SPOTLIGHT ON
MARYLAND

MHCC MARYLAND HEALTH CARE COMMISSION

PAYMENT FOR PROFESSIONAL SERVICES IN MARYLAND

INTRODUCTION

There are a number of delivery and payment initiatives at the federal and state levels intended to reduce payment rates—the price that payers and consumers pay for professional services. Many of these initiatives rely on modifying payment rates to incentivize providers to deliver care more efficiently by bundling payment for groups of services, tying reimbursement to quality or performance, or providing incentives for care coordination. Medicare and Medicaid initiatives have also used higher payment rates to encourage providers to serve more complex patients. This report examines the variation in payment rates for professional services in Maryland and provides a comparison of private payment rates to Medicare and Medicaid payment rates for the same services. Payment rates for professional services are defined as the payment per relative value unit (RVU) at the service level, and are primarily based on negotiations between payers and health care providers.

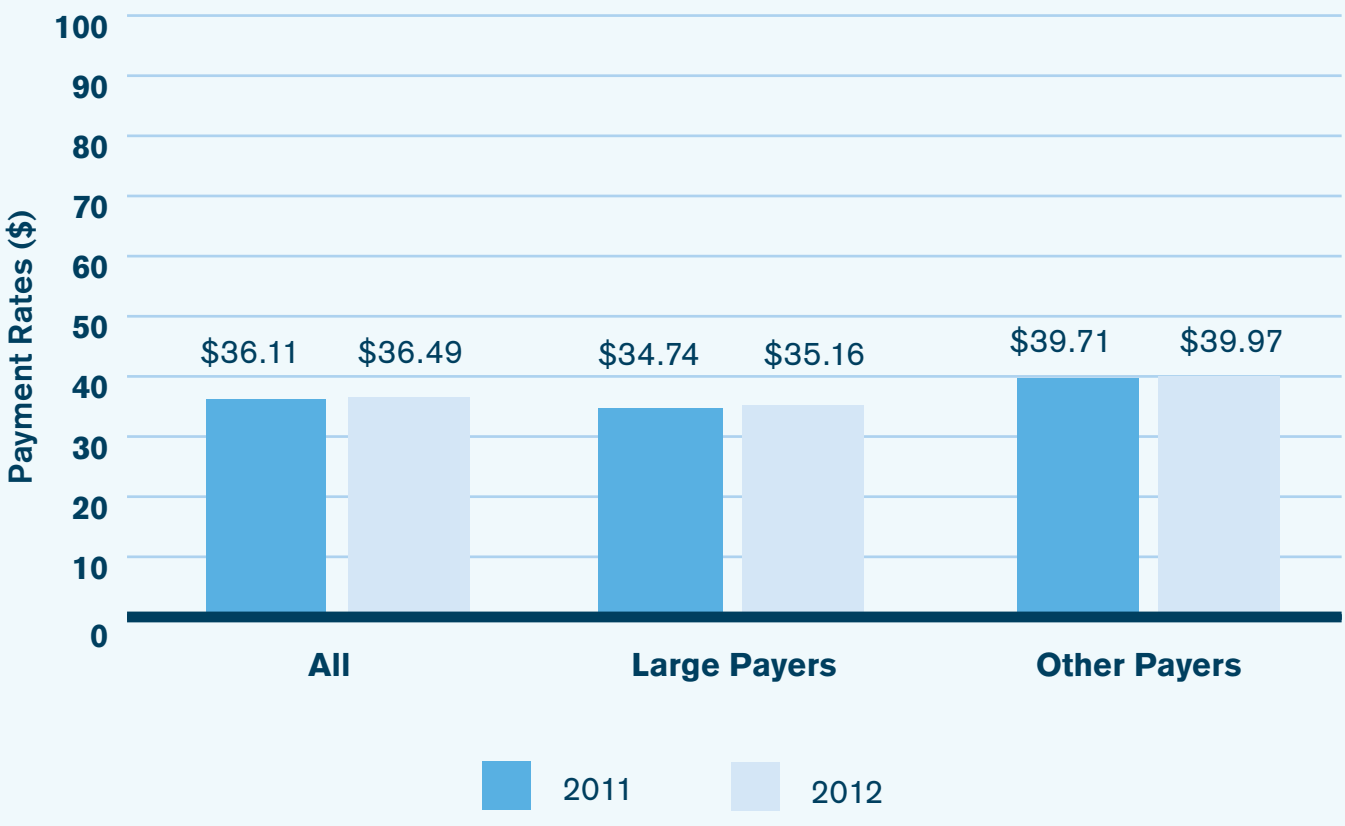
Highlights: Payment for Professional Services in Maryland

