



Agency for Health Care Administration

Cost Efficiencies in the Florida Medicaid Program

***Roberta K. Bradford,
Deputy Secretary for Medicaid***

***Phil E. Williams
Assistant Deputy Secretary for Medicaid Finance***

***Presented to the Senate Health and Human Services Appropriations
Committee***

January 21, 2010

Cost Efficiencies in Place

- The Florida Medicaid program, in partnership with the Legislature, has been engaged in a continual process of implementing cost efficiencies:
 - Utilization review
 - Prior Authorization
 - System edits
 - Increased fraud and abuse prevention

History of Budget Reductions

- In addition to the implementation of cost control measures, program cost reductions have occurred over the past several years.

Medicaid Budget Reductions FY 2006-2007 through FY 2009-2010		
	General Revenue	Total All Funds
FY 2006-2007	(22,176,550)	(53,798,119)
FY 2007-2008	(2,204,332)	(1,428,712)
FY 2007-2008 - Special Session C (October 2007)	(244,875,721)	(569,203,116)
FY 2008-2009	(279,166,153)	(600,147,470)
FY 2008-2009 - Special Session A (January 2009)	(195,941,014)	(462,845,893)
FY 2009-2010	(76,236,140)	(226,084,348)
Grand Total	(820,599,910)	(1,913,507,658)

- Reductions included
 - Provider Rate Reductions
 - Expanded Fraud and Abuse Recoupment
 - Additional Pharmacy and Medical Services prior authorization and utilization review



Medicaid Spending for Fiscal Year 2009-10

The Florida Medicaid program serves more than 2.7 million recipients and has a projected budget for the 2009-2010 fiscal year of more than \$18 billion dollars. Of those funds, slightly more than \$3 billion is state General Revenue.

Service	FY 2009-10 Estimated Spending	Percent of Total
Hospital Inpatient Services	\$3,271,274,262	17.42%
Prepaid Health Plans	\$2,822,781,216	15.03%
Nursing Home Care	\$2,752,779,470	14.65%
Prescribed Medicine/Drugs & Part D	\$1,614,560,519	8.60%
Low Income Pool	\$1,123,827,163	5.98%
Supplemental Medical Insurance	\$1,048,996,993	5.58%
Home & Community Based Services	\$1,007,396,736	5.36%
Hospital Outpatient Services	\$969,556,058	5.16%
Physician Services	\$938,654,899	5.00%
Intermediate Care Facility/DD	\$346,149,572	1.84%
Nursing Home Diversion Waiver	\$338,177,729	1.80%
Hospice Services	\$321,862,110	1.72%
Disproportionate Share Hospital Payments	\$246,570,577	1.31%
Home Health Services and Durable Medical Equipment	\$184,397,376	0.98%
Private Duty Nursing Services	\$164,193,443	0.88%
Other	\$1,632,963,947	8.69%
Total	\$18,784,142,070	100.00%

