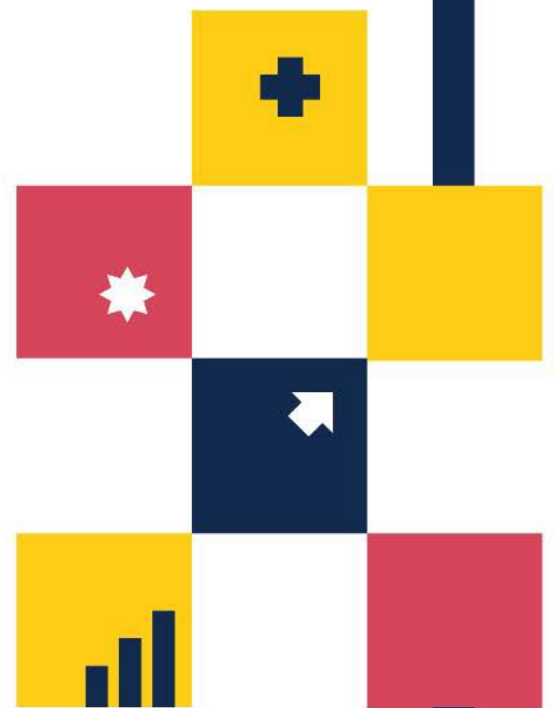


Payments for Professional Services in Maryland (In-Network services only)

2022





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Introduction:

This report examines the variations in payment rates for in-network professional services among private health insurance carriers. It benchmarks these payments to Medicare and Medicaid payment rates for the same services. In particular, variations in payments by payer market share and provider region are discussed.

The data source for all analyses in the report is the Maryland Medical Care Data Base (MCDB) from 2020 through 2022, which contains health claims and encounter data submitted by private payers for Maryland residents enrolled in privately insured health insurance plans. For this report, the MCDB professional services and enrollment files are used. To ascertain the trend from 2020 to 2021, the most recent version of the MCDB data was utilized. This version included updated information because of resubmissions from Aetna and Cigna payors. Consequently, minor discrepancies are present in the counts and rates for 2020 and 2021 when compared to the values reported in the 2021 professional services report.

Payment rates for professional services are the payments per Relative Value Unit (RVU) at the same service level. RVUs reflect the resources associated with each service, where each service has three component RVUs: the work component, or the amount of effort and skill a service entails; the practice expense component, or the costs to a physician practice for the equipment, facilities, nonphysician staff, and supplies needed to provide a service; and

2022 Professional Services Payment Rates: Highlights:

- Payments per RVU for all payers increased about 3.1% in 2022 compared to 2021 (\$39.32 and \$38.14 respectively). In contrast, we observed a 4.9% decrease from 2020 through 2021.
- The private payment rates for 2022 were about 108% of Medicare and about 118% of Medicaid. Compared to a year ago, private payments were about 101% and 126% of Medicare and Medicaid rates respectively.
- Private payment rates in 2022 varied by geographic region in Maryland, with the highest rates in DC Metro (\$41.02 compared to \$38.84 in the Baltimore Metro area and \$38.49 in the rest of Maryland).



the liability coverage component, or the cost of obtaining medical malpractice insurance for service. For this report, we used RVUs from 2022, 2021, and 2020 Medicare physician fee schedules (PFS), which contained information for more than 10,000 physician services.

Impact of Private Payer Market Share and Region on Payment Rates

Payment rates for professional services are determined by the payment per RVU for a given group of services. RVUs measure the quantity of care rendered per service in which more difficult, resource-intensive, and therefore more expensive services have a higher number of RVUs assigned.

Payment Rates by Private Payer:

The payment rate for all private payers combined was \$39.32 in 2022 compared to \$38.14 in 2021, an increase of 3.1%. The payment changes from 2020 to 2021 was a 4.9% decrease (see Figure 1). The payment per RVU was lower among large payers for all three years. The payment rate for large payers was 91% of the rate for other payers in 2020 (\$39.40 v. \$43.39), 93% of the rate in 2021 (\$37.71 v. \$40.36) and 79% of the rate in 2022 (\$37.61 v. \$47.78). The change in the year-over-year payment rate was lower among large payers compared to other payers from 2020 to 2021 (-4.3% v. -7.0%). This was consistent with the change from 2021 to 2022 (-0.3% v. 18.4%). These differences in growth rates were not enough to cause a material difference in payment rates by market share.



