

COMMITTEES:

TRANSPORTATION & INFRASTRUCTURE
RAILROADS, PIPELINES, AND HAZARDOUS MATERIALS, RANKING MEMBER
COAST GUARD AND MARITIME TRANSPORTATION
WATER RESOURCES AND ENVIRONMENT

VETERANS' AFFAIRS
HEALTH

MEMBERSHIPS:

CONGRESSIONAL BLACK CAUCUS
CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES
CONGRESSIONAL HUMAN RIGHTS CAUCUS
CONGRESSIONAL MISSING AND EXPLOITED CHILDREN'S CAUCUS
CONGRESSIONAL DIABETES CAUCUS
OLDER AMERICANS CAUCUS
PROGRESSIVE CAUCUS
THE DUMA CONGRESS STUDY GROUP

**Congress of the United States
House of Representatives
Washington, DC 20515**

CORRINE BROWN
3D DISTRICT, FLORIDA

REPLY TO:**WASHINGTON OFFICE:**

2336 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-0123
FAX: (202) 225-2256

DISTRICT OFFICES:

101 EAST UNION STREET
SUITE 202
JACKSONVILLE, FLORIDA 32202
(904) 354-1652
FAX: (904) 354-2721

805 SOUTH KIRKMAN ROAD
SUITE 202
ORLANDO, FLORIDA 32811
(407) 290-9031
FAX: (407) 298-9717

GAINESVILLE, FLORIDA
(352) 376-6476

June 15, 2011

Richard Jensen
Director
Division of State Demonstrations and Waivers
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore MD 21244-1850

Re: Florida Demonstration Project

Dear Mr. Jensen:

As the Representative for the Third District of Florida, which includes parts of Clay and Duval counties, I represent a large portion of the Medicaid beneficiaries and service providers engaged in Florida's Medicaid managed care pilot program. As you know, I am opposed to the extension of the pilot program without the addition of new safeguards to ensure that beneficiaries have stable access to high quality care. Based on your letter of April 28, 2011 to Secretary Dudek of the Florida Agency for Healthcare Administration, I understand that CMS also believes that stronger protections are warranted.

In an effort to contribute solutions to this process, I recently convened a meeting with local healthcare providers to develop recommendations for improving the pilot program. Shands Jacksonville, St. Vincent's Healthcare, Baptist Health, Duval County Health Department, and numerous primary care physicians and behavioral health providers participated. Representatives of CMS and the Florida Agency for Health Care Administration also attended the meeting.

The discussion produced some concrete ideas and many organizations have elaborated on them in writing. (Letters are attached.) Before detailing these recommendations, however, I want to share one fundamental observation: outreach by CMS and AHCA to providers has been insufficient. Many of the concerns raised by the providers are not new; yet it appeared as though administrators were hearing these concerns for the first time. Many in the room felt that even when concerns had been heard, little changed.

For these reasons, my highest priority recommendation is that CMS station at least two representatives in Florida – one for the Duval area and one for Broward. Judging the results of this experiment simply cannot be done based on quarterly reports and conference calls from Atlanta, Baltimore or Washington, D.C.. Patients and providers must have direct access to Medicaid officials on the ground in Florida in order to develop the kinds of relationships with stakeholders that allow for clear and accurate insights into the impact of the pilot program on a population that faces many challenges in addition to accessing healthcare. The need for an office in Florida is especially warranted given the State's desire to expand the program statewide.

Some other recommendations relate to program evaluation. For example, at least the appearance of a conflict or interest was created when the University of Florida was hired to evaluate the success of the

program. The University operates Shands HealthCare, which serves as a managed care organization and a service provider within the pilot program. Shands, d.b.a. First Coast Advantage, serves about half of all the Medicaid beneficiaries in Duval County. **To avoid any conflict of interest, we recommend that CMS require additional evaluations by truly neutral third parties before any expansion occurs.**

Similarly, several providers were surprised to hear from administrators that surveys indicate beneficiaries are generally satisfied with the program. This finding contradicts what providers in my district hear from their patients. While I recognize the challenges of communicating with certain elements of the Medicaid population, some measures must be developed to understand the experiences of people who do not participate in surveys. One means to this end is standardized encounter data. **Therefore, I echo the calls of many to recommend that CMS require that the State immediately compel MCOs and providers to produce validated encounter data.**

The last issue I will emphasize is a very personal one for me. You may not be aware that the population of Duval County is 43% non-white. As one doctor in the meeting noted, however, “no one that looks like them is taking care of them.” Although I would never suggest that minority patients must be treated by minority doctors, I was surprised to learn that neither CMS nor AHCA requires or even tracks participation by minority providers. **Some effort must be made to ensure that the provider community reflects the community it serves.**

I have attached letters from several local organizations with more detailed recommendations on a wide variety of topics. Some key areas of concern include the following:

- **Medical Loss Ratios** – Especially when all MCOs operate under a capitated rate, the public must have a guarantee that 80-85% tax dollars are spent on treatment.
- **Transportation** – In an area as geographically dispersed as Jacksonville/Duval County, reliable transportation is a must. Currently, taxi reimbursement rates are so low that patients cannot count on cabs to pick them up or take the home when a higher fare calls. Non-ambulatory patients must call an 800 number for a dispatcher in Miami. An integrated, reliable system would help ensure that patients keep their appointments so problems don’t get worse and more expensive to treat.
- **Mental Health** – Primary care physicians, hospitals, and behavioral health centers agree that managed care is not working for those with mental health needs. An MLR for mental health, carve outs, and removal of the IMD exclusion are some of the suggestions providers have made.
- **Timely Payments** – Several small providers complain that payment delays – not necessarily the rate – explain why they do not participate in the program.

Finally, when considering indigent healthcare in Duval county as compared to other pilot counties, one must remember that some counties, such as Broward are authorized to impose an Indigent Care Surtax or establish hospital taxing districts. Duval does not enjoy that authority and, therefore, operates at a significant disadvantage in serving the poor. **In Duval, Medicaid is our only hope and we cannot afford to experiment without very, very strong protections for our people.**

I look forward to working with CMS, AHCA and local providers to develop solutions that can make managed care work for all stakeholders.

