2018

Payments for Professional Services in Maryland (In-Network Services Only) Published January 2020

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Contents

Introduction:

The reimbursement for physician and other professional services are important because these payments impact the premiums paid by enrollees. To accomplish triple aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare, several federal and state health care reforms leverage payments to providers to create incentives for providing more efficient and less costly care to consumers. For example, alternate payment model and bundled payments initiatives to deliver high value care more efficiently. Medicare and Medicaid initiatives have used higher payment rates to incentivize providers to serve patients with more complex health challenges.

This report examines the variations in payment rates for in–network professional services among private health insurance carriers and benchmark these payments to Medicare and Medicaid payment rates for the same services. These variations are relevant because significant price difference for a given professional service after adjusting for certain observable characteristics of such service could suggest that providers have bargaining power with insurers. On the contrary, large payers also could take 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. Unless otherwise noted, the data source for all analyses in the report is the Maryland Medical Care Data Base (MCDB) from 2016 through 2018, which contains information on privately insured professional services used by Maryland residents.

Payment rates for professional services are the payment 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 practice of the equipment, facilities, nonphysician staff, and supplies needed to provide a service; and the liability coverage component, or the cost of obtaining medical malpractice insurance for a service. For this report we used RVUs from 2018, 2017 and 2016 Medicare physician fee schedule which provides information for more than 10,000 physician services. This report includes payment rates by type of service.

2018 Professional Services Payment Rates Highlights:

- In 2018, payments per RVU for all payers was $40.24, up by 1.2% compared to 2017 ($39.74). This is slower compared to 2.6% increase observed from 2016 through 2017.

- The private payment rates for 2018 was about 104% of Medicare and about 120% of Medicaid. Compared to a year ago, private payments were about 103% and 118% of Medicare and Medicaid rates respectively.

- Private payment rates in 2018 varied by geographic regions in Maryland, with the highest rates in the DC Metro ($41.51 compared to other two regions ($40.18 in Baltimore Metro and $38.72 in the Rest of Maryland).

- Consistent with previous years, private payment rates are similar to Medicare for evaluation and management services, and generally pay more for imaging and tests.
  - Private payments rates are about 27%, 28% and 30% higher than Medicare for imaging services during 2016, 2017 and 2018 respectively.
  - Private payers paid 34%, 42% and 48% higher price for tests services during 2016, 2017 and 2018 respectively.

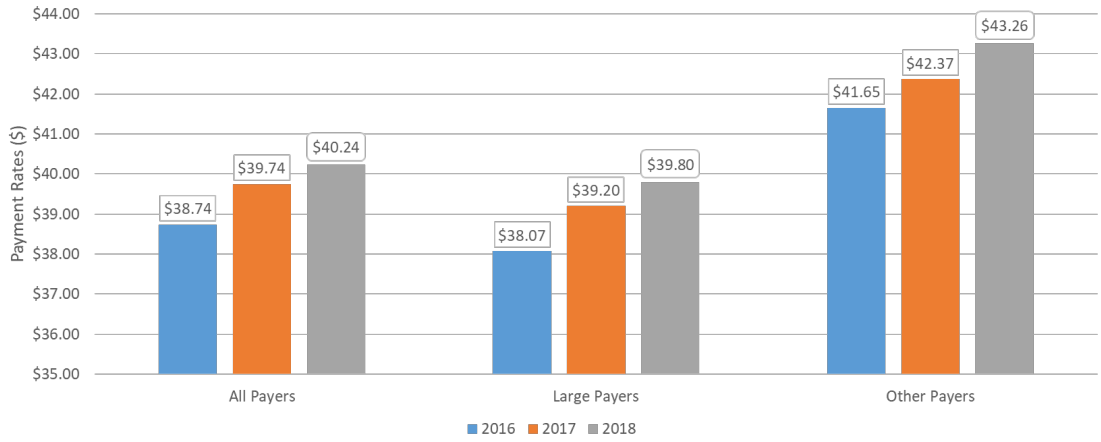
- Payment rates for private payers are generally higher compared to Medicaid payment rates.
  - Private payers paid 59%, 63% and 66% higher price for imaging services during 2016, 2017 and 2018 respectively.
  - Private payers paid 87%, 93% and 104% higher price for tests services during 2016, 2017 and 2018 respectively.

