RICK SCOTT
GOVERNOR

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May 6, 2016

Mr. Jarrod Fowler
Office of the General Counsel
Florida Medical Association
1430 Piedmont Drive East
Tallahassee, FL. 32308

Dear Mr. Fowler:

Thank you for your April 26, 2016, letter regarding the Managed Medical Assistance (MMA) program Physician Incentive Program. Below is information in response to the questions included in your letter.

Question:

Where does AHCA find the statutory authority to allow health plans to provide payment under the Physician Incentive Program to only "Qualified Providers"?

The statute provides that *"Effective care management should enable plans to redirect available resources and increase compensation for physicians. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. "*

This statute does not call for increased compensation for "certain physicians to be determined by AHCA" or only for pediatricians and OB/GYNs. The plain language indicates that it is for all physicians. Why is AHCA allowing the plans to only include board certified pediatricians and OB/GYNs?

Response:

You have not included the entire statutory section in your question. In full, the statute actually reads as provided below (emphasis added):

(a) Physician compensation.—Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect ***available resources*** *and increase compensation for physicians. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services.* ***The agency may impose fines or other sanctions on a plan that fails to meet this performance standard after 2 years of continuous operation.***

The statutory language contains three general concepts: (1) plans should utilize available resources to increase compensation to physicians; (2) these compensation increases must come from savings realized through efficiencies and not from additional appropriations; and

(3) the Agency has discretion in whether and how to enforce the provision via its plan contracts, as made clear by the use of the word may.

The Agency has performed an initial estimate of available resources (i.e., savings gained through efficiencies) and those resources would not be sufficient to effectuate a rate increase for all physicians. Thus, the Agency narrowed the scope of the initial rate incentive program to ensure that providers serving Medicaid recipient children will be those initially eligible to receive an incentive payment and that require health plans to set qualifications that will provide these provider types with a reasonable opportunity to earn the Medicare rate for services.

The Agency has no authority to, and will not, develop a program that requires an additional appropriation to fund rate increases. Rather, the Agency is bound to design a program that will utilize "available resources," and that it will enforce via the plan contracts.

Question:

Why should "Identified Providers", who are already providing care to Medicaid patients at below market rates, have to jump through additional hoops to "earn" the MMA physician incentive by becoming "Qualified Providers"?

Response:

Each Medicaid provider participating in the Managed Medical Assistance program has the opportunity to negotiate their reimbursement rate in their contract with each health plan. Based on information provided to the Agency by the health plans, many providers have negotiated rates well above the Medicaid fee-for-service rate. The incentive program gives certain identified physicians the opportunity to earn more than the rate that they have negotiated and accepted. Rate incentives are just that, incentives to achieve objective outcome, access, and efficiency measures intended to improve care and outcomes for Medicaid recipients within the scope of available resources. A goal of the rate incentive program is to align physician provider incentives with plan incentives (or disincentives) resulting in improved care for Medicaid recipients. Utilizing rate incentive rather than blanket rate increases allows a larger rate increase for a smaller number of providers who outperform their peers on objective measures, rather than a smaller rate increase to a larger population of providers with no guaranteed improvements in access, outcomes, or efficiencies.

Question:

Does AHCA have any parameters as to what the qualifications for the IHP Incentive Program can include?

Response:

Individual Health Plan Incentive Program proposals (IHP Incentive Proposal) must give identified providers a reasonable opportunity to earn the incentive payment.

Question:

Regarding Section 4 of Attachment 1, it appears that the health plans have broad discretion to exclude subsets of Identified Providers from the IHP Incentive Program. Why do health plans have such discretion?

Response:

As with all other components of a plans IHP Incentive proposal, any proposal to exclude providers must be approved by the Agency. The intention of this provision is to allow the plans to exclude providers who, through other mechanisms, are already earning at or above the Medicare rate or who do not have a relationship with the health plan.

Question:

Will the Physician Incentive Program be adopted through the rulemaking process?

Response:

No. Florida law gives the Agency discretion to enforce this provision via its contracts with the health plans. The statute specifically describes it as a "performance standard" that the Agency may enforce. The health plan contracts are not rules. See section 409.961, Florida Statutes (emphasis added).

409.961 Statutory construction; applicability; rules.—It is the intent of the Legislature that if any conflict exists between the provisions contained in this part and in other parts of this chapter, the provisions in this part control. Sections 409.961–409.985 apply only to the Medicaid managed medical assistance program and long-term care managed care program, as provided in this part. The agency shall adopt any rules necessary to comply with or administer this part and all rules necessary to comply with federal requirements. In addition, the department shall adopt and accept the transfer of any rules necessary to carry out the department's responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility and for ensuring compliance with and administering this part, as those rules relate to the department's responsibilities, and any other provisions related to the department's responsibility for the determination of Medicaid eligibility. ***Contracts with the agency and a person or entity, including Medicaid providers and managed care plans, necessary to administer the Medicaid program are not rules and are not subject to chapter 120.***

Question:

What penalties, if any, does AHCA intend to prescribe for health plans that do not comply with the Physician Incentive Program?

Response:

Penalties for non-compliance are still under development.

Question:

How did AHCA decide upon October 1, 2016 as the implementation date for the Physician Incentive Program?

Response:

October 1, 2016 is the first day of the new contract year following 2 years of continuous operation after the statutorily mandated implementation deadline for the Medicaid Managed Assistance program of October 1, 2014.

Question:

Could a health plan choose to exclude all Qualified Providers from their network so long as they meet the MMA program's network adequacy requirements?

Response:

No. Health plans are required to submit to the Agency a list of all qualifying providers by September 1, 2016 and the Agency will monitor against that list.

Question:

Does AHCA intend to gradually expand the range of providers included in the Physician Incentive Program? If so, has AHCA developed a strategy and timeline for doing so?

Response:

Yes. Expansion will be dependent on savings identified by the Agency and certified by the Agency's actuary.

Question:

Has AHCA estimated the cost of increasing compensation to all physicians to at least the Medicare rate? If so, what is the estimated cost and what assumptions were used in arriving at that estimate?

Response:

In the process of developing program parameters, the Agency estimated the cost of increasing compensation to primary care physicians for all services to children, as well as obstetricians, at approximately $400 million dollars.

Questions:

Have the health plans been able to achieve the efficiencies necessary to increase compensation for all physicians to at least the Medicare rate as described in statute? If not, why have the health plans been unable to recognize these efficiencies and what corrective actions are planned to address the shortfall?

Response:

> As you know, health plans participating in the MMA program were required to guarantee a 5% savings during the initial contract year. These savings totaled approximately $500 million, and were essentially returned to the tax payers. It appears that physicians have also seen significant increases in reimbursement under the MMA program, achieved through their negotiated plan contracts, which are presumably funded through program efficiencies achieved by the plans. Many of those rate increases doubtless occurred as a result of the strict network adequacy standards required by the Agency's contracts with the plans. The Agency welcomes further dialogue on this point.

We hope this information provides you with clarification regarding this program. Please do not hesitate to contact me if you have any additional questions or comments at (850) 412-4007.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/ks