Sincerely,



Corrine Brown
Member of Congress



800 Prudential Drive
Jacksonville, Florida 32207
Phone: 904.202.8732
wolfsonchildrens.org

Michael D. Aubin
Hospital President

June 9, 2011

The Honorable Corrine Brown
Member of Congress
3rd District, Florida
2336 Rayburn Building
Washington, D.C. 20515

Dear Representative Brown,

It was a pleasure to meet with you the other day and share our perspective about how we can improve the State of Florida's Medicaid Managed Care Pilot. While the program in Duval County has had numerous successes, I do believe that there are significant modifications that need to be made to make the program more accessible and to assure fiscal accountability.

The following recommended changes will significantly improve the program:

1. **Impose a medical loss ratio requirement and an independent real-time verification of qualified medical expenses** – In order for State and Federal agencies to assure fiscal accountability for the funding provided to the Managed Care contractors we need to have true transparency on this issue. Medical expenditures should fall into specific guidelines and be independently verified.
2. **Provide an Option for Children with Medically Complex Conditions to not participate in the Managed Care mandate** – Children with multiple and/or severe medical conditions require specialized care management both at the primary care and subspecialty care level. Mixing these patients into the standardized managed care environment leaves these patients at severe risk for inadequate patient evaluation and follow-up.
3. **Provide a “specialized” Managed Care Option which will create Primary Care Medical (Health) Homes for children with Chronic/Complex Conditions that has flexible funding to provide for unique services (i.e., psychosocial support staff; case coordinators; after hours/weekend phone call lines)** – Managing the care of complex patients in a specialized focus center has been proven to lead to improved patient outcomes, high family satisfaction, and significant reductions in emergency visits and hospitalizations with positive program cost savings. This type of program has been recommended to the states' governors by HHS Secretary Kathleen Sebelius.

4. **Increase Pediatric physician reimbursement levels to the same or higher than that provided in the Medicare program** - Ambulatory/outpatient access for Medicaid Managed Care patients to primary care pediatricians and pediatric subspecialists is presently restricted and in some areas rationed by providers due to the significantly low reimbursement offered. The poor funding offered can lead to the economic destabilization of a physician's practice. Lack of quick patient access to a provider leads to less lower-cost preventative and early symptom care and more higher-cost urgent/emergent and acute care.

We are prepared to elaborate on any of the proposed changes as may be necessary. Thank you for the opportunity to provide recommended changes.

Sincerely,



Michael D. Aubin

cc. Michael Collins, Legislative Assistant
Melanie Brown-Woofor, ACHA



June 9, 2011

Representative Corrine Brown
101 East Union Street, Suite 202
Jacksonville, FL 32202

Dear Congresswoman Brown:

Thank you for taking the time to meet with our group of Medicaid Providers yesterday. It offered an important time for us to make known the issues we have been dealing with and have attempted to bring to the attention of both the Medicaid HMOs as well as our FL legislative body. This letter provides the opportunity to share my experiences with Medicaid Reform in Duval County. My comments are pertinent to behavioral health services provided by Child Guidance Center, Inc., the largest provider of children's outpatient mental health services in Northeast Florida.

Current problems: The Medicaid Reform Pilot Program began over five years ago in Duval County. To date, the following has been our experience:

- There are excessive delays and denials of necessary services with some of the HMOs, primarily due to their own technical issues and/or due to the lack of understanding by their support staff of our population's issues.
- Recipients experience limits on medicines due to formulary changes.
- Providers experience increased administrative burden causing dollars to be shifted from services to back office administrative costs, i.e. chasing plans to get paid, etc.
- For-profit HMOs have taken significant profits from the service dollars since AHCA removed the requirement for Plans to spend 80% in the five Reform counties. All the other 62 counties must meet that requirement that community mental health providers have always been required to meet.
- Over \$50 million dollars in penalties was paid by HMOs to AHCA for fines in one year; however, these significant dollars were returned to the general fund and lost from mental health services.
- There is a lack of performance, quality and cost data.
- After over five full years of implementation, AHCA does not have encounter data to determine the level of services provided to recipients, thus evaluation of the pilot is incomplete.
- Six plans have left the reform pilot causing at least 54% of recipients to change plans.

Recommended solutions: Only five percent of Medicaid beneficiaries account for 50 percent of program spending; 10% of beneficiaries account for 75% of spending. It is these high spending groups that should be the focus of reform. These individuals have severe mental illnesses, developmental disabilities, physical disabilities, and chronic illnesses. They most likely have multiple co-morbidities. There are still substantial Medicaid expenditures for unnecessary care or care that would not be needed if diagnoses and treatment occurred earlier. This inappropriate spending is largely the result of a state's failure to manage beneficiaries with chronic illnesses and disabilities.

I would appreciate your consideration of the following proposal:

- target the disabled and chronically ill populations, using specialty managed care plans;
- continue with capitated and other risk sharing arrangements, but look at other models such as medical homes and truly integrated physical/behavioral health care arrangements;

- **require health plans to share savings with the state and reinvest those savings back into care;**
- **require health plans to spend at minimum 85 percent of their capitation payments on direct care;**
- risk-adjust capitation rates so plans are only paid for the level of risk assumed;
- **ensure health plans meet data reporting requirements;**
- provide more accessible and timely care, achieving better treatment outcomes; and
- **most importantly use experts – disability competent health plans, including those operated as provider service networks. HMOs do not have the needed experience to provide medical homes and chronic care/disease management to significantly impaired populations. **Use the providers involved, to voice the concerns of the patients/clients who cannot or will not speak for themselves.****

It is time we used more sophisticated strategies, ones in which the state maintains control, are consumer friendly, and ensure cost effective care by plans having ties to their communities and won't simply leave when rates are adjusted.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Rulien', written in a cursive style.

Theresa T. Rulien, PhD
President/CEO



RECOMMENDATIONS

In the state of Florida approximately 26% of children are classified as overweight or at risk of being overweight. On the local level, 16 % of Duval County's middle school students and 12 % of Duval County's high school students are reported as being obese or overweight.

