IGT TAP Members Present

1. Kevin Kearns
2. Tom Wilfong
3. Michael Good
4. David Verinder
5. Scott Davis
6. Margaret Brennan
7. Mary Lou Tighe (phone)
8. Chris Paterson

Agency Staff Present

1. Michele Morgan
2. Melanie Brown-Woofler
3. Phil Williams
4. Edwin Stephens
5. Shannon Bagenholm
6. Lecia Behenna

Non-Members Participating by Telephone

1. Robert Butler
2. Nick Simmons
3. Janet Carter
4. Marty Lucia
5. Duane Ashe
6. Stacy Kilroy
7. John Goodrich
8. Randy Lewis
9. Roger Hahn

Non-Members Participating in Person

1. Lori Hundley
2. Dwight Chenette
3. Mary Beth Dyer
4. Michele Summers
5. Jan Gorrie
6. Lindy Kennedy  
7. Jim Zingale  
8. Mary Pat Moore  
9. Clark Scott  
10. Elaine Peters  
11. Tony Carvalho  
12. John Owens  
13. Paul Belcher

I. Welcome/Opening Comments

Michele Morgan, Bureau Chief for Medicaid Program Analysis, opened the meeting at 9:00a.m.

II. Approval of October 13 and October 27, 2010 IGT TAP Meeting Minutes:

The meeting minutes from the October 13 and October 27, 2010 IGT TAP meetings were unanimously adopted.

III. Discussion

- Michele Morgan discussed the importance of reaching out to the counties. The Agency sent questions to the Association of Counties and asked that they reach out to their different contacts to see if we could get some feedback.
- Overview of questions to counties:
  1) Are the counties familiar with the purpose of the IGT Technical Advisory Panel?  
  2) Are there any concerns that have not been identified?  
  3) If Managed Care was to be expanded due to Legislative action therefore, fee for service hospital level decreased would counties consider a continued contribution through the managed care supplemental payment as an alternative?  
  4) If yes, what is the base of criteria: criteria for example being a contract; what kind of assurance they would want between the health plans and the hospitals?  
  5) Would the counties participate at a pass through level that is currently funded was not eligible to continue passed through at a reduced amount? Meaning if the IGT was not able to be returned or an allocation factor was not applied.  
  6) What assurances would the county want from the Agency? Meaning what could we build into our contract, what would they be looking for on our side? Follow up to question six is: What assurances do the counties want from the health plan; contractual agreements, payment agreements?  
  7) Is there anything the Agency can do to help the counties better understand the potential impact of Managed Care expansion? Are there any counties today that do not provide IGT funds that would see a benefit in providing IGTs in the future for their community?
- On behalf of Margaret Brennan, John Goodrich reported that: 1).The counties want to make sure they keep the current level of return. 2). A better understanding of how much the supplemental payment would be. 3). Which institutions in the region would receive the supplemental payment. In addition, the counties will not be able to commit to funding without getting direction and approval from the boards.
- Michele Morgan noted that with regards to asking the counties to commit, for the purposes of our report we are not looking for an actual commitment, we are looking
more for something that county staff or taxing authority qualifying sponsors of state share would actually be able to take to their board as a supportive initiative and provide them understanding that the board of county commissioners have the final say of whether or not it gets funded and things that are going on in that community.

- Michele Morgan explained that a concern that has been raised from the counties and hospitals is how we know the hospitals that put up money will get the benefit of the IGTs if it continues to be put up? The Agency cannot get involved in the actual negotiations and set the fees. A key part of this workgroup is to address the roles of the counties, hospitals and the health plans where outside negotiations between those parties is key on making a methodology work. What should we include in the report that the Legislature should be looking at as they are deciding how to move forward on this issue?

- Michele Morgan began a review of a draft report and addressed the definition of IGT and the concerns related to the IGT methodologies. She expressed that we want to get a feel for where those concerns are today and include those in the report.

- Scott Davis noted that the endorsement of a report is not an endorsement of a methodology. A general disclaimer to the Legislature should suffice. He added that there are some mechanical things that can be done to improve the odds. Options include doing with Medicaid what we do with Medicare.

- Scott Davis replied that HMOs, managed care plans and PSNs would pay the same way they are doing today then there would be a supplemental payment that the hospitals would send a bill to AHCA to get the differential between the full rate and county rate. On the shadow bill process that is right. A bill for a supplemental amount.

- Michele Morgan asked what the panel wants the report to show. Do you want to list through an example of a methodology or do you want to keep it more general that there are possibilities and give a short description that this could be done by direct payment to the health plan?

- Tom Wilfong noted that there should be options subject to CMS approval. The committee should represent whatever the different models are; we should have options, plan A, plan B, and plan C.

