Florida Medicaid Intergovernmental Transfer Technical Advisory Panel Report

January 2011

AHCA
Florida Agency for Health Care Administration
Better Health Care for all Floridians
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Executive Summary

The 2010-11 Florida Legislature passed Senate Bill 1484 (Chapter 2010-144, Laws of Florida), Section 2, which instructed the Secretary for the Agency for Health Care Administration to appoint and convene a technical advisory panel to advise the Agency in the study and development of intergovernmental transfer distribution methods.

“(2) The Secretary of the Agency for Health Care Administration shall appoint members and convene a technical advisory panel to advise the agency in the study and development of intergovernmental transfer distribution methods. The panel shall include representatives from contributing hospitals, medical schools, local governments, and managed care plans. The panel shall advise the agency regarding the best methods for ensuring the continued availability of intergovernmental transfers, specific issues to resolve in negotiations with the Centers for Medicare and Medicaid, and appropriate safeguards for appropriate implementation of any developed payment methodologies.

(3) By January 1, 2011, the agency shall provide a report to the Speaker of the House of Representatives, the President of the Senate, and the Governor on the intergovernmental transfer methodologies developed. The agency shall not implement such methodologies without express legislative authority.”

The Agency Secretary nominated nine members to compose the Intergovernmental Transfer Technical Advisory Panel. The Members are directly related to entities contributing intergovernmental transfers (IGTs) such as hospitals, medical schools, local governments, and within the scope of this report, managed care plans. The Agency, as facilitator and staff for the Panel, created and submitted a charter to the Panel at the first meeting. The Panel adopted the charter, which specified purpose and scope, as the basis and direction of the Panel. (See Appendix A.)

The panel convened XXX public meetings via conference call or face-to-face between XXXXXX, 2010 and XXXX, 2010. Minutes and documents pertaining to those meetings can be found on the Agency’s website at the following link:

XXXXXXXXXXXXXXXX

During the initial meetings of the Panel, the Agency provided an overview of the current processes and methodologies used for rate setting for both the managed care capitation and the hospital fee-for-service (FFS) rates. In addition an explanation of the current use of IGTs in the FFS and that no IGTs are collected for the purpose of managed care rates. Details of the process for collection and distribution of IGTs were also provided.
The panel was provided three scenarios to consider through the discussions regarding what the IGTs would be used to fund through the capitation rates. Currently, IGTs are used to fund Hospital Exemptions and Buybacks for FFS. If IGTs become a funding source for the Managed Care rates it is unclear what level would be required by IGTs.

1) IGTs to fund all exemptions and buybacks for all managed care recipients regardless of prior funding of General Revenue (GR) within the capitation rate.
2) IGTs to fund all Exemptions and Buybacks for only the expansion population from FFS into Managed Care.
3) IGTs to fund only the incremental portion for Exemptions and Buybacks for all managed care recipients regardless of prior process.

A single methodology could be usable regardless of the scenario selected. However, the complexity and the funding level of each scenario differ significantly.

Through the deliberations of panel concerns were identified from all parties. The primary concern was the counties and the willingness and or ability to provide the IGTs as the funding source for the purpose of managed care. Counties are currently required to fund a portion of hospital stays. In addition, counties can elect to provide IGTs for the purpose of Exemptions and Buybacks for FFS. Many Hospitals that receive funding for Exemptions and Buybacks do so under the authority of the Low Income Pool (LIP). The LIP provides authority and incentive for counties with excess dollars to provide those dollars for the benefit of other hospitals and programs outside of the county.

The LIP is a limited budget program of $1 Billion. Due to the growth of Exemptions and Buybacks, the program is unable to allow for continued funding levels for hospital Exemptions and Buybacks. This means that without more counties being able to provide funding for the hospitals in the community the hospital may not receive the same benefit of being eligible for exemptions or buybacks as the facility has in the past.

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.