Opportunities for Fraud Prevention

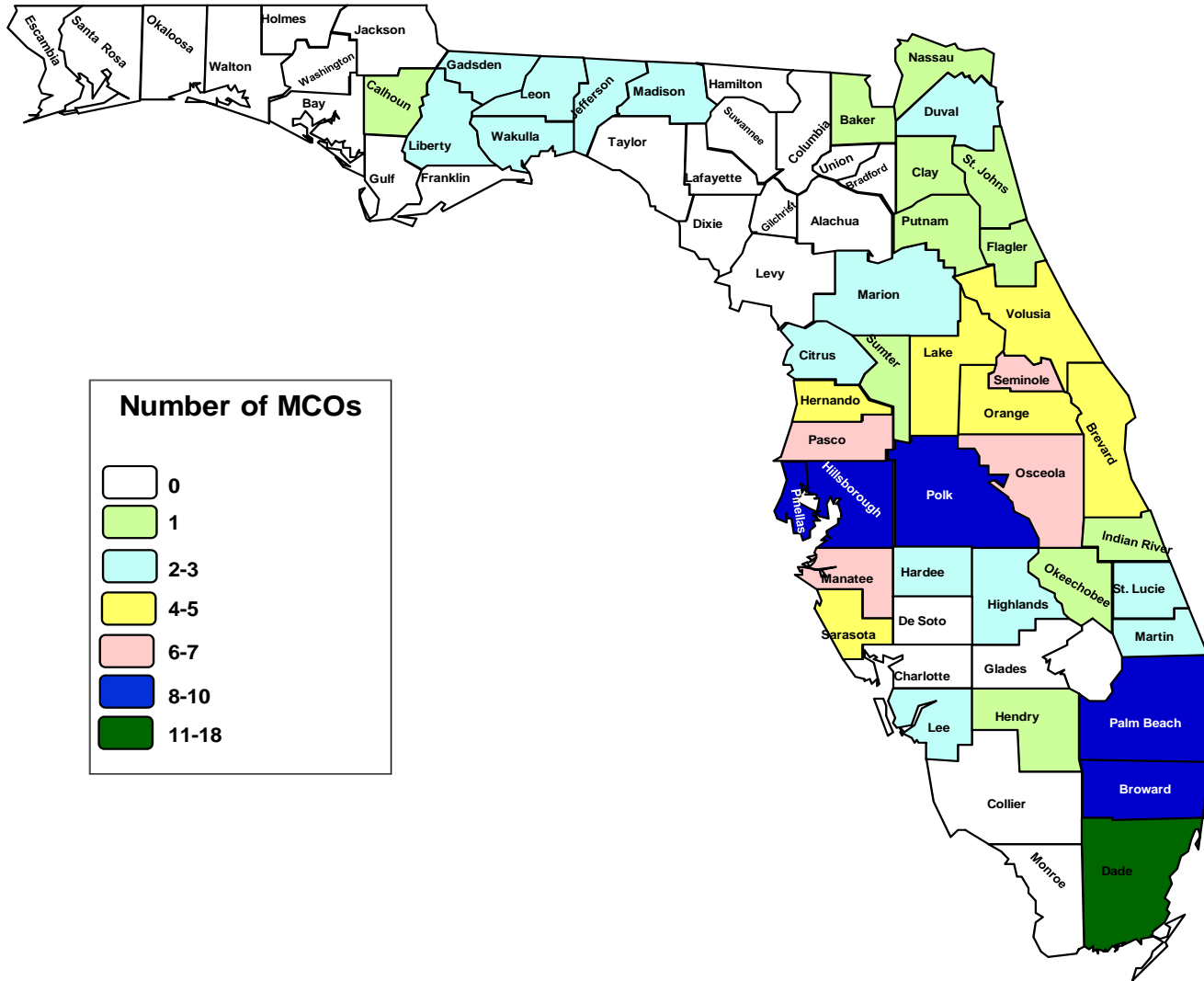
- Fighting fraud and abuse is a top priority for the Agency for Health Care Administration.
- Medicaid experience and data indicate that fraud and abuse is primarily a fee-for-service (FFS) system problem.
- Reducing that marketplace through increased managed care, including increased participation of health maintenance organizations (HMOs), provider service networks (PSNs) and other managed care organizations, will result in cost avoidance and expenditure predictability through additional fraud and abuse prevention.



Reduce FFS Marketplace through Managed Care Expansion

- Managed Care Plans are defined in s. 409.9122, Florida Statutes, as health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children’s Medical Services Network, and pediatric emergency department diversion programs.
- Opportunity for ensuring accountability through plan contract requirements regarding prevention and reporting of fraud and abuse.
- Medicaid managed care is regulated by both state and federal laws and rules.
- Florida’s 1915(b) Managed Care Waiver (non-reform) provides the State with the authority to mandatorily assign eligible beneficiaries to managed care plans.
- Not all Medicaid recipients are eligible for mandatory assignment into managed care. Some recipients are excluded from enrolling in managed care and others are excluded from mandatory assignment into managed care but allowed to enroll voluntarily in a plan.
 - ***Mandatory Population:*** Those required to enroll in managed care.
 - ***Voluntary Population:*** Those who can choose to enroll in managed care.

Managed Care Plan Penetration by County





Reduce FFS Marketplace through Managed Care Expansion

Option: Statewide Procurement for Services

- Statewide/ all counties – Transition recipients from MediPass into managed care plans
- 1915(b)
 - Mandatory eligibles:
 - Total population: 481,000
 - Potential Savings: \$45-89 million
 - Mandatory and voluntary eligibles:
 - Total population: 688,000
 - Potential Savings: \$65-128 million
- 1115
 - Mandatory eligibles:
 - Total population: 481,000
 - Mandatory and voluntary eligibles:
 - Total population: 688,000
- Federal CMS has preliminarily indicated that they would not allow the voluntary population to be reclassified as mandatory under the 1915(b) managed care waiver.
- Current 1115 Waiver provides the authority to require managed care plan enrollment for voluntary groups.



Reduce FFS Marketplace through Managed Care Expansion

*Option: Transition recipients from Medipass to Managed Care Plans/
Counties with 2 or more Managed Care Plans*

- 28 Counties with 2 or more managed care plans.
- Transition recipients from MediPass into managed care plans 1915(b)
 - Mandatory eligibles:
 - Total population: 284,000
 - Potential Savings: \$30-59 million
 - Mandatory and voluntary eligibles:
 - Total population: 438,000
 - Potential Savings: \$46-91 million
- Federal CMS has preliminarily indicated that they would not allow the voluntary population to be reclassified as mandatory under the 1915(b) managed care waiver.
- Current 1115 Waiver provides the authority to require managed care plan enrollment for voluntary groups.



