



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

OCT 12 2007

The Honorable Ulysses Currie  
Chairman  
Senate Budget and Taxation Committee  
3 West Miller Senate Office Bldg.  
Annapolis, MD 21401-1991

The Honorable Norman H. Conway  
Chairman  
House Appropriations Committee  
131 Lowe House Office Bldg.  
Annapolis, MD 21401-1991

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: 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 Currie, Middleton, Conway and Hammen:

The Department of Health and Mental Hygiene is required to annually submit a report pursuant to Section 1 of SB 481 – *Department of Health and Mental Hygiene – Reimbursement Rates*. The attached paper reports 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 provides analysis of other states' rates compared to Maryland; the schedule for raising rates; and an analysis of the estimated cost of implementing these changes. The report was due on September 1, 2007.

In addition, the Department has incorporated into this report information required by HB 627 – *Community Health Care Access and Safety Net Act of 2005*. Section 11 of this Act requires 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. The report being submitted satisfies the reporting requirements for both SB 481 and HB 627.

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The Honorable Ulysses Currie  
The Honorable Thomas M. Middleton  
The Honorable Norman H. Conway  
The Honorable Peter A. Hammen  
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If further information is required, please contact Tricia Roddy, Director of Planning, at (410) 767-5806.

Sincerely,



John M. Colmers  
Secretary

Enclosure

cc: John Folkemer  
Tricia Roddy  
Audrey Richardson  
Diane Herr  
Anne Hubbard

**Report on the Maryland Medical Assistance Program and the  
Maryland Children's Health Program – Reimbursement Rates  
October 2007**

**I. Introduction**

Chapter 464 (SB 481) of the laws of Maryland, enacted in 2002, directed the Maryland Department of Health and Mental Hygiene (the Department) to establish a process to annually set the fee-for-service reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program in a manner that ensures participation of providers. The law further stipulated that in developing the rate-setting process, the Department should take into account community rates as well as annual medical inflation, or utilize the Resource-Based Relative Value Scale (RBRVS) methodology used in the federal Medicare program and the 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 on the following:

1. The progress in establishing the rate-setting process mentioned above;
2. Comparison of Maryland Medicaid's reimbursement rates with the rates of other states;
3. The schedule for bringing Maryland's reimbursement rates to a level that assures provider participation in the Medicaid program; and
4. The estimated costs of implementing the schedule (item 3) and proposed changes to the fee-for-service reimbursement rates.

In addition, the Department has incorporated into this report information required by Chapter 280 (HB 627) from the 2005 session. Section 11 of this act requires 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 for the same services paid to: 1) providers under the Medical Assistance program and, 2) managed care organization (MCO) providers. On or before January 1 of every year the Department is to report this information and whether the fee-for-service rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule.

The purpose of this report is to provide a status report on the progress that Maryland Medicaid has made in updating reimbursement rates, in keeping with the requirements of both SB 481 and HB 627.

**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 Children's Health Programs. In 2002, SB 481 required submission of this report on an annual basis. This is the seventh annual report.

The Department's first annual report showed that Maryland's Medicaid reimbursement rates in 2001 were, on average, about 36 percent of Medicare rates. The report also included the results of a survey conducted by the American Academy of Pediatrics<sup>1</sup> in 1998/1999, which showed that Maryland's physician reimbursement for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the Legislature appropriated \$50 million additional total funds (\$25 million state funds) for increasing physician fees in the Medicaid program beginning July 2002. The increase was targeted to evaluation and management procedure codes largely used by primary care and specialty care physicians.

Senate Bill 836 of the 2005 General Assembly session, entitled Maryland Patients' Access to Quality Health Care Act of 2004 – Implementation and Corrective Provisions, in an effort to retain health care providers in the state, alleviated the impact of recent increases in the cost of physicians' malpractice liability insurance. This bill created the "Maryland Health Care Provider Rate Stabilization Fund" to subsidize physicians for the cost of obtaining malpractice insurance. The main revenues of the Fund are from a tax imposed on managed care organizations (MCOs) and health maintenance organizations (HMOs).

In addition to subsidizing physicians for the cost of obtaining malpractice liability insurance, 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 state funds (\$30 million total funds) in fiscal year 2006 to be used by the Department to increase both fee-for-service physician fees and to pay physicians in MCOs' networks "consistent with fee-for-service health care provider rates for procedures 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. After the FY 2006 increase in Medicaid fees, Maryland Medicaid's overall physician reimbursement rates were, on average, about 68 percent of 2005 Medicare rates.

SB 836 also required the Department to consult with the managed care organizations, the Maryland Hospital Association, the Maryland State Medical Society (MedChi), the Maryland Chapter of the American Academy of Pediatrics, and the Maryland Chapter of the American College of Emergency Room Physicians (collectively referred to as stakeholders in this report) when determining the new payment rates.

For FY 2007, based on the stakeholders' recommendation, the Department increased fees for procedures that are mainly used for general surgery (10000-19396), digestive surgery (40490-49999), ENT (ear/nose/throat)/otorhinolaryngology (69000-69990, 92502-92625), allergy/immunology (95004-95199), dermatology (96900-96999), and radiation oncology procedures (77261-77799). Also, fees for evaluation and management procedures were

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<sup>1</sup> 'Medicaid Reimbursement Survey' – (2001), *American Academy of Pediatrics*, <http://www.aap.org/research/medrcimintro.htm>

increased to a minimum of 78 percent of Medicare 2006 fees. With the FY 2007 fee increase, Maryland Medicaid physician fees were, on average, about 73 percent of Medicare 2006 fees. Table 1 shows the percentage of Medicare fees at the time of original fee increases for targeted groups of procedures in fiscal years 2003, 2006, and 2007.

**Table 1. Prior Fee Increases to Percentage of Medicare Fees**

<b>Fiscal Year</b>	<b>Procedure Code Group</b>	<b>Percent of Medicare Fees at the Time of Original Fee Increase</b>
2003	Evaluation & Management (99201-99499)	80%
2006	Four Specialties:	
	Orthopedic (20000-29999),	99.6%
	Obstetric/Gynecology (56405-59899)	99.6%
	Neurosurgery (61000-64999)	99.6%
	Emergency (99281-99285)	99.6%
2007	Anesthesia	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%

SB 836 allocated funds to increase capitation payments to MCOs to enable them to raise their physician fees. Accordingly, the Department has increased MCO capitation rates to reflect the cost 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.

SB 836 indicates that the Department must submit its plan for increasing Medicaid reimbursement rates to the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health and Government Operations Committee “prior to adopting the regulations implementing the increase.” In accordance with this requirement, in May 2007, the Department submitted a report entitled “Report on FY 2008 Reimbursement Rate Increase for Physicians Participating in the Maryland Medical Assistance Program and Maryland Children’s Health Program.” The report described the Department’s plan to increase Medicaid physician fees for FY 2008, which is described in the following section.

### **III. FY 2008 Increase in Medicaid Physicians’ Fees**

The Department convened the physician fee stakeholder meeting on February 22, 2007. Attendees included representatives from MCOs, the Maryland Hospital Association, the Maryland State Medical Society (MedChi), the Maryland Chapter of the American Academy

of Pediatricians, the Maryland Chapter of the American College of Surgeons, Mercy Medical Center, Johns Hopkins Hospital, St. Mary's Hospital, Holy Cross Hospital, University of Maryland Medical Center, a radiation therapy group, and anesthesiology.