In addition to the concern of IGT funding the counties and hospitals expressed the concern of distribution of IGTs to the intended facilities. A capitation rate is a prospective rate that is determined based on historical data and is projected based on trends and risk of the population. Under the FFS, the hospital receives direct payment related to the service and individual. Under a captitated methodology it is most likely that payment to the plan will be based on prior utilization of the hospital. Hospital utilization can change due to plan negotiations or recipient and provider practices.
The Managed Care plans expressed concerns of adequate funding and rate negotiations for the population in relation to the Hospitals in the Areas of operation. Representatives on the panel for the managed care plans expressed interest to treat any IGT methodology as pass through for the purpose of hospital services.

In addition, the IGT TAP addressed payment and methodology options that could be utilized to expand the Physician Upper Payment Limit program (Physician UPL). This is a payment process that allows the Medical Schools to provide state certified match and receive and increased payment for qualifying services rendered by approved staff. This payment program currently does not provide increased payments related to recipients served through Medicaid managed care plans.

As concerns and methods were identified and discussed, the Agency provided input related to Federal regulations and requirements allowing or preventing processes pertaining to reimbursement.

Possible methodologies were presented and discussed by the Panel. Due to the complexity of the program, the concerns and the uncertainty of program level the panel did not conscience on a single methodology to present through this report. Information related to the methods presented are attached to this report.
Panel Overview

The Agency for Health Care Administration (Agency) Intergovernmental Transfer Technical Advisory Panel Reimbursement was established under the authority of Senate Bill 1484 (Chapter 2010-144, Laws of Florida), Section 2.

The responsibilities of this Panel were to advise the agency regarding the best methods for ensuring the continued availability of intergovernmental transfers, specific issues to resolve in negotiations with the Centers for Medicare and Medicaid, and appropriate safeguards for appropriate implementation of any developed payment methodologies.

Based on this discussion and analysis, the Agency developed this report, to be submitted to the “The Speaker of the House of Representatives, the President of the Senate, and the Governor by January 1, 2011.” The Panel reviewed and evaluated various methodology alternatives and reported only on those methodologies funded through the Florida Medicaid program.

Discussions not covered by the description above (reimbursement and payment issues) are outside the scope of the Panel and were not to be included as topics of discussion.

This Panel consisted of nine members appointed by the Secretary for the Agency for health care Administration, based on the Legislative authority listed above. Agency staff served as facilitator and resources for, but not members of, the Panel.

Members of the Panel were:

2010 Intergovernmental Transfer Technical Advisory Panel Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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<tbody>
<tr>
<td>Tom Wilfong</td>
<td>Chief Operating Officer \nAmerigroup</td>
</tr>
<tr>
<td>Chris Paterson</td>
<td>Plan President \nSunshine State Health Plan</td>
</tr>
<tr>
<td>Kevin Kearns</td>
<td>President and Chief Executive Officer \nHealth Choices Network</td>
</tr>
<tr>
<td>David Verinder</td>
<td>Chief Operating Officer \nSarasota Memorial Health System</td>
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<tr>
<td>Mary Lou Tighe</td>
<td>Corporate Director, Governmental Relations \nJackson Memorial Health System</td>
</tr>
<tr>
<td>Margaret Brennan</td>
<td>Health Services Division Manager \nOrange Health Services</td>
</tr>
<tr>
<td>Mark Knight</td>
<td>Chief Financial officer \nHealth Care District of Palm Beach County</td>
</tr>
<tr>
<td>Scott Davis</td>
<td>Director, Revenue Cycle Management \nSouth Broward Health Care District/ Memorial Regional Hospital</td>
</tr>
<tr>
<td>Michael Good</td>
<td>Dean, College of Medicine \nUniversity of Florida</td>
</tr>
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The Panel met six times between July 2010 and October 2010 in order to accomplish the duties outlined in the statute above. Agency staff worked with members to develop supporting documentation of items for each meeting. All documentation and minutes of each meeting are posted online at:

Please refer to Appendix A – Panel Charter for complete details of Panel membership, duties, meetings, etc.

