Suggested Changes to IGT TAP Panel Report

Margaret Brennan – 12/7/10

On page 5

Please see paragraph starting with “Through the deliberations … Please change the following sentence to read: Counties are currently required to fund a portion of inpatient and nursing home costs.

Please see paragraph starting with “The LIP is a limited … Please change the following sentence to read: This means without continued participation from existing counties and/or expanding the number of counties willing to contribute, community hospitals may not receive …

Margaret Brennan – 12/9/10

Current paragraph regarding county contributions:

The IGT TAP went into great detail and reached out to counties through the Association of Counties to identify the ability and willingness to continue providing IGTs if the FFS population were transitioned into managed care. Many of the counties stated that they are unwilling to provide IGTs as a source of funding for managed care. Others stated they would consider it if there continued to be incentives to providing the funding for their counties and for others when needed.

Proposed Replacement Language:

Counties contribute in excess of $______ to support the state share of LIP and other Medicaid payments made by the Agency to providers in their communities, and so the IGT TAP reached out to the counties through the Association of Counties to identify the ability and willingness to continue providing IGTs if the majority of the FFS population is transitioned into capitated managed care. County funds used as IGTs are typically tax revenues the county has already committed to expend on qualified health services and appropriated to specific providers. Those providers then agree to provide services at no or reduced cost and leverage the funds as the state share of Medicaid payments those providers will receive in the course of providing FFS Medicaid services. Under FFS Medicaid, these supplemental payments are easy to track both prospectively and retrospectively, and so counties have assurances their providers actually get the funds they are entitled to receive for services provided to persons in the community.

The challenge for contributing counties under a capitated model is accounting for how their local tax dollars are spent. Once Medicaid is capitated, the Agency is not allowed to withhold a portion of the capitation rate, is not allowed to pay providers directly, and is
not able to require capitated plans to pay specific providers specified amounts. The Agency cannot guarantee the counties’ funds would flow back to any specific providers, nor can the Agency guarantee that any particular provider is held harmless. In addition, the Agency cannot engage in any conversations by and among plans and providers relative to the negotiations for any ‘pass through’ amounts, nor can the Agency mediate any disagreements between plans and providers should the parties have disputes over payments.

While it may be possible for the plans and providers to separately account for and contract for the local tax dollars and federal matching funds, these mechanisms have not been fully vetted or clearly defined. Further, it is not apparent what happens if there are significant changes in utilization of the providers historically supported by local tax dollars. For instance, if the local government taxes its citizens to support teaching hospitals and providers that care for a disproportionate share of indigent persons, even if those providers have higher inherent costs due to their teaching and charitable missions, managed care entities may not share this philosophy. If significant volumes of Medicaid patients are directed away from teaching hospitals it may make it more difficult for them to train and educate future physicians and nurses. Likewise, if paying Medicaid patients are not cared for by the providers that also care for the community’s uninsured, it may actually increase the tax burden because the provider’s ability to “cost shift” would be diminished.

This is further complicated because each MCO in a given region must be paid the same capitated rate regardless of their contractual relationship with or utilization of the providers supported by local tax dollars. If IGTs flow equally through all MCOs, providers may be forced to contract with all plans in order to recoup IGTs, which significantly impairs their ability to negotiate with the plans. Another unknown is whether each MCO is willing to work out equitable arrangements with providers associated with IGTs.

Therefore, when faced with all of the complexities and challenges associated with IGTs flowing through capitated plans, some counties have expressed hesitation to provide IGTs as a source of funding for managed care until and unless adequate safeguards can be defined and established to assure their tax payers that qualified health services will be funded. Other counties stated they would consider participation if there continued to be incentives to providing the funding for their counties and for others when needed; however, it is not clear whether the incentive payments can be retained under some of the models proposed.

Finally, under the reform FFS PSNs in Duval and Broward Counties the issue of tracking and accounting for IGTs and CPEs has not been an issue because supplemental payments are readily apparent to the contributing governmental entities. Therefore, FFS PSNs should be fostered and included in very model proposed.
Proposed Language: to follow the section relative to County Contributions

In addition to the $81 million in IGTs voluntarily provided by counties; public hospitals, health care districts and tax funds derived from general laws, which direct tax support to specified providers account for over $525 million in voluntary IGTs that support the state share of Medicaid FFS hospital payments (Table xx). Similar to the tax revenues expended by counties for health services, these local tax dollars are raised for express purpose of supporting qualified health services and appropriated to specific local providers. Under FFS Medicaid, the providers are able to track and account for the tax dollars in the same manner contributing counties are, which is through the direct reimbursement of supplemental FFS Medicaid payments to qualified providers. The partnership the Agency has forged with IGT contributing entities is possible because the governmental bodies have the same goal to assure and improve access to health care services for under-insured and uninsured persons.