At the first meeting, the Department presented four different fee increase options (listed below) for allocating the projected \$32.8 million fee increase funds for FY 2008.

1. Increase fees for evaluation and management procedures to a minimum of 80 percent of Medicare fees, and allocate the remaining funds to procedures with the lowest fees, which would raise their fees to a minimum of 56 percent of Medicare fees.
2. Increase fees for procedures with the lowest fees to a minimum of 50 percent of Medicare fees, and allocate the remaining funds to evaluation and management procedures, which would raise their fees to a minimum of 83 percent of Medicare fees.
3. Increase fees for evaluation and management procedures to a minimum of 85 percent of Medicare fees, and allocate the remaining funds to procedures with the lowest fees, which would raise their fees to a minimum of 46 percent of Medicare fees.
4. Allocate all funds to evaluation and management procedures, which are often considered the broadest way to spread the funds among physicians. This would raise fees for evaluation and management procedures to 92 percent of Medicare fees.

The stakeholder group recommended a new option based on options 1 and 2: increase fees for evaluation and management procedures to a minimum of 80 percent of Medicare fees, and increase fees for procedures with the lowest fees to a minimum of 50 percent of Medicare fees. This would leave some funds to address the specialty access issues. The stakeholder group raised concern about the challenges regarding access to some physician specialty services because of serious underpayments by the Medicaid program. Six areas singled out by the stakeholders for additional fee increases were evaluation and management procedures performed in hospital outpatient departments, three neonatology procedures (99294, 99296, and 99299), psychiatry, radiology, vaccine administration, and obstetric anesthesia procedures.

Based on the stakeholders' recommendations, the Department:

- Increased fees for evaluation and management procedures to a minimum of 80 percent of Medicare fees,
- Increased fees for evaluation and management procedures performed in hospital outpatient departments to a minimum of 50 percent of corresponding Medicare fees,
- Increased fees for the three neonatology procedures (99294, 99296, and 99299) to 90 percent of Medicare fees,
- Increased fees for radiology procedures to a minimum of 53 percent of Medicare fees,
- Increased fees for vaccine administration procedures from \$10 to \$13.50,
- Increased fees for procedures with the lowest fees to a minimum of 50 percent of Medicare fees,
- Increased fees for obstetric anesthesia procedures by about 9 percent, and
- Increased Medicaid fees for psychiatry procedures to the level of Mental Health Administration fees for these procedures.

The total state and federal matching funds available for the FY 2008 physician fee increase were \$32.8 million. Table 2 shows the Department's allocation of these funds among targeted procedures.<sup>2</sup>

**Table 2. FY 2008 Cost of Fee Increase for Target Procedures**

	<b>Cost of Fee Increase (Million \$)</b>	<b>Minimum % of Medicare 2007 Fees</b>	<b>Average % of Medicare 2007 Fees</b>
E&M Procedures	\$11.16	80%	83%
E&M Neonatology Procedures	\$0.42	90%	90%
E&M OPD Procedures (Excluding ER procedures)	\$0.96	50%	50%
Radiology (Excluding Radiation Oncology)	\$3.53	53%	59%
Vaccines Administration	\$1.80	66%	70%
Psychiatry	\$1.05	61%	86%
Anesthesia-Obstetric	\$0.40	119%	119%
All other procedures, including procedures with fee increase in previous years	\$13.48	50%	81%
<b>Total</b>	<b>\$32.80</b>	<b>50%</b>	<b>80%</b>

Note: Radiology procedures will receive \$600 thousand more than the amount that they would have received when their fees were increased to a minimum of 50 percent of Medicare fees.

<sup>2</sup> The average percentages reported in Tables 2 and 3 are weighted averages of Maryland fees as percentages of Medicare fees for all procedures in each specialty group.

#### **IV. Comparisons of Maryland Medicaid Fees with Medicare and Other States' Fees**

##### **A. Medicare Fees as a Benchmark**

The Department used the Medicare physician payment methodology as a benchmark when it increased physicians' fees in fiscal years 2003, 2006, 2007, and 2008. Medicare fees are based on the Resource-Based Relative Value Scale (RBRVS) methodology, which relates payments to the resources and skills that physicians use to provide services.

Medicare reimbursement rates are adjusted annually according to a complex formula designed to control overall spending while accounting for factors that affect the cost of providing care. This caused an overall decrease in Medicare rates in 2002. However, following federal legislative mandates, Medicare physician fees were increased by 1.6 percent in 2003, by 1.5 percent in 2004, and by 1.5 percent in 2005. Following similar legislative mandates, Medicare fees were held constant at the 2005 level in 2006 and 2007.<sup>3</sup>

In addition, Medicare fees are adjusted depending on where a procedure is performed. Medicare payments for some procedures are lower if they are performed in hospitals or skilled nursing facilities rather than in offices or other places. See Appendices 1 and 2 for a description of RBRVS and the Department's methodology for increasing physician fees.

Anesthesia procedures and payments are a distinct exception to the RBRVS system. Prior to December 1, 2003, the Medicaid program reimbursed anesthesia services based on a percentage of the surgical fee. The Maryland Medicaid program in general did not use the anesthesia current procedural terminology (CPT) codes, but rather the surgical CPT codes with a modifier.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that national standard code sets be used. Payment for anesthesia services could no longer be linked to surgical procedures. In late 2003, the Medicaid program complied with the federal standards. Since that time, all anesthesia services have been based on the anesthesia CPT procedure codes. Appendix 1 describes the Medicare anesthesia payment methodology.

##### **B. Maryland Medicaid Fees Compared to Medicare Fees**

Table 3 below shows the average percentage of Medicare 2007 fees for all specialty groups of procedures before and after the FY 2008 fee increase. It also shows the number of procedures in each specialty group that had a fee increase in FY 2008. The FY 2008 fee increase raised Medicaid physician fees to an average of 80 percent of Medicare 2007 fees. Because of a decline in Medicare fees for some specialty groups of procedures in 2007, the percentages of Medicare fees have increased to above 100 percent for some specialty groups.

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<sup>3</sup> Centers for Medicare and Medicaid Services (CMS) and Medicare Payment Advisory Commission (MedPAC). For example, see MedPAC's article "Physician Services Payment System: payment basics", at [http://www.medpac.gov/publications/other\\_reports/Sept06\\_MedPAC\\_Payment\\_Basics\\_Physician.pdf](http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_Physician.pdf) and [http://www.medpac.gov/chapters/Jun07\\_AppA.pdf](http://www.medpac.gov/chapters/Jun07_AppA.pdf)

