, subseq	$62	$62	$47	$47	$44	$44	$66	$60	$37	$49	$49	$44	$44
99381	Init Comp e/m, new pat, infant	$94	$61	$86	$57	$86	$57	$103	$91	$20	$73	$60	$63	$43
99391	Per Comp e/m estab pat, infant	$78	$52	$65	$49	$65	$49	$85	$75	$20	$60	$51	$53	$37
99392	Prevent visit, estab, age 1-4	$87	$61	$73	$57	$73	$57	$95	$84	$20	$67	$58	$59	$43
99393	Prevent visit, estab, age 5-11	$87	$61	$72	$57	$72	$57	$94	$84	$20	$67	$58	$59	$43
99394	Prevent visit, estab, age 12-17	$95	$70	$79	$65	$79	$65	$103	$92	$20	$74	$64	$65	$49
99469	Neonate critical care, subseq	$388	$388	$345	$345	$325	$325	$411	$375	N/A	$297	$297	$281	$281
99472	Ped critical care, subseq	$394	$394	$345	$345	$325	$325	$416	$378	N/A	$301	$301	$286	$286
99479	Int care inf 1500-2500 g subsq	$125	$125	$114	$114	$107	$107	$132	$119	N/A	$95	$95	$91	$91
	Average % of Medicare Fees			**82%**	**90%**	**81%**	**89%**	**106%**	**97%**	**44%**	**78%**	**87%**	**80%**	**81%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Integumentary and General Surgery													
10060	Drainage of skin abscess	$102	$88	$80	$71	$75	$66	$111	$98	$24	$77	$72	$69	$61
11042	Debride skin/tissue	$71	$46	$58	$38	$55	$35	$77	$67	$33	$53	$44	$49	$34
11721	Debride nail, 6 or more	$42	$29	$33	$23	$31	$22	$46	$40	$20	$32	$27	$29	$21
12001	Repair superficial wound(s)	$136	$97	$114	$77	$108	$73	$148	$131	$25	$103	$88	$93	$70
12011	Repair superficial wound(s)	$145	$100	$122	$80	$115	$76	$158	$139	$32	$109	$93	$99	$72
17110	Destruct benign lesion, 1-14	$102	$63	$76	$47	$71	$44	$114	$98	$49	$76	$62	$65	$42
17250	Chemical cautery, tissue	$69	$35	$58	$28	$55	$26	$77	$67	$26	$52	$39	$45	$24
	Average % of Medicare Fees			**81%**	**79%**	**76%**	**75%**	**110%**	**96%**	**30%**	**75%**	**92%**	**67%**	**71%**
	Musculoskeletal System													
20550	Inj tendon sheath/ligament	$56	$41	$56	$39	$56	$39	$60	$53	$32	$42	$37	$39	$30
20552	Inj trigger point, 1/2 muscle	$50	$35	$51	$33	$50	$33	N/A	$48	$31	$38	$32	$34	$25
20610	Drain/inject, joint/bursa	$73	$49	$72	$48	$72	$48	$80	$69	$24	$55	$46	$49	$36
25600	Treat fracture radius/ulna	$259	$234	$266	$232	$259	$232	$283	$246	$115	$195	$186	$176	$161
29075	Apply forearm cast	$80	$59	$82	$58	$80	$58	$89	$76	$46	$60	$53	$54	$41
29125	Apply forearm splint	$61	$40	$63	$39	$61	$39	$68	$59	$26	$46	$38	$41	$28
29130	Apply finger splint	$37	$28	$38	$27	$37	$27	$40	$36	N/A	$28	$25	$26	$20
29515	Apply lower leg splint	$65	$48	$65	$47	$65	$47	$71	$62	$35	$49	$43	$44	$34
	Average % of Medicare Fees			**101%**	**98%**	**100%**	**98%**	**103%**	**95%**	**42%**	**75%**	**89%**	**68%**	**71%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Respiratory													
30300	Remove nasal foreign body	$207	$113	$173	$95	$163	$89	$233	$200	$23	$155	$120	$130	$74
31231	Nasal endoscopy, dx	$177	$75	$144	$61	$135	$57	$199	$171	$59	$133	$95	$113	$52
31500	Insert emergency airway	$109	$109	$83	$83	$78	$78	$115	$104	$72	$84	$84	$81	$81
31575	Diagnostic laryngoscopy	$110	$75	$90	$61	$85	$58	$121	$106	$69	$83	$70	$73	$52
31622	Dx bronchoscope/wash	$309	$145	$254	$116	$239	$109	$342	$139	$134	$232	$171	$202	$105
31624	Dx bronchoscope/lavage	$313	$146	$259	$117	$244	$110	$348	$141	$135	$236	$174	$205	$105
	Average % of Medicare Fees			**81%**	**79%**	**76%**	**75%**	**110%**	**80%**	**46%**	**75%**	**101%**	**67%**	**71%**
	Cardiovascular System Surgery													
36400	Bl draw < 3 yrs fem/jugular	$26	$18	$20	$14	$19	$14	$28	$25	N/A	$19	$17	$18	$13
36406	Bl draw < 3 yrs other vein	$17	$9	$14	$7	$13	$7	$19	$16	N/A	$13	$10	$11	$7
36410	Non-routine bl draw > 3 yrs	$19	$9	$15	$7	$14	$7	$21	$18	N/A	$14	$10	$12	$6
36556	Insert non-tunnel cv cath	$234	$122	$208	$97	$196	$91	$258	$117	$113	$176	$135	$156	$90
36569	Insert PICC cath	$272	$100	$243	$77	$229	$73	$305	$95	$87	$204	$140	$176	$73
36620	Insertion catheter, artery	$51	$51	$39	$39	$37	$37	$53	$49	$48	$39	$39	$38	$38
	Average % of Medicare Fees			**87%**	**78%**	**82%**	**74%**	**110%**	**55%**	**42%**	**75%**	**111%**	**66%**	**73%**
	Hemic, Lymphatic and Mediastinum													
38220	Bone marrow aspiration	$154	$60	$133	$48	$125	$45	$172	$149	$55	$115	$81	$98	$42
38221	Bone marrow biopsy	$171	$77	$146	$61	$138	$57	$190	$165	$70	$128	$93	$110	$54
38525	Biopsy/removal, lymph nodes	$396	$396	$302	$302	$284	$284	$422	$375	$156	$300	$300	$285	$284
38792	Identify sentinel node	$40	$40	$32	$32	$30	$30	$43	$38	N/A	$30	$30	$27	$27
	Average % of Medicare Fees			**83%**	**78%**	**78%**	**73%**	**110%**	**96%**	**38%**	**75%**	**100%**	**67%**	**71%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Digestive System													
42820	Remove tonsils and adenoids	$279	$279	$228	$228	$215	$215	$301	$268	$184	$212	$212	$194	$194
42830	Removal of adenoids	$197	$197	$162	$162	$152	$152	$214	$189	$134	$149	$149	$135	$135
43235	Upper GI endoscopy, diagnosis	$291	$144	$246	$112	$232	$105	$324	$281	$125	$219	$164	$190	$102
43239	Upper GI endoscopy, biopsy	$337	$171	$283	$132	$267	$125	$374	$325	$149	$253	$192	$220	$121
45378	Diagnostic colonoscopy	$384	$214	$321	$167	$302	$157	$425	$370	$181	$289	$226	$254	$153
45380	Colonoscopy and biopsy	$461	$258	$383	$200	$361	$189	$510	$444	$225	$347	$272	$305	$184
45385	Lesion removal colonoscopy	$520	$306	$430	$237	$405	$224	$573	$500	$268	$391	$312	$346	$219