In order to increase access to healthy food and nutrition and increase the consumption of healthy foods and the amount of physical activity children receive, and in alignment with Healthy Kids Healthy Jacksonville, **Wellness 4 KIDZ**, a component of **Auntie Roz Children's Workshop** is a model that is in place and ready to execute the following recommendation that we submit to you for funding:

1. Provide parents with true and adequate health information
2. Fund community gardens as a means to grow healthy food items
3. Provide children with access to safe playing spaces
4. Partner with schools and community organizations to integrate physical activities during and after school.

Source: Healthy Kids Healthy Jacksonville, **2006 Florida Youth Tobacco Survey**

Roslyn Burrough, Founder, Director

Auntie Roz Children's Workshop is a 501 3 (c) not for profit corporation.



623 BEECHWOOD STREET
JACKSONVILLE, FL 32206
904.358.1211 FAX 904.358.1551
www.communityrehabcenter.org
MAKING LIVES WHOLE



May 25, 2011

Dear Congresswoman Corrine Brown

These are the Medicaid Reform Bill Key Points and Potential Issues that I along with many Mental Health Providers would like addressed as the federal government review the State of Florida request to implement Manage Care/Medicaid Reform in the State of Florida.

The Medicaid legislation that passed requires AHCA to write the waiver and provide an opportunity for public comment before sending it to the feds.

There are very few research reports or advocates that believe the current waiver has been successful and if anything harmful. Although the legislation tried to address some of the problems the managed care model is still very much HMO driven and not consumer friendly especially for persons who are seriously mentally ill.

Some areas where the delegation may be able to help are the following.

- 1) One key issue that the Florida legislators chose to ignore was the statement Center for Mental Services had stated to Agency Healthcare Administration (AHCA) when it rejected Florida's request to extend the current waiver. The letter from Sebelius stated clearly that any request must include medical loss ratios to assure that consumers are provided an adequate level of services. The federal Affordable Health Care legislation includes an 85/15 percent Medical Loss Ratio (MLR).

The lack of a Medical Loss Ratio is a key point I would make with the delegation. It is the only way to determine how much money managed care companies are spending on direct services rather than administration and profits. The Achieved Saving Rebate that the legislation uses has no proven data to demonstrate that consumers receive the services they need.

Recommendation: The federal government should reject Florida's managed care wavier until it includes 2 MLRs - One MLR for physical health care and one MLR for behavioral health care set at least at 85/15 each. A separate behavioral health care MLR is necessary in order to protect persons with serious mental health and substance abuse disorders. Research shows that managed care plans will redirect their behavioral health care capitation away from behavioral health care services and use it for administration or profit.

In the Florida Reform counties where plans were not required to follow the statutory requirement of the 80/20 behavioral health MLR providers experienced a 50% drop in authorization for direct care services.

- 2) Another area that proved problematic in Florida Reform was allowing plans to have their own formulary and that they changed regularly. Persons with severe disabilities found it impossible to know what the differences of each plan where.

Recommendation: Although the new legislation requires plans to post and update their drug formulary within 24 hours after changes and that prior authorization process be readily accessible to health care

BOARD OF DIRECTORS

providers it would be better if plans were required to follow the state Medicaid formulary without exception.

- 3) The legislature and the federal government require plans to submit encounter data; however after more than 3 years, HMOs and AHCA have been unable to report any encounter information. This session's legislation requires plans to submit encounter data once again and has added that if a plan fails to report after 30 days the agency **may** assess a fine of \$5,000/day. On the 31st day of noncompliance the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance.

Recommendation: Since encounter data is the only way to know what services are being delivered the federal government should mandate a fine and require that Florida report to the federal government the name of any plan that is out of compliance. There should be federal penalties as well.

- 4) The legislation requires AHCA to seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program \$10 a month.

Recommendation:

- 5) The legislation requires recipients to pay \$100 for each emergency room visit if the visit was not an emergency. This creates a tremendous burden on recipients who may have no idea whether it is an emergency or have no other place to turn. Plus waiting lists to see a Medicaid provider can take days or weeks.

Recommendation: The federal government should not approve this request.

- 6) The legislation requires plans to encourage and reward healthy behavior that at a minimum include a medically approved smoking cessation program, a weight loss program, and an approved alcohol and drug abuse recovery program., Requires each plan to identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse disorders in order to secure the enrollees written agreement to secure the enrollees commitment to participate in these programs.

Recommendation: Plans should reward healthy behaviors but requiring written agreement to participate is of concern especially since there is no discussion if they do not or any guarantee that the plan will authorize the treatment, treatment providers feel are appropriate. This area needs to be eliminated or more thought out.

- 7) The legislation provides intent language to allow provider service networks to plans to create specialty plans targeted to individuals with special needs.

Recommendation: Since it is well recognized that persons with severe mental illness do not do well in traditional plans it would be helpful if the federal government strongly encouraged Florida to do so.

Good Afternoon Mike

These are additional recommendations provided by Community Rehabilitation Center to submit to Center for Medicaid and Medicare Services.

CRC recommends the following:

1. HMO's (Cenpatico/ Sunshine State) is required to educate and inform the consumer of the services provided is limited.
2. HMO's explain to consumers that other choices are available, and they have a right to choose another HMO.
3. Providers have the right not to accept Cenpatico/Sunshine HMO.
4. Providers have the right to share a list of alternate HMO's and Insurance that they do accept.
5. Require the State of Florida to contract with local providers to provide transportation for patients receiving services from medical institutions such as Shands and Jacksonville Hospital.



Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

6/10/2011

Congresswoman Corrine Brown
101 E. Union St., Suite 202
Jacksonville, FL 32202

Congresswoman Brown:

The Duval County Health Department appreciates the invitation to comment on Medicaid Reform at your meeting in Jacksonville on June 7, 2011. This is a summary of our comments. As you know, we are a significant network partner with most of the Medicaid health plans in Duval County, including the two largest, Sunshine State and First Coast Advantage. We operate 13 clinic sites and employ more than 40 physicians, dentists, nurse practitioners and physician assistants. We serve more than 23,000 medical/pediatric and 23,000 dental Medicaid health plan enrollees and provide more than 105,000 clinical encounters annually to primarily Medicaid and uninsured clients.