- The payment rate for privately insured professional services in 2012 averaged $36.49, a 1.1 percent increase from 2011.
- In 2012, the payment rate for large private payers was 88 percent of that for other private payers.
- Out-of-network private payment rates, on average, were almost twice as much as in-network private rates in 2012.
- The private payment rate in 2012 was comparable to what Medicare would have paid for a similar set of services, while the private payment rate was about 31 percent higher than the Medicaid payment rate.
- On average, in 2012 large private payers paid 6 percent less than Medicare paid, while other private payers paid about 7 percent more. Private payment rates for both large and other payers were about 26 percent and 46 percent more, respectively, than the Medicaid rate.

A higher market share allows large payers to negotiate more favorable rates with providers than other payers are able to negotiate.

- The overall payment rate in 2012 was $36.49 compared with $36.11 in 2011.
- Payment per RVU was lower among large payers—the payment rate for large payers in 2012 was 88 percent of the rate for other payers ($35.16 vs. $39.97).
- The change in the overall payment rate from 2011 to 2012 was higher among large payers than among other payers (1.2 percent vs. 0.7 percent), although the difference in growth rates was not sufficient to have an impact on the gap in payment rate by market share.

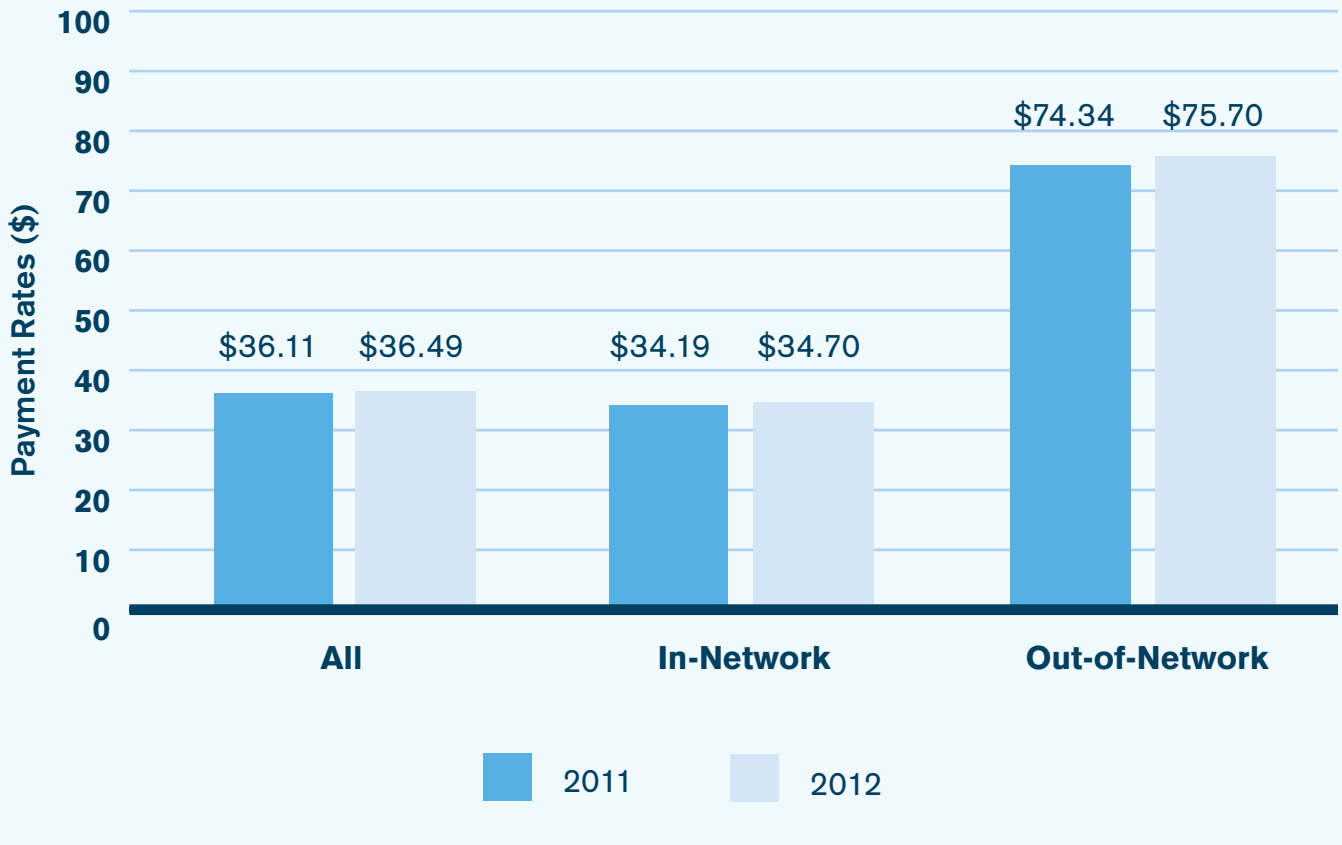
FIGURE 1. Private Payment Rates by Payer Market Share, 2011 and 2012