47562	Laparoscopic cholecystectomy	$684	$684	$540	$540	$509	$509	$727	$647	$589	$520	$520	$480	$498
49080	Puncture, peritoneal cavity	$169	$72	$152	$56	$143	$52	$188	$69	$64	$127	$91	$109	$51
	Average % of Medicare Fees			**83%**	**79%**	**78%**	**74%**	**110%**	**94%**	**54%**	**75%**	**96%**	**67%**	**71%**
	Urinary and Male Genital													
51600	Injection for bladder x-ray	$204	$47	$174	$37	$164	$34	$230	$45	$32	$152	$94	$127	$34
51701	Insert bladder catheter	$64	$29	$56	$22	$53	$21	N/A	$62	$25	$48	$35	$42	$21
51798	US urine capacity measure	$23	$23	$17	$17	$16	$16	N/A	$21	$14	$17	$17	$15	$15
52000	Cystoscopy	$224	$134	$175	$101	$165	$95	$247	$129	$75	$168	$135	$148	$94
54150	Circumcision w/regional block	$180	$104	$156	$79	$147	$74	$198	$99	$79	$135	$107	$120	$75
	Average % of Medicare Fees			**86%**	**76%**	**81%**	**71%**	**106%**	**55%**	**41%**	**75%**	**106%**	**66%**	**72%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Gynecology-Obstetric													
57452	Exam of cervix w/scope	$108	$91	$108	$88	$108	$88	$116	$103	$40	$101	$93	$76	$65
57454	Bx/curett of cervix w/scope	$152	$135	$152	$133	$152	$133	$163	$145	$106	$143	$135	$108	$98
58300	Insert intrauterine device	$77	$55	$81	$52	$77	$52	$84	N/A	$17	$72	$62	$54	$40
59025	Fetal non-stress test	$47	$47	$46	$46	$46	$46	$51	$44	$18	$44	$44	$24	$24
59409	Obstetrical care	$782	$782	$860	$860	$860	$860	$817	$717	$1,200	$734	$734	$951	$951
59410	Obstetrical care, w postpartum	$905	$905	$942	$942	$942	$942	$950	$834	$1,200	$850	$850	$1,092	$1,092
59430	Post partum care only	$141	$127	$139	$125	$139	$125	$149	$130	N/A	$132	$126	$166	$153
59514	Cesarean delivery only	$925	$925	$993	$993	$993	$993	$968	$717	$1,200	$869	$869	$1,125	$1,125
59515	Cesarean delivery with postpartum	$1,089	$1,089	$1,124	$1,124	$1,124	$1,124	$1,144	$834	$2,050	$1,022	$1,022	$1,310	$1,310
	Average % of Medicare Fees			**106%**	**106%**	**106%**	**106%**	**105%**	**86%**	**136%**	**94%**	**94%**	**118%**	**118%**
	Endocrine System													
60100	Biopsy of thyroid	$113	$82	$88	$61	$83	$58	$123	$109	$66	$86	$74	$77	$59
60240	Removal of thyroid	$928	$928	$711	$711	$670	$670	$985	$879	$591	$705	$705	$675	$675
	Average % of Medicare Fees			**77%**	**76%**	**72%**	**72%**	**107%**	**95%**	**63%**	**76%**	**78%**	**72%**	**73%**
	Neurosurgery													
62270	Spinal fluid tap, diagnostic	$150	$76	$159	$73	$150	$73	$166	$144	$42	$112	$85	$98	$54
62311	Inject spine lumbar/sacral (cd)	$183	$81	$210	$79	$183	$79	$204	$177	$75	$138	$100	$119	$58
64450	Nerve block, other peripheral	$99	$70	$99	$68	$99	$68	$108	$95	$21	$75	$64	$68	$51
64475	Inject paravertebral l/s	$225	$79	$266	$76	$225	$76	$252	$217	$72	$168	$114	$143	$56
64483	Inject foramen epidural l/s	$258	$104	$307	$101	$258	$101	$288	$249	$95	$193	$136	$166	$74
64614	Destroy nerve, extrem muscle	$161	$135	$177	$132	$161	$132	$175	$156	$123	$122	$112	$110	$94
	Average % of Medicare Fees			**112%**	**97%**	**100%**	**97%**	**111%**	**96%**	**36%**	**75%**	**113%**	**65%**	**71%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Eye Surgery													
65855	Laser surgery of eye	$294	$258	$244	$209	$230	$197	$320	$284	$237	$222	$209	$200	$178
66984	Cataract surgery w/iol, 1 stage	$659	$659	$531	$531	$500	$500	$712	$637	$603	$500	$500	$456	$456
67028	Injection eye drug	$186	$149	$155	$119	$146	$112	$203	$180	$136	$141	$127	$127	$104
67210	Treatment of retinal lesion	$599	$579	$462	$444	$435	$418	$647	$578	$375	$455	$448	$416	$404
67228	Retinopathy Treatment	$1,033	$909	$785	$683	$740	$644	$1,126	$997	$491	$781	$735	$701	$627
67311	Revise eye muscle	$513	$513	$398	$398	$375	$375	$556	$495	$468	$389	$389	$354	$354
	Average % of Medicare Fees			**79%**	**78%**	**74%**	**74%**	**108%**	**97%**	**75%**	**76%**	**78%**	**69%**	**69%**
	Ear Surgery													
69200	Clear outer ear canal	$114	$53	$121	$52	$114	$49	$128	$110	$30	$85	$63	$73	$37
69210	Remove impacted ear wax	$47	$31	$47	$31	$44	$29	$51	N/A	$20	$35	$30	$32	$23
69436	Create eardrum opening	$156	$156	$160	$160	$151	$151	$170	$150	$99	$118	$118	$107	$107
69990	Microsurgery add-on	$217	$217	$214	$214	$202	$202	$228	$199	$201	$164	$164	$164	$164
	Average % of Medicare Fees			**102%**	**100%**	**96%**	**94%**	**109%**	**57%**	**52%**	**75%**	**85%**	**68%**	**70%**
	Radiology													
70450	CT head/brain w/o dye	$230	$230	$190	$190	$179	$179	$259	$219	$117	$171	$171	$147	$147
71010	Chest x-ray	$25	$25	$21	$21	$20	$20	$28	$24	$19	$19	$19	$16	$16
71020	Chest x-ray	$33	$33	$27	$27	$26	$26	$37	$32	$25	$25	$25	$21	$21
72193	CT pelvis w/dye	$342	$342	$278	$278	$262	$262	$385	$326	$140	$254	$254	$217	$217
73610	X-ray exam of ankle	$32	$32	$26	$26	$24	$24	$36	$30	$27	$24	$24	$20	$20
73630	X-ray exam of foot	$31	$31	$26	$26	$24	$24	$35	$30	$19	$23	$23	$20	$20
74000	X-ray exam of abdomen	$26	$26	$22	$22	$21	$21	$29	$25	$18	$20	$20	$17	$17
74160	CT abdomen w/dye	$383	$383	$282	$282	$266	$266	$432	$366	$149	$285	$285	$242	$242
76805	Ob US ≥14 wks Evaluation	$152	$152	$118	$118	$111	$111	$170	$146	$78	$141	$141	$99	$99
76815	Ob US, limited, fetus(s)	$95	$95	$76	$76	$71	$71	$106	$91	$64	$88	$88	$62	$62
	Average % of Medicare Fees			**80%**	**80%**	**75%**	**75%**	**112%**	**95%**	**53%**	**78%**	**77%**	**64%**	**64%**

