Draft Plan for Enhanced Primary Care Funding under the Low Income Pool

As part of House Bill 5001, the General Appropriations Act for State Fiscal Year 2010-11, Specific Appropriation 191 provides for allocation of the $1 billion in funding for the Low Income Pool program. A new initiative included as part of the proviso language under the Low Income Pool program seeks to increase access to primary care services. The language reads as follows:

"From the funds in Specific Appropriation 191, $4,615,400 from the General Revenue Fund, $5,000,000 from the Grants and Donations Trust Fund and $15,385,640 from the Medical Care Trust Fund are provided to increase access to primary care services in the state to reduce and prevent unnecessary emergency room visits and inpatient hospitalizations. In developing a plan to increase access to primary care services and the funding of these primary care services, the agency shall solicit proposals from general acute care hospitals, county health departments, faith based and community clinics, and Federally Qualified Health Centers in order to establish new primary clinics for the uninsured and underinsured. Of the funds provided, the agency shall use $25,001,040, which includes $4,615,400 in general revenue and $5,000,000 in local funding pay for the increased access to primary care services. The use of general revenue is contingent upon an equal amount of local funds being provided in cash. The agency shall award grants to those programs most capable of reducing health spending and improving the health status of uninsured and underinsured persons in their community and meeting the requirements of this section. The programs receiving these grants shall reduce unnecessary emergency room visits and preventable hospitalizations by providing disease management; improving patient compliance; and coordinating services. The agency shall contract with an entity having experience in evaluating the Medicaid program to develop reporting requirements for grant recipients and to measure the effectiveness of the grant-funded programs. The specific reporting requirements shall be incorporated into the competitive solicitation which will also identify the evaluation methodology and establish a time-table for publishing results. The agency shall develop a plan for expanding primary care services by October 1, 2010, and submit the plan to the Legislative Budget Commission for approval before expending any grant funding."

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The American Recovery and Reinvestment Act of 2009 (the Stimulus) provided for an across-the-board increase in Federal Medical Assistance Percentage (FMAP) given to states. The amount of the increase was based on a tiered system reflecting percent increase in unemployment for each state, with the highest tier receiving an 11.5% increase. Florida's unemployment rate qualified the state for the highest tier. The enhanced FMAP was authorized through December 31, 2010.

The legislation recently passed by Congress provides for continuation of a stepped down version of the enhanced FMAP from January 1, 2011 through June 30, 2011.

The General Appropriations Act for 2010, passed during the 2010 Legislative session, contained several "contingency provisions" relating to budget reductions and other items contained in the GAA, allowing that, should the ARRA enhanced FMAP be extended, alternative funding methodologies be imposed. The back of the bill language would have increased the enhanced primary care funding from $25 million to $49 million. However due to specific instructions of the back of the bill language $10.1 million of the increase for this program is targeted for specific hospital entities, leaving an award distribution of $38.9 million. (See Attachment 1 for the "back

of the bill" contingency language.) The State has not adopted modifications to the appropriations or specific authorities required to implement the modified FMAP.

The Agency anticipates using an open application process and releasing the application in September. Each new project award, including match, is anticipated to be up to $1,500,000 per award. The Agency anticipates awarding between 25 up to 40 individual awards. The new projects will be selected based on specific criteria and the quality and design of the proposed project. The Agency will rate the proposals based on specific criteria including but not limited to: availability of in-kind contributions; ability to serve diverse geographic and minority markets, diverse delivery systems; and entities providing uncompensated care. The following are the core areas in which the applications will be evaluated and the awards will be based.

- Reduce unnecessary emergency room visits by developing initiatives to identify persons inappropriately using hospital emergency rooms or other emergency care services and refer those persons to primary care medical homes;

- Expansion of primary care infrastructure to provide additional people with a medical home, thereby supporting meaningful emergency room diversion efforts while also improving overall health care in the community.

- Initiatives to increase the availability of disease management services for persons with ambulatory care sensitive conditions such as diabetes, asthma, hypertension, COPD, and high cholesterol, who are not enrolled in a Medicaid MCO or DM program.

- Expansion of primary care through expanded service hours, example: evening or weekend hours.

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An Agency review team will be appointed to review proposals. The responsibility of the review team will be to review and rate each proposal based on specific criteria such as merit, ability to provide a design to meet the core areas as listed above and the quality and design of the reporting of the results for the core areas. Once the review team completes the review, a recommendation to award will be provided to Agency management.

The Agency anticipates that the 25 to 40 awards will be made in November and that distribution of funds based on the number of viable applications will start prior to December 31st.

The plan for expanding primary care services will be submitted to the LBC by September 2010. The plan must be submitted and approved before funding can be distributed.

