SPOTLIGHT ON
MARYLAND

PAYMENT FOR PROFESSIONAL SERVICES IN MARYLAND

Factors Contributing to Variation and Comparison to Public Payers

INTRODUCTION. Amidst a continued system-wide focus on improving quality and restraining cost growth, a number of federal and state health care reforms leverage payments to providers to create incentives for providing more efficient and less costly care. Reforms range from those that emphasize restructuring care delivery, such as the patient-centered medical home and accountable care organizations, to those that primarily rely on altering payment incentives, including bundled payments, shared savings programs, and pay-for-performance initiatives. These reforms, along with input from providers, payers, and negotiations between these two groups, are likely to drive changes in payment rates for professional services. This Spotlight explores the variation in payment rates among commercial carriers, benchmarks these rates to Medicare and Medicaid payment rates, and discusses the policy context in which payment rates are determined. The approach to benchmarking is described later.

Variation in payment rates in the private insurance market may be attributable to a number of factors, including the market power of insurers and providers. Maryland's commercial market for insured health benefit plans is dominated by two large payers that together account for slightly more than two-thirds of the market, whether measured in terms of number of services; total resources—relative value units (RVUs); or total payments. This market dominance by large payers enables them to negotiate better rates with providers, compared with other payers who may have a smaller share of the market. Large payers also have the advantage in areas where providers are organized in small physician group practices that have little leverage in negotiating payment rates; if they do not join the payer networks, these smaller providers may lose access to the payers' enrollees.

While the majority of Maryland's physicians are in small practices, physicians in rural areas where there are few physicians may have more bargaining power because, without their participation, payers may not have a sufficient number of physicians in their network. There are also regional markets within Maryland that are dominated by large hospital systems, particularly academic medical centers, which are better able to negotiate higher rates because of the demand for their services. Providers also may show their market power by declining to sign participation agreements with payers; although only about 5 percent of services are delivered by non-participating or out-of-network providers, the higher payments they receive can have an impact on overall payment rates and affect relative payment rates by geographic area and type of service.

This Spotlight examines the variation in payment rates for professional services covered by Maryland's commercial payers and provides a comparison of private payment rates to Medicare and Medicaid payment rates. In particular, variation in rates by payer market share, provider region, type of service, and network participation are discussed.

HIGHLIGHTS

- The payment rate for professional services in 2011 averaged $36.45, up 1.5 percent from 2010.
- In 2011, the payment rate for large payers was 87 percent of that for other payers.
- Payment rates varied across the Maryland region, with the highest rates in Other Service Areas ($39.69) and the National Capital Area ($38.21).
- The highest payment rate by type of service was for procedures ($39.13), and the lowest was for tests ($35.14); the largest increase in 2011 was for non-psychiatric evaluation and management services (3.8 percent).
- Out-of-network payment rates were almost twice as much as in-network rates in 2011.
- The private payment rate in 2011 was comparable to what Medicare would have paid for a similar set of services, while the private payment rate was about 29 percent higher than the Medicaid payment rate. These relationships were unchanged from 2010.
- On average, large payers paid 4 percent less than Medicare in 2011, while other payers paid about 8 percent more. Payment rates were higher for both large and other payers for Medicaid, where they paid about 24 percent and 44 percent more, respectively, than the Medicaid rate.

The Impact of Payer Market Share and Other Factors on Payment Rates

Payment rates for professional services are defined as the payment per RVU for a given group of services. RVUs are a measure of the quantity of care in which more complex, resource-intensive, and thereby more expensive services have a higher number of RVUs. This definition of payment standardizes the measure by controlling for complexity and allows for valid comparisons across payers, regions, and types of service.