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Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Laboratory													
80053	Comprehensive metabolic panel	$15	$15	$12	$12	$11	$11	N/A	$15	N/A	$15	$15	N/A	N/A
80061	Lipid panel	$18	$18	$14	$14	$13	$13	$17	$19	$14	$19	$19	N/A	N/A
81002	Urinalysis nonauto w/o scope	$4	$4	$3	$3	$3	$3	$2	$4	$4	$4	$4	N/A	N/A
83655	Assay of lead	$18	$18	$13	$13	$13	$13	$8	$17	$10	$17	$17	N/A	N/A
85025	Complete CBC w/auto diff WBC	$11	$11	$9	$9	$8	$8	$5	$11	$6	$11	$11	N/A	N/A
86592	Blood serology, qualitative	$5	$5	$4	$4	$4	$4	$3	$6	$4	$5	$5	N/A	N/A
87081	Culture screen only	$10	$10	$8	$8	$7	$7	$4	$10	$5	$9	$9	N/A	N/A
87086	Urine culture/colony count	$12	$12	$9	$9	$9	$9	$6	$12	$8	$10	$10	N/A	N/A
87491	Chlamydia, amp probe techniq	$45	$45	$36	$36	$33	$33	$23	$50	$23	$45	$45	N/A	N/A
87880	Strep A assay w/optic	$18	$18	$14	$14	$13	$13	$7	$16	$6	$17	$17	N/A	N/A
	Average % of Medicare Fees			**78%**	**78%**	**73%**	**73%**	**47%**	**101%**	**50%**	**96%**	**96%**	**N/A**	**N/A**
	Psychiatry													
90801	Psychiatric dx interview	$157	$131	$124	$105	$117	$99	$169	$153	$26	$120	$110	$110	$94
90804	Psych tx, office, 20-30 min	$69	$58	$50	$45	$47	$42	$70	$67	$26	$48	$47	$46	$40
90805	Psych tx, office, 20-30 min w/ E&M	$77	$65	$57	$50	$54	$47	$78	$74	$26	$53	$52	$51	$45
90806	Psych tx, office, 45-50 min	$96	$89	$73	$68	$69	$64	$97	$93	$39	$69	$67	$65	$61
90847	Family psych tx w/patient	$111	$104	$88	$84	$83	$79	$118	$108	$13	$83	$82	$79	$75
90853	Group psychotherapy	$32	$30	$24	$23	$23	$22	$34	$31	$4	$23	$23	$22	$21
90862	Medication management	$57	$46	$44	$37	$42	$35	$61	$55	$15	$43	$39	$39	$33
	Average % of Medicare Fees			**77%**	**78%**	**73%**	**73%**	**105%**	**97%**	**26%**	**73%**	**79%**	**69%**	**70%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Dialysis													
90935	Hemodialysis, one evaluation	$68	$68	$53	$53	$50	$50	$73	$66	$50	$52	$52	$48	$48
90937	Hemodialysis, repeated eval	$112	$112	$86	$86	$81	$81	$119	$108	$50	$85	$85	$79	$79
90945	Dialysis, one evaluation	$71	$71	$55	$55	$52	$52	$76	$69	$35	$54	$54	$50	$50
	Average % of Medicare Fees			**77%**	**77%**	**73%**	**73%**	**107%**	**97%**	**70%**	**76%**	**76%**	**70%**	**70%**
	Gastroenterology													
91034	Gastroesophageal reflux test	$204	$204	$179	$179	$169	$169	$230	$196	$178	$152	$152	$129	$129
91105	Gastric intubation treatment	$81	$17	$71	$14	$67	$13	$92	$78	N/A	$60	$37	$51	$13
91110	GI tract capsule endoscopy	$921	$921	$787	$787	$742	$742	$1,044	$892	N/A	$687	$687	$571	$571
	Average % of Medicare Fees			**86%**	**86%**	**76%**	**81%**	**113%**	**97%**	**22%**	**75%**	**77%**	**62%**	**62%**
	Ophthalmology and Vision Care													
92004	Eye exam, new patient	$131	$92	$102	$70	$96	$65	$142	$127	$59	$99	$85	$88	$65
92012	Eye exam estab patient	$73	$47	$57	$35	$54	$33	$80	$71	$29	$55	$46	$49	$33
92014	Eye exam and treatment	$107	$72	$83	$53	$78	$50	$117	$104	$45	$81	$68	$71	$51
92015	Refraction	$33	$19	$36	$15	$33	$14	$36	$32	$5	$25	$20	$21	$13
92060	Special eye evaluation	$56	$56	$43	$43	$41	$41	$61	$54	N/A	$42	$42	$37	$37
92081	Visual field examination(s)	$50	$50	$41	$41	$38	$38	$56	$48	$28	$38	$38	$32	$32
	Average % of Medicare Fees			**81%**	**76%**	**76%**	**71%**	**109%**	**97%**	**41%**	**76%**	**93%**	**67%**	**70%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	ENT (Otorhinolaryngology)													
92551	Pure tone hearing test, air	$11	$11	$8	$8	$8	$8	$13	$11	$8	$8	$8	$7	$7
92552	Pure tone audiometry, air	$23	$23	$20	$20	$19	$19	$26	$21	$8	$17	$17	$14	$14
92557	Comprehensive hearing test	$47	$44	$54	$53	$47	$44	$50	$44	$29	$35	$34	$33	$32
92567	Tympanometry	$18	$17	$23	$21	$18	$17	$20	$17	$12	$14	$13	$13	$12
92568	Acoustic refl threshold test	$19	$19	$17	$17	$16	$16	$20	$18	$10	$14	$14	$13	$13
92585	Auditory evoked potentials (ABR comprehensive)	$105	$105	$108	$108	$102	$102	$117	$99	$27	$78	$78	$68	$68
92587	Evoked auditory (oto-acoustic emission) testing	$41	$41	$50	$50	$41	$41	$46	$38	$44	$30	$30	$27	$27
	Average % of Medicare Fees			**103%**	**104%**	**89%**	**89%**	**111%**	**94%**	**68%**	**75%**	**76%**	**66%**	**66%**
	Cardiovascular Medicine													
93000	Electrocardiogram, complete	$22	$22	$19	$19	$18	$18	$24	$21	$21	$16	$16	$14	$14
93010	Electrocardiogram report	$9	$9	$7	$7	$6	$6	$10	$9	$8	$7	$7	$6	$6
93016	Cardiovascular stress test	$25	$25	$19	$19	$18	$18	$27	N/A	$22	$19	$19	$18	$18
93042	Rhythm ECG, report	$8	$8	$6	$6	$6	$6	$9	$8	$7	$6	$6	$6	$6
93303	Echo, transthoracic	$229	$229	$184	$184	$173	$173	$256	$219	$157	$171	$171	$148	$148