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.

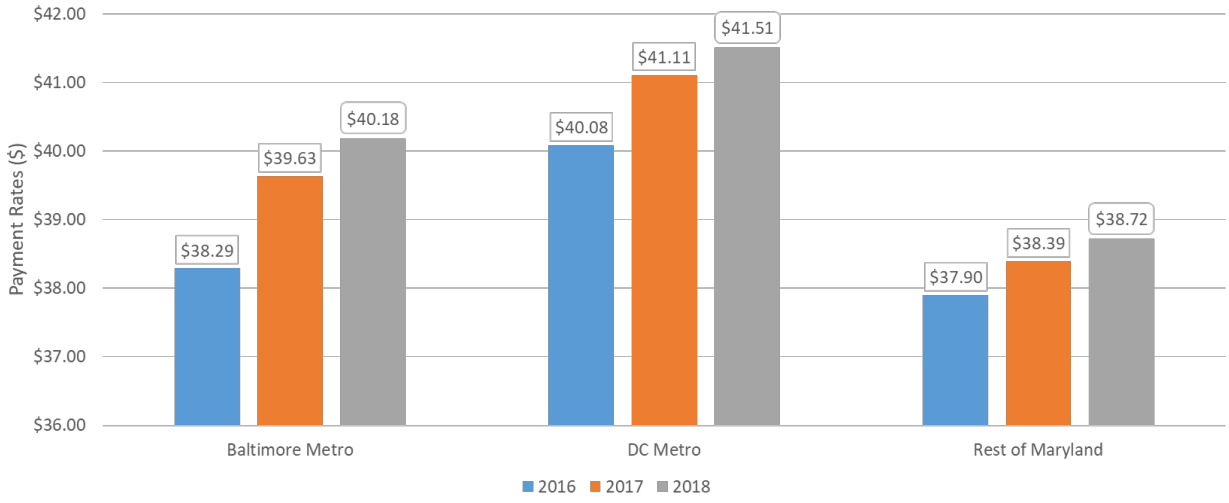
Payment Rates by Private Payer:
The payment rate for all types of private payers combined was $40.24 in 2018 compared to $39.74 in 2017, an increase of 1.2%. The payment change from 2016 to 2017 was by about a 2.6% increase (see Figure 1). The payment per RVU was lower among large payers for all three years. The payment rate for large payers was 90.61% of the rate for other payers in 2016 ($37.07 v. $41.65) 91.92% in 2017 ($38.20 v. $42.37) and 91.31% of the rate in 2018 ($39.80 v. $43.26). The change in the year over year payment rate was higher among other payers compared to large payers from 2017 to 2018 (2.1% v. 1.5%). This was in contrast with change from 2016 to 2017 (1.73% v. 3.0%) because of lower payment in 2016 within large payers ($38.07) 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, 2016 – 2018



Payment Rates by Region:
The payment rates varied by region, based on various factors including but not limited to the resource cost and payer mix (large vs. other payers) in each region. As shown in Figure 2, payment rates were highest in the DC Metro area in 2016 through 2018 which is influenced by the high cost of living indices in Montgomery County, Prince Georges County, and the District of Columbia of 142.8, 116.8 and 158.5 respectively. In other words, the cost of living is about 42.8%, 16.8%, and 58.5% higher than the national average for Montgomery County Prince Georges County, and the District of Columbia respectively. Similar to the DC Metro, payment rates increased every year in the Baltimore Metro and Other Maryland regions as well.

Figure 2: Private Payment Rates by Maryland Region, 2016 – 2018



Payment Rates by Type of Service:

Payment rates for different type of services are comparable with previous years. In 2018, private payers paid $39.33 for Evaluation and Management (E/M), $39.68 for surgical, $6.54 for medical, $51.34 for imaging, $59.29for test and $43.39 for other services.

Private rates for E/M, surgery and medical services are comparable to Medicare rates but 30% higher for imaging and 48% higher for test services. In comparison to Medicaid payment rates, private payers paid substantially higher for imaging (66%) and test (104%) services. These variances are consistent with 2017 and 2016 payment rates. Although Private payment ratio for Imaging and Test services were more compared to other services they only contributed 15% and 2% (Figure 5) respectively towards total professional services expenditure in 2018. E/M service contributed to 48% of total expenditure resulting in $515 million of allowed spending.