The past 4½ years of Medicaid Reform have been challenging to our patients and staff, and have required significant innovation to adapt our infrastructure and business systems to this new environment. Fortunately, the situation appears to have stabilized and we have seen gradual but steady improvements in eligibility verification, health plan assignment, speed and accuracy of reimbursement, etc. We think there is still more work to be done in the development and implementation of electronic data exchanges that will allow for more efficient patient management, reduced system redundancies, and improved clinical quality while containing costs.

As the largest provider of Medicaid services of all the 67 county health departments in Florida, we rely on Medicaid cost-based reimbursement (CBR) to maintain the level of services to our clients. CBR is an AHCA-approved Medicaid fee-for-service rate that includes the cost of preventive, wrap-around services and is unique to county health departments throughout Florida. It also allows us to provide care to the uninsured. While we have been successful in negotiating a continuation of this payment methodology with Medicaid managed care organizations to date, it is anticipated that health plans will move to more austere payment schedules as Reform continues to mature.

The loss of CBR reimbursement is a serious threat to the sustainability of our clinic network and our ability to continue with Medicaid participation. Initially it was anticipated that First Coast Advantage, the largest PSN in Duval County, would begin managing risk, setting their own fee schedules, and paying claims on October 1, 2009.

Implementation of these changes would most likely eliminate CBR reimbursement for a significant portion of our patients. Fortunately, this has been postponed until October, 2011. We hope it will be extended in the waiver renewal

We support a medical home model of disease management and care coordination. In fact, we are successfully providing some of these services to our Medicaid enrollees and also to more than 800 uninsured persons through our Hospital Emergency Room Alternatives Program (HERAP). This is made possible through Low Income Pool (LIP) Council funding. We hope the LIP program will be continued in the waiver renewal

We are also very involved in several health information technology (HIT) innovations, including electronic prescribing, development of a statewide CHD electronic health record (EHR), and electronic health information exchange (HIE). These offer great promise to improve the quality and efficiency of Medicaid services and public health outcomes.

We look forward to working with you on these challenging issues.



Robert G. Harmon, MD, MPH
Director



The Honorable Corrine Brown
Member of Congress -3rd District, Florida
2336 Rayburn Building
Washington, D.C. 20515

Dear Representative Brown,

Thank you for the interest you have taken to ensure the efficacy of the Medicaid Program in Florida. The Florida Association of Children's Hospitals believes that there are significant modifications that need to be made to make the program more accessible and to assure fiscal accountability.

The following changes will improve Medicaid Services as well as ensure access:

1. **Impose a medical loss ratio requirement and an independent real-time verification of qualified medical expenses** – In order for State and Federal agencies to assure fiscal accountability for the funding provided to the Managed Care contractors, true transparency is essential. Medical expenditures should fall into specific guidelines and be independently verified.
2. **Allow Children with Medically Complex Conditions to be excluded from the Managed Care mandate** – Children with multiple and/or severe medical conditions require specialized care management both at the primary care and subspecialty care level. Mixing these patients into the standardized managed care/Medicaid HMO environment leaves these patients at severe risk.
3. **Provide a “specialized” Managed Care Option which will create Primary Care Medical (Health) Homes for children with Chronic/Complex Conditions that has flexible funding to provide a coordinated system of care (i.e., psychosocial support staff; case coordinators; after hours/weekend phone call lines)** – Managing the care of complex patients in a specialized focus center has been proven to lead to improved patient outcomes, high family satisfaction, and significant reductions in emergency visits and hospitalizations with positive program cost savings. This type of program has been recommended to the states' governors by HHS Secretary Kathleen Sebelius. Please see attached document
4. **Increase Pediatric physician reimbursement levels to the same or higher than that provided in the Medicare program** - Ambulatory/outpatient access for Medicaid Managed Care patients to primary care pediatricians and pediatric subspecialists is presently restricted and in some areas rationed by providers due to the significantly low reimbursement offered. The poor funding offered can lead to the economic destabilization of a physician's practice. Lack of quick patient access to a provider leads to less lower-cost preventative and early symptom care and more higher-cost urgent/emergent and acute care.

We are prepared to elaborate on any of the proposed changes as may be necessary. Thank you for the opportunity to provide recommended changes.

Sincerely,

Dana Ferrell Birchfield

Dana Ferrell Birchfield
Executive Director
Florida Association of Children's Hospitals

cc. Michael Collins, Legislative Assistant
Melanie Brown-Woofers, ACHA



JACKSONVILLE TRANSPORTATION AUTHORITY

P.O. DRAWER "O" ● 100 N. MYRTLE AVENUE ● JACKSONVILLE, FLORIDA 32203
TEL 904.630.3181 FAX 904.630.3166

MICHAEL CAVENDISH
Chairman

EDWARD E. BURR
Vice Chairman

ALAN R. MOSLEY, P.E.
Secretary

CLEVE E. WARREN
Treasurer

STEVE DIEBENOW

DONNA L. HARPER

AVA L. PARKER

●
MICHAEL J. BLAYLOCK
Executive Director/CEO

June 10, 2011

The Honorable Corrine Brown
U. S. House of Representatives
Florida's 3rd District
2336 Rayburn House Office Building
Washington, DC 20515

Dear Congresswoman Brown:

Thank you for hosting the June 7, 2011 meeting with representatives for the Centers for Medicare and Medicaid Services (CMS) and the Florida Agency for Health Care Administration (AHCA), regarding the June 30, 2011 expiration of the Medicaid Managed Care Pilot Program that is currently being conducted in five (5) pilot counties in Florida, including Duval County.

It was heartening and encouraging to learn that we have leadership at the federal level representing Duval that understands the importance of these critical services. As you may recall, at the meeting I verbally placed on record the Jacksonville Transportation Authority's (JTA) position and recommendation related to the transportation component of the pilot program. As requested, I have reduced these statements to writing to be made a part of your comprehensive recommendation to the Medicaid administration.

1. The Medicaid Non-emergency Transportation (MNET) program should be returned to the coordinated system. As you are aware, JTA provides over one million passenger trips per month via the fixed route bus system, Community Shuttle, the Skyway and Connexion services (paratransit). Connexion alone averages 35,000 passenger trips per month. However, should it be returned, it is important to note that JTA can only accept this critically important service provided the cost sharing or reimbursement element is disbursed more equitably by the State than in previous years when the MNET program was a part of the coordinated system. There must be reasonable reimbursements of the cost of a trip, and not place an undue fiscal burden on the coordinated transit system and other transit services. Additional benefits and efficiencies of having the services provided by a coordinated system include, but are not limited to, service providers and drivers who already have specific training and experience in handling a delicate

JTA-Regional Transportation Solutions

www.jtafla.com

population of clients, such as Medicaid constituents; shared vehicles which provides economies of scale, and the use of scheduling options to yield multi-load efficiencies.