**Table 3. Average Percentage of Medicare 2007 Fees by Procedure Group**

Specialty Group	CPT Codes	Pre-Increase Percent of Medicare Fees	Post-Increase Percent of Medicare Fees	Number of Procedures with Fee Increase
Anesthesia	00100-01999	110%	111%	10
Integumentary/General Surgery	10000-19396	83%	83%	2
Musculoskeletal System	20000-29999	102%	102%	410
Respiratory	30000-32999	36%	53%	217
Cardiovascular	33010-37790	30%	53%	460
Lymphatic	38100-38794	40%	53%	50
Mediastinum	39000-39561	34%	50%	14
Digestive System	40490-49905	83%	83%	6
Urinary & Male Genital	50010-55999	23%	50%	387
Gynecology-Obstetric	56405-59899	104%	104%	49
Endocrine System	60000-60699 & 95250	40%	51%	28
Neurosurgery	61000-64999	104%	104%	163
Eye Surgery	65091-68899	56%	66%	200
ENT/Ear Surgery	69000-69990, 92502-92700	97%	99%	7
Radiology (excluding 77261-77799)	70010-79900	48%	59%	424
Radiation Oncology	77261-77799	78%	78%	3
Laboratory	80048- 89356	69%	76%	147
Vaccine Administration	90465-90779	52%	70%	59
Psychiatry	90801-90911	37%	86%	42
Dialysis	90918-90999	18%	50%	13
Gastroenterology	91000-91299	32%	50%	22
Ophthalmology	92002-92499	23%	50%	46
Cardiovascular	92950-93798	33%	56%	90
Non-Invasive Vascular Tests	93875-93990	11%	50%	22
Pulmonary	94010-94799	45%	61%	32
Allergy/Immunology	95004-95199	89%	89%	0
Neurology/Neuromuscular	95805-96004	20%	51%	74
CNS Assessment Tests	96100-96155	65%	65%	8
Chemotherapy Administration	96400-96571	10%	50%	23
Dermatology Procedures	96900-96999	68%	68%	0
Phys Medicine/Rehab/Therapy	97001-97804	45%	57%	29
Osteopathic/Chiropractic & Other Medicine	97810-99195	57%	86%	23
Evaluation & Management (E&M)	99201-99499	79%	83%	31
E&M in Outpatient Hospitals	99201-99397	27%	50%	28
<b>Total</b>		<b>73%</b>	<b>80%</b>	<b>3,109</b>

Note: The before and after fee increase percentages remain the same for some specialty groups while several procedures in the group have fee increases. The reason is that these procedures have very low utilization.

### C. Maryland Medicaid Fees Compared to Other States' Medicaid Fees

Like Maryland, the neighboring states have their own Medicaid fee schedules. For this report, we conducted a new survey of Medicaid physician fees in the neighboring states of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, DC. Although Virginia and West Virginia did not participate in our survey, we obtained their latest physician fee schedules from their websites. Pennsylvania did not respond to our survey, and their physician fee schedule is not accessible through their web site. Therefore, Pennsylvania fees are not included in the following tables and have been excluded from the analysis. We collected each state's current Medicaid fees for approximately 140 high-volume procedures. The procedures consist of a sample of procedures from the list of procedures that had a fee increase in July 2007.

In Tables 4 through 19, procedure fees are rounded to the nearest dollar amount. Table 4 compares Maryland's old and new Medicaid fees for high-volume evaluation and management procedures with neighboring states' Medicaid fees, as well as with the corresponding Medicare fee schedule for Maryland.

**Table 4. Medicaid Fees for High-Volume Evaluation and Management Procedures**

Procedure Code	Procedure Description	MD Old (FY07) <sup>1</sup>	DC	DE	VA	W VA	MD New (FY08) <sup>2</sup>	Medicare Fee in MD <sup>3</sup>
99204	Office/outpatient visit; new Comprehensive	\$112	\$69	\$141	\$109	\$101	\$116	\$145
99213	Office/outpatient visit; established Extended	\$43	\$27	\$60	\$48	\$42	\$50	\$62
99214	Office/outpatient visit; established Comprehensive	\$68	\$42	\$91	\$72	\$64	\$75	\$94
99215	Office/outpatient visit; established Complicated	\$98	\$62	\$123	\$97	\$88	\$101	\$127
99223	Initial hospital care, comprehensive 70 minutes	\$127	\$78	\$175	\$140	\$129	\$142	\$178
99232	Subsequent hospital care, 25 minutes	\$45	\$28	\$64	\$52	\$47	\$52	\$65
99233	Subsequent hospital care, 35 minutes	\$64	\$40	\$92	\$74	\$67	\$75	\$93
99244	Office consultation Comprehensive	\$141	\$87	\$182	\$143	\$130	\$149	\$186
99254	Initial inpatient consult, 80 Minutes	\$115	\$71	\$158	\$129	\$116	\$129	\$161
99282	Emergency dept visit	\$28	\$17	\$37	\$26	\$28	\$30	\$38
99291	Critical care, first hour	\$210	\$109	\$259	\$201	\$186	\$212	\$265
99294	Pediatric critical care, subsequent	\$331	\$205	\$377	\$298	\$281	\$345	\$383
99296	Subsequent neonatal critical care, per day	\$332	\$206	\$378	\$298	\$278	\$345	\$384
99299	Intensive Care, low birth weight infant, 1500-2500 gm	\$107	\$68	\$124	\$98	\$92	\$114	\$126
	<b>Average % of Medicare Fees</b>	<b>79%</b>	<b>47%</b>	<b>98%</b>	<b>77%</b>	<b>71%</b>	<b>83%</b>	

1- MD Old in all relevant tables refers to Maryland Medicaid fees prior to the July 2007 fee increase.

2- MD New in all relevant tables refers to Maryland Medicaid fees after the July 2007 fee increase.

3- Medicare 2007 Fee schedule for Maryland in all relevant tables.

The last row of Table 4 shows the average of each state's fees for surveyed evaluation and management procedures as a percent of Medicare fees in Maryland.<sup>4</sup> As these data indicate, Medicaid fees for evaluation and management procedures in Maryland are lower than the Medicaid fees in Delaware, but are higher than the corresponding Medicaid fees in the other neighboring states, with the exception of procedure codes 99232 and 99254 in Virginia.

For purposes of this report, we have compared Maryland Medicaid and other state Medicaid rates to the Medicare fee schedule for Maryland. Average Medicare fees in Maryland are about equal to average Medicare fees in Virginia, but are about 3 percent higher than Medicare fees in Delaware, and about 8 percent higher than Medicare fees in West Virginia. Average Medicare fees in Washington, DC are about 7 percent higher than average Medicare fees in Maryland.

Like Table 4, the following Tables 5 through 19 compare Maryland's old and new Medicaid fees for **respiratory, cardiovascular surgery, lymphatic, urinary system, endocrine system, eye surgery, radiology, laboratory, vaccine administration, psychiatry, dialysis, gastroenterology, ophthalmology, cardiovascular medicine, vascular tests, pulmonary, neurology, CNS assessment, chemotherapy, physical and therapeutic and other medical procedures** with the corresponding Medicare and the neighboring states' Medicaid fees.

The data in Table 5 compare Maryland Medicaid fees for respiratory procedures with other states' Medicaid fees, and with the corresponding Medicare fee in Maryland.

**Table 5. Medicaid Fees for Respiratory Procedures**

Proce- -dure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medi- care Fee in MD
31500	Insert emergency airway	\$31	\$66	\$106	\$82	\$80	\$54	\$108
31515	Laryngoscopy for aspiration	\$24	\$85	\$199	\$146	\$136	\$104	\$207
31520	Dx laryngoscopy, newborn	\$50	\$81	\$151	\$114	\$110	\$77	\$155
31600	Incision of windpipe	\$110	\$201	\$388	\$297	\$293	\$198	\$396
31622	Dx bronchoscope/wash	\$113	\$125	\$316	\$231	\$214	\$165	\$329
31624	Dx bronchoscope/lavage	\$113	\$124	\$323	\$236	\$217	\$168	\$336
32020	Insertion of chest tube	\$42	\$130	\$176	\$135	\$134	\$90	\$180
	<b>Average % of Medicare Fees</b>	<b>27%</b>	<b>50%</b>	<b>97%</b>	<b>73%</b>	<b>70%</b>	<b>50%</b>	

<sup>4</sup> The average percent of Medicare fees reported in Tables 4 through 19 are simple averages of percent of Medicare fees for surveyed procedures. The average percentages reported in Tables 2 and 3 are weighted averages of Maryland fees as percentages of Medicare fees for all procedures in each specialty group.