Figure 1: Private Payment Rates by Payer Market Share, 2020 – 2022

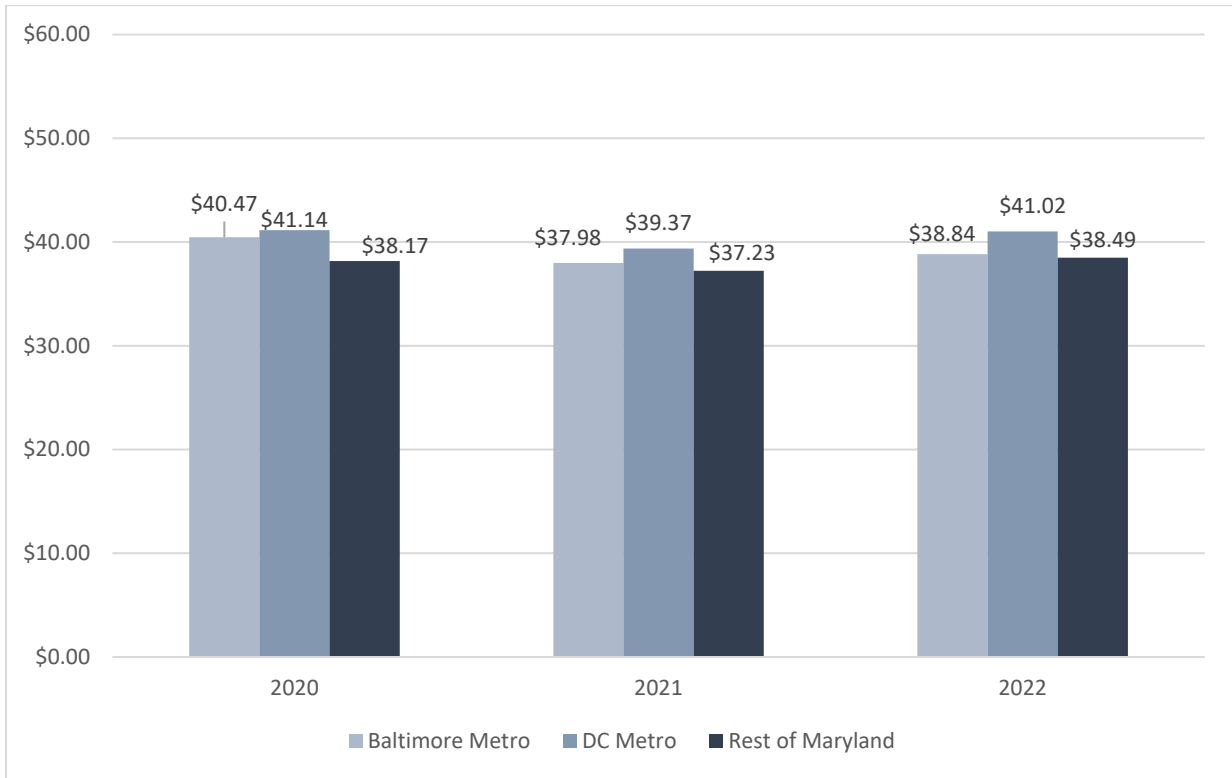


Payment Rates by Region:

Payment rates in Maryland varied by region, based on various factors including but not limited to the resource cost and payer mix (large payers vs. other payers) in each region. Participating providers in locations with higher resource costs tend to receive higher rates from payers because carriers account for differences in resource costs associated with the provider’s geographic region, much as Medicare does in the Medicare Physician Fee Schedule (MPFS). Many private payers align their fee schedules with the MPFS or with certain components of the MPFS. Medicare’s geographic practice cost indices (GPCIs) for the “DC + MD/VA SUBURBS” region is the highest compared to any other geographic area in Maryland (not shown). Private payers apply a similar approach. Providers located in the “DC Metro” area received a higher average payment rate than other providers located in Maryland, regardless of payer market share, as shown in Figure 2, where payment rates were highest in the DC Metro area from 2020 to 2022.