93307	Echocardiography w/o color Doppler, complete	$186	$186	$159	$159	$150	$150	$208	$177	$140	$139	$139	$120	$120
93320	Doppler echo exam, heart	$82	$82	$71	$71	$66	$66	$92	$78	$65	$61	$61	$53	$53
93325	Doppler color flow add-on	$57	$57	$66	$66	$57	$57	$64	$53	N/A	$42	$42	$39	$39
	Average % of Medicare Fees			**89%**	**89%**	**82%**	**82%**	**111%**	**94%**	**64%**	**75%**	**75%**	**65%**	**65%**
	Noninvasive Vascular Diagnostic Tests													
93880	Extracranial study	$194	$194	$151	$151	$142	$142	$296	$184	$148	$195	$195	$166	$166
93970	Extremity study, comple study	$198	$198	$154	$154	$145	$145	$302	$188	$147	$199	$199	$176	$172
93971	Extremity study, limited study	$127	$127	$98	$98	$92	$92	$200	$121	$100	$132	$132	$113	$113
93976	Vascular study	$225	$225	$174	$174	$164	$164	$256	$214	$131	$171	$171	$149	$149
	Average % of Medicare Fees			**77%**	**77%**	**73%**	**73%**	**139%**	**95%**	**69%**	**92%**	**92%**	**80%**	**80%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Pulmonary													
94010	Breathing capacity test	$34	$34	$28	$28	$27	$27	$39	$33	$15	$26	$26	$22	$22
94060	Evaluation of wheezing	$61	$61	$48	$48	$46	$46	$68	$58	$19	$45	$45	$39	$39
94375	Respiratory flow volume loop	$38	$38	$30	$30	$28	$28	$43	$37	$31	$29	$29	$25	$25
94640	Airway inhalation treatment	$14	$14	$11	$11	$11	$11	$16	$13	N/A	$10	$10	$9	$9
94664	Evaluate patient use of inhaler	$16	$16	$13	$13	$12	$12	$18	$15	$12	$12	$12	$10	$10
94760	Measure blood oxygen, limitd	$3	$3	$2	$2	$2	$2	$3	$3	$2	$2	$2	$2	$2
94761	Measure blood oxygen, compl	$6	$6	$5	$5	$5	$5	$7	$5	$4	$5	$5	$5	$5
	Average % of Medicare Fees			**80%**	**80%**	**75%**	**75%**	**112%**	**94%**	**39%**	**74%**	**74%**	**64%**	**64%**
	Allergy and Immunology													
95004	Percutaneous allergy skin tests	$6	$6	$5	$5	$4	$4	$7	$6	$2	$5	$5	$4	$4
95024	Intracut. allergy test, drug/bug	$7	$7	$6	$6	$5	$5	$8	$7	$5	$5	$5	$4	$4
95115	Immunotherapy, one injection	$11	$11	$11	$11	$10	$10	$13	$10	$4	$8	$8	$7	$7
95117	Immunotherapy injections	$13	$13	$14	$14	$13	$13	$15	$13	$7	$10	$10	$8	$8
95165	Antigen therapy services	$12	$3	$9	$3	$9	$2	$14	$12	$3	$9	$6	$7	$2
	Average % of Medicare Fees			**96%**	**98%**	**91%**	**92%**	**114%**	**95%**	**43%**	**74%**	**77%**	**61%**	**61%**
	Neurology and Neuromuscular													
95810	Polysomnography, 4 or more	$806	$806	$675	$675	$636	$636	$909	$775	$347	$601	$601	$510	$510
95816	EEG, awake and drowsy	$226	$226	$177	$177	$167	$167	$255	$218	$23	$169	$169	$143	$143
95819	EEG, awake and asleep	$243	$243	$179	$179	$169	$169	$274	$234	$23	$181	$181	$153	$153
95860	Muscle test, one limb	$84	$84	$69	$69	$65	$65	$92	$80	$30	$63	$63	$56	$56
95903	Motor nerve conduction test	$64	$64	$53	$53	$50	$50	$71	$61	$38	$48	$48	$42	$42
95904	Sense nerve conduction test	$48	$48	$41	$41	$39	$39	$54	$46	$22	$36	$36	$31	$31
95926	Somatosensory testing	$120	$120	$83	$83	$79	$79	$135	$115	$58	$89	$89	$76	$76
95934	H-reflex test	$49	$49	$35	$35	$33	$33	$54	$47	N/A	$37	$37	$33	$33
95957	EEG digital analysis	$268	$268	$194	$194	$183	$183	$298	$257	$138	$201	$201	$175	$175
	Average % of Medicare Fees			**81%**	**81%**	**76%**	**76%**	**113%**	**96%**	**33%**	**75%**	**75%**	**63%**	**63%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	CNS Assessment Tests													
96110	Developmental test, limited	$14	$14	$12	$12	$11	$11	$15	$11	$11	$10	$10	$11	$11
96111	Developmental test, extended	$134	$131	$103	$101	$97	$95	$141	N/A	$50	$102	$101	$97	$95
	Average % of Medicare Fees			**79%**	**79%**	**74%**	**75%**	**106%**	**23%**	**50%**	**75%**	**76%**	**75%**	**75%**
	Chemotherapy Administration													
96411	Chemo, IV push, addl drug	$67	$67	$57	$57	$54	$54	$76	$64	$53	$50	$50	$42	$42
96413	Chemo, IV infusion, 1 hr	$156	$156	$135	$135	$127	$127	$177	$150	$125	$116	$116	$95	$95
96415	Chemo, IV infusion, addl hr	$35	$35	$30	$30	$28	$28	$39	$33	$28	$26	$26	$23	$23
96417	Chemo IV infusion each addl	$78	$78	$66	$66	$63	$63	$88	$74	$62	$58	$58	$48	$48
96450	Chemotherapy, into CNS	$218	$91	$235	$81	$218	$76	$243	$210	$77	$163	$116	$139	$64
96523	Irrig drug delivery device	$27	$27	$23	$23	$22	$22	$30	$26	$19	$20	$20	$16	$16
	Average % of Medicare Fees			**88%**	**87%**	**83%**	**66%**	**114%**	**96%**	**77%**	**74%**	**76%**	**62%**	**62%**
	Special Dermatology													
96910	Photochemotherapy with UVB	$66	$66	$49	$49	$46	$46	$76	$64	$20	$49	$49	$40	$40
96912	Photochemotherapy with UVA	$85	$85	$63	$63	$59	$59	$98	$82	$20	$63	$63	$51	$51
	Average % of Medicare Fees			**74%**	**74%**	**70%**	**70%**	**115%**	**96%**	**26%**	**74%**	**74%**	**60%**	**60%**