2. During the meeting, there was discussion and support for an independent professional survey to obtain feedback from the clients on the services provided through the pilot period. Should you proceed with this recommendation, we recommend that a question about transportation service delivery be included as part of the survey. JTA will be pleased to provide input in the framing of this question.

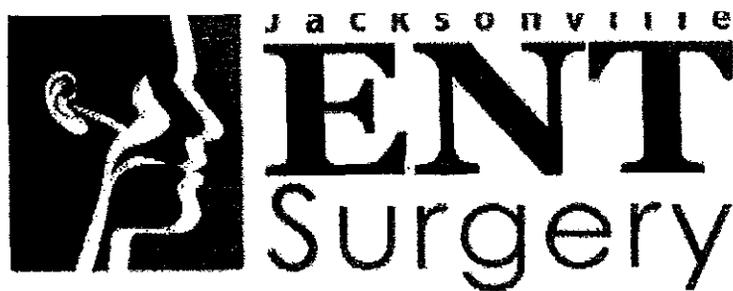
Again, we thank you for the opportunity to allow us to provide input into this critically important issue.

Sincerely,



Clinton B. Forbes
Director of Mass Transit

c: Michael Blaylock, Executive Director/CEO
Blair Fishburn, Deputy CEO/CFO
Jacquie Gibbs, Chief Administration Officer



Charles C. Greene, MD, PhD, PA

www.JacksonvilleENTsurgery.com

June 13, 2011

The Honorable Corrine Brown
Member of Congress
101 E. Union Street, Suite 202
Jacksonville, FL 32202

Subject: Managed Medicaid Program Plan "Guidelines"

Dear Representative Brown:

I write in response to your request for the Northeast Florida Medical Society (NEFMS) to provide Guidelines for "Medicaid Reform Pilot Project" passed by The Florida Legislature last month. This correspondence focuses on Managed Medicaid Programs operating in Northeast Florida. The recommendations stem from observations and personal experiences of NEFMS members. Do to the short notice we received, this list will not be exhaustive and we welcome the opportunity to meet with you to further develop the ideas set forth in this correspondence. The areas in which we feel guidance is most needed are as follows:

- I. **Provider Enrollment Criteria:** Medicaid programs are designed to provide quality health care to economically disadvantaged patients who otherwise would not have health benefits. While it is true that the demographic of eligible patients in North East Florida is diverse, it is also true that the population percentage is weighted towards people of color. This fact is especially evident in North Jacksonville. For decades, these disadvantage patients have been cared for by Physicians Providers of Color who work in independent practices in the community. With the emergence of Managed Medicaid Programs, the demographic of the providers interested in caring for these patients has and will continue to change because of the potential for better reimbursement provided by Administrated Plans.

Satellite Office
789 W. Duval Street
Lake City, FL 32055
(866) 419-2054 (p)
(904) 419-2057 (f)

Main Office
6100 Kennerly Rd, Ste 102
Jacksonville, FL 32216
(904) 419-2054 (p)
(904) 419-2057 (f)

Satellite Office
6484 Ft. Caroline
Jacksonville, FL 32216
(904) 419-2054 (p)
(904) 419-2057 (f)

But at what cost to the patients? We maintain the idea that patients in this demographic receive the best care when they are treated by providers who are culturally sensitive and who were willing to render care prior to the introduction of Plan Administrators into city. Simply put, we recommend that, within the enrollment criteria, guidelines are placed to ensure that providers with the same demographic as the patients are enrolled in the Managed Medicaid Program plan.

- II. **Reimbursement Criteria, Compliance and Relief:** The experience of NEFMS members with Managed Medicaid Program reimbursement practices has not been good. They have a problem with timely reimbursement and accounting. Furthermore, it is very difficult to get in touch with anyone or have someone call back when these problems arise. This results in countless hours wasted by providers who are already taxed by an increasingly burdensome healthcare system. Therefore, strict guidelines for provider reimbursement and responsiveness by Managed Medicaid Programs must be established. Penalties including 12% interest charge being levied against the company when they exceed the reimbursement deadline need to be established. Significant penalties and fines need to be levied for repeat offenses.
- III. **Carve Outs:** Providers should be allowed to negotiate carve outs for CPT reimbursement for certain specialized procedures or services. This ability is offered by most traditional insurance companies and can lead to savings for the Managed Medicaid Programs and better care for the patients.
- IV. **Scope of Services and Medications:** The scope of services, number and types of specialist, medications, and other treatment options for Managed Medicaid Programs needs to be expanded. In some cases, patients in the Managed Medicaid Program plans have been put at jeopardy because of limited services or access to specialist. Clearly, provision of care by a single hospital system cannot be the only option for these patients. We are happy to have a subcommittee of our organization help develop the services and make recommendations for formulary changes that will ensure that patients get quality care at a reasonable cost.
- V. **Provider Incentives:** We believe it is in the best interest of Managed Medicaid Programs to provide incentives to primary care physicians are efficient in managing patients and keeping cost down. For example, Medicaid patients frequent the

Emergency Department because they have access to the ED without personally absorbing the high cost of ED services. If a provider manages his/her patients in such a way that it drives down cost for the Managed Medicaid Programs, some of those benefits should be passed on to the provider as a financial incentive to continue providing good, cost effective care. Again, we are happy to have a sub-committee from NEFMS meet with Managed Medicaid Programs to help develop an incentive plan. Also see section X below.

- VI. **Oversight Committee:** Some members of NEFMS have experienced chart reviews from Managed Medicaid Programs that are frankly, unreasonable. The reviewers used by some Managed Medicaid Programs have made recommendations to NEFMS providers that if followed, would cause the provider to fall below the Standard of Medical Care. They term this, "over utilization of services." This appears to be a term that Managed Medicaid Programs use when they want to refuse to pay for legitimate services. Providers do not have time to continually respond to these assertions and, we believe that may be part of some Managed Medicaid Program's strategy. This area requires more detailed discussion that is beyond the scope of this correspondence. Clearly physician oversight is needed in this area. We believe that a peer review committee should be established for chart review and that committee needs to be formed by members in the community.