Figure 2: Private Payment Rates by Maryland Region, 2020 – 2022





How Private Payment Rates Compare with Medicare and Medicaid Payments

Medicare payments for services are often used as a benchmark for private payment rates because Medicare is a large purchaser of professional services. Medicare payment rates are based on a resource-based relative value scale (RBRVS)¹. On a national basis, private payment rates are between 118% and 179% higher than Medicare prices, with an average of 143% over the past ten years². Much of the variation in professional payments is due to physicians' and insurers' market power, types of physicians' services used in the analysis, and payment components included in the calculation.

A 2016 survey of Medicaid physician fees shows that although Maryland's Medicaid payment rate was higher than the national average (Maryland Medicaid's fee index was 1.35 of the national Medicaid fee index), it was significantly lower than the

¹ Medicare payment rates for specific services are derived from a systematic assessment of clinician time and expertise, practice resources including equipment and staff, and medical liability expenses using RBRVS. A standard conversion factor is applied to the resources estimated to produce a service which yields a payment rate. The rate is further adjusted by variations in the costs of inputs in local markets. The RBRVS approach allows for a fair comparison of the resources needed for any specific service. The conversion factor then sets the payment rate and geographic adjustments establish a basis for ensuring payment equity across regions.

² <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>



Medicare payment rate. The ratio of the Medicaid-to-Medicare payment rate was 0.88 in Maryland in 2016.³ In other words, the Medicaid payment rate was about 12% lower than the Medicare payment rate in Maryland in 2016.

What would Medicare have paid?

As shown in Figure 3, the payment rate for services reimbursed by all private payers was comparable to what Medicare would have paid for a similar set of services, with ratios of 1.08 for 2022, 1.01 for 2021, and 1.03 for 2020. Based on the difference in payment rates between large payers and other payers, the ratio of the private payment rate to the Medicare payment rate varied slightly by payer market share. Large payer payment rates were 3% higher than Medicare in 2022, same in 2021, and 1% higher in 2020.

The payment rate for large payers was \$37.61, \$37.71, and \$39.40 in 2022, 2021, and 2020, respectively, compared with \$36.36 in 2022, \$37.77 in 2021, and \$39.03 in 2020 for Medicare. Payment per RVU among other payers was \$47.78, \$40.36, and \$43.39 in 2022, 2021, and 2020, respectively; it would have been \$36.24, \$37.59, and \$38.97 in 2022, 2021, and 2020, respectively, if other payers used the Medicare fee schedule to reimburse a similar set of services (see Figure 4). Other payers paid on average about 32% higher in 2022, and 7% higher in 2021 and 11% higher in 2020 for covered services than what Medicare would have paid. The difference in what Medicare would have paid for services provided by large payers vs. other payers is due to the difference in the intensity of services provided by those payers.

Figure 3: Ratio of Private-to-Medicare Payment Rate by Payer Market Share, 2020 – 2022