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

Table 3. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees (Continued)

Procedure Code	Procedure Description	MC NF	MC FA	MD 09 NF	MD 09 FA	MD 10 NF	MD 10 FA	D.C.	DE	PA	VA NF	VA FA	WV NF	WV FA
	Physical Medicine and Rehabilitation													
97001	Patient evaluation	$72	$72	$56	$56	$53	$53	$78	$70	$45	$55	$55	$50	$50
97010	Hot or cold pack therapy	$5	$5	$4	$4	$4	$4	$5	$5	$17	$4	$4	N/A	N/A
97014	Electric stimulation therapy	$14	$14	$11	$11	$10	$10	$15	$13	$17	$10	$10	$9	$9
97035	Ultrasound therapy	$12	$12	$9	$9	$9	$9	$13	$11	$10	$9	$9	$8	$8
97110	Therapeutic exercises	$29	$29	$22	$22	$21	$21	$31	$28	$8	$22	$22	$20	$20
97112	Neuromuscular reeducation	$30	$30	$23	$23	$22	$22	$32	$29	$17	$23	$23	$20	$20
97140	Manual therapy	$27	$27	$20	$20	$19	$19	$29	$26	$21	$20	$20	$18	$18
97530	Therapeutic activities	$31	$31	$23	$23	$22	$22	$33	$30	$13	$23	$23	$20	$20
	Average % of Medicare Fees			**77%**	**77%**	**72%**	**72%**	**108%**	**97%**	**61%**	**76%**	**76%**	**66%**	**66%**
	Osteopathy, Chiropractic, and Other Medicine													
98941	Chiropractic manipulation	$35	$31	$27	$23	$25	$22	$37	N/A	$13	$27	$25	$24	$22
99144	Moderate Sedation by same physician, age 5+ yrs	$39	$39	$30	$30	$28	$28	N/A	N/A	N/A	$64	$64	N/A	N/A
99173	Visual acuity screen	$3	$3	$2	$2	$2	$2	$3	$2	$6	$64	$64	$2	$2
99183	Hyperbaric oxygen therapy	$197	$116	$161	$92	$151	$86	$215	$189	$107	$148	$119	$132	$85
	Average % of Medicare Fees			**83%**	**82%**	**78%**	**76%**	**92%**	**76%**	**111%**	**994%**	**1196%**	**54%**	**53%**