Private insurers contract with networks of providers to provide services at discounted rates and, increasingly, to steer consumers to providers that meet cost and quality standards.

- Payment rates for out-of-network providers were twice that for in-network providers ($75.70 vs. $34.70).
- With only about 4 percent of services provided by out-of-network providers, the impact on overall rates is small. However, the higher payment rates received by out-of-network providers have an impact on overall rates for certain services and in specific geographic areas, depending on availability of providers, specialty mix, and payer market share.
- Change in payment rates between 2011 and 2012 was slightly higher for out-of-network payers (1.8 percent) compared with in-network payers (1.5 percent).

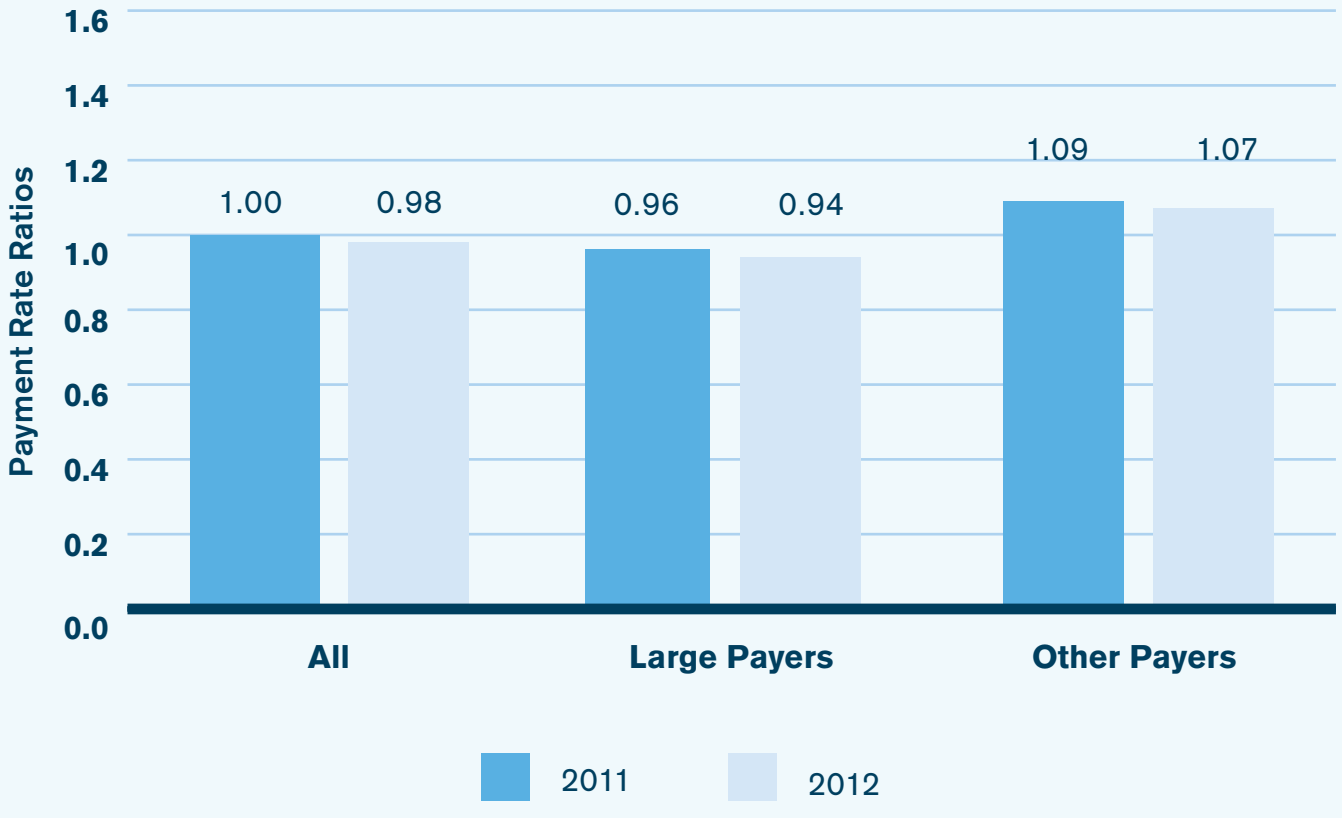
FIGURE 2. Private Payment Rates by Participation Status, 2011 and 2012