³ <https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump>



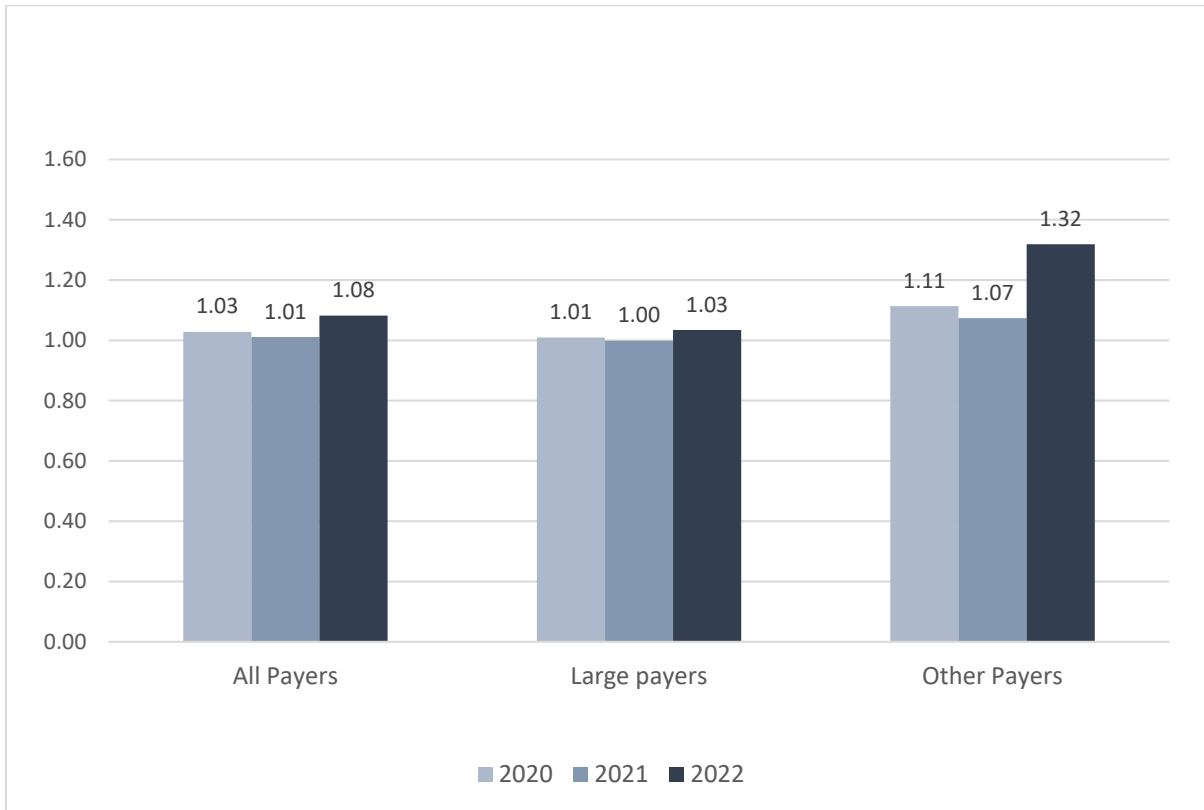


Figure 4: Private vs. Medicare Payment Rates, by Payer Market Share, 2020 – 2022

Market share	2020		2021		2022	
	Private	Medicare	Private	Medicare	Private	Medicare
All Payers	\$40.11	\$39.02	\$38.14	\$37.74	\$39.32	\$36.34
Large payers	\$39.40	\$39.03	\$37.71	\$37.77	\$37.61	\$36.36
Other Payers	\$43.39	\$38.97	\$40.36	\$37.59	\$47.78	\$36.24

How Private Professional Payment Rates in Maryland Compare Nationally

Milliman released a White Paper in November 2023 examining national commercial reimbursement rates compared to Medicare rates. The study revealed consistent variation among states, echoing findings from the HCCI study⁴. Wisconsin boasts the highest reimbursement rates, while Alabama

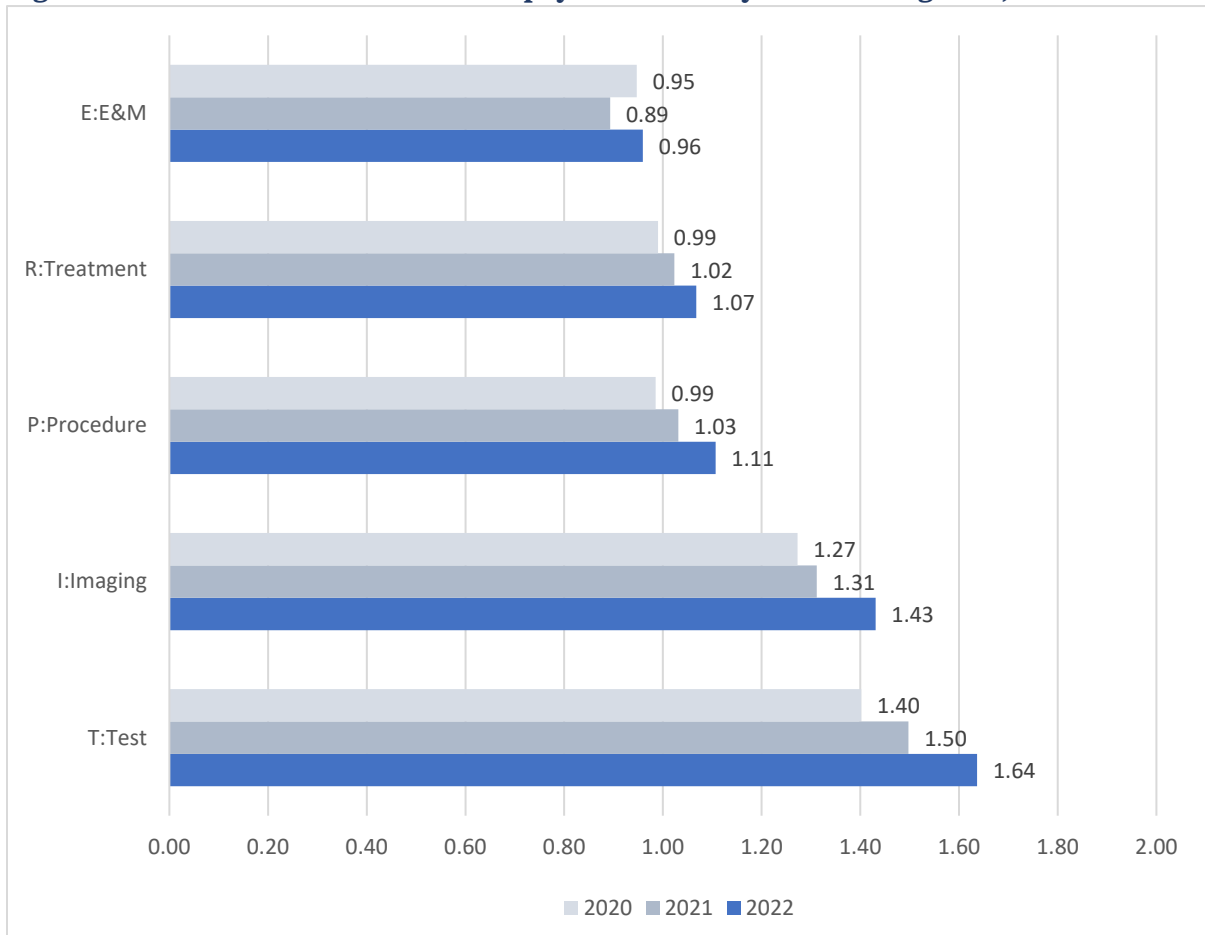
⁴ <https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices>