Voluntarily transferred IGTs were first used to fund the state's Medicaid disproportionate share program; funding from three counties was leveraged to draw down federal matching dollars for the state's largest charity and teaching hospitals in support of their charitable, teaching and research missions. The use of IGTs was expanded with the advent of the Upper Payment Limit program (UPL), which enhanced payments to additional teaching hospitals, trauma centers, and those providing significant levels unfunded care. Most recently, the use voluntary IGTs increased under the Low Income Pool Program (LIP), which is part of the State's Medicaid Reform 1115 Waiver, and even a greater number of providers have been afforded supplemental Medicaid payments.

As the Medicaid program transitioned into each of these programs, the state share of these expansions was voluntarily provided by IGT contributing entities in lieu of being funded through state general revenue. With each expansion, accounting for the growing amount of IGTs became more complex, in part because some entities are able to finance more of the program than others, and some recipient providers are not able to contribute at all. LIP affords the greatest degree of flexibility in this regard; contributing entities are incentivized to participate and repayment of their IGTs is guaranteed. This level of accountability is key; taxing authorities and public hospital boards have a fiduciary duty to make sure that IGT dollars raised and earned by these entities are used for their intended purposes. Reimbursement under LIP, traditional FFS, and FFS PSNs allows contributing entities to easily track and account for IGTs.
Under federal law, once the Agency makes a capitated payment to a Medicaid plan, the Agency cannot pay providers directly for the same Medicaid service. The Agency is also prohibited from dictating how the plans reimburse participating providers or providers associated with IGT contributors. Medicaid plans are free to negotiate reimbursement rates and payment terms with providers, and the Agency cannot dictate what, if any, “pass through” payments are made by those plans to specific providers. There are statutory provisions for payments made to non-contracted providers, but free market principles apply to Medicaid plan/provider negotiations.

Over 1.3 million Medicaid eligible persons are enrolled in managed care organizations, another 600,000 are in MediPass, and just fewer than 1 million are in traditional FFS. Most of those under traditional FFS are exempt from managed care; these include the dually eligible, Medically Needy, and newly eligible persons in the process of selecting an MCO. Currently, IGTs are only used to support FFS payments, and to the extent eligible persons remain under a FFS system, the opportunity to voluntarily enhance those payments through IGTs should be maintained.

In addition to retaining IGTs under FFS, Medicaid reform under the 1115 Waiver has illustrated that robust FFS PSNPs owned and operated by entities associated with significant levels of IGTs (and CPEs) offers a viable managed care alternative while giving contributing entities the assurances they need to continue their IGT support of Medicaid. Lessons learned from reform include the need to have sufficient plan enrollment, efficacy of risk-adjusted rates, and ability to manage enrollees prescription drugs benefits. If additional lives are placed in MCOs, FFS PSNPs must be an integral part of any proposal.

Another mechanism that would maintain the existing assurances and guarantees regarding the use of IGTs would be the “carve out” hospital payments from capitated rates, so that base Medicaid rates and supplemental payments may be paid directly to the intended providers by the Agency.

There are multiple unknowns at the present time. Foremost is the uncertainty of the extension of Florida’s 1115 Waiver. If the waiver is not extended, LIP will cease to exist, and the ability of some entities to contribute IGTs will be significantly diminished. A second unknown is whether, and what, CMS will approve. Thirdly, and perhaps most importantly, without express guarantees and assurances, some IGT contributors will no longer be able to partner with the State in support of the Medicaid program.
IGT TAP Report – Physician Supplemental Payment

Recommend editing the following paragraphs in Draft Report as shown – changes are underlined:

Definition of Intergovernmental Transfer (IGT)

Intergovernmental transfers are the transfer of public funds from different levels of governmental or governmental entities/taxing districts to the state government, commonly referred to as IGTs. Use of IGTs is a common mechanism for states to fund the non-federal share of certain Medicaid payments. Once used as part of the state share of Medicaid funding, the transferred funds are matched with federal Medicaid dollars and then paid to qualifying Medicaid providers as either higher payment rates or special Medicaid payments. Another source of the state share of Medicaid funding is certified public expenditures (CPEs), which are certified as match rather than transferred.