- VII. **Insurance Verification and Authorization:** A web based, reliable, user-friendly system for verification of patients who are members of the Managed Medicaid Program plan needs to be established and maintained. The same is true for Authorization of Services.

- VIII. **Physician Assignment and Stability:** Medicaid programs are well known to randomly re-assign patients to different providers. Managed Medicaid Programs need to provide both notification of assignment and have a policy of ensuring that the assignments will be stable for a certain specified time frame.

- IX. **Referrals:** This was addressed in part in section IV. NEFMS members have established referral patterns to providers who have rendered quality care to their patients and have seen their patients in a timely fashion. We want to ensure that those referral patterns can be maintained. We are hopeful that we will be allowed to

recommend specialist who should be targeted for enrollment based on those historical patterns.

- X. **Facility Access, Imaging, Labs, etc:** We want to ensure that Managed Medicaid Program providers have the ability to select a wide range of facilities including hospitals, labs, and imaging centers for our patients. This is critical in order to effect cost savings and for maintaining quality care. For example, if a provider is forced to send a patient to an imaging center that provides a poor quality images or poor interpretation of the images, the provider is put in the very uncomfortable position of making decisions with sub-standard data. We would like to have input into the facilities used. Also, we would like physician incentives for performing services in office. These services provide cost savings for Managed Medicaid Programs that we feel should be shared in some percentage with the providers.
- XI. **Global Periods.** There have been reports by NEFMS members that some Managed Medicaid Programs do not always adhere to the global periods established by Medicare. We recommend that strict adherence to Medicare CPT Guidelines be enforced and that significant consequences such as fines and damages awarded when there is non-compliance. These failures on the part of Managed Medicaid Programs result in letter writing and claim re-filing exercises that are financially burdensome for the providers.

I am emailing you this document today because of your impending deadline. A formal letter under the cover of the NEFMS letterhead is forthcoming with some additional and more specific recommendations. Thank you for your attention to these important matters. Again, these recommendations are preliminary and need further development.

Sincerely,

A handwritten signature in black ink, appearing to read "Charles C. Greene". The signature is fluid and cursive, with the first name "Charles" being the most prominent.

Charles C Greene, MD, PhD

For: Rogers Cain, MD-President, Shelly Thompson, MD-Vice President, Kenneth W. Jones, MD-Treasurer, and Kenneth Nixon, MD-Member

Joan Turner
Program Manager of the City of Jacksonville's Independent Living
Program, Adult Services Division in the City's Recreation and
Community Services Department

Recommendations to Florida's Pilot Managed Care Project-2011

- Designate additional Medicaid funding in the pilot project to include case management services with the attending physician, medical social worker and the family-caregiver, the homebound and frail elderly. Currently services are minimum or lacking to reach this population after they are discharged from the hospital or outpatient care. Carefully planned aftercare services through immediate followup would assure the appropriate support services for curative care. e.g. physical therapy, medication management ,personal care and home-making and food preparation, or partnerships with other aging-network and mobilization and resource providers.etc.
- Designate Medicaid funding in the pilot project to include nutrition education and additional community-based services for forging the gaps in support services and illness prevention to the frail and homebound edlerly. i.e development of 'community gardening' on premises of residential facilities, senior centers etc. where seniors can grow their own vegetables for healthier nutrition and coordinate with the health department or PSN for education on cooking and food preparation.
- Respond to the fragmentation of service deliver for the elderly by developing a 'clearinghouse' (one- call not automated service) for access to accurate information and referral services is essential both for direct service providers and for the elderly and their caregivers. Development of an easily read medical resource directory to be mailed or provided at the initial visit and/orientation of each Medicaid client/family.
- Develop educational programs within the Medicaid Pilot project that would provide accurate information and encourage proper personal care and medication management through health-education seminars, support groups, 'wellness wagons' that offers various health-screenings and provide prompt follows to low-income seniors,i.e. many seniors have no idea why they are taking the 9-10 medications, the dosage or the toxicity involved with mixing OTC medicines, and other herbal/alternatives. This poly-pharmaceutical phenomenal on this vulnerable population can lead to deaths and dementia like illnesses if not properly monitored.
- Provide and identify mental health problems/issues: Within this Medicaid Pilot Project provide early assessment and diagnosis through intergrated mental health care with other supportive services, intensive psychotherapist care either on an

out-patient and/or day-treatment along with counselling services and community education through outreach to faith-based communities, residential facilities, senior centers and areas where seniors congregate. Additionally, provide a method of payment that would include PSNs as contractual service providers within or outside network for proper intervention to the disabled and elderly population.

- Include a greater assess to healthcare whether curative or preventative for the frail elderly through aggressive home-health care and increased reimbursement rates that would attract and encourage the services of physicians that would make house calls to those sick elderly who are discouraged from going to a doctor's office because of in- assessibility to medical transportation. This is easily remedied by funding appropriate reimbursements for local transportation providers as the Jacksonville Transportation Authority,etc for assessibility and familiarity among the low-income homebound elderly and/or increased partnerships with other local disadvantage transportaion vendors/companies.

June 9, 2011

To: Michael Collins
Legislative Assistant for Representative Corrine Brown

Re: Expansion of Medicaid Managed Care

Listed below are Medicaid Reform Bill Key Points and Potential Issues that many Mental Health Providers believe should be addressed as the federal government reviews the State of Florida request to implement Managed Care/Medicaid Reform in the State of Florida. The Medicaid legislation that passed requires AHCA to write a waiver and provide an opportunity for public comment.

There are very few research reports or advocates that believe the current waiver has been successful. Although the legislation tried to address some of the problems the managed care model is still very much HMO driven and not consumer friendly especially for persons who are seriously mentally ill.

Some areas where the delegation may be able to help are the following.

- 1) One key issue that Florida legislators did not address was the statement of the Center for Mental Services to the Agency for Healthcare Administration (AHCA) when it rejected Florida's request to extend the current waiver. The letter from Health & Human Services Secretary Kathleen Sebelius stated clearly that any request must include medical loss ratios to assure that consumers are provided an adequate level of services. The federal Affordable Health Care legislation includes an 85/15 percent Medical Loss Ratio (MLR).