and Maryland rank lowest in reimbursement rates among the states analyzed⁵.

Private vs. Medicare Payment Rates, by BETOS Category

As shown in Figure 5, the private payment rates in 2022 for Imaging, and Tests were 143%, and 165% higher, respectively than what Medicare would have paid for these service categories based on the Berenson-Eggers Type of Service (BETOS) 2022 classification system. In contrast, private payment rates were 96% of Medicare for Evaluation and Management services and 111% and 107% of Medicare for both Procedures and Treatments categories based on the BETOS 2022 classification system.

Figure 5: Ratio of Private-to-Medicare payment rates by BETOS categories, 2020 -2022



What would Medicaid have paid?

⁵ <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-payment-rates-medicare-fee-for-service>



As shown in Figure 6, the payment rate for services reimbursed by all private payers combined was 18% higher in 2022 and 26% higher in 2021, and 21% higher in 2020 than what Medicaid would have paid for a similar set of services. Both large payers and other payers paid substantially higher than Medicaid across all three years.

For services reimbursed by large payers, the payment per RVU was about 13% (2022) and 24% and 19% (2021 and 2020) higher than if the services were reimbursed under the Medicaid fee schedule. Large payers paid \$37.61, \$37.71, and \$39.40 in 2022, 2021, and 2020 respectively, compared with \$33.23 in 2022, \$30.33 in 2021 and \$33.24 in 2020 if Medicaid reimbursed the services (see Figure 7).

The difference in payment rates between other payers and Medicaid was greater than that between large payers and Medicaid. In the years 2020 to 2022, payments per RVU were 43.39, \$40.36, and \$47.78, respectively, for services reimbursed by other payers, compared with \$33.42, \$30.22, and \$33.32, respectively, for the years 2020 through 2022 if Medicaid reimbursed the services (see Figure 8).

Figure 6: Ratio of Private-to-Medicaid Payment Rate by Payer Market Share, 2020 – 2022