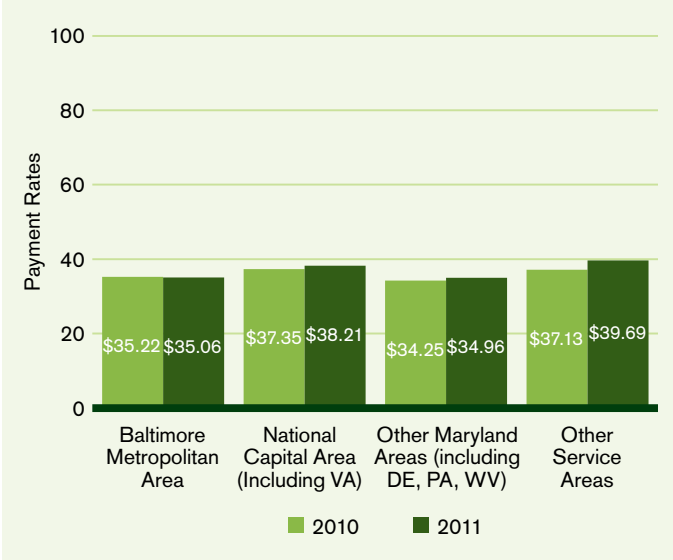
BY PAYER. The overall payment rate in 2011 was $36.45 compared with $35.90 in 2010, an increase of 1.5 percent (see Figure 1). Payment per RVU was lower among large payers—the payment rate for large payers in 2011 was 87 percent of the rate for other payers ($35.06 vs. $40.12). The change in the overall payment rate from 2010 to 2011 was slightly higher among large payers than among other payers (1.6 percent vs. 1.0 percent), although the difference in growth rates was not sufficient to have an impact on the gap in payment rate by market share.

FIGURE 1. Private Payment Rates by Payer Market Share, 2010 and 2011

BY REGION. Payment rates varied by region, based on a number of factors, including resource cost and the mix of large versus other payers in each locality. As shown in Figure 2, payment rates in 2011 were highest in Other Service Areas, which had a higher-than-average proportion of out-of-network services; and in the National Capital Area, where the large payers had less of a presence. Payment rates increased the most in Other Service Areas (6.9 percent), contributing to the higher-than-average payment rates for services delivered outside of Maryland in 2011. The payment rates for services provided in the Baltimore Metropolitan Area showed a slight decrease (0.5 percent).

The gap in payment rates between large and other payers varied relatively little by region. The payment rate for large payers was 86 percent to 87 percent of that for other payers except in Other Service Areas, where the average payment rate was about the same for large payers ($39.70) and other payers ($39.60) (data not shown).

FIGURE 2. Private Payment Rates by Maryland Region, 2010 and 2011



NOTE: Based on the extent of economic integration, we divided providers in the Medical Care Data Base (MCDB) into four regions—Baltimore Metropolitan Area (BMA); National Capital Area (NCA), including Virginia; Other Maryland Areas, which includes neighboring Delaware, Pennsylvania, and West Virginia; and Other Service Areas, which includes parts of the country not captured in the previously defined jurisdictions.

BY TYPE OF SERVICE. Variation in payment rates by type of service is shown in Figure 3. Across all payers in 2011, payment rates were lowest for tests ($35.14) and highest for procedures ($39.13). Between 2010 and 2011, payment rates for tests declined slightly, while payment rates for non-psychiatric evaluation and management (E/M) services showed the largest increase (3.8 percent).

Payment rates for large and other payers also varied by type of service (data not shown). Although payment rates for large payers were lower than for other payers across all services, the largest gap was for non-psychiatric E/M services, where large payers paid only 83 percent, on average, of the rate paid by other payers. The gap in payment rate by market share was smaller than the overall average for psychiatric E/M services, imaging, and tests, with large payers paying approximately 92 percent to 93 percent of the rate paid by other payers.

BY PROVIDER PARTICIPATION STATUS. In the negotiation of rates between payers and providers, providers may exercise their leverage by not signing a participation agreement with payers. Payment rates for non-participating, or out-of network, providers were consistently higher than for participating

FIGURE 3. Private Payment Rates by Type of Service, 2010 and 2011

NOTE: Berenson-Eggers Type of Service (BETOS) codes are assigned for each Healthcare Common Procedure Coding System (HCPCS) procedure code. They are used to classify Medicare claims according to type of service (such as evaluation and management [E/M], procedures, imaging, and tests).

providers across services and regions and by market share. As shown in Figure 4, the payment rates for non-participating providers were about twice that for participating providers, with a similar ratio between non-participating and participating providers for large and other payers.