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

VI. Trauma Center Payment Issues

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

Historically, the Maryland Medical Assistance program has had low dental fees. Unlike physician services, there is no federal public program (such as Medicare) to serve as a benchmark for oral health service fees. However, the American Dental Association (ADA) publishes a biennial survey reporting the national and regional average charges for approximately 165 of the most common dental procedures, offering data for comparison. Also, a book entitled the National Dental Advisory Service (NDAS) contains the percentile of charges for approximately 520 (of a total of approximately 580) dental procedures.

During the 2003 session of the Maryland General Assembly, the legislature included budgetary language in HB 40 that stated, "It is also the intent of the General Assembly that $7.5 million of the funds included in the CY 2004 Managed Care rates for dental services be restricted to increasing fees for restorative procedures." The $7.5 million funding increase was based on a University of Maryland Dental School analysis of the impact of increasing certain restorative procedure fees to the 50th percentile levels of the ADA survey. In compliance with the budgetary language, effective March 1, 2004, MCOs were required to reimburse their contracted providers at ADA's then current 50^{th} percentile of charges for 12 restorative procedures. At the same time, Medicaid increased fee-for-service rates to ADA's 50^{th} percentile levels for the same restorative procedures. Maryland Medicaid tripled the average reimbursement rates for dentists in July 2000 and increased reimbursement for 12 restorative procedures in 2004.

In June 2007, the Secretary of the Maryland Department of Health and Mental Hygiene convened the Dental Action Committee to increase access to dental care services for poor and low-income children in Maryland. 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 of the 2008 session of the General Assembly allocated $7 million in state funds ($14 million total funds) for increasing dental fees in FY 2009. The rate increase targeted preventive procedures and went into effect on July 1, 2008. Table 4 shows Maryland and neighboring states' Medicaid fees for 12 selected high-volume dental procedures. It also shows the benchmark (ADA's 50th percentile of charges in the South Atlantic region)[1] for these procedures.

Table 4. Dental Procedures Targeted for Fee Increase in FY 2009

Proc Code	Description	MD (FY08)	D.C.	PA	VA	MD (FY09)	ADA's 50th Percentile
D0120	Periodic Oral Examination	$15.0	$35.0	$20.0	$20.15	$29.08	$35.0
D0140	Oral Evaluation-Limited-Problem Focused	$24.0	$50.0	N/A	$24.83	$43.20	$52.0
D0145	Oral Evaluation, Patient < 3 Years Old	$20.0	$0.0	N/A	$20.15	$40.0	$40.0
D0150	Comprehensive Oral Evaluation	$25.0	$77.50	$20.0	$31.31	$51.50	$62.0
D1110	Prophylaxis, Adult 14 years and Over	$36.0	$77.50	$36.0	$47.19	$58.15	$70.0
D1120	Prophylaxis, Child Up to Age 14	$24.0	$47.0	$30.0	$33.52	$42.37	$51.0
D1203	Topical Application of Fluoride, Child (Exclude Prophylaxis)	$14.0	$29.0	$18.0	$20.79	$21.60	$26.0
D1204	Topical Application of Fluoride, Adult (Exclude Prophylaxis)	$14.0	$26.0	N/A	$20.79	$23.26	$28.0
D1206	Topical Fluoride Varnish	$20.0	$0.0	$18.0	$20.79	$24.92	$30.0
D1351	Topical Application of Sealant per Tooth	$9.0	$38.0	$25.0	$32.28	$33.23	$40.0
D7140	Extraction, Erupted Tooth or Exposed Root	$42.0	$110.0	$65.0	$69.0	$103.01	$124.0
D9248	Non-Intravenous Conscious Sedation	$0.0	$0.0	$184.0	$110.0	$186.91	$225.0

[1] The South Atlantic Region consists of: Delaware, Washington, D.C., Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. The South Atlantic 50th percentile of charges is based on data from the 2007 American Dental Association survey.

The last column of Table 4 shows the median (ADA's 50th percentile) of fees charged by dentists in 2007 in the South Atlantic region, that is, 50 percent of dentists in this region charge this amount or less. It should be noted that the South Atlantic median is based on the charges by dentists, which is not the same as the reimbursement received and payments made by insurance companies and public agencies.

Based on the recommendations of the Dental Action Committee, effective July 1, 2009, an administrative service organization (ASO) – Doral Dental -- coordinates 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 dental services through the ASO. Table 5 shows Maryland Medicaid FY 2009 and FY 2010 weighted average dental fees by groups of procedures as percentages of the ADA's 50th percentile of charges.

Table 5. Average of Maryland Medicaid Dental Fees as Percent of ADA's 50th Percentile of Charges

Procedure Groups	**Medicaid FY 2009 Fees**	**Medicaid FY 2010 Fees**
D0100-D1999 Diagnostic and Preventive Procedures	74%	74%
D2000-D2999 Restorative Procedures	65%	67%
D3000-D3999 Endodontic Procedures	39%	69%
D4210-D6999 Periodontics and Prosthodontics	53%	55%
D7000-D7999 Oral and Maxillofacial Surgery	55%	73%
D8000-D9999 Orthodontics and Adjunctive General Services	32%	33%
All Procedures Combined	**61%**	**64%**

VIII. Physician Participation in the Maryland Medicaid Program

Physicians' claims and encounter data pertaining to FY 2002 (the year before the July 2002 fee increase), FY 2006, FY 2007 and FY 2008 were analyzed for the number of physicians who had either partial or full participation in the Medicaid program.[2] In the following tables, physicians who had fewer than 25 claims during the fiscal year are included in the data for all physicians. Physicians who had more than 25 claims, but less than 50 patients, were considered partial participants in the Medicaid program. Physicians who had at least 50 patients during the year were considered full participants in the Medicaid program.