Current Use of IGTs

Intergovernmental transfers are currently used as a funding source for exemptions and buyback policies within the Hospital Inpatient and Outpatient Fee-For-Service rate methodology. There are no IGTs used as a funding source for any portion of the Prepaid Health Plan capitation payments as authorized by the GAA. Qualifying authorities such as taxing districts and local governments execute a Letter of Agreement with the Agency that secures that state share of matching funds required to fund the levels of exemptions and buybacks for the communities around the State. CPEs are currently used for supplemental payments to teaching faculty physicians at the state’s medical schools.

Recommend adding the following paragraphs to the Draft Report:

Current Status and Participation of IGTs

Medical school teaching faculty physicians provide essential primary care and specialty services to Medicaid eligible Floridians. They also educate and train Florida’s much needed future physician workforce. Currently, Florida medical schools provide $------- in CPEs, which generate $----- in federal Medicaid matching dollars that are paid as supplemental amounts to medical school faculty practice plans. Supplemental payments are currently only paid to teaching faculty physicians when providing services to Medicaid patients in Fee-For-Service (FFS) arrangements. These supplemental physician payments are presently not available to teaching faculty physicians when providing services to Medicaid patients enrolled in capitated managed care plans.
Physician Payments

The Florida Medicaid state plan authorizes the Agency to provide for supplemental payments for services provided to Medicaid FFS patients by doctors of medicine and osteopathy employed by or under contract with either:

- A medical school that is part of the public university system
- A private medical school that places over 50 percent of its residents with a public hospital; or
- Nova Southeastern University.

The Medicaid state plan includes the exact methodology for supplemental payments related to services provided via fee-for-service. This methodology does not apply to services provided to Medicaid patients enrolled in capitated managed care plans. As Medicaid managed care expands in Florida, teaching physician supplemental payments are in jeopardy. If the state does not develop a reliable and approvable methodology for making supplemental payments to teaching faculty physicians serving managed care patients, the state will lose millions of dollars in federal Medicaid payments.

The supplemental physician payments help ensure Medicaid recipient access to quality care, including primary and specialty care. This access is a challenge even in fee-for-service arrangements. It is vital that any managed care approach be designed to preserve access to care for Medicaid patients and preserve federal Medicaid matching funds available to teaching faculty as a result of CPEs provided by state medical schools.

Florida’s supplemental payments to teaching faculty physicians also support the mission of the state’s Colleges of Medicine by providing funding for essential primary care and specialty services. Without access to the critical mass of patients, the Colleges would not be able to educate medical students or train resident physicians, necessary to meet Florida’s growing physician shortage.

As the State of Florida looks to better managing the care of its Medicaid beneficiaries and moving more individuals to managed care, reform solutions must:

a) provide a reliable new mechanism for federally-funded teaching physician payments for services provided to Medicaid managed care patients,

b) retain existing teaching physician supplemental payments for services provided to Medicaid patients in Fee-for-Service (FFS) under the state plan, and

c) allow the continuation and expansion of non-capitated provider-based managed care options, such as cost effective shared savings FFS Provider Service Networks.
Models to achieve new, reliable mechanisms for supplemental teaching physician payments under managed care must preserve the CPE mechanism as the state share of Medicaid funding, to do otherwise would create an untenable cash-flow crisis at state medical schools.

Before the state could implement a dual track approach for teaching physician supplemental payments for managed care members, the use of CPEs as the state share of Medicaid and other design elements, would require express approval by CMS. Due to the complexity of federal policies relating to supplemental provider payments, until CMS approval is obtained, there is no guarantee that vital Federal funds being secured by medical school CPEs would continue in a managed care environment. The state and its medical schools cannot afford to put over $100 million in federal funds at risk.

When exploring models for supplemental payments and managed care, it is also important to note that faculty practice plans not only care for persons from the county where the College or Practice Plan operates, but these academic experts typically care for patients from throughout a large region, and in some types of complex cases, statewide. Patient care services provided by medical school faculty are often an essential access point for Medicaid patients throughout the state.

If CPE funds are included in a Medicaid MCO capitation, AHCA staff has indicated that federal rules will prohibit AHCA from guaranteeing that the funds flow back to any specific providers or that any CPE/IGT providers could be held harmless in terms of even recouping their CPE/IGT payments. Consequently, teaching faculty payment scenarios that include supplemental payments to MCOs would depend on each individual MCO making timely and accurate voluntary payments to teaching faculty throughout the state. In this type of scenario, the flow of Medicaid funding from numerous MCOs to the medical schools would be uncertain and administratively cumbersome. In addition, medical schools would not be able to seek assistance from the state if an MCO did not make a complete or timely supplemental payment to the teaching faculty. The administration of teaching faculty payments under such an option would be very complex and potentially unworkable. The complexity, time lag, and uncertainty could result in medical schools being unable to provide the CPEs required to secure federal funding for supplemental teaching faculty payments.