Overall, only about 4 percent to 5 percent of services and RVUs and 9 percent of payments were provided by out-of-network providers in 2011.[1] The out-of-network share varied somewhat by region and type of service, with 14 percent of RVUs provided by non-participating providers in Other Service Areas and 18 percent of RVUs provided by non-participating providers for psychiatric E/M services. The difference between payment rates for in-network and out-of-network providers varied by provider region. In 2011, in-network payment rates were highest for the National Capital Area ($36.40 compared with $34.60 for all regions combined), while out-of-network payment rates were highest in Other Service Areas ($76.30 versus $71.20 for all regions). The largest differences between in-network and out-of-network payment rates were in Other Maryland Areas and Other Service Areas.

There was also variation in payment rates for participating versus non-participating providers by type of service. In-network payment rates were highest for procedures ($37.50 compared with $34.60 for all services), while out-of-network payment rates were highest for imaging ($85.70 versus $71.20 overall). The lowest payment rates per RVU for both in-network and out-of-network providers were for psychiatric E/M services.

1 Data presented in the remainder of this subsection are not shown in figures.

FIGURE 4. In-Network and Out-of-Network Payment Rates by Payer Market Share, 2010 and 2011

How Do Private Payment Rates Compare With Fees Paid by Medicare and Medicaid?

Payments for services under Medicare are often used as a comparison for private payment rates, because Medicare is a large purchaser of professional services, and Medicare's resource-based fee schedule serves as the framework for other payers. Private payment rates for fee schedule services have been shown to be approximately 25 percent higher than Medicare payment rates on a national basis.[2] Compared with the national average, private payment rates in Maryland have been lower, with the result that the ratio of private-to-Medicare payment rates in Maryland is lower than the national average.[3] Compared to Medicare, Medicaid rates tend to be lower still and are used in this analysis as another point of comparison. A 2012 survey of Medicaid physician fees shows that, although Maryland's Medicaid payment rate was higher than the national average, it was significantly lower than the Medicare payment rate—the ratio of Medicaid-to-Medicare payment rate was 0.73 in Maryland in 2012.[4]

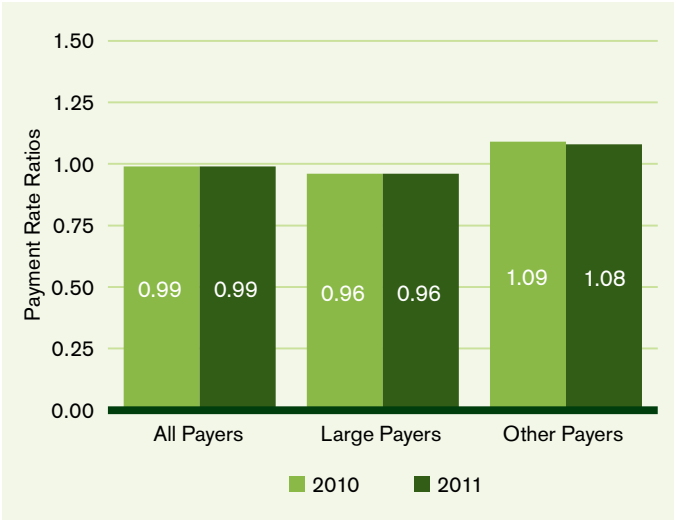
WHAT WOULD MEDICARE HAVE PAID? In 2011, the payment rate for services reimbursed by private payers was comparable to what Medicare would have paid for a similar set of services, with a ratio of 0.99 (private rate to Medicare rate; data not shown). This ratio was unchanged from 2010.

2 Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2013, page 76.

3 Nguyen N, Kronick R, and Sheingold S, "Comparing Physician Payment Rates Between Medicare and Private Payers in 2009," Presentation at AcademyHealth annual meeting, June 2013.

4 Zuckerman S and Goin D, "How Much will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Kaiser Commission on Medicaid and the Uninsured (December 2012).