- Scott Davis asked to point out the strength and weaknesses of all the alternatives; like what California has done with CPE based models.

- Tom Wilfong noted that the biggest challenge is keeping the funding streams intact.

- Scott Davis discussed that to the extent we do not have a mechanism of tying this all back together to return IGTs to the resources; geographic limitations.

- Michele Morgan noted that in future discussions with CMS, we need to determine where the authority is and how clear it is.

- Michele Morgan proposed identifying the pros and cons of the GME shadow billing, physician UPL and supplemental payments. All of them require CMS’ approval. A con of GME shadow billing and supplemental payments are not clear authorities because there is not an immediate solution. Capitation supplemental payment is something that can be billed into a methodology.

- Tom Wilfong noted that a pro to one is utilization would be identical, payment would equal utilization. A pro or con, depending on your prospective, to the other model is that retrospective utilization is not necessarily indicator of future utilizations so you have the issue of two separate periods being used to determine the funding sources so both parties will be at risk.

- Michele Morgan noted that HMOs are paid on an area specific rate. We are not looking for a direct payment from a county that would go into a pot of money and
would lose its identity. It would be area specific to where the money that came from that area would be repaid to the HMOs and capitated programs that participated with those hospitals in that specific area.

- Tom Wilfong began a review of a model. This is the expense side not the revenue side; it is the expense the state is currently paying the hospitals. This is the incremental value of the exempt and the IGT. Of the utilization that exists, what happens if the utilization changes in subsequent periods? It gets redistributed between hospitals A, B and C; what would be the resulting impact on those hospitals? So what we have done is compensated for a reduction in utilization for a unit cost.

- Tom Wilfong continued to note that if we do not find a way to fix the value of payments, the fee for service payment would be $50 million; the question is do you still fund $10 million to get $50 million back? They are going from funding $12 million to netting $113 million.

- Michele Morgan noted that with the counties and hospitals, for the purpose of the report, if there is not a guarantee of payback of IGT is this is a no go? Counties want that option clarified in the report.

- Michele Morgan noted that if there was a way to provide an adequate payment that would guarantee a pass through or a payback at the same level that they would achieve under LIP or any of the current programs right now, it would still be a viable option? It would end up being an individual decision by county.

- Michele Morgan noted that regardless of what the total is in the current year the problem is going to be where does the money have to go back to? Even if there is an ability state-wide to build in this amount, the additional amount, it may not be feasible to build it into the appropriate areas.

- Scott Davis noted that as far as the report goes, unless there is a way of ensuring the funding coming back there is no way to ensure the funds going up.

- Kevin Kearns expresses that he struggles to understand if it is $161 million and it’s put in and they get their money back and maybe an allocation factor why does it matter what the utilization is in counties if the rates are set based on the overall utilization as they are today.

- Michele Morgan responded by explaining that by transitioning populations out of Managed Care: we do not clearly specified in our methodology that this is going to be used to set forward and therefore be part of our distribution, and if there is a push to go from Fee For Service into Managed Care you are going to lose that Fee For Service, those cost limit is going to go down, that money is now going to be looked at from the Managed Care side. If that portion is not built into the cost limit, there will not be enough money or authority within those cost limits to justify that payment even if the authority existed. Making those cost limits and amending the reimbursement document would be very key and essential. The Agency is also in the process of negotiating the renewal of that waiver; those terms and conditions are subject to review by CMS. We are not sure if we are going to continue those terms and conditions as they currently exist right now.

- Scott Davis noted that it is an all inclusive rate not just a hospital component. With Managed Care you get paid for a patient not for a patient’s hospital care. And then out of that you have to they are getting. What proportion of that capped rate CMS would buy off as allowing for the hospital component of services versus the rest of the component?
- David Verinder noted that the actual rate cancellation to the plans does not change by putting more people into the plan. What changes is the calculation of the funding source for those payments to the plan.
- Scott Davis noted that in order to keep the state whole, you have to separate the incremental value of the IGT payment because that would not have been funded through general revenue, which would have had to come from a different funding source.
- Tom Wilfong added that the panel will have to minimally say here are the counties that benefit in the participation level by counties so that topically everyone understands that. So you list all the counties and what they get back.

IV. Follow-up Conference Call Schedule

- November 30, 2010 10:00AM – 12:00PM
- December 7, 2010 10:00AM – 12:00PM
- December 9, 2010 10:00AM – 12:00PM
- December 14, 2010 10:00AM – 12:00PM
- December 16, 2010 10:00AM – 12:00PM

V. Adjournment

- Meeting adjourned at 2:15pm