Potential models for preserving vital physician supplemental payments in managed care environment include: 1) risk pool for supplemental teaching physician payments; 2) ensuring availability of fee-for-service, shared cost saving alternatives to capitated managed care plans, including but not limited to, FFS Provider Service Networks; and 3) direct payment of teaching physician supplemental amounts based on utilization. These models are not mutually exclusive. A combination of models may be required to enable the state to
continue to utilize CPEs and retain federal matching funds for teaching physician supplemental payments despite changes in Medicaid managed care penetration.

1. Risk Pool - AHCA suggested that, “A risk pool will be designed and implemented for the purpose of the Physician UPL and will not be included in the base rate [to MCOs] or the supplemental rate [to MCOs].” The details on how such a risk pool mechanism might be structured will be critical, including how AHCA calculates teaching physician supplemental payments for managed care members, the process and criteria used for distributing these funds, and the ability to utilize a CPE approach to fund the state share of these teaching physician payments. The criteria and process should be as comparable to the existing criteria and methodology for making teaching faculty supplemental payments for Medicaid patients in FFS as possible in order to retain access for patients and support for state medical school teaching faculty.

2. FFS PSNs – There should be a clear role for provider-based managed care options that do not preclude the state making direct supplemental teaching physician payments to medical school faculty practice plans. One example is the successful shared-savings, FFS Provider Service Network serving over 46,000 Medicaid members in Duval County. This stable, cost-effective PSN operated by the University of Florida and Shands Jacksonville has been essential for Medicaid reform members to have access to care. It has demonstrated shared savings and strong patient satisfaction and quality performance. Under the shared savings PSN model, faculty physician supplemental payments are maintained because the plans are not capitated for physician services. Under non-capitated PSNs, CPEs also continue to be allowable as the State share of these essential teaching physician supplemental payments. Under a managed care expansion, the state should provide for the continuation and expansion of non-capitated provider-based managed care options which do not place federal physician supplemental payments in jeopardy. The state should allow PSNs to remain FFS if CMS has not approved a mechanism for AHCA to make comparable teaching physician UPL payments directly to medical schools in a managed care environment. The state should also consider options that include other FFS managed care models in regions that are served by medical school faculty practice plans in order to preserve vital federal funding for teaching faculty.

Based on experience in reform counties, fee-for-service PSNs achieve critical goals including: 1) managing care, 2) ensuring stable access to quality care for Medicaid patients, 3) preserving and protecting medical school CPEs and other IGTs, and 4) providing the necessary guarantee to contributing entities that local money contributed to Medicaid for the purpose of providing health care is in fact doing so. However, not all regions or all medical schools may be able to support a PSN model.
During the reform pilot, valuable lessons were learned regarding FFS PSNs, including, the need to have “critical mass” and the tools needed to better manage patient care. For example, PSNs should have at least 25,000 members in order to be sustainable and operationally efficient. For greater cost effectiveness results, PSNs should have the same ability as HMOs to manage prescription drug utilization.

3. Direct Payment of Faculty Physician Supplemental Payments – There is a limited exception under the federal prohibition to pay providers directly once under a capitated system, and the exception should allow for the direct payment of the teaching faculty supplemental amounts for patients enrolled in managed care patients. Under this model, the Agency could calculate a supplemental teaching physician payment amount for managed care members based on utilization related to Medicaid managed care patients and pay such amounts quarterly to the faculty practice plans, in addition to the physician supplemental payments made on behalf of Medicaid FFS patients. This dual track approach for physician supplemental payments is important to establish if Medicaid patients transition out of FFS and into capitated managed care arrangements over time.

To the extent more Medicaid members transition to capitated managed care plans, the current teaching physician supplemental payments based on FFS utilization measures will decline. Without an alternative approach, this decline in FFS Medicaid patients will result in a loss of substantial federal funds to the state’s Colleges of Medicine and will jeopardize Medicaid patients’ access to primary and specialty care provided by medical school faculty practice plans.

To avoid a dangerous reduction in funds supporting access to Florida’s medical school faculty and disruptions in access to care for Medicaid patients, the state should provide a clear role for non-capitated managed care approaches and link any expansion of capitated plans with CMS approval of a mechanism that ensures direct payment of federally-funded supplemental teaching physician payments will continue.