Government Cost Savings Task Force

Medicaid Reform

Contents

Report ......................................................................................................................................................... 2
Recommendations ........................................................................................................................................... 8
1. Reduce Medicaid fraud & abuse .................................................................................................................. 8
   A. Managed Care Fraud Controls .................................................................................................................. 8
   B. Site Visit Verification ............................................................................................................................... 8
   C. Criminal and Administrative Sanctions .................................................................................................... 8
   D. Pre-payment review/Correct Coding Initiative (CCI) .............................................................................. 8
   E. Recovery Audit Contractors (RAC) .......................................................................................................... 9
   F. Evaluation and Management Codes ...................................................................................................... 9
   G. Additional Surety Bonds ......................................................................................................................... 9
   H. Establish a reward for identifying and/or reporting fraud ...................................................................... 9
   I. Implement a moratorium on new home health and durable medical equipment providers ............... 9
   J. Increase use of predictive modeling to identify fraud ........................................................................... 9
2. Alternatives to Medicaid provider rate reductions .................................................................................... 10
   A. Medicaid provider assessments .............................................................................................................. 10
   B. Medicaid co-payments ............................................................................................................................ 11
3. Mitigate effect of Medicaid provider rate reductions ................................................................................ 12
   A. Limit malpractice liability for Medicaid providers ............................................................................... 12
   B. Medicaid Nurse Staffing Requirements ................................................................................................ 12
4. Medicaid optional services ....................................................................................................................... 13
5. Enhance eligibility screening for Medicaid applicants ................................................................................ 14
6. Conduct durable medical equipment audits ............................................................................................. 15
7. Medicaid Waiver Program administrative service support ....................................................................... 16
Foreword

The Government Cost Savings Task Force for FY2011-2012, made fourteen specific recommendations to reform the Florida’s Medicaid system. Of these recommendations, some form of nine recommendations were implemented by the Florida Legislature and signed into law.

**Implemented Legislation:**

1. **Expand Medicaid managed care – MediPass**
   - HB 7107 and 7109 expanded MediPass, saving tens of millions per year.

2. **Implement Medicaid statewide managed care**
   - HB 7107 and 7109 implemented statewide managed care in order to provide fiscal savings and predictability to the state.

3. **Medicaid patient centered medical home**
   - HB 7107 and 7109 introduced a statewide patient centered medical home system that could save upwards of $100 million per year.

4. **Medicaid managed long term care**
   - SB 2144 increased the use of managed long term care, increasing home and community based services, rather than institutionalized care.

5. **Medicare Special Needs Plan (SNPs)**
   - HB 7107 and 7109 require the state to manage care for dual eligibles by mandating enrollment into Medicare Advantage Special Needs Plans.

6. **Reduce Medicaid fraud and abuse – Criminal and Administrative Sanctions**
   - HB 7109 increases the disqualification period from five to ten years for those found to have committed fraud.

7. **Alternatives to Medicaid provider rate reductions – Medicaid co-payments**
   - HB 7109 requires a $100 co-pay for non-emergency services provided in a hospital.

8. **Mitigate effect of Medicaid provider rate reductions – Nursing Staffing Requirements**
   - SB 1244 reduced the nursing staff ratio from 3.9 to 3.6 hours.

9. **Implement a statewide managed incontinence supplies program**
   - SB 2000 created a statewide program for purchasing disposable incontinence supplies
Introduction

The magnitude of Florida’s $20 billion Medicaid program is immense, in terms of the number of people served, its critical importance and certainly, its cost. The program provides a medical safety net for nearly three million Floridians. Half of those in the program are children, but the elderly account for most of the spending. Florida Medicaid covers the state’s most vulnerable populations:

- 27% of Florida’s children
- 63% of nursing home days
- 51.2% of newborn deliveries
- 1,162,020 adults – parents, aged and disabled

Medicaid is a federal-state partnership through which states administer the program under federally approved plans. Federal law mandates certain benefits for certain populations, although there are a number of optional services states can provide. Services must be available statewide in the same amount, duration, and scope.

Both levels of government pay for the program and the costs are massive. Florida is expected to spend $20.3 billion in the current fiscal year (FY2011-12) on the program, with the federal government providing 55.94 percent of the cost and Florida picking up the other 45.06 percent.

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Non-Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20.3 billion</td>
<td>$50.2 billion</td>
</tr>
<tr>
<td>29%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Figure 1: Medicaid Spending as a Percent of the Total $70.5 Billion State Budget
FY2011-12

The state’s share of contributed costs have been lower than usual over the last three years because of additional federal assistance through the economic stimulus plan.