The data in Table 6 compare Maryland Medicaid fees for cardiovascular procedures with other states' Medicaid fees, and with the corresponding Medicare fee in Maryland.

**Table 6. Medicaid Fees for Cardiovascular Surgery Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
36010	Place catheter in vein	\$42	\$90	\$754	\$538	\$488	\$397	\$794
36425	Vein access cut down>1 yr	\$14	\$19	\$37	\$27	\$27	\$19	\$37
36556	Insert non-tunnel cv catheter	\$124	\$171	\$283	\$207	\$192	\$147	\$295
36558	Insert tunneled cv catheter	\$275	\$381	\$288	\$673	\$619	\$490	\$979
36569	Insert PICC catheter >5 yrs	\$137	\$191	\$322	\$233	\$214	\$169	\$338
36589	Removal tunneled cv catheter	\$69	\$103	\$169	\$126	\$121	\$87	\$174
36620	Insertion catheter, artery	\$21	\$36	\$50	\$39	\$38	\$25	\$51
	<b>Average % of Medicare Fees</b>	<b>33%</b>	<b>50%</b>	<b>87%</b>	<b>71%</b>	<b>67%</b>	<b>50%</b>	

The data in Table 7 compare Maryland Medicaid fees for Lymphatic/Mediastinum and Urinary Systems procedures with other states' Medicaid fees, and with the corresponding Medicare fee in Maryland.

**Table 7. Medicaid Fees for Lymphatic/Mediastinum and Urinary Systems Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
<b>Lymphatic Systems/Mediastinum</b>								
38100	Removal of spleen, total	\$356	\$430	\$981	\$754	\$743	\$500	\$999
38510	Biopsy/removal of lymph nodes	\$78	\$237	\$466	\$350	\$337	\$240	\$480
39400	Visualization of chest	\$149	\$218	\$484	\$367	\$357	\$248	\$497
	<b>Average % of Medicare Fees</b>	<b>27%</b>	<b>45%</b>	<b>98%</b>	<b>74%</b>	<b>72%</b>	<b>50%</b>	
<b>Urinary System</b>								
51600	Injection for bladder x-ray	\$8	\$115	\$218	\$156	\$142	\$115	\$229
51701	Insert bladder catheter	\$24	\$0	\$75	\$56	\$50	\$39	\$78
51798	US urine capacity measure	\$8	\$0	\$18	\$13	\$13	\$10	\$19
52000	Cystoscopy	\$44	\$133	\$213	\$157	\$146	\$111	\$221
54150	Circumcision w/regional block	\$18	\$148	\$129	\$97	\$92	\$66	\$133
	<b>Average % of Medicare Fees</b>	<b>22%</b>	<b>44%</b>	<b>96%</b>	<b>61%</b>	<b>66%</b>	<b>50%</b>	

The data in Table 8 show Maryland Medicaid fees and other states' Medicaid fees and the corresponding Medicare fees in Maryland for endocrine system and eye surgery procedures.

**Table 8. Medicaid Fees for Endocrine System and Eye Surgery Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
<b>Endocrine System</b>								
60100	Biopsy of thyroid	\$29	\$68	\$109	\$82	\$77	\$56	\$112
60220	Partial removal of thyroid	\$251	\$384	\$698	\$532	\$521	\$357	\$714
60240	Removal of thyroid	\$352	\$527	\$899	\$687	\$677	\$460	\$920
	<b>Average % of Medicare fees</b>	<b>33%</b>	<b>57%</b>	<b>98%</b>	<b>74%</b>	<b>72%</b>	<b>50%</b>	
<b>Eye Surgery</b>								
66761	Revision of iris	\$121	\$186	\$387	\$287	\$268	\$200	\$400
66821	After cataract laser surgery	\$82	\$123	\$275	\$203	\$189	\$142	\$284
67038	Strip retinal membrane	\$587	\$877	\$1,424	\$1,074	\$1,016	\$731	\$1,461
67210	Treatment of retinal lesion	\$248	\$366	\$588	\$442	\$418	\$302	\$603
67228	Destruction of retinopathy	\$284	\$447	\$925	\$693	\$653	\$476	\$952
	<b>Average % of Medicare fees</b>	<b>34%</b>	<b>51%</b>	<b>97%</b>	<b>73%</b>	<b>68%</b>	<b>50%</b>	

The data in Table 9 show Maryland Medicaid and other states' Medicaid fees and the corresponding Medicare fees in Maryland for radiology procedures.

**Table 9. Medicaid Fees for Radiology Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
71010	Chest x-ray, single view	\$10	\$15	\$26	\$19	\$18	\$15	\$28
71020	Chest x-ray, two views	\$16	\$19	\$35	\$25	\$24	\$19	\$36
73610	X-ray exam of ankle	\$13	\$16	\$30	\$22	\$20	\$17	\$32
74000	X-ray exam of abdomen	\$10	\$16	\$28	\$21	\$19	\$16	\$30
76805	Ob Ultrasound, after first trimester, single fetus	\$56	\$71	\$138	\$125	\$95	\$77	\$145
76811	Ob US, detailed, single fetus	\$98	\$130	\$235	\$214	\$167	\$130	\$245
76815	Ob ultrasound, limited, fetus(s)	\$24	\$48	\$90	\$82	\$62	\$50	\$94
76830	Transvaginal US, non-ob	\$25	\$51	\$104	\$94	\$71	\$58	\$109
	<b>Average % of Medicare fees</b>	<b>35%</b>	<b>51%</b>	<b>96%</b>	<b>78%</b>	<b>65%</b>	<b>53%</b>	

The data in Table 10 show Maryland Medicaid and other states' Medicaid fees, as well as the corresponding Medicare fees in Maryland for laboratory procedures.

**Table 10. Medicaid Fees for Laboratory Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
84030	Assay of blood pku	\$0	\$4	\$8	\$7	N/A	\$4	\$8
86580	TB intradermal test	\$3	\$5	\$5	\$7	\$6	\$5	\$10
88300	Surgical path, gross	\$6	\$8	\$14	\$16	\$15	\$12	\$23
88305	Tissue exam, level IV	\$38	\$51	\$98	\$76	\$70	\$54	\$109
88307	Tissue exam, level V	\$54	\$87	\$167	\$141	\$131	\$101	\$202
88342	Immunohistochemistry	\$15	\$44	\$86	\$68	\$63	\$48	\$96
	<b>Average % of Medicare Fees</b>	<b>21%</b>	<b>46%</b>	<b>79%</b>	<b>73%</b>	<b>64%</b>	<b>50%</b>	

N/A: Data are not available.

Table 11 shows Maryland Medicaid and other states' Medicaid fees, as well as the corresponding Medicare fees in Maryland for vaccine administration procedures.

**Table 11. Medicaid Fees for Vaccine Administration Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
90465	Immune admin 1 inj, <8 yrs	\$10	\$0	N/C	N/A	\$13	\$13.50	\$20
90466	Immune admin addl inj, <8 yrs	\$10	\$0	N/C	N/A	\$7	\$13.50	\$11
90471	Immunization administration	\$10	\$4	N/C	N/A	\$13	\$13.50	\$20
90472	Immunization admin, each add	\$10	\$3	N/C	N/A	\$7	\$13.50	\$11

N/C: Not Covered.