Figure 3: Private Payment Rates by Type of Service, 2016 – 2018

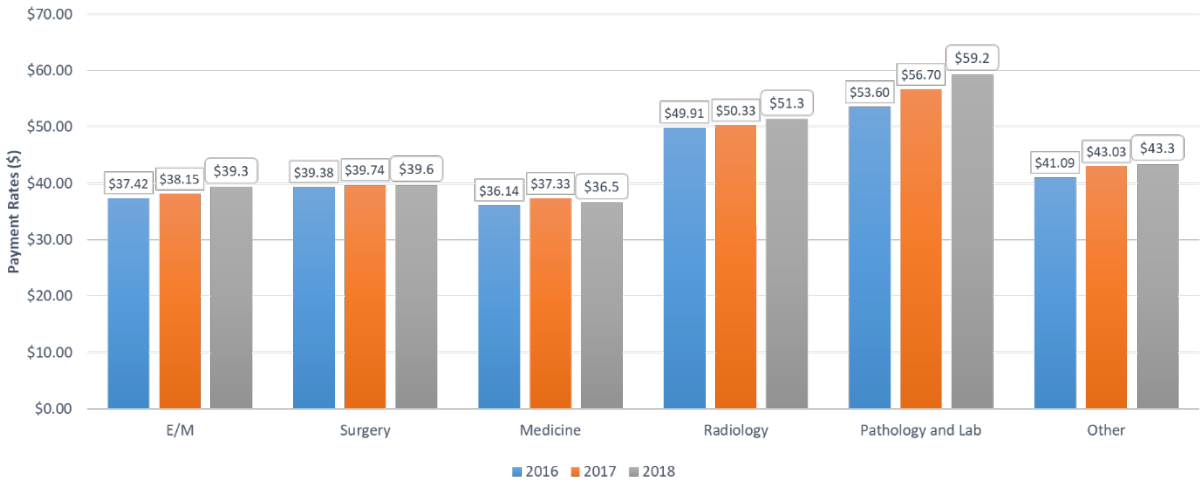


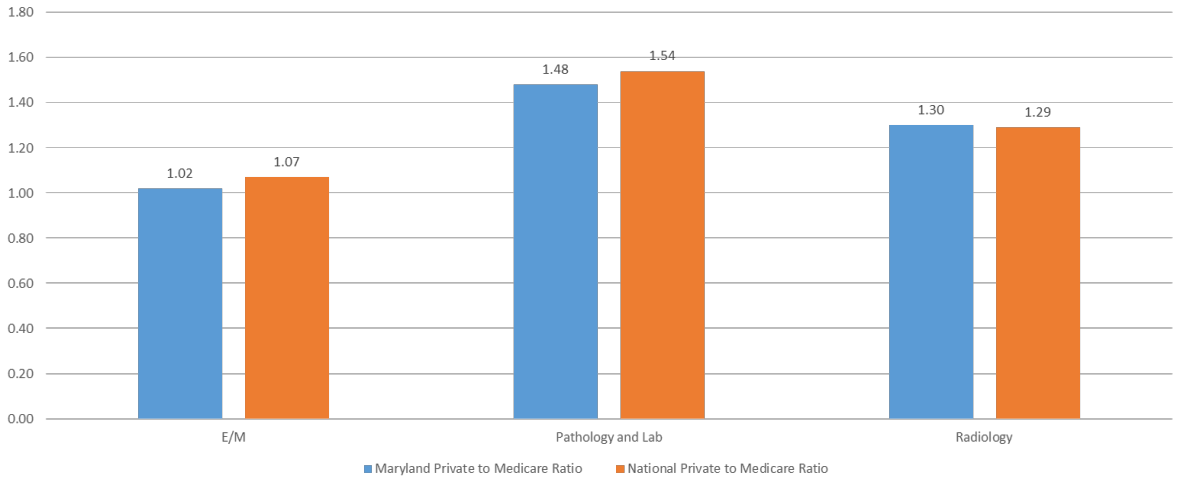
Figure 4: Private vs. Medicare/Medicaid Payment Ratios, by Type of Service, 2016 – 2018