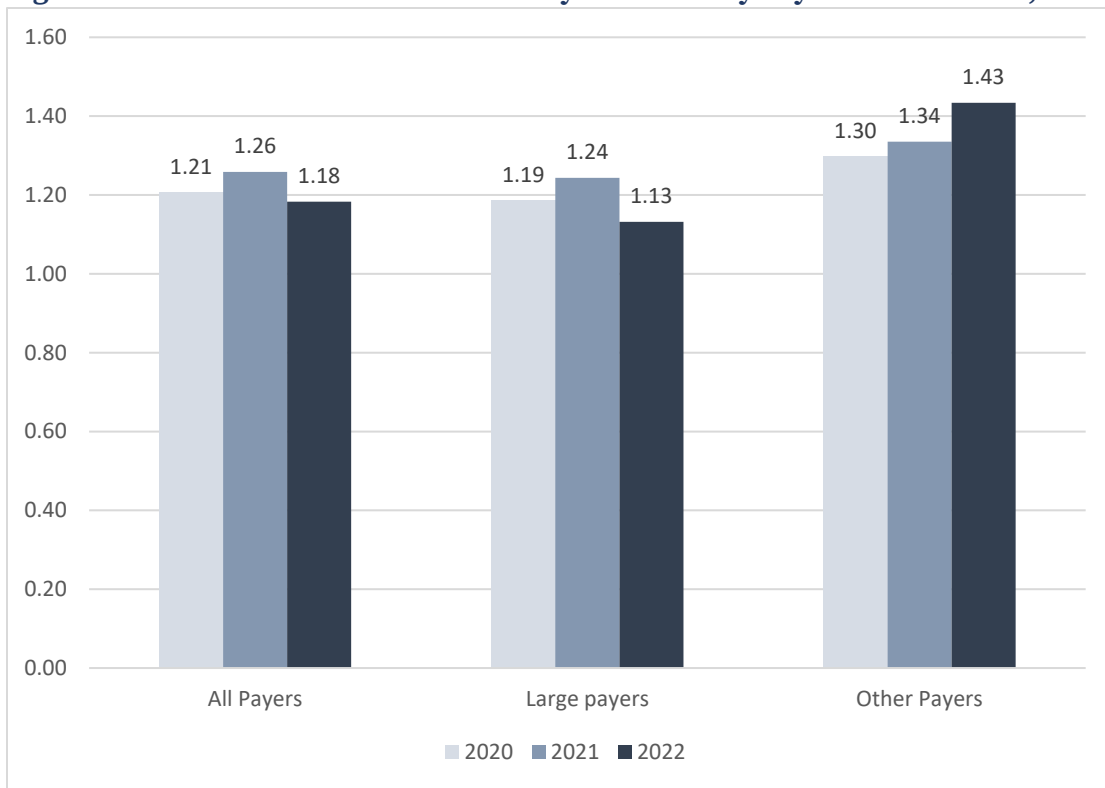


Figure 7: Private vs. Medicaid Payment Rates, by Payer Market Share, 2020 – 2022



	2020		2021		2022	
	Private	Medicaid	Private	Medicaid	Private	Medicaid
Market share						
All Payers	\$40.11	\$33.27	\$38.14	\$30.31	\$39.32	\$33.24
Large payers	\$39.40	\$33.24	\$37.71	\$30.33	\$37.61	\$33.23
Other Payers	\$43.39	\$33.42	\$40.36	\$30.22	\$47.78	\$33.32

Appendix

Data Sources.

The analyses for this report used 2020 to 2022 payment and service data from the Maryland Medical Care Data Base (MCDB) professional services files for all coverage types except Medicare and Medicare Advantage. The data includes fully insured and self-insured plans.

Relative Value Units (RVUs) of Care.

Relative value units (RVUs) are nonmonetary, relative units that measure the value of health care and relative differences in resources consumed when providing different procedures and services. The Centers for Medicare and Medicaid Services (CMS) assign relative values or weights to medical procedures primarily for the reimbursement of services performed. More complex, resource-intensive (and typically more expensive) services have a higher number of RVUs and measure the level of resources used to produce a particular service.

Payment Rate.

The average payment per RVU measures the payment rate in a standardized manner controlling for the complexity of a given service. A synthetic fee for large payers and other private payers was developed separately using the allowed amount by CPT code from the MCDB professional services files and limited to in-network services only.

Medicare Payment Rate.



RVUs assigned in Medicare's physician payment system are added to valid services in the MCDB by CPT/HCPCS codes. The Medicare conversion factor is applied to the total RVUs to produce the total payment for the service. Service-level payment and RVUs are aggregated across payer market share or provider region. The aggregated payments, which are adjusted for geography, are divided by the aggregate number of unadjusted RVUs to calculate an average payment per RVU. 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 the Medicare payment.



Medicaid Payment Rate.