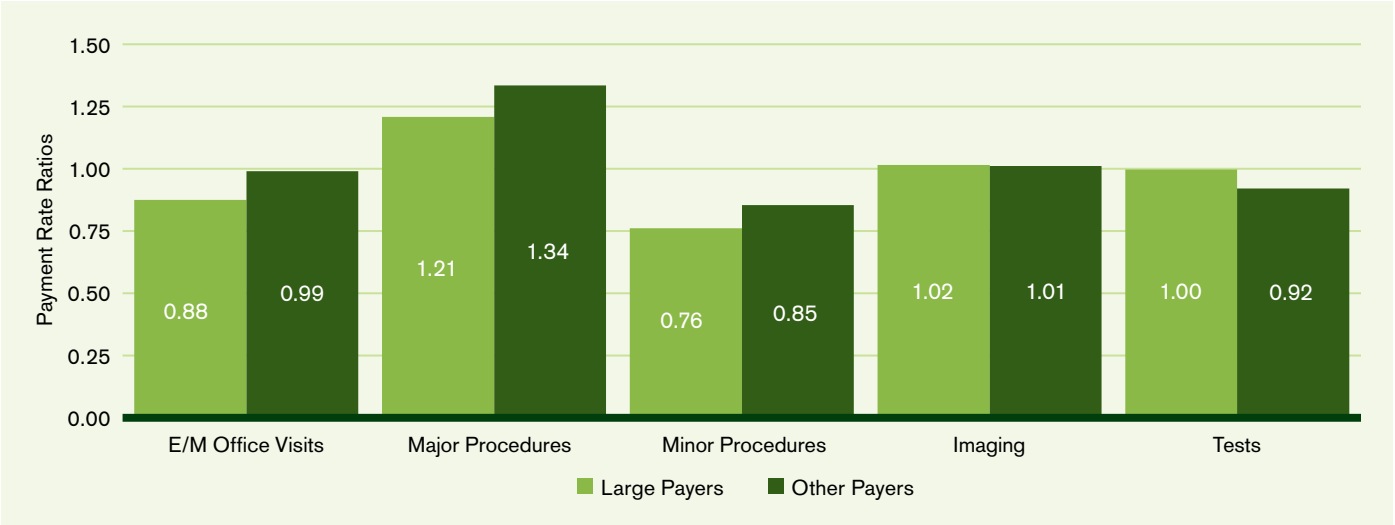
FIGURE 5. Ratio of Private-to-Medicare Payment Rate, by Payer Market Share, 2010 and 2011



Based on the difference in payment rates between large and other payers, the ratio of the private payment rate to the Medicare payment rate varied by payer market share. Large payers paid 4 percent less than Medicare would have paid; in 2011, the private payment rate was $34.45 for large payers compared with $35.81 for Medicare. Payment per RVU was $39.05 among other payers for 2011; it would have been $36.13 had other payers used the Medicare fee schedule to reimburse their covered services (data not shown). Thus, other payers on average paid 8 percent higher for their covered services than Medicare would have paid. As shown in Figure 5, the ratio of the private-to-Medicare payment rate remained virtually unchanged between 2010 and 2011, regardless of payer market share.[5]

5 The difference in what Medicare would have paid for the services provided by large payers versus other payers reflects differences in the mix of services provided by those payers.

FIGURE 6. Ratio of Private-to-Medicare Payment Rate, by Type of Service and Payer Market Share, 2011



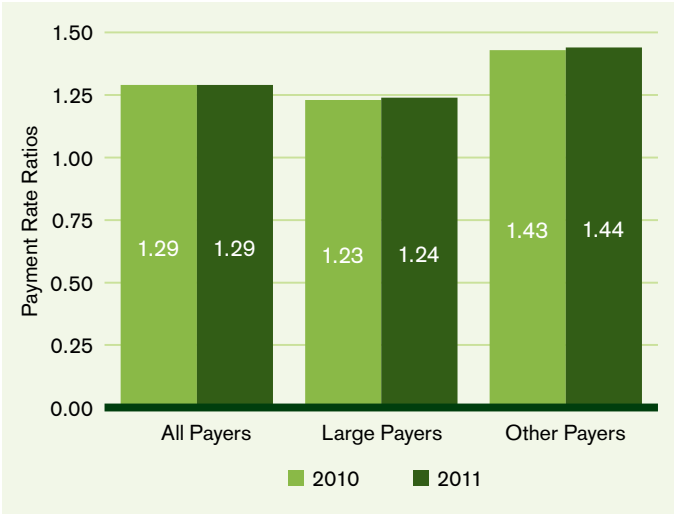
In addition to the variation by payer market share, the private payment rate relative to the Medicare payment rate varied by type of service. In 2011, the large payers paid substantially less for minor procedures and E/M office visits than did Medicare (24 percent and 12 percent less, respectively), but significantly more than Medicare for major procedures (21 percent more; see Figure 6). Other payers paid about the same as Medicare for E/M office visits and imaging services but significantly higher (34 percent) for major procedures. Among all major service categories, tests are the only services for which large payers paid significantly more than other payers relative to the Medicare rate. The differential gap between private and Medicare payment rate by payer market share reflects a different service mix as well as differences in negotiation power between large and other payers.