N/A: Data are not available.

Table 12 compares Maryland Medicaid fees with other states' Medicaid fees and with the corresponding Medicare fees in Maryland for psychiatry procedures.

**Table 12. Medicaid Fees for Psychiatry Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
90801	Psy dx interview	\$41	\$77	\$147	\$112	\$105	\$141	\$150
90804	Psytx, office, 20-30 min	\$21	\$33	\$63	\$48	\$45	\$47	\$64
90805	Psytx, offic, 20-30 min w/E&M	\$24	\$37	\$69	\$52	\$49	\$68	\$70
90806	Psytx, office, 45-50 min	\$41	\$50	\$91	\$70	\$66	\$85	\$92
90853	Group psychotherapy	\$13	\$16	\$31	\$23	\$22	\$23	\$31
	<b>Average % of Medicare Fees</b>	<b>36%</b>	<b>53%</b>	<b>98%</b>	<b>75%</b>	<b>70%</b>	<b>86%</b>	

The data in Table 13 show Maryland Medicaid and other states' Medicaid fees as well as the corresponding Medicare fees in Maryland for dialysis and gastroenterology procedures.

**Table 13. Medicaid Fees for Dialysis and Gastroenterology Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
<b>Dialysis</b>								
90925	ESRD related services, day	\$0	\$162	\$8	\$6	\$6	\$4	\$8
90935	Hemodialysis, one evaluation	\$15	\$52	\$68	\$52	\$49	\$35	\$70
90937	Hemodialysis, repeated eval	\$15	\$92	\$111	\$85	\$80	\$57	\$113
90945	Dialysis, one evaluation	\$15	\$90	\$71	\$54	\$51	\$36	\$73
	<b>Average % of Medicare fees</b>	<b>18%</b>	<b>564%</b>	<b>98%</b>	<b>74%</b>	<b>71%</b>	<b>50%</b>	
<b>Gastroenterology</b>								
91010	Esophagus motility study	\$69	\$81	\$210	\$152	\$140	\$110	\$220
91034	Gastroesophageal reflux test	\$96	\$147	\$229	\$165	\$150	\$120	\$241
91105	Gastric intubation treatment	\$16	\$13	\$91	\$66	\$59	\$48	\$96
	<b>Average % of Medicare Fees</b>	<b>29%</b>	<b>37%</b>	<b>95%</b>	<b>69%</b>	<b>63%</b>	<b>50%</b>	

Table 14 shows Maryland Medicaid and other states' Medicaid fees and the corresponding Medicare fees in Maryland for ophthalmology procedures.

**Table 14. Medicaid Fees for Ophthalmology Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
92004	Eye exam, new patient	\$27	\$80	\$123	\$87	\$85	\$64	\$127
92012	Eye exam established pat	\$21	\$50	\$63	\$46	\$43	\$33	\$65
92014	Eye exam & treatment	\$27	\$80	\$93	\$69	\$63	\$48	\$96
92015	Refraction determination	\$5	\$80	\$57	\$42	\$38	\$30	\$60
92060	Special eye evaluation	\$8	\$30	\$54	\$40	\$37	\$28	\$56
92081	Visual field examination(s)	\$15	\$49	\$50	\$36	\$33	\$26	\$52
92083	Visual field examination(s)	\$15	\$42	\$74	\$54	\$49	\$39	\$78
	<b>Average % of Medicare Fees</b>	<b>22%</b>	<b>80%</b>	<b>96%</b>	<b>70%</b>	<b>65%</b>	<b>50%</b>	

The data in Table 15 show Maryland and other states' Medicaid fees, as well as the corresponding Medicare fees in Maryland for cardiovascular medicine procedures.

**Table 15. Medicaid Fees for Cardiovascular Medicine Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
93015	Cardiovascular stress test	\$34	\$62	\$106	\$77	\$73	\$55	\$110
93230	ECG monitor/report, 24 hrs	\$42	\$99	\$162	\$116	\$110	\$85	\$170
93303	Echo transthoracic	\$38	\$125	\$224	\$163	\$152	\$117	\$235
93307	Echo exam of heart	\$34	\$117	\$199	\$144	\$135	\$104	\$209
93312	Echo transesophageal	\$34	\$149	\$294	\$214	\$202	\$153	\$306
93325	Doppler color flow add-on	\$10	\$66	\$101	\$72	\$69	\$53	\$107
93510	Left heart catheterization	\$80	\$941	\$131	\$1,228	\$179	\$125	\$251
	<b>Average % of Medicare Fees</b>	<b>20%</b>	<b>101%</b>	<b>89%</b>	<b>129%</b>	<b>66%</b>	<b>50%</b>	

Table 16 compares Maryland Medicaid's fees with other states' Medicaid fees, as well as the corresponding Medicare fees in Maryland for non-invasive vascular test procedures.

**Table 16. Medicaid Fees for Non-Invasive Vascular Test Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
93880	Extracranial study	\$20	\$105	\$191	\$181	\$170	\$100	\$201
93886	Intracranial study	\$20	\$121	\$209	\$222	\$208	\$110	\$220
93923	Extremity study	\$20	\$73	\$186	\$133	\$124	\$98	\$196
93970	Extremity veins study	\$20	\$112	\$195	\$179	\$170	\$102	\$205
93971	Extremity veins study, limited	\$20	\$75	\$124	\$120	\$114	\$65	\$130
93976	Vascular limited study	\$20	\$100	\$219	\$160	\$152	\$115	\$230
	<b>Average % of Medicare Fees</b>	<b>11%</b>	<b>50%</b>	<b>95%</b>	<b>85%</b>	<b>80%</b>	<b>50%</b>	

Table 17 shows Medicaid fees in Maryland and other states and the corresponding Medicare fees in Maryland for pulmonary procedures.

**Table 17. Medicaid Fees for Pulmonary Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
94010	Breathing capacity test	\$13	\$22	\$33	\$24	\$22	\$18	\$35
94060	Evaluation of wheezing	\$20	\$38	\$57	\$41	\$38	\$30	\$59
94240	Residual lung capacity	\$13	\$45	\$38	\$28	\$26	\$20	\$40
94375	Respiratory flow volume loop	\$10	\$20	\$36	\$26	\$25	\$19	\$38
94640	Airway inhalation treatment	\$5	\$15	\$13	\$9	\$9	\$7	\$14
94664	Evaluate pt use of inhaler	\$6	\$11	\$14	\$10	\$10	\$7	\$15
94720	Monoxide diffusing capacity	\$13	\$38	\$51	\$37	\$35	\$27	\$54
	<b>Average % of Medicare Fees</b>	<b>33%</b>	<b>78%</b>	<b>95%</b>	<b>69%</b>	<b>65%</b>	<b>50%</b>	

Table 18 shows Medicaid fees in Maryland and other states and the corresponding Medicare fees in Maryland for neurology and neuromuscular procedures.