Type of Service	2018		2017		2016	
	Private-to-Medicare	Private-to-Medicaid	Private-to-Medicare	Private-to-Medicaid	Private-to-Medicare	Private-to-Medicaid
E/M	1.02	1.11	0.99	1.07	0.97	1.05
Surgery	1.01	1.32	1.01	1.30	1.01	1.29
Medicine	0.95	1.12	0.97	1.15	0.94	1.12
Radiology	1.30	1.66	1.28	1.63	1.27	1.59
Pathology and Lab	1.48	2.04	1.42	1.93	1.34	1.87
Other	1.11	1.33	1.09	1.52	1.04	1.42

Figure 5: Distributions of Private Allowed Amount By Type of Service 2018 (in $ Millions)

Type of Service	Allowed Amount	Allowed Amount Distribution
E/M	$515	48%
Surgery	$76	7%
Medicine	$296	28%
Radiology	$163	15%
Pathology and Lab	$24	2%
Other	$0	0%
Total	$1,075	100%

Figure 6: Comparison of Maryland v. National* Private to Medicare Payments Ratio



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, and Medicare's resource-based fee schedule serves as the benchmark for other payers. On a national basis, private payment rates are between 10% and 33% higher than Medicare FFS prices on average over the past ten years.[2] However, private payments in Maryland have been lower compared to the national average. Areas with lower payment rates for the basket of physician services—such as Maryland—also are areas with lower payment rates across service categories. For example, Bethesda, Maryland, has relatively low payment rates for 58 of 74 service categories.[3] 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 average 3% above Medicare. Also, for 2003, the average HMO-FFS payment rate was also approximately 3% less than the Medicare rate and about 2% more than Medicare for non-HMO-FFS payment rates.[4] A 2016 survey of Medicaid physician fees shows that although Maryland's Medicaid payment rate was higher than the national average (1.35 Medicaid fee index), it was significantly lower than the Medicare payment rate—the ratio of Medicaid-to-Medicare payment rate was 0.88 in Maryland in 2016.[5] In other words, the Medicaid payment rate was about 12% lower than the Medicare payment rate in Maryland in 2016.

[2] https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/53441-workingpaper.pdf
[3] http://medpac.gov/docs/default-source/reports/Jun11_Ch07.pdf
[4] https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/plr_healthmd_Utilization.aspx
[5] https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump

What would Medicare have paid?

As shown in Figure 7, the payment rate for services reimbursed by private payers (large and other payers) was comparable to what Medicare would have paid for a similar set of services, with ratios of 1.04 for 2018 and 1.03 for 2017 and 1.00 in 2016. Based on the difference in payment rates between large and other payers, the ratio of the private payment rate to Medicare payment rate varied slightly by payer marker share. Large payers paid about 3% more, 2% more, and slightly less than Medicare would have paid in 2018, 2017, 2016 respectively. The payment rate for large payers was $39.80, $39.20, and $38.07 in 2018, 2017 and 2016 respectively compared with $38.76, $38.58, and $38.57 in 2018, 2017 and 2016 respectively for Medicare. Payment per RVU among other payers was $43.26, $42.37, and $41.65 in 2018, 2017 and 2016 respectively; it would have been $38.72, $38.77, and $38.65 in 2018, 2017 and 2016 respectively if other payers used the Medicare fee schedule to reimburse a similar set of services (see Figure 8). Other payers paid on average about 12% higher in 2018, 9% higher in 2017, and 8% higher in 2016 for covered services than what Medicare would have paid. The difference in what Medicare would have paid for service provided by large payers vs. other payers is due to the difference in the intensity of services provided by those payers.

