IGT TAP Minutes
December 7, 2010
10:00 a.m. - 12:00 p.m.
Meeting Minutes

IGT TAP Members
1. Tom Wilfong
2. Michael Good
3. Scott Davis
4. Margaret Brennan
5. Chris Paterson
6. Guerlin EscarMangos for Mary Lou Tighe

Agency Staff Present
1. Michele Morgan
2. Melanie Brown-Woofte
3. Edwin Stephens
4. Shannon Bagenholm

Non-Members Participating by Telephone
1. Roger Hahn
2. Randy Lewis
3. Mary Pat Moore
4. Stacy Kilroy
5. Chip Carbone
6. Deborah Breen
7. Jeff Harris
8. Mary Beth Dyer
9. Janet Carter
10. Lori Hundley
11. Paul Belcher
12. Marty Lucia

I. Welcome/Opening Comments

Michele Morgan, Bureau Chief for Medicaid Program Analysis, opened the conference call at 10:00 a.m.

Michele Morgan discussed the purpose of the conference call was to catch up on postponed Minute approvals and reviews; go through physician UPL summary; walk
through the revised draft report to get some feedback on what else should be included and find out how the panel is feeling about the tone; request any suggestions and submit any changes for consideration and input into the report; go through some data and table requests. Things included in the packet: Physician supplemental payment summary; updated county referral and utilization patterns; draft report.

Tom Wilfong asked to discuss the county referral pattern and utilization. It will help evaluate by county if we can cross reference that to the funding by county we will see who the winners and contributors are. It also makes it interesting for the counties in that if they would like to do something unique that would give the opportunity for those who contribute to highlight how their contributions are being used to benefit those counties that do not contribute.

II. Approval of November 16, 2010 and November 30, 2010 IGT TAP Meeting Minutes

The meeting minutes from the November 16, and November 30, 2010 IGT TAP meetings were postponed until the next meeting.

III. Physician UPL

Dr. Michael Good began by going over the summary of the Physician UPL first two paragraphs are suggested edits for the draft report mainly helping to clarify some of the issues so the suggested additions are the underlined text and also wanting to help set the framework for this process involves certified public expenditures and it is a way of helping to fund costs of medical education that currently flow through the Medicaid program;

Dr. Michael Good noted that on the first page we suggest that the appropriate portion of the report we talk about the medical school teaching of faculty physicians. The broad scope and depth of Medicaid services that are provided at the University of Florida for our faculty group practice plan 25% of our patients are Medicaid patients; so we attempt to describe the current system which draws down federal funds to help support provision of services to Medicaid patients in the teaching environment, where students and residents are present. We describe the current system which is set up around the Fee for Service. At the bottom of page one the current conditions or the supplemental payments are directed to a medical school as part of the public school university system. On page two: we talk about how the current supplemental payments are based on a Fee for Service mechanism so our challenge is figuring out how to preserve these federal draw down dollars as the State moves to capitated Managed Care plans. If we do not develop that methodology, we will lose the federal funds which are currently in excess of one hundred million dollars. Toward the middle of page two, we tried to outline, as the state moves to Managed Care towards Medicaid
beneficiaries, we need a new reliable mechanism to draw down the federal support for the teaching physicians as the state makes the transition, to set the stage for a dual track. Over time a greater portion of patients will move to Managed Care but in the early years will still be patients who are in the Fee for Service mechanism so we need to try to preserve that, the supplemental payment provisions of the Fee for Service system under the state plan. In item C we discuss provider service networks and the authority to establish this network is a part of the State’s Medicare plan and CMS waiver so it does require CMS approval. The provider service network is a shared savings Fee for Service approach and it has over 45,000 beneficiaries at present. We believe this is one way to help continue the supplemental teaching physician payments. The solutions and potential models we talked about in the beginning of this workgroup included looking at a risk pool approach maintaining the Fee for Service component that is in place since it does work and then you have to set up a parallel track for a patient to move to capitated Managed Care plan. Currently those patients, the supplemental payment mechanism to the teaching physicians do not follow. We then describe each of the approaches and point out that we do not necessarily have to have a single solution. Our eventual solution is maybe one that involves components of each approach already addressed. Then we try to wrap it up, and I have made the analogy that right, wrong or indifferent, this country tries to support its graduate medical education through the Medicare program and for many historical reasons, Florida medical schools are supported with federal funds through the Medicaid program. So we try to encourage the Legislature and others who in a different venue and approach are funding the State’s medical schools that this is an important source of federal funds not to lose.

Tom Wilfong asked if there is anything you are aware of in the Certified Public Expenditures (CPE) process that would preclude a retrospective utilization review and a supplemental payment to the capitated PSNs and HMOs that would allow for a similar process that we discussed for the hospitals. So we would look in the rearview mirror and see how much utilization used and if supplemental payment would be made to the health plans and the health plans would turn and provide you the reimbursement consistent with the current reimbursement? Would the same funding mechanisms that would allow for a retrospective utilization than a prospective payment to the health plans that the health plans could then pay the base rate and the additional dollars that exist in FFS continue to work?

Michele Morgan replied yes, if we build in the component into the PMPM then it would be based on historical utilization then we would assume that we would have to adjust for that the same way we would for the hospital payment.

Tom Wilfong asked if essentially there is a formula that would make the medical schools whole, to the extent that utilization in the future mirrors utilization in the past. Michele noted that there is a formula.
Dr. Michael Good noted that to the degree of however those details would work out, mirror the current program, which is based on utilization, in concept that is what happens as we certify our expenditures as the State portion and then the federal portions are paid to use based on utilization retrospectively at the end of the quarter.

Tom Wilfong noted that if a proxy was made between that expenditure and the Managed Care utilization and we were funded we could probably accelerate payments to you we just could not true up?

Michele Morgan replied that is correct. The difference is the fact in the FFS environment when we make those quarterly payments we can tie it directly to that utilization and by building it into the Managed Care we have to convert it into a prospective risk bearing payment so that is where we cannot make the payment to the health plan to pass directly to you for those actuals so you are going to lose some of that direct relationship that could make for ups and downs over the six month period.

Dr. Michael Good asked if it would or would not be related to utilization.

Michele Morgan replied that it would be related to utilization but it would not be the same as what you are seeing in the FFS because right now you get paid right after that quarter ends based on the claims of the utilizations you send to us. You are going to get paid how the health plans pay you so you could be submitting that but what we build into the capitation is going to be based on projected utilization based on your history.

Michele Morgan noted that there will be a time lag based on the data we use to do the prospective rate. There will not be a time lag on how they reimburse you.

Dr. Michael Good asked if AHCA or CMS would have to approve this on the CPE mechanism. Is that something that is doable?

Michele replied that is primarily a CMS issue. CMS does not typically view CPEs the same way they do qualified IGTs. So I am not able to give you an answer right now on whether or not I think that will fly.

Tom Wilfong asked does the South Carolina model do this.

Michele Morgan noted that South Carolina does not do CPEs.

Dr. Michael Good noted they do not use CPEs or IGTs; they actually use state general revenue. They push state general revenue into the third party core for the state share so their model is different than the way we use CPEs.

Michele Morgan noted that we will start imputing the draft report into the next version.
Michele Morgan asked the panel members if they would prefer to table the walk through of the draft report until Thursday December 9, 2010. Michele Morgan explained to the panel that we will have a summary sheet to compile all of the edits suggested for the draft report.

IV. Adjournment

- Meeting adjourned at 11:15am