**Table 18. Medicaid Fees for Neurology and Neuromuscular Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
95810	Polysomnography, w 4 or more parameters of sleep	\$155	\$429	\$819	\$589	\$542	\$430	\$860
95816	EEG, awake and drowsy	\$30	\$98	\$201	\$145	\$134	\$105	\$211
95819	EEG, awake and asleep	\$30	\$111	\$188	\$136	\$126	\$98	\$197
95861	Muscle test, 2 limbs	\$41	\$67	\$115	\$86	\$81	\$59	\$118
95900	Motor nerve conduction test, without F-wave	\$13	\$31	\$62	\$45	\$41	\$32	\$64
95903	Motor nerve conduction test, with F-wave	\$16	\$34	\$67	\$49	\$45	\$35	\$70
95904	Nerve conduction test, sensory	\$11	\$26	\$53	\$38	\$35	\$28	\$55
	<b>Average % of Medicare Fees</b>	<b>21%</b>	<b>51%</b>	<b>96%</b>	<b>70%</b>	<b>65%</b>	<b>50%</b>	

The data in Table 19 show Medicaid fees in Maryland and other states and the corresponding Medicare fees in Maryland for CNS assessment, chemotherapy, physical medicine and rehabilitation therapy, and chiropractic and other medicine procedures.

**Table 19. Medicaid Fees for Health Assessment Tests, Chemotherapy Administration, Physical Medicine & Rehabilitation Therapy, and Chiropractic and Other Medicine Procedures**

Procedure Code	Procedure Description	MD Old (FY07)	DC	DE	VA	W VA	MD New (FY08)	Medicare Fee in MD
<b>Health and Behavior Assessment</b>								
96154	Health and behavior intervention, w family & the patient present	\$0	\$25	\$0	\$17	N/C	\$11	\$22
	<b>Average % of Medicare Fee</b>	<b>0%</b>	<b>116%</b>	<b>0%</b>	<b>76%</b>	<b>N/A</b>	<b>50%</b>	
<b>Chemotherapy Administration</b>								
96450	Chemotherapy, into CNS	\$33	\$166	\$305	\$219	\$200	\$160	\$320
	<b>Average % of Medicare Fee</b>	<b>10%</b>	<b>52%</b>	<b>95%</b>	<b>69%</b>	<b>62%</b>	<b>50%</b>	
<b>Physical Medicine and Rehabilitation Therapy</b>								
97001	Patient evaluation	\$21	\$38	\$71	\$54	\$51	\$37	\$73
97110	Therapeutic exercises	\$11	\$15	\$27	\$20	\$19	\$14	\$28
97112	Neuromuscular reeducation	\$10	\$15	\$28	\$21	\$20	\$14	\$29
97140	Manual therapy	\$10	\$25	\$25	\$19	\$18	\$13	\$26
97530	Therapeutic activities	\$11	\$15	\$29	\$21	\$20	\$15	\$30
	<b>Average % of Medicare Fees</b>	<b>35%</b>	<b>61%</b>	<b>97%</b>	<b>73%</b>	<b>69%</b>	<b>50%</b>	
<b>Chiropractic and Other Medicine</b>								
98941	Chiropractic manipulation	\$12	\$19	N/C	\$26	\$24	\$17	\$34
99183	Hyperbaric oxygen therapy	\$11	\$72	\$205	\$152	\$142	\$106	\$212
99195	Phlebotomy	\$3	\$18	\$39	\$27	\$25	\$20	\$41
	<b>Average % of Medicare Fees</b>	<b>16%</b>	<b>44%</b>	<b>95%</b>	<b>71%</b>	<b>66%</b>	<b>50%</b>	

N/C: Not covered.

N/A: Not applicable.

## **V. 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 rate (the Baltimore Medicare facility rate) when they provide trauma care to Medicaid's fee-for-service and HealthChoice program enrollees. The enhanced Medicaid fee only applies to services rendered in a trauma center designated by Maryland Institute for Emergency Medical Services Systems (MIEMSS) for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fee was limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, the passage of HB 1164 during the 2006 legislative session extends the enhanced rate to any physician, beginning July 1, 2006. MHCC and HSCRC fully cover the additional outlay of general funds that the Maryland Medicaid program incurs due to enhanced trauma fees (relevant percent of the difference between 100 percent of Medicare rates and Medicaid's current rates). MHCC pays physicians directly for uncompensated care and on-call services.

## **VI. Reimbursement for Oral Health Services**

Historically, the Maryland Medicaid program has had low dental fees. Unlike physician services, there is no federal public program (such as Medicare) that could serve as a benchmark for oral health service fees. In addition, there are no published data available on average payment levels by private payers for dental services. However, the American Dental Association (ADA) publishes a survey reporting the national and regional average charges for nearly 165 most commonly used dental procedures, offering data for comparisons.

During the 2003 session of the Maryland General Assembly, the legislature included budgetary language in HB 40, which stated, "It is also the intent of the General Assembly that \$7.5 million of the funds included in the CY 2004 Managed Care rates for dental services be restricted to increasing fees for restorative procedures." The \$7.5 million funding increase was based on a University of Maryland Dental School analysis of the impact of increasing certain restorative procedure fees to the 50th percentile levels of the ADA survey.

In compliance with the budgetary language, effective March 1, 2004, MCOs were required to reimburse their contracted providers at the ADA 50<sup>th</sup> percentile levels for 12 restorative procedure codes. At the same time, Medicaid increased fee-for-service rates to the ADA 50<sup>th</sup> percentile levels for the same restorative procedures. Maryland Medicaid tripled average reimbursement rates for dentists in July 2000, and then increased reimbursement for 12 restorative procedures in 2004.

Table 20 compares Maryland Medicaid dental reimbursement rates for some of the more common procedures. Delaware Medicaid pays 85 percent of the charges for all dental

procedures, and it does not have specified fees for dental procedures. Furthermore, data for West Virginia dental fees were not included in their fee schedule. Therefore, dental reimbursement rates for Delaware and West Virginia are not included in Table 20. On the other hand, Medicaid dental reimbursement rates for New Jersey and New York were available on their web sites and are reported in Table 20.

**Table 20. Oral Health Reimbursement Rates for Selected Procedures**

Procedure Code	Description	DC	NJ	NY	VA	MD	South Atlantic Median (50th Percentile) of Charges
D0120	Periodic oral evaluation	\$35	\$15	\$29	\$20	\$15	\$33
D0150	Comprehensive Oral Evaluation	\$78	\$15	\$29	\$31	\$20	\$55
D0220	Intraoral periapical first film	\$20	\$4	\$14	\$11	\$9	\$20
D0272	Bitewings-two films	\$40	\$5	\$17	\$20	\$15	\$30
D0330	Panoramic film	\$80	\$16	\$40	\$54	\$42	\$80
D1110	Prophylaxis-adult	\$78	\$17	\$58	\$47	\$36	\$65
D1120	Prophylaxis-child	\$47	\$14	\$43	\$34	\$24	\$48
D1201	Topical application of fluoride with prophylaxis	\$0	\$24	N/C	\$54	\$35	\$63
D1203	Topical application of fluoride - no prophylaxis	\$29	\$10	\$14	\$21	\$14	\$24
D1351	Sealant-per tooth	\$38	\$10	\$43	\$32	\$9	\$36
D1510	Space maintainer – fixed – unilateral	\$230	\$85	\$116	\$138	\$84	\$225
D1515	Space maintainer – fixed – bilateral	\$325	\$123	\$174	\$228	\$144	\$305
<i>D2140</i>	<i>Amalgam – one surface, Primary or permanent</i>	\$90	\$32	\$55	\$59	\$70	\$90
<i>D2150</i>	<i>Amalgam - two surfaces, Primary or permanent</i>	\$115	\$38	\$84	\$76	\$88	\$111
<i>D2330</i>	<i>Resin – one surface – anterior</i>	\$106	\$36	\$58	\$74	\$84	\$105
<i>D2331</i>	<i>Resin – two surfaces – anterior</i>	\$135	\$43	\$87	\$89	\$102	\$135
<i>D2332</i>	<i>Resin – three surfaces – anterior</i>	\$165	\$50	\$108	\$115	\$125	\$160
<i>D2391</i>	<i>Resin-Based Composite-One Surface</i>	\$120	\$32	\$55	\$74	\$93	\$115
<i>D2392</i>	<i>Resin-Based Composite-Two Surface</i>	\$160	\$38	\$84	\$89	\$120	\$150
<i>D2930</i>	<i>Prefabricated stainless steel crown - primary</i>	\$102	\$76	\$116	\$137	\$154	\$198
D3220	Therapeutic pulpotomy	\$134	\$28	\$87	\$83	\$60	\$140
D7140	Extraction, Erupted Tooth or Exposed Root	\$110	\$32	\$45	\$69	\$42	\$110
D9110	Palliative Emergency Treatment	\$85	\$10	\$29	\$48	\$20	\$75
D9230	Analgesia	\$46	\$15	*	\$34	\$18	\$50
	<b>Average % of SA Median Charges</b>	<b>100%</b>	<b>30%</b>	<b>59%</b>	<b>68%</b>	<b>55%</b>	