Figure 7: Ratio of Private-to-Medicare Payment rate, by Payer Market Share, 2016 – 2018

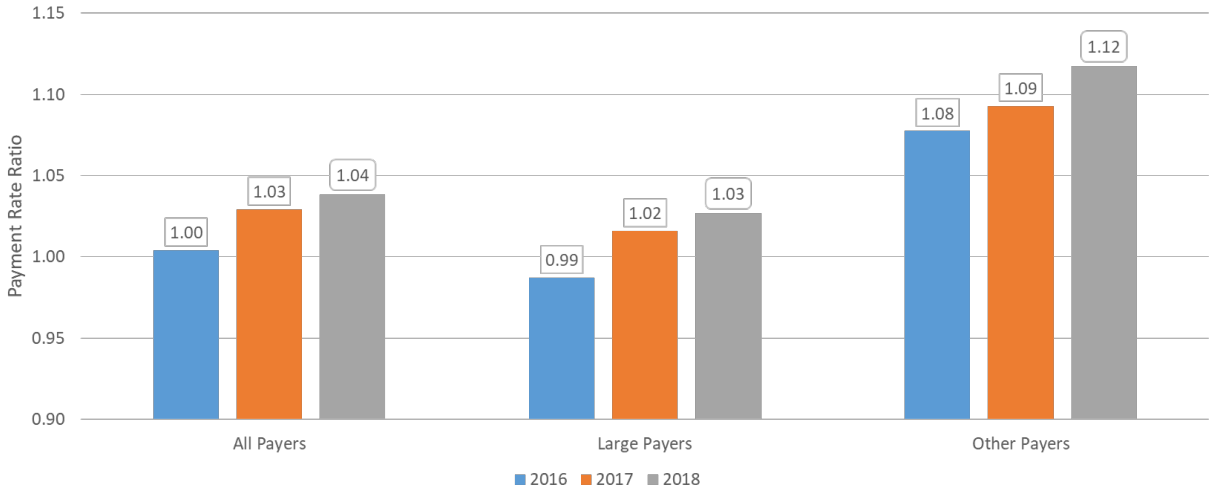


Figure 8: Private vs. Medicare Payment Rates, by Payer Market Share, 2016 – 2018

	2018		2017		2016	
Payer Type	Private	Medicare	Private	Medicare	Private	Medicare
Large Payers	$39.80	$38.76	$39.20	$38.58	$38.07	$38.57
Other Payers	$43.26	$38.72	$42.37	$38.77	$41.65	$38.65
All Payers	$40.24	$38.75	$39.74	$38.61	$38.74	$38.58

What would Medicaid have paid?

As shown in Figure 9, the payment rate for services reimbursed by all private payers combined was 20%, 18%, and 15% higher in 2018, 2017 and 2016 respectively than what Medicaid would have paid for a similar set of services. Both large and other payers paid substantially higher than Medicaid across all three years with a material gap (magnitude difference) in changes between the private payment rate and Medicaid payment rates across payer market shares from 2016 to 2018.

For services reimbursed by large payers, the payment per RVU was about 18%, 16% and 13% higher than if the services were reimbursed under the Medicaid fee schedule for 2018, 2107 and 2016 respectively. In the years 2016 to 2018, large payers paid $38.07, $39.20 and $39.80 per RVU respectively compared with $33.78, $33.73 and $33.60 respectively for the years 2016 through 2018 had the Medicaid fee schedule for reimbursement was used (see Figure 10).

The difference in payment rates between other payers and Medicaid was greater than that between large payers and Medicaid. In the years 2016 to 2018, payment per RVU was $41.65, $42.37 and $43.26 respectively for services reimbursed by other payers, compared with $33.81 and $33.64 and $33.56 respectively for the years 2016 through 2018 if Medicaid reimbursed the services.

Figure 9: Ratio of Private-to-Medicaid Payment rate, by Payer Market Share, 2016 – 2018