Reduce FFS Marketplace through Managed Care Expansion

- Savings reflected are total savings (including state and federal funding)
- Savings for fraud and abuse prevention under the managed care model not specifically factored in.
- Rate setting:
 - Agency has identified issues/ adjustments from the Managed Care Reimbursement Workgroup report
 - Use of encounter data will better set rates based on actual utilization.
 - Phased in approach to use encounter data for rate setting purposes.
- Issues to consider:
 - Intergovernmental transfers: Implications of continued local government contributions if not directly tied back to local facility.

Options for addressing overutilization and increasing FFS program efficiency

- Expansion of post-service prepayment review of claims either through contract or increasing current staffing levels. This should include both targeted reviews rising from clinical based rules and/or other mediums to identify outliers, as well as on a random basis.
- Cost Savings:
 - Estimated contract costs \$3-\$5 million.
 - Estimated return on investment: 6:1.
 - Estimated cost avoidance: \$18-\$30 million with a net savings of \$15-\$25 million.

Options for addressing overutilization and increasing FFS program efficiency

- Reduce the timeframe for which a provider can submit a claim for payment from 12 months to 6 months. 42 CFR 447.45(d) requires states to require claims submission *no later than* 12 months from the date of service; however, does not prohibit states from being more stringent.
- The longer a provider has to submit a claim the more likely the claim would be improper. California has implemented a 6 month timely filing requirement, which has a savings potential of \$22m based on California's claims experience.
- Increased accountability for program regarding cash balances and more timely identification of claim submission problems.
- An estimate of initial savings for Florida is \$3 million, which is based on the fiscal agent review of Florida's claims experience.

Options for addressing overutilization and increasing FFS program efficiency

- Sanctions: monetary fines modified from a flat amount to an escalating portion based on the amount of identified overpayments; and with a higher minimum for fines.
- Sentinel effect - This action is not about the fine, but more the deterrent factor.
- Giving the deterrent/ preventative nature of this change, estimating cost savings associated is difficult; however, we anticipate \$1-3 million in cost avoidance based on providers' increased diligence to ensure appropriate documentation to support claims submitted.

Expansion of Prepaid Dental Program

- Currently two Prepaid Dental Health Plans (PDHP) operating in Dade County. Both plans serve children under age 21.
- Expand the prepaid dental health plans (PDHPs) statewide.
- Procure the PDHP contractors using competitive bid process.
- Expansion of PDHP may allow for:
 - Increased accountability,
 - Better management of fraud and abuse related to dental services, and
 - Increased number of dental providers available to Medicaid recipients.
- Budget neutral, but may provide increased number of providers to serve Medicaid recipients.

Expand HIV/AIDS Specialty Plan

- Expand Specialty Plan to other parts of the state
 - Caseload (07-08): 66,502
 - Expenditures (07-08): \$134 million
 - Savings would depend on discount applied
- Expand Specialty plan to include home and community based services
 - Enhanced coordination for acute and long term care services.
 - Savings would be achieved based on increased coordination of services.

Amend Disease Management Contracts

- Eliminate the Disease Management program incentive payment for the final year of operation.
 - Current statewide contract allows for incentive payment based on vendor (Pfizer) meeting or exceeding quality and performance benchmarks
 - Elimination of incentive payments could save up to \$1.8 Million in final year of the current DM contract
- Revise current statewide Disease Management program to implement a community based chronic care management program
 - Utilize local CHDs and FQHCs for service provision statewide
 - Non-risk contract for service provision
 - Increases continuity of care as recipients who lose Medicaid eligibility would be able to continue to receive the care management services through the local CHD or FQHC
 - Fiscal may be neutral as funds authorized for current statewide DM program may be allocated for this program.

Amend Disease Management Contracts

- Exclude Dual Eligibles from the current HIV/AIDS Disease Management program
- Currently, dual eligible may enroll in the DM program if the dual is receiving Project AIDS Care (PAC) waiver services
 - The programs provide comparable yet unduplicated services
 - Duals were allowed to enroll in the DM program prior to implementation of Medicare Part D.
 - Medicaid provides limited services to the Medicare FFS dual eligible population
- Potential Savings: \$ 4 million over life of contract.