WHAT WOULD MEDICAID HAVE PAID? In 2011, the overall payment rate for services reimbursed by private payers was 29 percent higher than what Medicaid would have paid for a comparable set of services. That difference was virtually unchanged from 2010. Both large payers and other payers paid significantly higher than Medicaid paid in 2011, with the gap between the private payment rate and the Medicaid payment rate changing only minimally from 2010 to 2011, regardless of payer market share.

For services reimbursed by large payers, payment per RVU was 24 percent and 23 percent higher than if the services were reimbursed under the Medicaid fee schedule in 2011 and 2010, respectively, as shown in Figure 7. In 2011, large payers paid $34.27[6] per RVU compared with $27.64 had they used the Medicaid fee schedule for reimbursement (data not shown).

6 All payment rates in this section were calculated using all services in the MCDB and for which a fee was published by Medicaid. Services reimbursed by modifier(s) in addition to a CPT code are excluded.

FIGURE 7. Ratio of Private-to-Medicaid Payment Rate, by Payer Market Share, 2010 and 2011.

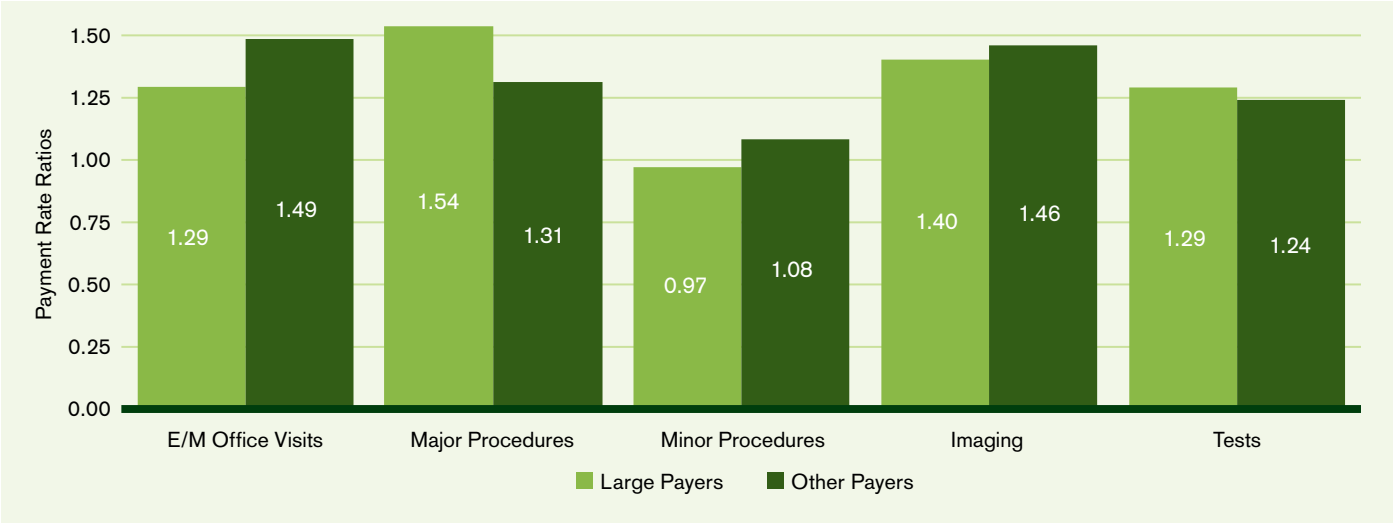


Large payers and Medicaid raised their payment rates at a similar pace between 2010 and 2011. As a result, the ratio of private-to-Medicaid payment rate changed very little.