An overview of this proviso was presented to the LIP Council at the July 21st meeting. The Council was very interested in this project funding, and in providing input as the plan is developed. The Council asked for more details, and this issue will be brought back to the Council for specific input on the questions outlined above as part of the agenda for the Council's August 18th meeting.

Timeline

- Mid August – Meet to determine evaluation criteria.
- Mid September
    - Post application to participate in distributions.
    - Submit plan to Legislative Budget Commission for approval
- October
    - Close application process.
    - Review and grade applications.
    - Announce providers to be awarded distributions.
- November – Contract with Counties and taxing districts for state share of distributions.
- December - Begin distribution of funding.

The Agency must determine which entities will be eligible for funding under this program. Through the LIP program, the Agency has extensive experience working with hospitals, County Health Departments (CHDs), and Federally Qualified Health Centers (FQHCs). To date, the Agency has limited experience working with faith based and non-FQHC community clinics. The Department of Health, through its Volunteer Health Services Program, does have experience with these entities. Agency staff has received from DOH a listing of more than 100 faith based and community clinics with which the department has ongoing relationships. This list will serve as the basis of outreach by the Agency to these entities.

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In order to receive Medicaid funds, all entities would need to be enrolled as Medicaid providers or partner with a Medicaid enrolled provider through which project funds could flow.

Examples of considerations include:

- One of the hospital districts partners with a clinic operated by the local First Baptist Church for purposes of the hospital's ER diversion program. If that cooperative venture were to seek project funds, the funding would need to flow to the hospital district or the church clinic would need to enroll as a Medicaid provider. Participation criteria such as this will be specified and emphasized in the application process.
- Distribution of the funding among the eligible entities. The Agency will determine "set asides" for each type entity eligible for funding—that is, a certain amount or percentage for hospitals, for CHDs, for FQHCs, for faith based and community clinics. Examples include but are not limited to specific grant awards for:
    - Specified geographic areas
    - Target population
    - Sustainability of programs (e.g., other funding sources)
    - Diversity of eligible provider entities

The Agency will establish up to $1.5 million cap per award, depending on the nature of the proposed project and the history of the project entity(ies) with similar projects. To have the maximum impact on emergency room diversion the provider would have to invest a substantial amount to expand primary care services —enough to support extended clinic hours on nights

and weekends, establishing disease management or medical home capability, to include pharmacy assistance programs and a referral and tracking system.

Another requirement of this proviso is specific to entering an agreement with an entity with evaluation experience to develop the reporting/evaluation requirements for the program. The Agency will utilize an existing contractor that has experience with grants and reimbursement methodology for the uninsured. It should also be noted that the Department of Health has done some of this work and has standards in place already for its LIP funded projects. The Agency will evaluate criteria that may be refined and used for this purpose.

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Attachment 1: HB 5001--Back of the Bill Language (Part of Section 84)

From the funds in Specific Appropriation 191, $4,676,400 from the General Revenue Fund, $11,180,673 from the Grants and Donations Trust Fund and $33,145,007 from the Medical Care Trust Fund are provided to increase access to primary care services in the state to reduce and prevent unnecessary emergency room visits and inpatient hospitalizations. In developing a plan to increase access to primary care services and the funding of these primary care services, the agency shall solicit proposals from general acute care hospitals, county health departments, faith based and community clinics, and Federally Qualified Health Centers in order to establish new primary clinics for the uninsured and underinsured. Of the funds provided, the agency shall use $38,947,353, which includes $4,676,400 in general revenue and $7,926,963 in local funding to pay for the increased access to primary care services. The use of general revenue is contingent upon an equal amount of local funds being provided. The agency shall award grants to those programs most capable of reducing health spending and improving the health status of uninsured and under insured persons in their community and meeting the requirements of this section. The programs receiving these grants shall reduce unnecessary emergency room visits and preventable hospitalizations by providing disease management; improving patient compliance; and coordinating services. The agency shall contract with an entity having experience in evaluating the Medicaid program to develop reporting requirements for grant recipients and to measure the effectiveness of the grant-funded programs. The specific reporting requirements shall be incorporated into the competitive solicitation which will also identify the evaluation methodology and establish a time-table for publishing results. The agency shall develop a plan for expanding primary care services by October 1, 2010, and submit the plan to the Legislative Budget Commission for approval before expending any funding. The agency shall use $10,054,727 of these funds for hospitals providing primary care to low-income individuals and participating in the Primary Care Disproportionate Share Hospital (DSH) program in Fiscal Year 2003-2004 shall be paid $10,054,727 distributed in the same proportion as the Primary Care DSH payments for Fiscal Year 2003-2004, excluding Imperial Point Hospital, Memorial Regional Hospital, and Memorial Hospital Pembroke, who will receive individual amounts equal to $536,489, $1,620,659, and $536,489 respectively. These funds are contingent on the state share being provided through grants and donations from counties, local governments, public entities, or taxing districts.

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