**Definition of Intergovernmental Transfer (IGT)**

Intergovernmental transfers are the transfer of funds from different levels of governments or governmental entities/taxing districts to the state government, commonly referred to as IGTs. Once used as part of the state share of Medicaid funding, the transferred funds would be matched with federal Medicaid dollars and then returned to the local government or taxing district through higher provider payment rates or special Medicaid payments.

**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. (add attachment for 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 the state share of matching funds required to fund the levels of exemptions and buybacks for the communities around the State.

**Issues of Concern Related to the Current IGT Methodology**

The members of the Panel identified issues of concern related to the evaluation of alternative reimbursement and payment methodologies for managed care including prospective payment methodologies. The panel would report its findings, including any recommendations, to the Director of Medicaid as to the outcome of their fact finding.
Goals and Alternatives

Each member was given the opportunity to offer what he or she felt was the most important goals and objectives for the Panel to accomplish by the end of the panel’s term and to mention any specific concerns they had regarding possible IGT approaches in Medicaid managed care. The Panel members agreed on the following list of common goals and concerns:

- The need for a base methodology to establish a supplemental payment for managed care
- Minimize any potential disruption in IGTs/CPEs that finance Medicaid provider payments to hospitals and physicians if Medicaid managed care is expanded
- Create a clear, approvable methodology to establish supplemental payments to hospitals and medical school faculty funded by IGTs/CPEs
- Preserve access to care for Medicaid patients, including access to specialty care and access to medical school faculty practice plans
- Retain incentives for existing local financing arrangements for Medicaid provider payments
- Be careful not to disrupt use of IGTs that are not bound by specific regional/county geographical constraints today
- Consider retrospective payment process so no party is hurt
- Investigate other opportunities for federal matching, such as ways to expand the pool of IGT providers, within federal rules
- Concern that the supplemental payment would be made to the managed care organizations and, theoretically, passed on to the safety net providers

Current Status and participation of IGTs

There are XXXX counties that provide IGTs for the purpose of Exemptions and Buybacks. Current IGTs are provided at XXXX level. There are approximately XXXX Medicaid recipients potentially eligible for transition from FFS to Managed Care. This population currently utilize: XXX days Inpatient and XXX outpatient encounters. Exemptions for the potential transition population would be XXXX of the current provided IGTs.

There are XXXX Hospitals in XXXX counties that benefit from the current FFS IGT funding process. Of which XXXX are contributing Counties or Hospitals. XXX counties provide excess funding, while XXXX provide partial or no funding. Without a secure process of obtaining Funding the excess may not be eligible for use to fund other areas of the state which would result in lower payments to the non-contributing with excess Hospitals.

Current HMO methodology and Issues

Possible impact of Managed Care Expansion and Impact on FFS Hospital
Solutions resulting from Use of IGTs (methodology and distribution detail)

Physician Payments

Funding Source

The introduction of IGTs into the Managed Care as a funding source is a requirement of a successful supplemental payment methodology. However, this concept is not supported by all qualifying authorities for the IGTs. The Agency and as a part of the IGT TAP requested feedback from counties and taxing authorities related to the TAP and the prospect of bringing IGTs in as a funding source. (include feedback responses if approved) The responses varied due to factors such as ability to provide funding and interest of providing funding to be used for payments to the managed care plans.

Closing Comments

Additional details relating to the issues, goals and alternatives are discussed later in this report.
Appendices

Appendix A

INTERGOVERNMENTAL TRANSFER TECHNICAL ADVISORY PANEL

This body shall be known as the Agency for Health Care Administration (AHCA or the Agency) Technical Advisory Panel on Intergovernmental Transfers under the authority of Chapter 2010-144, Laws of Florida.