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1 AHCA, “AHCA Presentation to the House of Representatives”, January 2011.
Cost Are Rising Rapidly

Medicaid makes up 28.8 percent of the FY2011-12 state budget and spending in Florida has increased by 46.5 percent in just the last four years (FY2007-08 to FY2011-12), rising from $14.8 billion to $21.6 billion. In addition, the cost is expected to continue to increase rapidly, exceeding the growth of the revenues to pay for it. It was estimated that the cost of the Medicaid program would grow by 37 percent by the end of FY2010-11. The state’s general revenue expenditures for Medicaid will increase significantly over the next three years, rising by some 27 percent to nearly $5.5 billion.

In addition to already increasing costs, the recently enacted Federal Health Reform package will expand enrollments and increase provider payments beginning in 2014, further increasing costs. Health reform is projected to cost $49 billion over the first six years through 2019. While most of this will be paid by the federal government, it will also increase state costs by an average of almost $1 billion annually over those six years.

Three main factors that drive Medicaid growth, and thus costs, are increasing caseloads, the rising cost of health care, and the increasing utilization of services. The counter cyclical nature of Medicaid further complicates its funding. When the economy is down, government revenues decrease. However, unemployment and income also fall, meaning Medicaid enrollment rises.
This is just what happened in Florida during the last few years. The number of people receiving Medicaid benefits is also increasing. The last three years have seen average monthly caseloads increase by more than 800,000 Floridians, reaching close to $3.234 million. Federal health care reform is projected to add 1.9 million cases to Florida’s system by FY2016-17.

Figure 3: Growth in Average Monthly Medicaid Caseloads

Estimates based on January 2011 Social Services Estimating Conference
The number of caseloads is also increasing faster than Florida’s population, meaning a larger and larger percentage of Floridians are in the Medicaid system. From a recent low of 9.4 percent of the population in FY1998-99, average monthly caseloads are now nearly 16 percent of Florida’s population. In FY2013-14, the first year of the federal healthcare reform impact, that percentage is projected to reach 16.9 percent.

**Medicaid Fraud Must Be Addressed**

Fraud is a huge problem throughout the healthcare system and Medicaid fraud in Florida is costing taxpayers billions of dollars. There is no generally accepted estimate of Medicaid fraud. The National Health Care Anti-Fraud Association estimates that at least 3 percent of all health care spending, approximately $68 billion, is lost to health care fraud each year. The FBI estimate is even higher – 10 percent of all healthcare spending.

In Florida, the Attorney General’s office calls Medicaid fraud “epidemic” and says that it costs Florida and the federal government billions of dollars annually. A 2008 OPPAGA report states that estimates of waste, fraud, and abuse in Florida range from 5 to 20 percent of total Medicaid funds.

The OPPAGA report\(^2\) gives examples of fraud, including providers overbilling Medicaid for health care services that are not medically necessary, performing expensive procedures when less

costly alternatives are available, or billing for services that were never delivered. More sophisticated fraud schemes can involve kickbacks to other providers for client referrals, or “hit and run” schemes where fake providers are paid for a large volume of false claims and then close their business before they are identified by fraud detection methods. OPPAGA also states that fraud or abuse can occur at the corporate level of a managed care organization. “For example, managed care plans may withhold or delay payments to providers, pay excessive salaries or administrative fees, engage in practices to exclude enrolling sicker beneficiaries, deny medically necessary treatment, or falsify provider networks.”

**Auditor General Finds Internal Controls Lacking**

Florida’s Auditor General (AG) has recently completed several audits of Florida’s Medicaid system dealing with internal controls and legal compliance issues. These audits raise a number of concerns that the state may be paying more in claims than it should.

Some of the major findings include that the Agency for Health Care Administration (AHCA) paid $792 million in emergency payments to hospitals, doctors and other health care providers that was not clearly authorized by law or supported by valid claims. In one-quarter of the cases reviewed by the AG, the Department of Children & Families failed to fully document Medicaid eligibility for patients. Nineteen nursing homes were paid $40.6 million during FY2008-09 without the facilities submitting actual cost data.

The AG also found that AHCA did not timely review and score the performance of the Medicaid fiscal agent or fully assess damages for its underperformance. The fiscal agent is the private company whose primary responsibility is to process medical claims submitted for payment.

The Auditor General is also currently conducting an operational audit to review and evaluate AHCA’s Medicaid fraud and abuse systems, as required by the 2010 Legislature.

