

**Florida Medicaid
Intergovernmental
Transfer
Technical Advisory
Panel Report**

January 2011



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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:

XXXXXXXXXXXXXXXXXX

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.

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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 inpatient and nursing home days. 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 without participation from existing counties and/or expanding the number of counties willing to contribute, community hospitals may not receive the same benefit of being eligible for exemptions or buybacks as the facility has in the past.

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 eligible to receive for services provided to persons in the community.

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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 base supplemental capitated rate regardless of their contractual relationship with or utilization of the providers supported by local tax dollars. The base supplemental would be adjusted based on utilization. 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 capitated 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.

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 at the same level experienced today.

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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.

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 an 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 concur on a single methodology to present through this report. Information related to the methods presented are attached to this report.

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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

Name	Affiliation
Tom Wilfong	Chief Operating Officer Amerigroup
Chris Paterson	Plan President Sunshine State Health Plan
Kevin Kearns	President and Chief Executive Officer Health Choices Network
David Verinder	Chief Operating Officer Sarasota Memorial Health System
Mary Lou Tighe	Corporate Director, Governmental Relations Jackson Memorial Health System
Margaret Brennan	Health Services Division Manager Orange Health Services
Mark Knight	Chief Financial officer Health Care District of Palm Beach County
Scott Davis	Director, Revenue Cycle Management South Broward Health Care District/ Memorial Regional Hospital
Michael Good	Dean, College of Medicine University of Florida

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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 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. (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. CPEs are currently used for supplemental payments to teaching faculty physicians at the state's medical schools.

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.

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

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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. 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 and providers are able to negotiate reimbursement rates and payment terms with providers, and the Agency cannot require what level of "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. Many of those under traditional FFS are exempt or voluntary eligibles for 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.

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,

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some IGT contributors will no longer be able to partner with the State in support of the Medicaid program.

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.

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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,

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- 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.

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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.

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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.

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.

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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

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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.

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Appendix B

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