The difference in payment rates between other payers and Medicaid was even greater than that between large payers and Medicaid. In 2011, payment per RVU was $38.87 for services reimbursed by other payers, compared with $27.02 had the services been reimbursed by Medicaid (data not shown). In both 2010 and 2011, the private payment rate was more than 40 percent higher than the Medicaid payment rate for the mix of services reimbursed by other payers.

As shown in Figure 8, the ratio of the private-to-Medicaid payment rate varied by service type. For large payers, the gap between the private payment rate and the Medicaid payment rate was greatest for major procedures (54 percent) and for imaging (40 percent). For minor procedures, large

FIGURE 8. Ratio of Private-to-Medicaid Payment Rate, by Type of Service and Payer Market Share, 2011



payers paid at a rate that was slightly less than Medicaid would have paid. For the other payers, the gap between the private and Medicaid payment rates was largest for E/M office visits and imaging, where the private payment rate was more than 40 percent more than what Medicaid would have paid. The payment rate for other payers was only 8 percent higher than for Medicaid for minor procedures.

Implications

The payment rate—characterized as payment per RVU—is the per-unit price that payers and consumers pay for privately insured professional services in Maryland, one substantial component of health care services. That price reflects, at least in part, a negotiation between payers and providers. The final "price" is influenced by payer market share and provider bargaining power, complexity and intensity of service, and variation in local resource costs. By standardizing for differences in complexity across services, payment per RVU allows for valid comparisons across payers, regions, and services.

As in past years, market share had a substantial impact on payment rates, especially for in-network services. The payment rate for large payers was 88 percent of that paid by other payers for in-network services, which is based on their dominance in the marketplace, where they account for more than two-thirds of services, RVUs, and dollars. Provider influence on payment rates is observed primarily through the difference between in-network and out-of-network payment rates. Although there was considerable variation across services and regions, out-of-network payment rates were approximately twice those of in-network rates. Between 2010 and 2011, there was very little change in either the relationship between payment rates for large payers and other payers or between the payment rates for participating and non-participating providers; the former gap narrowed very slightly, while the latter grew very slightly.

Continued implementation of the Affordable Care Act (ACA) will affect payment rates through a variety of mechanisms and initiatives. While the operation of the Maryland Health Benefit Exchange will increase transparency through the required offering of standard packages, it is likely that large payers will dominate and that market dynamics will not change markedly. On the other hand, the Maryland Insurance Administration recently approved premiums that were substantially lower than those requested by carriers and lower than those in many of the other states with approved rates for their exchanges,[7] which could put downward pressure on private payment rates in the state.

Other aspects of the ACA related to the Medicaid program may also affect payment rates. Although participation by Maryland providers in Medicaid is high, the impact of relatively low Medicaid payment rates on provider participation in the program and hence on access to care for Medicaid enrollees remains an issue. Access issues may be exacerbated by increased enrollments as part of the Medicaid expansion. To mitigate potential problems, under Section 1202 of the ACA, Medicaid reimbursement rates for primary care delivery of E/M services will increase to at least 100 percent of Medicare rates for 2013 and 2014, with the federal government funding the difference in cost between what a state's Medicaid rate was on July 1, 2009, and the applicable Medicare rate.[8] Monitoring the outcome of these two countervailing forces will be an essential part of ensuring access for Medicaid enrollees.

As indicated earlier, there are a number of delivery and payment initiatives at the federal and state levels intended to reduce payment rates. Many of these initiatives rely on modifying payment rates to incentivize providers to deliver care more efficiently, including bundled payments, shared savings, and pay-for-performance initiatives. Other changes may temper the downward pressures for certain types of services or providers. Maryland's Assignment of Benefits legislation has the potential to fuel increases in out-of-network payments, because it may allow hospital-based specialists to receive more favorable rates by declining to participate with carriers. The growth in concierge practices also may increase some providers' willingness to opt out of payer participation agreements.