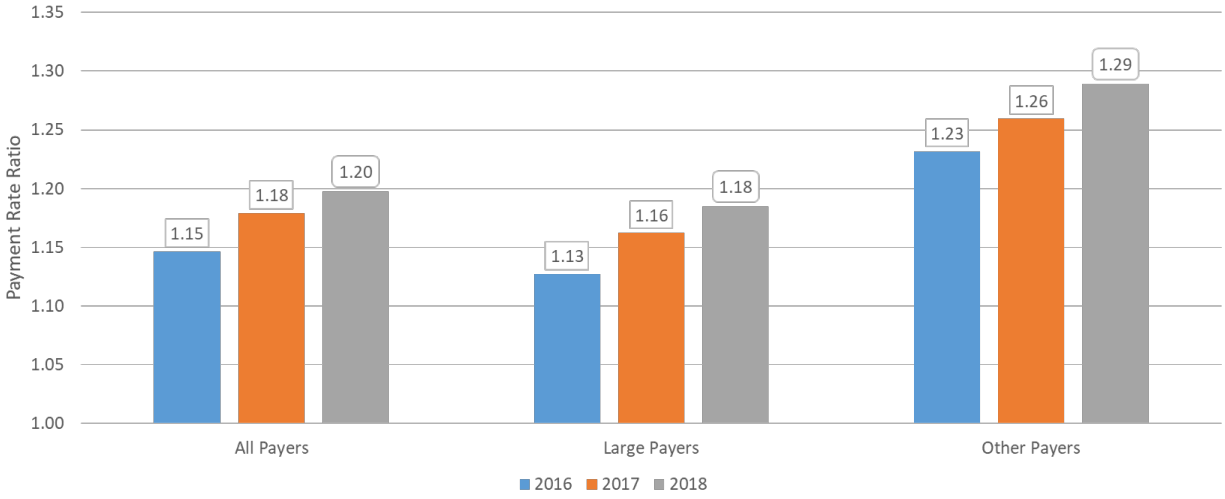


Figure 10: Private vs. Medicaid Payment Rates, by Payer Market Share, 2016 – 2018

	2018		2017		2016	
Payers	Private	Medicaid	Private	Medicaid	Private	Medicaid
Large Payers	$39.80	$33.60	$39.20	$33.73	$38.07	$33.78
Other Payers	$43.26	$33.56	$42.37	$33.64	$41.65	$33.81
All Payers	$40.24	$33.60	$39.74	$33.72	$38.74	$33.79

Appendix

Methods

Data Sources.
The analyses used 2016 to 2018 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 of measure that indicate 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. This standardized measure controls for the complexity of service. A synthetic fee for large and other private payers were developed separately using the allowed amount from the MCDB professional services files. We developed these private fees by CPT for 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 get 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 fee schedule provided the Maryland Medical Assistance (Medicaid) program lists the amount Medicaid would pay for a service. The 2018 Medicaid fee schedule is merged to the MCDB from respective years (2016 to 2018) by CPT/HCPCS codes. Service-level Medicaid payment 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 with Medicare and Medicaid Payment Rate.
To examine relative payment rates, we calculate 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
Large Payers	86.9%	64.1%	86.3%
Other Payers	13.1%	35.9%	13.7%
Total	100.0%	100.0%	100.0%

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 under age 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 due to *Gobeille v. Liberty Mutual Ins. Co.* SCOTUS ruling for 2015 and beyond.

Cost of Living Index.

The cost-of-living index gives the percentage difference in the cost of living between your location and another. For this report, the cost-of-living index compares to the U.S. which has an index of 100. An index greater than 100 means that the cost of living is greater than the national average. For example, an index of 120 means that the cost of living is 20% higher than the national average.

Figure A2: Cost of Living Index By County

Cost of Living Index By County

	Index
Baltimore Metro	
Baltimore City	89.5
Baltimore County	108.8
Harford County	114.1
Howard County	142.4
Anne Arundel County	126.1
DC Metro	
Montgomery County	142.8
Prince George's County	116.8
Rest of Maryland	
Garrett County	102.6
Allegany County	109.3
Washington County	92.5
Carroll County	112.6
Frederick County	118.8
St. Mary's County	111.2
Charles County	111.8
Calvert County	113.9
Cecil County	108.7
Kent County	102.8
Queen Anne's County	117.8
Talbot County	117.4
Caroline County	99.7
Dorchester County	109.9
Wicomico County	111.5
Somerset County	109.5
Worcester County	109.3
District of Columbia	
DC	158.5

Source: https://www.bestplaces.net/cost_of_living/county/maryland/baltimore

Note: The cost of living index for the District of Columbia is included here only for reference.

Examples where private payer payment rates are lower than Medicare payment rates in Maryland

Figure A3: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims v. Medicare, 2004 and 2013[5]

Table 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%

Table 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%

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