N/C: Not Covered.

\* New York uses other procedures for analgesia.

Note: South Atlantic Region consists of: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. The South Atlantic 50<sup>th</sup> percentile of charges is based on data from the 2005 American Dental Association survey. The procedures identified in italics are among the 12 restorative procedures targeted for the 2004 restorative fee increase.

The last column of Table 20 shows the median of fees charged by dentists in 2005 in the South Atlantic Region. The median (50th percentile) of charges in South Atlantic Region

means that 50 percent of dentists in this region charge this amount or less. It is important to note, however, that the South Atlantic median is based on the fees charged by dentists for the services performed, which do not equate to the payment received as reimbursement from insurance companies, public agencies, or private pay patients.

**VII. Physician Participation in the Maryland Medicaid Program**

Physicians’ claims and encounter data pertaining to FY 2002 (the year before the July 2002 fee increase), FY 2005, and FY 2006 were analyzed for the number of physicians who had either partial or full participation in the Medicaid program.<sup>5</sup> 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.

Tables 21 and 22 show the percentage changes in the numbers of participating physicians of all specialties (including primary care) who participate in fee-for-service (FFS), MCO networks, and the total Medicaid program. As the data in Table 21 indicate, there were significant increases in physician participation in fee-for-service, MCO networks, and the total Medicaid program between fiscal years 2002 and 2006.

**Table 21. FY 2002-06 Percent Change in Number of Participating Physicians of All Specialties**

	<b>FFS</b>	<b>MCO Networks</b>	<b>Total Medicaid<sup>6</sup></b>
Partial Participation	22.4%	16.5%	51.1%
Full Participation	36.0%	0.9%	12.3%
All Physicians	18.2%	23.0%	48.8%

Similarly, the data in table 22 indicate that following the FY 2006 fee increase, there were significant increases in physician participation between fiscal years 2005 and 2006.

**Table 22. FY 2005-06 Percent Change in Number of Participating Physicians of All Specialties**

	<b>FFS</b>	<b>MCO Networks</b>	<b>Total Medicaid</b>
Partial Participation	1.8%	6.1%	11.6%
Full Participation	0.4%	2.0%	1.1%
All Physicians	2.6%	6.9%	12.6%

<sup>5</sup> The data in these tables pertain to FY 2002 through FY 2006. Therefore, these tables do not measure the impact of FY 2007 and FY 2008 fee increases on physician participation in the Medicaid program.

<sup>6</sup> Because some physicians participate in both FFS and MCO networks, percents of total physicians participating in the Medicaid program are not the sum of FFS and MCO network physicians.

### **Caveats for Tables 21 and 22**

It should be noted that percent increases in the number of physicians with partial participation in Medicaid in Tables 21 and 22 represent a change in the number of physicians who did not participate in the Medicaid program before the fee increase, and after the fee increase started to partially participate in the program, minus the number of physicians who were partial participants in the program before the fee increase, and decided to fully participate in the program after the 2002 fee increase.

Similarly, percent increases in the number of physicians with full participation in Tables 21 and 22 represent a change in the number of physicians who were partial participants in the program before the fee increase, and decided to fully participate in the program after the fee increase, plus the number of physicians who did not participate in the Medicaid program before the 2002 fee increase, and after the 2002 fee increase started to fully participate in the program.

In addition, the MCO data show increased concentration of care among physicians participating in the HealthChoice program. For example, while in FY 2002 about 19 percent of physicians provided 87 percent of services; in FY 2006 less than 16 percent of physicians provided about 88 percent of MCO physician services. This trend is consistent with national trends.

### **VIII. Plan for Future Physician Fee Increases**

The Department will continue to consult with stakeholders on future physician fee increases. Our goal remains reimbursing physicians at 100 percent of Medicare rates. This goal is obtainable with the additional funding allocated through Senate Bill 836 (Ch. 1 of the Acts of 2005).

## 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 a conversion factor are used to convert the weights to fees. Medicare rates are adjusted annually. In some years, including 2002, overall Medicare rates have actually decreased. However, following federal legislative mandates, Medicare physician fees were increased by 1.6 percent in 2003, by 1.5 percent in 2004, and by 1.5 percent in 2005. Following a similar legislative mandate, Medicare fees were held constant at the 2005 level in 2006 and 2007.

For approximately 13,000 physician procedures, Medicare RBRVS assigns the associated relative value units (RVUs) and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending on the place of service where each procedure is performed. Medicare fees for some procedures are lower if they are performed in hospitals or skilled nursing facilities than if they are performed in offices or other places. The implementation of RBRVS resulted in increased payments to office-based procedures, and reduced payments for hospital-based procedures.

The RBRVS determines relative weights (RVUs) for all procedures. These weights reflect resource requirements of each procedure performed by physicians. The Medicare physician fees are adjusted to reflect the variations in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice expense). The 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.

Efforts are currently underway in the United States Congress to change the Medicare physician payment system to include "pay for performance" and quality improvement incentives instead of relying on the SGR formula for updating the physicians' reimbursement rates.

Table A1 shows Medicare conversion factor and its percentage change for years 2000 through 2007.

**Table A1. Medicare Conversion Factor**

<b>Year</b>	<b>Conversion Factor</b>	<b>Percent Change from Prior Year</b>
2000	\$36.6137	
2001	\$38.2581	4.5%
2002	\$36.1992	-5.4%
2003	\$36.7856	1.6%
2004	\$37.3374	1.5%
2005	\$37.8975	1.5%
2006	\$37.8975	0.0%
2007	\$37.8975	0.0%

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 2006 is \$18.04 per unit. The Medical Assistance 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 Medical Assistance Program reimbursed anesthesia services based on a percentage of the surgical fee. The Program in general did not use the anesthesia CPT procedure codes, but rather the surgical CPT codes with a modifier. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that national standard code sets be used. In late 2003, the Medical Assistance program complied with the federal standards. Since that time, all anesthesia services have been identified based on the anesthesia CPT procedure 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 Medical Assistance Program started the financial transition from a fixed anesthesia rate for each surgical procedure to the national methodology, which recognized anesthesia time as the key element. The Department increased payment rates for anesthesia procedures to 100 percent of Medicare fees starting in FY 2007.

