Family Planning Medicaid Waiver Evaluators Conference Call
MINUTES
December 8, 2008 1:00 – 2:00 pm EST

Participants

Evaluators: Kathy Vetter (IL); Andrea Johnson, Bo Martin (NC); Dave Murday (SC)

State Staff: Lynn Smith, Karen Jackson, Catherine McGrath, Susan McNamara (FL); Tysha David, Bernie Operario, Marcia Swartz (NC); Susan Barber (TN)

Sheps Center: Julie DeClerque, Priscilla Guild, Ellen Shanahan

Others: Adam Sonfield, Guttmacher Institute; Jerry Zellinger, CMS Medical Advisor

The December 8th conference call began with a review of the purpose of the calls and a brief historical overview — mainly for the benefit of Jerry Zellinger from CMS who was joining for the first time. But it was also a good excuse to remind everyone of where we have been and what we are trying to accomplish. Adam summarized things nicely saying the purpose of the calls was generally to identify common challenges, shared solutions, and best practices from an evaluator's point of view and the development and analysis of common indicators to assist program staff in gauging what is and is not working in each state. Common indicators we have been developing: % eligibles enrolled, % enrolled seen for any waiver service, % eligibles seen for any waiver service. As Jerry pointed out, this is quite a task given options available to states.

The remainder of the call picked up on the discussion from November, and the work that Dave Murday and his workgroup had done paring down a list of procedure codes based on expense (reimbursement) and frequency of use. The purpose of this exercise is to investigate variations in provider participation in the waivers and whether it might be a factor in provider mix and ultimately access and utilization rates. There are two tasks, basically. The first is to shrink the codes down to a manageable number of meaningful (representative) codes that are acceptable across the states. The second issue is the fee schedules: determining what is a "benchmark" fee for each code, and then how Medicaid pays for those codes, and the variation by provider type, setting both within and across the states.

Dave's group identified a proposed set of ten codes for consideration covering office visits and more complicated services codes. They sent out a list of the proposed codes and the fee schedules associated with those codes. (HCPCS 58300, 58301, 58670, 58671, 99203, 99204, 99212, 99213, 99385, 99395) They looked at the frequencies of those codes in SC and NC to verify that these actually are the most commonly used. SC, NC and Nancy Hardt (FL) sent codes. Nancy took the next step and provided both the Medicaid fee schedule plus those of another provider (Humana). After considerable discussion, there was unanimous consent by the group for the proposed set of codes. For the moment, shall we limit the exercise to private offices to limit the amount of work. This makes sense and probably has the greatest impact on provider mix .

<u>Benchmarking</u>

The next step then was to see how Medicaid pays for these codes in each state. We need to decide on benchmarks for each code. We want to be able to say, "Medicaid is x% of the benchmark. Medicare often serves that purpose, but in this case the group decided it may not be the best one, as they may not exist. There was much discussion about this topic with many important points raised:

- Medicare has benchmarks called UPLs that may be helpful for this exercise. Using a conversion factor, each state can develop rates for any procedure even though Medicaid doesn't cover the procedure. Q: would private MDs respond positively to this?
- Even if we do not have data for all the states, it may be useful to complete the exercise for those that do, so that the other states can use the information to lobby for policy change at home. Comparable data from other states may provider information to help convince legislatures to increase reimbursement rates.
- State health fee-for-service plan as the initial benchmark may be similar across states and within states cover a large enough population. Under SCHIP, there are rules for benchmarking: they use the state BCBS or largest private provider.
- All states use a BCBS plan for state employees (those present on call thought).

Decision: Use the fee schedule from the largest BCBS PPO for state employees

Action #1: All please check to see what the largest state employee (for most states it seems to be BCBS PPO) pays for the 10 codes listed by the Workgroup as well as the State's Medicaid rates (for those State's who have not yet sent). Review the attached spreadsheet file and see if you have any questions. Bring your questions to the call on Monday. Send the completed file to Dave Murday murday@gwm.sc.edu by Wednesday, January 28th. If available, add facility and non-facility rate, but we are most interested in using the non-facility rate.

Action #2: Contact Kathy Vetter (via email) if you are interested in joining the workgroup investigating different provider types. Kathy has the details.

Action #3: Each state should send their most recent evaluation report to the group. There have been several requests for this from the evaluators in the group. This is to share results between evaluators.

The next meeting will include a discussion of topics for next year. Be thinking of issues you would like to see discussed that relate to developing common indicators or assessing evaluation issues for the waivers. We will decide on priority topics during the meeting. If you can't make the meeting, email Dave Murday with your requests.

Next Call: January 12th from 1 until 2 PM EDT. The call-in number for all the calls is (919) 962-2740.