PURPOSE/SCOPE

The responsibilities of this Panel shall be to advise the Agency in the study and development of intergovernmental transfer distribution methods. The Panel shall advise the Agency regarding the best methods for ensuring the continued availability of intergovernmental transfers, specific issues to resolve in negotiations with the Centers for Medicare and Medicaid, and appropriate safeguards for appropriate implementation of any developed payment methodologies. Based on these discussions, the Agency for Health Care Administration will develop a report to be submitted to the Speaker of the House of Representatives, the President of the Senate, and the Governor on the intergovernmental transfer methodologies developed. The agency shall not implement such methodologies without express legislative authority.

Discussions not covered by the description above are outside the scope of the Panel and will not be included as topics of discussion.

MEMBERSHIP

The Panel will be composed of representatives from contributing hospitals, medical schools, local governments, and managed care plans.

Agency staff will be the Facilitator and resources for, but not members, of the Panel.

Members of the Panel shall be appointed by the Secretary of the Agency for Health Care Administration.

Resignation/Vacancies: A member wishing to resign prior to the end of his/her term shall submit a letter of resignation to the Agency Facilitator of the Panel and the Secretary of the Agency for Health Care Administration. The Secretary of the Agency for Health Care Administration shall fill each vacancy on the Panel for the balance of the unexpired term, if appropriate. Priority consideration must be given to the appointment of an individual whose primary interest, experience, or expertise lies with clients of the Agency.

Nominations for member vacancies will be submitted to the Agency Facilitator of the Panel. If an appointment is not made within 120 days after a vacancy occurs on the Panel, the vacancy may be eliminated at the will of the Agency.
The Agency shall appoint a Facilitator of this Panel. The term of the Facilitator shall be until the Panel is disbanded. The Facilitator will be an employee of the Agency and selection is at the discretion of the Secretary of the Agency for Health Care Administration.

Five members shall constitute a quorum.

**DUTIES OF THE PANEL**

The Agency will author a report on the Panel’s findings and retains control of its content.

The duties of the Panel shall include the following:
A. Evaluation of alternative reimbursement and payment methodologies for managed care including prospective payment methodologies.
B. Report findings, including any recommendations, to the Director of Medicaid as to the outcome of their fact finding.

**MEETINGS**

The Panel shall meet once a month for the first July and August and begin meeting twice a month in September and October. The length of each meeting will be two hours.

Meeting materials shall be coordinated through the Facilitator. The Facilitator will work with the individual members to develop an agenda that is inclusive of their related topics; however the Agency will retain control of the final contents of the agenda. Staff will work with members to develop supporting documentation of their items for each meeting.

As part of the agenda, technical resource persons may present information to the Panel.

Audience participation shall be limited to attendance. The Panel meetings will not be open for public comment. However, items for the Panel’s agenda can be submitted to the Facilitator for consideration by the Agency.

**ABSENCES**

Members shall inform the Facilitator if they are unable to attend a scheduled meeting. In the event that a quorum will not be met, the Secretary for the Agency for Health Care Administration will determine if the meeting is to be rescheduled or proceed without quorum.

**REMUNERATION**

Members shall receive no compensation, or reimbursement for time or travel.

**PARLIAMENTARY AUTHORITY**

RULES OF ORDER: Except where there is conflict with this document, the rules contained in the current edition of “Robert’s Rules of Order” shall govern the Panel in all cases to which they
are applicable. Any special rules of order that the Panel or Agency may promulgate shall take precedence over “Robert’s Rules of Order.”

**FACILITATOR**

The Facilitator of the Technical Advisory Panel on Intergovernmental Transfers is responsible for providing necessary support to enable the Panel to accomplish its mission. In addition to facilitating the meetings of the Panel, the Facilitator will be responsible for: planning, organizing meetings; processing nomination and appointment papers; assisting in the implementation of plans, preparing status reports, implementation plans and progress reports; preparing summaries of meetings; and other activities as appropriate. The Facilitator shall not be a member of the Panel. The Facilitator shall be an employee of the Agency.