The lack of a Medical Loss Ratio is a key point that should be made with the delegation. It is the only way to determine how much money managed care companies are spending on direct services rather than administration and profits. The Achieved Saving Rebate that the legislation uses has no proven data to demonstrate that consumers receive the services they need.

Recommendation: The federal government should reject Florida's managed care waiver until it includes 2 MLRs - One MLR for physical health care and one MLR for behavioral health care set at least at 85/15 each. A separate behavioral health care MLR is necessary in order to protect persons with serious mental health and substance abuse disorders. Research indicates that managed care plans will redirect their behavioral health care capitation away from behavioral health care services and use it for administration or profit. In the Florida Reform counties where plans were not required to follow the statutory requirement of the 80/20 behavioral health MLR providers experienced a 50% drop in authorization for direct care services.

- 2) Another area that proved problematic in Florida Reform was allowing plans to have their own formulary resulting in regular changes to the formulary. Persons with severe mental health disabilities found it impossible to know what the differences of each plan were and how to manage their required medications.

Recommendation: Although the new legislation requires plans to post and update their drug formulary within 24 hours after changes and that prior authorization process be readily accessible to health care providers, it would be better if plans were required to follow the state Medicaid formulary without exception.

- 3) The legislature and the federal government require plans to submit encounter data; however after more than 3 years, HMOs and AHCA have been unable to report any encounter information. This session's legislation requires plans to submit encounter data once again and has added that if a plan fails to report after 30 days the agency may assess a fine of \$5,000/day. On the 31st day of noncompliance the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance.

Recommendation: Since encounter data is the only way to know what services are being delivered the federal government should mandate a fine and require that Florida report to the federal government the name of any plan that is out of compliance. There should be federal penalties as well.

- 4) The legislation requires AHCA to seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program \$10 a month.

Recommendation: There should be no fees attached to participants for enrollment or pre-treatment. Participants may not be able to afford additional expenses and it may deter them from seeking needed treatment. It is certainly not a preventive measure or incentive, especially for families with multiple Medicaid recipients.

- 5) The legislation requires recipients to pay \$100 for each emergency room visit if the visit was not an emergency. This creates a tremendous burden on recipients who may have no idea whether their problem is an emergency or have no other place to turn. Waiting lists to see a Medicaid provider can take days or weeks to get an appointment.

Recommendation: The federal government should not approve this request.

- 6) The legislation requires plans to encourage and reward healthy behavior that at a minimum includes a medically approved smoking cessation program, a weight loss program, and an approved alcohol and drug abuse recovery program. Requires each plan to identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse disorders in order to secure the enrollees written agreement to secure the enrollees commitment to participate in these programs.

Recommendation: Plans should reward healthy behaviors but requiring written agreement to participate is of concern especially since there is no discussion of what happens if they do not enroll or any guarantee that the plan will authorize the treatment that treatment providers recommend as appropriate. This area needs to be eliminated or more clearly prescribed.

- 7) The legislation provides intent language to allow provider service networks to create specialty plans targeted to individuals with special needs.

Recommendation: Since it is well recognized that persons with severe mental illness do not do well in traditional plans it would be helpful if the federal government strongly encouraged Florida to allow the creation of specialty plans for individuals with special needs.

- 8) The authorization process is quite antiquated. The primary HMO in Clay County is Cenpatico. Authorizations have to be faxed and the turn around time is 7 to 10 days. During this time frame services cannot be delivered as the HMO does not grant retroactive authorizations.

Recommendation: Managed care plans develop on-line systems for authorizing services and turn around time be time limited to no more than 72 hours for authorization of services. Retroactive authorization of services from the time the request is submitted would allow the provision of services to those clients/patients in need of immediate services.

- 9) Authorizations can be very limited for case management services even if the client clearly meets criteria. This increases the administrative time used by direct service personnel to complete reauthorizations for services that are clearly needed.

Recommendation: The number units of services authorized for case management should be increased to reasonable units of services for the clients/patients that would result in less administrative justification for continuing services required by the recipient.

- 10) The denial/appeal process is very convoluted and time consuming, again, requiring more and more administrative time needed by direct service personnel.

Recommendation: Streamline the denial/appeal process

- 11) Our service area currently deals with at least 4 different reform plans and they all have their own set of rules. It is our understanding that these entities should follow the same rules and regulations as AHCA when it comes to reimbursement guidelines. This does not seem to be the case. Some reform plans pay for certain HCPC codes and some do not.

Recommendation: Require uniform reimbursement rules/plans for each HMO/PCN and ensure that they follow the rules and regulations as required by AHCA for reimbursement guidelines.

- 12) Vocational services are very difficult to get authorized through these reform plans. These services fall under the Psychosocial Rehabilitation section of the Medicaid handbook which requires an authorization. Many clients are not able to pursue employment successfully without the support and guidance from the program, but they are often turned down for these services by the HMO's because they do not meet the entrance criteria of emotional instability.

Recommendation: If clients meet eligibility criteria for Psychosocial Rehabilitation services under Medicaid reimbursement for vocational services should be allowed without having to meet the criteria for emotional instability as currently required.

13) Often when there is centralization, an unintended consequence is duplication of reporting results or data in various formats to several parties.

Recommendation: Implement one central clearinghouse for all data that must be reported to AHCA, DCF and managed care plans by providers. Eliminate any requirement for reporting the same data to each of these different agencies.

The following is a summary of key points of the legislation. There may be areas that you see that you feel the delegation should be made aware of.