[2] The data in these tables pertain to FY 2002 through FY 2008. Therefore, these tables do not measure the impact of fee changes (increase and decreases) in FY 2009 or FY 2010 on physician participation in the Medicaid program.

Tables 6, 7, and 8 show the percentage changes in the numbers of participating physicians from all specialties (including primary care) who participate in fee-for-service (FFS) programs, MCO networks, and the total Medicaid program. As the data in Table 6 indicate, there were significant increases in physician participation in fee-for-service program, MCO networks, and the total Medicaid program between fiscal years 2002 and 2008.

Table 6. FY 2002-08 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid*
Partial Participation	29.1%	30.6%	75.9%
Full Participation	38.3%	26.1%	33.5%
All Physicians	22.0%	49.3%	76.8%

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

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

Similarly, the data in Table 7 indicate that, following the FY 2007 and FY 2008 fee increases, there were significant increases in physician participation between FY 2006 and FY 2008.

Table 7. FY 2006-08 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	5.6%	10.2%	15.7%
Full Participation	2.8%	21.2%	16.8%
All Physicians	3.3%	17.7%	16.6%

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

The 10.2 percent increase in the number of physicians who are partial participants in the MCO networks and 21.2 percent increase in number of physicians who are full participants in the HealthChoice program indicates that, following the FY 2007 and FY 2008 fee increases, many physicians who were not participating in the HealthChoice program decided to become full or partial participants. Also, some physicians who were partial participants decided to become full participants in the program.

Similarly, the data in Table 8 indicate that the increasing trend in physician participation in the Medicaid program continued between FY 2007 and FY 2008.

Table 8. FY 2007-08 Percent Change in Number of Participating Physicians of All Specialties

	FFS	MCO Networks	Total Medicaid
Partial Participation	3.7%	12.2%	9.6%
Full Participation	3.1%	7.8%	8.2%
All Physicians	3.6%	18.1%	9.6%

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

The increase in number of physicians who are partial participants in the MCO networks and the 7.8 percent increase in number of physicians who are full participants in the HealthChoice program indicate that, following the FY 2008 fee increase, many physicians who were not participating in the HealthChoice program decided to become partial or full participants.

Analyses of claims for physicians who fully participate in the Medicaid program indicate that provision of care has become more concentrated among physicians participating in the program, which is consistent with national trends. In addition, the data show that the concentration of care among physicians participating in the program has stabilized. In FY 2002, approximately 21 percent of physicians provided 86 percent of services. In both FY 2007 and FY 2008, approximately 16 percent of physicians provided 84 percent of physician services. The increased concentration of Medicaid patients among physicians is consistent with national trends.

Caveats for Tables 6, 7, and 8

It should be noted that the percent increases in the number of physicians with partial participation in Medicaid shown in Tables 6, 7, and 8 represent a change in the number of physicians who did not participate in the Medicaid program before the fee increase, but began to partially participate in the program after the fee increase, minus the number of physicians who were partial participants in the program before the fee increases and decided to fully participate in the program after the fee increases.

Similarly, the percent increases in the number of physicians with full participation shown in Tables 6, 7 and 8 represent a change in the number of physicians who were partial participants in the program before the fee increases, but decided to fully participate in the program after the fee increases, plus the number of physicians who did not participate in the Medicaid program before the fee increases, but began to fully participate in the program after the fee increases.

IX. Plan for Future Fee Increases

In the future, when state funds become available for increasing provider reimbursement rates, the Department will consult with stakeholders with regard to targeting the fee increases to different procedures. One of the Department's goals remains to reimburse physicians at 100 percent of Medicare reimbursement rates. Another goal is to increase the dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges for all dental procedures.

Appendix 1

Medicare Resource-Based Relative Value Scale and Anesthesia Reimbursement

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

For approximately 13,000 physician procedures, the Centers for Medicare and Medicaid Services (CMS) determines the associated relative value units (RVUs) and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending on the place where each procedure is performed. For example, Medicare fees for some procedures are lower if they are performed in facilities such as hospitals and skilled nursing facilities than if they are performed in non-facilities (e.g., offices), where physicians must pay more for practice expenses. The implementation of RBRVS resulted in increased payments to office-based (non-facility) procedures and reduced payments for hospital-based procedures.

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

The Centers for Medicare and Medicaid Services (CMS) annually updates the conversion factor based on the Sustainable Growth Rate (SGR) system, which ties the updates to growth in the national economy, as a measure of change in funds available for payments to physicians. The SGR system is based on formulas designed to control overall spending while accounting for factors that affect the costs of providing care.

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

Medicare payments for anesthesia services represent a departure from the RBRVS system. The most complex surgical (and usually primary) procedure performed during any given surgical session is identified and linked to one and only one anesthesia code. The anesthesia time for any additional procedures during the same operative session is

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

Each anesthesia procedure code has a non-variable number of base units. Similar to the RBRVS work value, the base units represent the difficulty associated with a given group of procedures. The base units for the selected anesthesia code are added to the units related to anesthesia time, and the result is multiplied by a conversion factor to convert to dollars. The Baltimore area Medicare conversion factor for 2009 is $21.37 per unit. The Maryland Medicaid program calculates the payment slightly differently, by using minutes instead of quarter-hour blocks, but the net result is the same.

Prior to December 1, 2003, the Medicaid program reimbursed anesthesia services based on a percentage of the surgical fee. The program in general did not use the anesthesia CPT codes, but rather the surgical CPT codes with a modifier. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required that national standard code sets be used. In late 2003, the Medicaid program complied with the federal standards. Since that time, all anesthesia services have been identified based on the anesthesia CPT codes. More than 5,000 surgical procedure codes exist, but there are less than 300 anesthesia codes. Payment for anesthesia services could no longer be linked to individual procedures, and the Medicaid program started the transition from a fixed anesthesia rate for each surgical procedure to the Medicare's national methodology, which recognized anesthesia time as the key element.