The analyses presented here have relied on payment per RVU as a standardized measure to support accurate comparisons across groups of services. Many reform-related efforts are aimed at influencing the *relative* payments for different types of services by influencing underlying inputs to the Medicare fee schedule as well as delivery system changes that would increase payment rates for E/M services relative to procedures. On the fee schedule side, these issues have been receiving considerable attention within the federal government, and the extent of exposure in the popular press may hasten change. Maryland's Multi-Payer Patient-Centered Medical Home Program, as well as a similar program by one of the state's large payers, also may contribute to changes in relative payments, which in turn may influence the mix of services provided over the longer term. To the extent that these programs rely on bonus or incentive payments that are outside the fee-for-service system, they are not currently captured in the Maryland Medical Care Data Base (MCDB). These payments likely will become more significant as similar shared savings or other incentive programs take hold. The MCDB expansion plan addresses this and, in the future,

7 *http://www.baltimoresun.com/health/health-care/bs-hs-insurance-rates-20130726,0,5672986.story*

8 *http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf*

will require carriers to provide information on lump-sum payments that are not part of the claims reporting system. Monitoring of the trends in payment rates will continue to be a focus of the Commission during this period of transformation.

METHODS

DATA SOURCE. The analyses rely on 2010 and 2011 payment and service data from Maryland's Medical Care Data Base (MCDB), which contains health claims and encounter data, submitted to the Maryland Health Care Commission (MHCC) by most private health insurance plans serving Maryland residents. The MCDB contains extracts of insurance claims for the services of physicians and other medical practitioners such as podiatrists, nurse practitioners, and therapists. Payment amounts are imputed for capitated services and included in the payment rate calculations. Claims for all enrollees, both full year and part year, are included. Insurance companies and health maintenance organizations meeting certain criteria[9] are required to submit these data to MHCC under the Code of Maryland Regulations (COMAR) 10.25.06 on health care practitioner services provided to Maryland residents. For both 2010 and 2011, the Commission received usable data from 20 payers, including all major health insurance companies.[10]

RELATIVE VALUE UNITS (RVUS) OF CARE. RVUs is a measure of the quantity of care developed by the Centers for Medicare and Medicaid Services, where more complex, resource-intensive (and typically more costly) services have a higher number of RVUs. A more sophisticated measure of the quantity of care than a simple count of services, RVUs measure the level of resources used to produce a particular service. RVUs are used to define payment rate in this Spotlight. Medicare's physician payment system was used as the source of information on the number of RVUs for each service. For this Spotlight, RVUs from the 2011 Medicare fee schedule were applied to both 2010 and 2011 data.

PAYMENT RATE. Payment rate is measured by the average payment per RVU. This is a standardized measure that controls for the complexity of a service. It allows valid comparisons across payers, regions, and services. Payment includes both payer and patient obligations. Patient obligations include deductibles, coinsurance and/or copayment, and, in cases of out-of-network services, balance billing.

MEDICARE PAYMENT RATE. RVUs assigned in Medicare's physician payment system are added to valid services in the MCDB by Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) codes. The Medicare conversion factor is applied to total RVUs to get total payment for the service. Service-level payment and RVUs are aggregated over various dimensions (overall, payer market share, provider region, or type of service), and aggregate payments are divided by aggregate number of RVUs to calculate average payment per RVU along the corresponding dimension. The calculated payment per RVU reflects the average amount a provider would have received for services collected in the MCDB had Medicare been the payer. This calculated payment per RVU is referred to as the Medicare payment rate in this Spotlight.

MEDICAID PAYMENT RATE. The fee schedule provided by the Maryland Medical Assistance (Medicaid) program lists the amount Medicaid would pay for a service. The 2010 and 2011 Medicaid fee schedule are merged to the MCDB from respective years using CPT/HCPCS codes. Service-level Medicaid payment and Medicare RVUs are aggregated at various levels (overall, payer market share, provider region, or type of service), and the average payment per RVU is calculated by dividing aggregated payments by aggregated RVUs. This average payment per RVU reflects what Medicaid would have paid on average for services in the MCDB and is referred to as the Medicaid payment rate in this Spotlight.

BENCHMARKING WITH MEDICARE AND MEDICAID PAYMENT RATE. To examine relative payment rates, we calculated the ratio of the average payment rate among private insurers in the MCDB to what Medicare or Medicaid would have paid (Medicare payment rate and Medicaid payment rate, respectively) for the service mix included in the MCDB.

9 The companies are licensed in Maryland and collect more than $1 million in health insurance premiums.

10 A number of small payers received waivers from contributing data, but these payers together account for less than 1 percent of total health insurance premiums reported in Maryland.

Acknowledgments

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