Summary:

- 1) Mandatory enrollment for all Medicaid enrollees except for women eligible only for family planning, women eligible for only breast and cervical cancer services, persons eligible for emergency Medicaid for aliens, and children receiving services in a pediatric center. There is voluntary enrollment for residents in DJJ facilities or DD facilities, refugees, and recipients in a home and community based waiver.
- 2) AHCA is to issue ITNs no later than 1/1/13 with implementation by mid or late 2013.
- 3) Allows PSNs to provide all covered services or may limit the provision of services to specific target populations based on age, diagnosis, chronic disease state, or medical condition.
- 4) Includes substance abuse services as a benefit.
- 5) Creates 11 regions that correspond to current Medicaid Areas.
- 6) Limits the number of plans by Region and requires at least 1 be a PSN: Region 1 -2 plans (1 must be a PSN); Region 2 – 2 plans; Region 3 – 3 to 5 plans; Region 4 – 3 to 5 plans; Region 5 – 2 to 4 plans; Region 6 – 4 to 7 plans; Region 7 – 3 to 6 plans; Region 8 – 2 to 4 plans; Region 9 – 2 to 4 plans; Region 10 – 2 to 4 plans ; Region 11 – 5 to 10 plans.
- 7) Does not subject specialty plans to regional plan numbers if the target population does not include 10% of the enrollee population.
- 8) Allows AHCA to assign enrollees who qualify for a specialty plan and do not choose a plan into a specialty plan if one is available.
- 9) Establishes an ITN process to select qualified plans.
- 10) Gives preferences to plans that have well-defined patient-centered medical homes and provides increased compensation for medical homes.
- 11) Requires plans to be paid via risk-adjusted rates; PSNs may be fee-for-service for 2 years after becoming operational.
- 12) Establishes a 5 year contract with each plan that cannot be renewed.
- 13) Requires a guaranteed savings of 5% in the first year of the program
- 14) Includes penalties and fees for early exit.
- 15) Creates Achieved Savings Rebate that places limits on plan profit margins greater than 5%.

- 16) Creates an auditing process using independent CPAs to audit the financial statements of the plans to validate the achieved savings rebate.
- 17) Establishes Medically Needy managed care enrollment.
- 18) Establishes Long-term care managed care program.
- 19) Established an ACO representing all Healthy Start Coalitions enrollees in the waiver.
- 20) Does not include Dual Eligible's.
- 21) HB 7109 eliminates all prepaid plans by October 1, 2014, implements long-term care by October 2016.
- 22) HB 7109 provides limits damages for personal injury or wrongful death arising from medical negligence of a practitioner not to exceed \$300,000 per claimant unless the claimant pleads and proves by clear and convincing evidence that the practitioner acted in a wrongful manner. Limits liability to \$200,000 in non-economic damages per claimant unless the claimant pleads and proves by clear and convincing evidence that the practitioner acted in a wrongful manner.

June 11, 2011

Congresswoman Corrine Brown
101 E. Union Street
Suite 202
Jacksonville, Florida 32202

Dear Congresswoman Brown,

Thank you for all of your efforts in insuring that the expansion of Florida's Medicaid Reform Pilot Project" passed by the Florida Legislature last month will consist of measures fair and beneficial to all (taxpayers, patients, providers, etc.).

Attached is a list of recommendations and concerns that the Northeast Florida Medical Society would like to add to the growing list of those measures:

- Decrease the total number of Medicaid managed care plans;
- Require all plans to reflect the ethnic diversity of their networks, by increasing the ethnic diversity of their providers;
- Contract with independent entities to provide patient and provider satisfaction survey;
- Require plans to publish their HEDES measures, and require an independent entity to verify such data;
- Establish a fourteen (14) day payment/reimbursement period to providers who submit a "clean electronic claim";
- Enforce a twelve percent (12%) penalty to be paid to the provider when such "clean electronic claim" is not received within twenty one (21) business days(disallowing the so-called "picking and choosing" of certain claims for payment while delaying and/or disallowing other "clean electronic claims");
- Contract with independent entities to provide reports to physicians on their quality measures;
- Allow any willing provider to participate as long as they conform with State requirements to be a Medicaid provider (Primary Care and Specialist alike);
- Fair and equitable distribution of patients regardless of their co-morbidities - Enforce rule that "Non-emergent" pre-authorizations be no longer than seventy two (72) hours;
- Establish a "Mental Health Carve-out" for payment for mental health services

Congresswoman Corrine Brown
101 E. Union Street
Suite 202
Jacksonville, Florida 32202
Page 2

- Administer some sort of Dental Plan;
- Pay for certain DME equipment that would decrease ER visits (e.g. Nebulizers, Spacers, etc.);
- Establish a "Community Board" with Physicians included to monitor the Providers (PSNs) and their compliance with these measures;
- Increase immunization reimbursement commensurate with attainment/purchase cost plus a preset administration fee;
- Also please be advised that hospitals may express similar concerns as well as others not listed here.

Once again, thank you for all your time and efforts as well as your inclusiveness in attempting to provide proper medical care to Florida's underserved and under privileged.

Sincerely,

Rogers Cain MD
President

cc: Kenneth W. Jones MD
Charles Greene MD
Shelly Thompson MD
Kenneth Nixon MD



June 10, 2011

Corrine Brown
Member of Congress
3rd District, Florida
2336 Rayburn Building
Washington, D.C. 20515

Dear Congresswoman Brown,

River Point Behavioral Health is licensed for 99 inpatient beds and Wekiva Springs is licensed for 68 beds-therefore we have more inpatient beds than all of the other providers in our area combined. In the past two years, we have provided free treatment to the tune of 5 million dollars which is placing an unfunded government mandate on the private sector since EMTALA regulations prevent us from turning anybody in need away. We need to be exempted from the IMD-Exclusion criteria regarding free standing psychiatric hospitals. Because we are considered an "Institute for Mental Disease (IMD)" we are not eligible for Medicaid funds. Therefore we are unable to bill for individuals not participating in an HMO (i.e. with straight Medicaid) or participate with our local Provider Service Network (First Coast Advantage). First Coast Advantage is still billing fee for service and has not moved to capitation.

Please revise the Medicaid Pilot in Duval County to allow a free standing psychiatric hospital to bill straight Medicaid. This would allow reimbursement for all Medicaid recipients not enrolled in an HMO and allow us to participate with our local Provider Service Network, First Coast Advantage. If you have any questions regarding these comments, please contact me. Again, thank you for working towards improving health care for our residents particularly individuals with disabilities.

Sincerely,

Emma Hayes, M.Ed., L.M.H.C.
Director of Clinical Services
River Point Behavioral Health
904-724-9202 or 904-349-7123

MAKING A DIFFERENCE IN MIND, BODY, SPIRIT.