Medicare's relative value scale serves as a framework for other payers and offers a useful comparison to private payment rates.

- In 2012, the average 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 0.98 (private rate to Medicare rate).
- This ratio is slightly lower than the 2011 ratio (1.00).
- The ratio of private payment rate to Medicare payment rate varied by payer market share: in 2012, large payers paid 6 percent less than Medicare would have paid, while other payers on average paid 7 percent more for their covered services compared with Medicare.

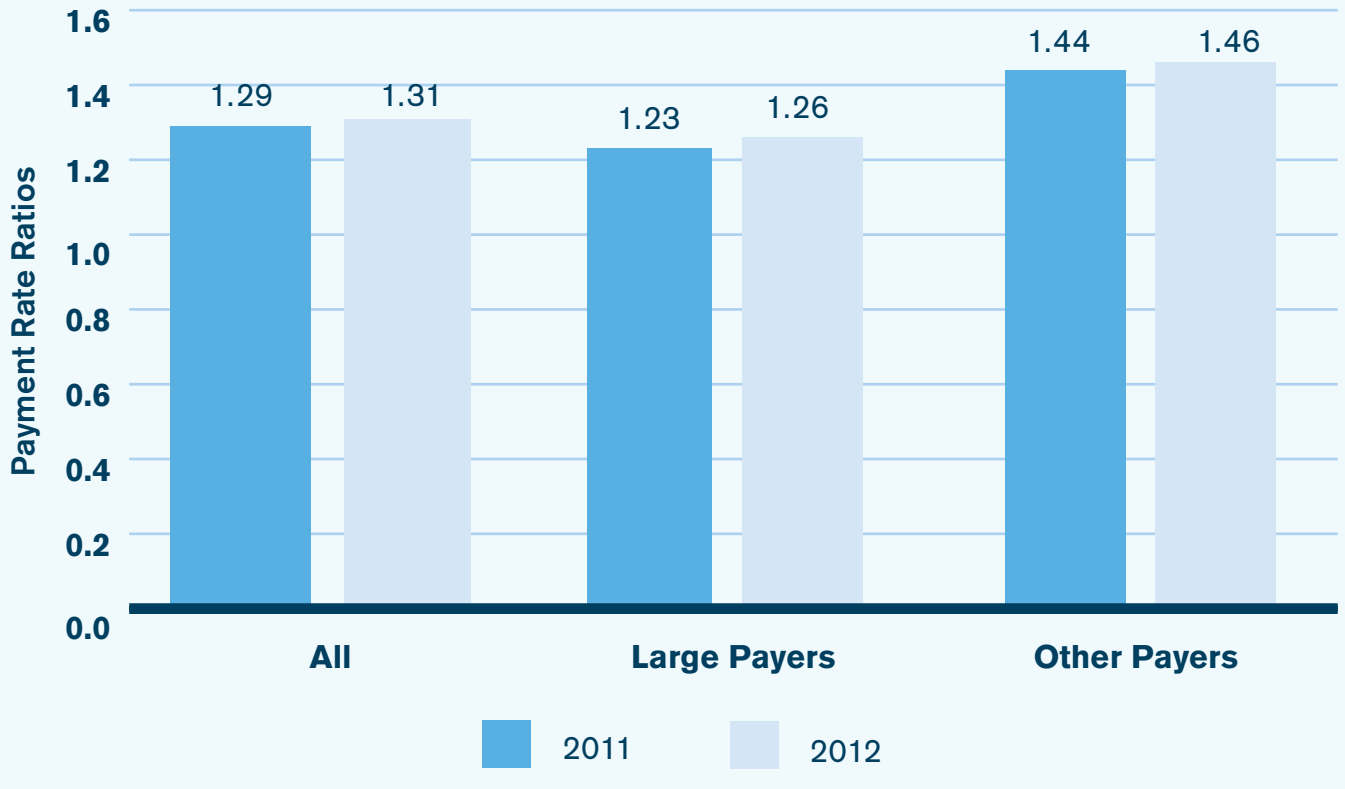
FIGURE 3. Ratio of Private-to-Medicare Payment Rate, by Payer Market Share, 2011 and 2012