The Maryland Medical Assistance Program (Medicaid) fee schedule lists the amount Medicaid would pay for a service. The 2022 Medicaid fee schedule is merged with the MCDB from respective years (2020 to 2022) by CPT/HCPCS codes. Service-level Medicaid payments and Medicare RVUs are aggregated at various levels (payer share and provider region), and the average payment per RVU is calculated by dividing aggregated geographically adjusted payments by unadjusted aggregated RVUs. This average payment per RVU is the Medicaid payment.

Benchmarking Medicare and Medicaid Payment Rate.

To examine relative payment rates, we calculated the ratio of the average payment rate among private payers 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.

Maryland Regions.

- **Baltimore Metro:** Baltimore City, Baltimore County, Harford County, Howard County, and Anne Arundel County
- **DC Metro:** Montgomery County and Prince George's County
- **Other Maryland:** Western Maryland, Eastern Shore/Southern Maryland
 - Western Maryland: Garrett County, Allegany County, Washington County, Carroll County, and Frederick County
 - Eastern Shore/Southern Maryland: St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County, and Worcester County

Payer Market Share.

Large Payers: CareFirst, United Healthcare

Other Payers: All other private payers that are not CareFirst or United Healthcare

Note: This report excludes Kaiser.



Figure A1: Data Distribution - Large Payers v. Other Payers

	Distribution		
	No. of Services	No. of RVUs	Total Spending
Largest Payers	88%	83%	81%
Other Payers	12%	17%	19%
Total	100%	100%	100%

Limitations:

- The results in this report are for in-network services only.
- All services are rendered in Maryland only.
- The private population is limited to those under age of 65
- The private synthetic fees are based on the allowed amount reported by private payers. However, some of these amounts are estimated by some private payers.
- The Medicaid fees are MCO imputed fee-for-service equivalents provided by Medicaid.
- Data excludes self-insured ERISA plans for 2015 and beyond due to the *Gobeille v. Liberty Mutual Ins. Co.* SCOTUS ruling for 2015 and beyond.
- Federal Employee Health Benefit (FEHB) Program data were excluded from this year’s report because of the reporting restriction imposed by the Office of Personnel Management (OPM) on payers who have a contract with the Office to stop reporting all FEHB data to APCDs.

Figure A2: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims v. Medicare, 2004 and 2003⁶

Table A 2-1: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims versus Medicare, 2004

CLASSIFICATION	NON-HMO PLAN				HMO PLAN			
	Pymt Per RVU Using Medicare Rate	% of Pymt	Pymt Per RVU	% Diff from Medicare	Pymt Per RVU Using Medicare Rate	% of Pymt	Pymt Per RVU	% Diff from Medicare
Total	\$38.82	100%	\$39.82	2.6%	\$38.95	100%	\$37.76	-3.0%

⁶ https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/plr_healthmd_Utilization.aspx



Table A 3-1: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims versus Medicare, 2003

CLASSIFICATION	NON-HMO PLANS				HMO PLANS			
	Pymt per RVU Using Medicare Rates	% of Pymts	Pymt per RVU	% Diff from Medicare	Pymt per RVU Using Medicare Rates	% of Pymts	Pymt per RVU	% Diff from Medicare
Total	\$38.19	100%	\$38.90	1.8%	\$38.39	100%	\$37.36	-2.7%

Private payments in Maryland have been lower than the national average since MHCC began benchmarking private payer payments almost twenty years ago. In 2004, private payment rates in Maryland for professional services were very close on average, to the Medicare rate.

Fee-for-service (FFS) payments for HMO plans were 3% below the Medicare rate, while payments from non-HMO plans averaged 3% above Medicare. Also, for 2003, the average HMO-FFS payment rate was approximately 3% less than the Medicare rate and about 2% more than Medicare for non-HMO-FFS payment rates⁷.