Appendix 2
Rate of Non-Federal Physicians per 100,000 Civilian Population, 2008

Rank	Geographic Area	Number of Non-Federal Physicians, 2008	2008 Population	Number of Physicians per 100,000 Population
Average	**United States**	**990,652**	**308,013,761**	**322**
1	Washington, D.C.	5,074	591,833	857
2	Massachusetts	34,320	6,497,967	528
3	New York	88,179	19,490,297	452
4	**Maryland**	**25,354**	**5,633,597**	**450**
5	Vermont	2,778	621,270	447
6	Rhode Island	4,591	1,050,788	437
7	Connecticut	15,257	3,501,252	436
8	Pennsylvania	49,575	12,448,279	398
9	New Jersey	33,501	8,682,661	386
10	Maine	4,898	1,316,456	372
11	Hawaii	4,636	1,288,198	360
12	New Hampshire	4,510	1,315,809	343
13	Michigan	34,091	10,003,422	341
14	Minnesota	17,702	5,220,393	339
15	Ohio	38,566	11,485,910	336
16	Oregon	12,669	3,790,060	334
17	Illinois	42,510	12,901,563	329
18	Florida	58,565	18,328,340	320
19	Washington	20,923	6,549,224	319
20	California	115,740	36,756,666	315
21	Colorado	15,408	4,939,456	312
22	Delaware	2,718	873,092	311
23	Virginia	24,091	7,769,089	310
24	Wisconsin	17,311	5,627,967	308
25	Missouri	17,946	5,911,605	304
26	Puerto Rico	11,812	3,954,037	299
27	Tennessee	18,560	6,214,888	299
28	West Virginia	5,387	1,814,468	297
29	Louisiana	12,926	4,410,796	293
30	North Carolina	26,716	9,222,414	290

Rank	Geographic Area	Number of Non-Federal Physicians, 2008	2008 Population	Number of Physicians per 100,000 Population
31	Nebraska	5,131	1,783,432	288
32	New Mexico	5,583	1,984,356	281
33	Kansas	7,816	2,802,134	279
34	North Dakota	1,786	641,481	278
35	Montana	2,636	967,440	272
36	Arizona	17,248	6,500,180	265
37	Kentucky	11,318	4,269,245	265
38	South Carolina	11,829	4,479,800	264
39	South Dakota	2,069	804,194	257
40	Iowa	7,704	3,002,555	257
41	Indiana	16,273	6,376,792	255
42	Alaska	1,707	686,293	249
43	Alabama	11,510	4,661,900	247
44	Texas	59,797	24,326,974	246
45	Georgia	23,489	9,685,744	243
46	Utah	6,588	2,736,424	241
47	Oklahoma	8,712	3,642,361	239
48	Arkansas	6,684	2,855,390	234
49	Wyoming	1,237	532,668	232
50	Nevada	5,954	2,600,167	229
51	Idaho	3,196	1,523,816	210
52	Mississippi	6,071	2,938,618	207

The ratio of physicians to 100,000 people in Maryland increased from 446 in 2007 to 450 in 2008. The ranking of Maryland among all states went up from fifth in 2007 to fourth in 2008.

Note: Nonfederal physicians are members of the U.S. physician population who are employed in the private sector. They represent 98% of total physicians.

Sources: Data for physicians are from American Medical Association (2008). Data for civilian population are from the U.S. Census Bureau (December 22, 2008).

Appendix 3
Rate of Non-Federal Dentists per 100,000 Civilian Population, 2008

Rank	Geographic Area	Total Number of Dentists, 2008	2008 Population	Dentists per 100,000 Population
Average	**United States**	**233,008**	**308,013,761**	**76**
1	Washington, D.C.	859	591,833	145
2	Massachusetts	7407	6,497,967	114
3	Nebraska	1837	1,783,432	103
4	Hawaii	1258	1,288,198	98
5	New Jersey	8289	8,682,661	95
6	California	35074	36,756,666	95
7	Connecticut	3306	3,501,252	94
8	**Maryland**	**5312**	**5,633,597**	**94**
9	New York	17729	19,490,297	91
10	Washington	5785	6,549,224	88
11	Alaska	581	686,293	85
12	Colorado	4160	4,939,456	84
13	Pennsylvania	10156	12,448,279	82
14	Utah	2229	2,736,424	81
15	Michigan	8013	10,003,422	80
16	Minnesota	4143	5,220,393	79
17	Montana	762	967,440	79
18	Idaho	1188	1,523,816	78
19	Vermont	482	621,270	78
20	New Hampshire	1010	1,315,809	77
21	Illinois	9863	12,901,563	76
22	Kentucky	3263	4,269,245	76
23	Virginia	5847	7,769,089	75
24	Florida	13693	18,328,340	75
25	Wisconsin	4157	5,627,967	74
26	Nevada	1871	2,600,167	72
27	Arizona	4663	6,500,180	72
28	Iowa	2148	3,002,555	72
29	Oregon	2650	3,790,060	70
30	Ohio	7924	11,485,910	69
31	Tennessee	4196	6,214,888	68
32	Rhode Island	687	1,050,788	65

Rank	Geographic Area	Total Number of 2008 Dentists	2008 Population	Dentists per 100,000 Population
33	Wyoming	343	532,668	64
34	North Dakota	408	641,481	64
35	West Virginia	1147	1,814,468	63
36	Kansas	1771	2,802,134	63
37	Indiana	4008	6,376,792	63
38	Maine	819	1,316,456	62
39	Missouri	3644	5,911,605	62
40	South Carolina	2744	4,479,800	61
41	Louisiana	2692	4,410,796	61
42	Oklahoma	2210	3,642,361	61
43	North Carolina	5465	9,222,414	59
44	South Dakota	474	804,194	59
45	New Mexico	1108	1,984,356	56
46	Delaware	477	873,092	55
47	Alabama	2520	4,661,900	54
48	Georgia	5226	9,685,744	54
49	Texas	12982	24,326,974	53
50	Arkansas	1403	2,855,390	49
51	Mississippi	1442	2,938,618	49
52	Puerto Rico	1583	3,954,037	40

The ranking of Maryland among all states dropped from sixth in 2007 to eighth in 2008.

Sources: American Dental Association (2008). Data for civilian population are from the U.S. Census Bureau (December 22, 2008).

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