Discontinue coverage of partial dentures for adults

- Discontinue coverage of partial dentures for adults
- Most Medicaid recipients cannot pay for cleanings or fillings to bring the mouth up to optimum oral health before a partial is provided.
- Despite this, the patient may insist that the dentist make a partial to replace the extracted or missing teeth, but there may be teeth left in the mouth that are decayed or diseased (gum disease).
- When a partial denture is attached to unstable teeth, it is a matter of months before the patient needs to have the rest of their teeth removed due to decay or disease and a full denture, making the provision of the partial an excess expense paid for by Medicaid.
- Savings: In SFY 2007-2008, Medicaid provided partial dentures to 1,974 recipients at a cost of \$851,113.



Consolidate Home and Community Based Services Waivers

- Consolidating smaller programs (Alzheimer’s Disease, Adult Day Health Care, Channeling) that operate in limited areas of the state into existing larger waivers that operate statewide.
- Provide recipients with the full choice of services and service providers and could reduce confusion about multiple, similar programs.
- Some individuals transitioning into larger waivers will have access to a greater number of potential services at a lower overall average cost.
- Federal reporting will be reduced and State oversight will be reduced by eliminating six contracts between the State and providers.
- Smaller waiver programs were created without an increase in state staff positions. Staff will be capable of providing greater contract monitoring, quality oversight, and increased utilization management that could result in a decrease in inappropriate service provision and billings.

Waiver Program	Average monthly cost per person minus ADA cost	Average monthly per person savings	Average annual per person savings	Unduplicated Recipient Count	Annual Savings*
Alzheimer's Disease	\$1,174 - \$648	\$526	\$6,312	416	\$2,625,792
Adult Day Health Care	\$1,107 - \$648	\$459	\$5,508	42	\$231,336
Channeling	\$725 - \$648	\$77	\$924	1,781	\$1,645,644
TOTAL SAVINGS					\$4,502,772

*Annual savings may vary if recipients choose to enroll in the Nursing Home Diversion waiver or Assisted Living for the Elderly waiver.

Behavioral Health Overlay Services in Child Welfare Settings (BHOS CW) Placed under Medicaid Managed Care

- This is the only community mental health service that is not in either managed care or subject to prior authorization.
- This service is provided in both child welfare and juvenile justice settings.
- Savings are produced by:
 - Taking the managed care discount from the BHOS and the ancillary mental health and medical care services
 - Taking an additional discount to account for overutilization.
 - Eliminating BHOS provider reviews, which are contracted to First Health.
- Potential Savings: \$1.9 million

Reduce Maximum Daily Number of Home Health Aide Visits from 4 to 3

- Reduce home health aid visits
- The first visit would allow for assistance with Activities of daily living (ADLs) and breakfast preparation.
- The second visit would allow for lunch, toileting, and midday assistance.
- The third visit would allow for dinner and preparation for bed.
- Recipients can use any combination of skilled nursing or home health aide visits. Most of the Medicaid approved visits are home health aide visits. There were 62,415 visits by either a home health aide or nurse that were in excess of 3 per day.

Number of Visits Per Day > 3 Authorized	Reimbursement per Aide Visit	Cost if All Units Used	Reduction	Potential Cost Savings
62,415	\$17.46	\$1,089,765.90	90%	\$980,789.31

Limit private duty nursing services

- Hold Private Duty Nursing services to 12 continuous hours when possible.
- Medicaid policy currently allows 24 hour per day private duty nursing.
- Exceptions would be allowed based on strict medical necessity criteria.
- Savings calculations are based on the private duty nursing LPN reimbursement rate and expenditures are based on a 365 day calendar year.
- Overall the percentage reductions used to calculate the savings below assume that children receiving up to 16 hours are reduced on average by about one hour, children receiving up to 23 hours are reduced by about two hours, and children receiving 24 hours are reduced by about three hours.

Hours Currently Approved	Potential Expenditures if all Hours Used	Average Percentage Reduction in Hours	Potential Savings
13-16/hours/day	\$26,908,000	8%	\$2,152,640
17-23 hours/day	\$42,090,000	12%	\$5,050,800
24 hours/day	\$37,710,000	13%	\$4,902,300
Total			\$12,105,740

Maximize Provider Assessments

- Provider Assessments make use of a provision in federal law that allows states to claim federal financial participation on payments for services that are funded from the receipts of eligible health care provider assessments.

Facility Type	Current Assessment Percentage	Current Assessments	Increased Assessment Percentage	Additional Assessments at Maximum Percentage
Nursing Facility	5.06	\$295 million	5.5	\$53 million
ICF/ DD	4.3	\$9.041 million	5.5	\$2.52 million
Hospital Inpatient (PMATF)	1.5	\$321 million	5.5	\$856 million
Hospital Outpatient (PMATF)	1.0	\$111 million	5.5	\$500 million

Facility Type	Current Assessment Percentage	Current Assessment	Increase Assessment Percentage	Additional Assessment Maximum Percentage
HMO	0	0	1.0	\$76 million

Questions?