

Medicaid Provider Rate Review Advisory Committee: Workgroup Discussion Summaries

From May through July, members of the Medicaid Provider Rate Review Advisory Committee (MPRRAC) split into three workgroups to discuss the 2017 Analysis Reports and prepare to present at the July 21st MPRRAC Meeting. Below is a summary of workgroup discussion items.

Physician Services

- The Department should rebalance all physician service rates (under review in year two) to the budget neutral benchmark, with exceptions for codes that received specific targeted rate increases (TRIs), e.g., developmental screenings under cognitive capabilities assessments. The Department should share more information regarding other targeted rate increases.
- The Department should set physician service rates at a minimum of 80% of Medicare.
- An additional long-term suggestion is that the Department could create calipers around the 80th percentile, which wouldn't be touched initially, but could be tightened over time to get all codes closer to 80% of Medicare.

Surgery and Anesthesia

- Increase surgery rates:
 - Goal of increasing all payment rates for surgical services, with a goal of parity with Medicare rates.
 - A more short-term goal of further investigation of surgical codes scattered well above and well below the benchmark.
- The Department should research the validity and impact of using Medicare facility versus non-facility benchmarks.
- Comment: the Department should continue to refine the Access to Care Index, e.g., identify other metrics that could be incorporated into the index, evaluate if metrics should be weighted differently, etc.
- Like surgery rates, increase anesthesia rates:
 - Parity with an adjusted benchmark rate.
 - Medicare should not be used as the benchmark (reasons why are outlined in documents provided to the Department during the January MPRRAC meeting).
- For anesthesia services:
 - Consider a case rate payment for obstetrical labor anesthesia services.
 - Include base units in the Department financial data for anesthesia services to allow for comparison with other available data sources.
 - Separate hospital facility data and outpatient facility data, financial or otherwise, in all future reports

Home- and Community-Based Services (HCBS) Waivers

- Respite:
 - In-home respite should be offered on the CMHS Waiver.
 - There should be some sort of intensity scale for high-needs clients.
 - The Department should look at changing the unit of measure for in-home respite for adults (i.e., from a day unit to some sort of hourly unit).
 - The Department should look at the way that the 30-day limit is counted

- Comment: There are discrepancies between the 2017 Analysis Report and what stakeholders say; the 2017 Recommendation Report should acknowledge this fact. Efforts should be made to understand why these discrepancies exist.
- The Department should examine the staffing ratio needed for memory care in ACFs.
- For NMT services, the Department should monitor how utilization is impacted by:
 - the targeted rate increase from FY 2016-17 legislative session, and
 - PUC changes enacted in 2016.
- Personal Care/Homemaker services:
 - Lila brought up: differences between personal care and homemaker rates and attendant wages.
 - The workgroup expressed a need to dispel myths around such differences.
 - Randie mentioned that other states have enhanced payments to providers that are paying their attendants more than the median wage.
- When the number of providers is small (~15 or fewer) the Department should examine if this is an access issue.
- Comment: With regards to CDASS – though it was reviewed in a different way, what is the status of the differences in rates for CDASS and agency-based homemaker and personal care services?
- Comment: Utilization of prevocational service numbers are going down for clients enrolled in the DD Waiver; however this may not be a concern.