## Appendix 2

### **Summary of Methodology to Determine Maryland Medicaid Physician Fees**

The Department's methodology determines the new Medicaid fees for targeted procedures as a percentage of Medicare fees. The percentage of Medicare fees is the dependent variable in the process of determining the fees. The independent variable is the total amount of funds that are available for the fee increase. First, we compare the existing Medicaid fee for each procedure with the corresponding Medicare fees. If the current Medicaid fee is higher than the percentage of Medicare fee, then the Medicaid fee remains unchanged. Fees for procedures are set as a percentage of the corresponding Medicare fees such that the projected total cost of the fee increase would be equal to the available funds. The projected cost of the fee increase incorporates projected enrollment and utilization increases between the base year and the implementation year.

### Appendix 3

#### Rate of Non-Federal Physicians per 100,000 Civilian Population, 2006

Rank		Total 2006 Non- Federal Physicians	2006 Population	Physicians per 100,000 Population
<b>Average</b>	<b>United States</b>	<b>943,499</b>	<b>299,398,484</b>	<b>315</b>
1	District of Columbia	4,752	581,530	817
2	Massachusetts	32,785	6,437,193	509
3	New York	86,618	19,306,183	449
<b>4</b>	<b>Maryland</b>	<b>24,658</b>	<b>5,615,727</b>	<b>439</b>
5	Vermont	2,686	623,908	431
6	Connecticut	14,746	3,504,809	421
7	Rhode Island	4,478	1,067,610	419
8	Pennsylvania	47,800	12,440,621	384
9	New Jersey	32,858	8,724,560	377
10	Maine	4,755	1,321,574	360
11	Hawaii	4,489	1,285,498	349
12	Ohio	37,918	11,478,006	330
13	Michigan	33,333	10,095,643	330
14	Minnesota	16,880	5,167,101	327
15	Oregon	11,914	3,700,758	322
16	Illinois	41,116	12,831,970	320
17	New Hampshire	4,174	1,314,895	317
18	Washington	19,894	6,395,798	311
19	Colorado	14,716	4,753,377	310
20	Delaware	2,641	853,476	309
21	Florida	55,858	18,089,888	309
22	California	111,221	36,457,549	305
23	Virginia	23,021	7,642,884	301
24	Wisconsin	16,608	5,556,506	299
25	Missouri	17,434	5,842,713	298
26	Tennessee	17,888	6,038,803	296
27	Louisiana	12,644	4,287,768	295
28	Puerto Rico	11,382	3,927,776	290
29	West Virginia	5,263	1,818,470	289
30	North Carolina	25,280	8,856,505	285
31	Nebraska	4,926	1,768,331	279
32	New Mexico	5,382	1,954,599	275

Rank		Total 2006 Non- Federal Physicians	2006 Population	Physicians per 100,000 Population
<b>Average</b>	<b>United States</b>	<b>943,499</b>	<b>299,398,484</b>	<b>315</b>
33	North Dakota	1,747	635,867	275
34	Kansas	7,534	2,764,075	273
35	Montana	2,570	944,632	272
36	Arizona	16,269	6,166,318	264
37	Kentucky	11,017	4,206,074	262
38	South Carolina	11,291	4,321,249	261
39	South Dakota	1,974	781,919	252
40	Indiana	15,912	6,313,520	252
41	Iowa	7,494	2,982,085	251
42	Alaska	1,650	670,053	246
43	Utah	6,200	2,550,063	243
44	Alabama	11,147	4,599,030	242
45	Texas	56,695	23,507,783	241
46	Georgia	22,523	9,363,941	241
47	Oklahoma	8,448	3,579,212	236
48	Arkansas	6,496	2,810,872	231
49	Nevada	5,637	2,495,529	226
50	Wyoming	1,159	515,004	225
51	Idaho	3,016	1,466,465	206
52	Mississippi	5,984	2,910,540	206

Compared to the 2004 figures (shown in previous reports), the number of physicians per 100,000 populations has increased in all states. The United States' average increased from 281 physicians per 100,000 populations in 2004 to 315 physicians per 100,000 populations in 2006. The ratio of physicians to 100,000 people in Maryland increased from 389 in 2004 to 439 in 2006. The fourth ranking of Maryland among all states stayed the same between 2004 and 2006.

**Notes:** Nonfederal physicians are members of the U.S. physician population that are employed in the private sector. They represent 98 percent of total physicians. The U.S. total includes nonfederal physicians in the U.S. Territories.

**Sources:** Data for physicians are from American Medical Association, Physicians Professional Data as of 2006, copyright 2006. Downloaded from: Kaiser Family Foundation State Health Facts Online: <http://statehealthfacts.kff.org>

Data for civilian population are from Annual Estimates of the Population for the United States, Regions, and States and Puerto Rico, July 1, 2006. Release Date: December 22, 2006.

## Appendix 4

### Rate of Non-Federal Dentists per 100,000 Civilian Population, 2006

Rank		Total 2006 Dentists	Dentists per 100,000 Population
<b>Average</b>	<b>United States</b>	<b>198,967</b>	<b>66</b>
1	District of Columbia	764	131
2	Massachusetts	6,251	97
3	Nebraska	1,622	92
4	New Jersey	7,563	87
<b>5</b>	<b>Maryland</b>	<b>4,823</b>	<b>86</b>
6	New York	16,496	85
7	Connecticut	2,878	82
8	California	29,843	82
9	Hawaii	1,029	80
10	Alaska	508	76
11	Pennsylvania	9,117	73
12	Washington	4,655	73
13	Colorado	3,369	71
14	Kentucky	2,900	69
15	Minnesota	3,545	69
16	Illinois	8,725	68
17	Michigan	6,832	68
18	Utah	1,677	66
19	Virginia	4,947	65
20	Iowa	1,894	64
21	New Hampshire	817	62
22	Wisconsin	3,447	62
23	Nevada	1,539	62
24	Idaho	890	61
25	Oregon	2,194	59
26	Ohio	6,691	58
27	Tennessee	3,512	58
28	West Virginia	1,039	57
29	Vermont	354	57
30	Montana	529	56
31	Florida	10,125	56

Rank		Total 2006 Dentists	Dentists per 100,000 Population
<b>Average</b>	<b>United States</b>	<b>198,967</b>	<b>66</b>
32	Arizona	3,365	55
33	Oklahoma	1,950	54
34	Louisiana	2,323	54
35	Indiana	3,389	54
36	Rhode Island	569	53
37	Missouri	3,088	53
38	Kansas	1,455	53
39	South Carolina	2,237	52
40	North Dakota	326	51
41	Wyoming	262	51
42	Texas	11,759	50
43	Maine	659	50
44	North Carolina	4,353	49
45	Alabama	2,245	49
46	Georgia	4,482	48
47	South Dakota	370	47
48	Delaware	401	47
49	Mississippi	1,307	45
50	New Mexico	862	44
51	Puerto Rico	1,714	44
52	Arkansas	1,182	42

For number of dentists per 100,000 people, Maryland ranks fifth among all states.

**Sources:** American Dental Association, Dental Data, copyright 2006: Special data request. Data are for December 2006. US total does not include the territories. Downloaded from: Kaiser Family Foundation State Health Facts Online: <http://statehealthfacts.kff.org>

Data for civilian population, that are used to derive dentist to population rates, are from Annual Estimates of the Population for the United States, Regions, and States and Puerto Rico, July 1, 2006. Release Date: December 22, 2006.

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