Figure A3:

Average Nationwide Private Physician Payment Rates, 2017⁸

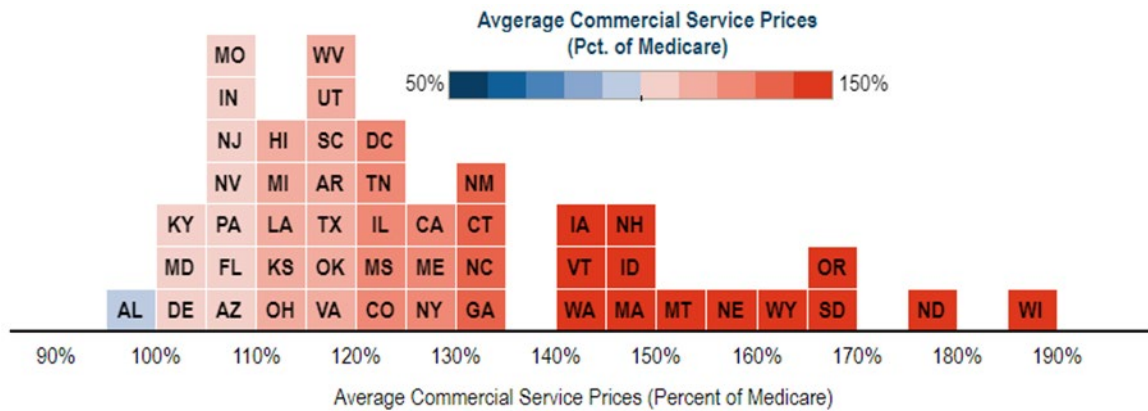


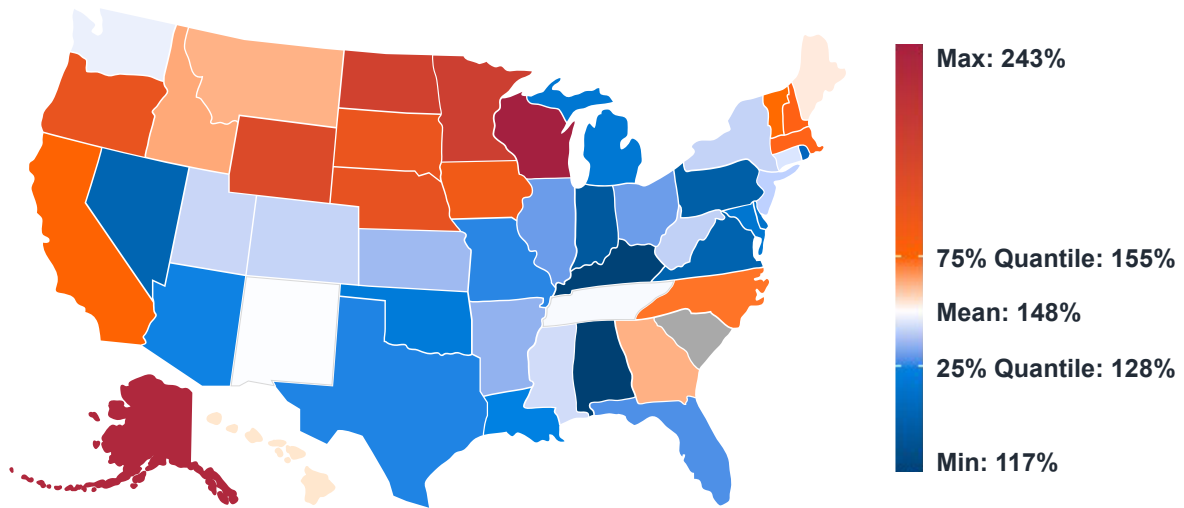
Figure A3:

⁷ https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/plr_healthmd_Utilization.aspx

⁸ <https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices>



Estimated average commercial professional reimbursement as a percentage of Medicare FFS rates.⁹



**Table A3 – 1:
Milliman and HCCI professional reimbursement benchmarks**

	PROFESSIONAL	
	MILLIMAN	HCCI
Valuation Year	2023	2017
Nationwide Mean	139%	122%
Highest	243% (WI)	188% (WI)
Lowest	117% (AL)	98% (AL)
Data Volume (\$M)	\$108,312	\$13,389
Repricing/Methodology	Full-service, line-level claim repricing using the Medicare Physician Fee Schedule (PFS)	Medicare PFS amount with limited modifier adjustments (26, TC, and 53 only)

Acknowledgments

The Center for Analysis and Information Systems staff of the Maryland Health Care Commission conducted this report on payments for professional services in Maryland. Shankar Mesta was the staff member involved in the development of this report. Questions about the report should be directed to Shankar Mesta (shankar.mesta@maryland.gov).

⁹ <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-payment-rates-medicare-fee-for-service>



The Maryland Health Care Commission is an independent regulatory commission administratively located within the Maryland Department of Health.

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