Although Medicaid rates have been historically below private payment rates, the impact of the Affordable Care Act's (ACA) Medicaid primary care payment parity requirements on this gap will be closely monitored.

- In 2012, the overall payment rate for services reimbursed by private payers was 31 percent higher than what Medicaid would have paid for a comparable set of services, with a ratio of 1.31 (private rate to Medicaid rate).
- This ratio is higher than the 2011 ratio (1.29).
- The ratio of private payment rate to Medicaid payment rate varied by payer market share in 2012; large payers paid 26 percent more and other payers paid 46 percent more than if services were reimbursed under the Medicaid fee schedule.
- Both large payers and other payers paid significantly more than Medicaid paid in 2012, with the gap between the private payment rate and the Medicaid payment rate changing only minimally from 2011 to 2012.
- For services reimbursed by large payers, payment per RVU was 26 percent and 23 percent higher than if services were reimbursed under the Medicaid fee schedule in 2012 and 2011, respectively.
- For services reimbursed by other payers, payment per RVU was 46 percent and 44 percent higher than if services were reimbursed under the Medicaid fee schedule in 2012 and 2011, respectively.

FIGURE 4. Ratio of Private-to-Medicaid Payment Rate, by Payer Market Share, 2011 and 2012



METHODS

DATA SOURCES. Figures in this brief are based on services and payments captured in the Medical Care Data Base (MCDB). The MCDB contains extracts of insurance claims[1] for the services of physicians and other medical practitioners such as podiatrists, nurse practitioners, and therapists. Insurance companies and HMOs meeting certain criteria[2] 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 calendar year 2012, the Commission received usable data from 19 payers, including all major health insurance companies.[3]

RELATIVE VALUE UNITS (RVUs) OF CARE. RVUs are a measure of the quantity of care developed by the Centers for Medicare & Medicaid Services (CMS), 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 brief. Medicare's physician payment system was used as the source of information on the number of RVUs for each service. For this brief, RVUs from the 2012 Medicare fee schedule were applied to both 2011 and 2012 data.

[1] The MCDB also includes information on capitated services, but some capitated primary care is not submitted to MHCC.

[2] The companies are licensed in the State of Maryland and collect more than $1 million in health insurance premiums.

[3] 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.

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) code. The Medicare conversion factor is applied to total RVUs to get total payment for the service. We aggregate service-level payment and RVUs over various dimensions (overall, payer market share, provider region, or type of service) and divide aggregate payment 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. We refer to this calculated payment per RVU as the Medicare payment rate in the brief.

MEDICAID PAYMENT RATE. The fee schedule provided by the Maryland Medical Assistance (Medicaid) program lists the amount Medicaid pays 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, by payer market share, provider region, or service type), 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 the brief.

BENCHMARKING WITH MEDICARE AND MEDICAID PAYMENT RATES. The relative payment level between private payers and Medicare or Medicaid has implications for provider participation in the public insurance programs and access to care for the elderly and the poor. To examine relative payment rates, we calculated the ratio of 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.

Acknowledgments

The preparation of this Spotlight was conducted under contract with Social & Scientific Systems, Inc. (SSS), of Silver Spring, Maryland. The principal authors are Niranjana Kowlessar, PhD; Lan Zhao, PhD; and Claudia Schur, PhD. Bryan Sayer contributed to the analysis.

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