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Medicaid Reform Recommendations

1. **Reduce Medicaid fraud & abuse**
   Health care fraud is a serious and costly problem that affects all taxpayers. Estimates range from a low of 1 percent to a high of 10 percent of expenditures lost due to health care fraud, abuse, and waste. This is likely to increase as the cost of health care is projected to increase. Federal law requires each state to have a Medicaid program integrity unit within the Medicaid state agency to detect and investigate Medicaid fraud and abuse. Federal law also requires a state to establish and operate a state Medicaid Fraud Control Unit (MFCU) to conduct a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. Combating Medicaid fraud, abuse and waste is a significant effort that requires the partnership of states, beneficiaries, providers, and contractors to ensure that taxpayer dollars are spent appropriately.

Florida needs to develop an annual Fraud and Abuse Prevention plan to identify and prevent fraudulent and abusive activities in the Medicaid program and to prevent improper payments as a result of fraud and abuse. Additional efforts are needed in the following areas:

   **A. Managed Care Fraud Controls**
   There needs to be greater fraud and abuse reporting requirements for managed care plans and increased monitoring by the agency.

   **B. Site Visit Verification**
   There needs to be broadened statutory authority to conduct site visits as a requirement for provider enrollment in the Medicaid program for moderate and high risk providers. These in-depth due diligence clinic investigations could be outsourced to private investigation firms. For example, these site visits or in-depth investigations could verify clinics' physical location and inspect the facility; verify all medical licenses of healthcare workers and medical directors; conduct surveillance to determine number of individuals entering/exiting clinic, interview claimant, insured, and all medical staff on premises; conduct background checks on the owners; and determine if treatment is actually being conducted.

   **C. Criminal and Administrative Sanctions**
   There needs to be increased criminal and administrative sanctions for providers that have committed Medicaid fraud and abuse. Passed in the 2011 session, House Bill 7109 increased the disqualification period from five to ten years for those found to have committed Medicaid fraud.

   **D. Pre-payment review/Correct Coding Initiative (CCI)**
   There needs to be a required and enhanced prepayment review including the implementation of a comprehensive correct coding initiative to prevent the payment of inappropriate claims.
E. Recovery Audit Contractors (RAC)
Florida needs to implement a post adjudication process that identifies areas for further investigation and the use of recovery audit contractors to investigate and assist the agency in recovering inappropriate payments.

F. Evaluation and Management Codes
There should be a requirement for additional review and edits prior to and after payment of claims for extended and comprehensive coding levels.

G. Additional Surety Bonds
There needs to be further increases in the types of providers that would be required to post a surety bond (or other alternatives, such as letters of credit or reserve accounts for selected providers) prior to enrollment in to the Medicaid program based upon risk analysis.

H. Establish a reward for identifying and/or reporting fraud
The state could establish a program to incentivize individuals to report Medicaid fraud, waste, or abuse where a certain percentage of the savings could be provided as a reward to the whistle-blower. Alternatively, a certain portion of the recovery could be shared with the government entity identifying the fraud, waste, or abuse as an incentive.

I. Implement a moratorium on new home health and durable medical equipment providers
Medicaid fraud is often concentrated in certain service areas. Health and durable medical equipment are areas where fraud remains high. Implementing a temporary moratorium on new providers will help reduce fraud in these areas.

J. Increase use of predictive modeling to identify fraud
Predictive modeling is the process by which a model is created or chosen to try to best predict the probability of an outcome. Extensive use of the most modern predictive evaluation engine would help identify potential aberrant Medicaid claims prior to any field investigation, which could reduce or eliminate unnecessary investigative work.

If Florida implemented a Fraud and Abuse Prevention plan including, but not limited to these, additional efforts it is estimated that a 1 percent savings of general revenue funds could be achieved and provide savings of $223.8 million in general revenue funds FY2012-13.

Recommendation: The Legislature should direct the agency to develop a Fraud and Abuse Prevention plan that targets savings in the Medicaid program of at least 1 percent and details specific areas to focus on in terms of the types of services targeted, any specific geographic areas, specific methodologies that will be used to combat fraud and abuse, savings targets, and measurement of results.
2. Alternatives to Medicaid provider rate reductions
Before considering provider rate reductions, Florida should first explore enacting alternatives that can achieve similar savings at a lower cost to the providers, thereby lessening concerns over negatively affecting Medicaid recipients’ access to care.

A. Medicaid provider assessments
The federal government allows states to impose provider assessments to fund the state share of Medicaid expenditures. Most states use the assessments as a mechanism to generate new state funds and match them with federal funds. The assessment is currently limited to 5.5 percent of revenues but increases to 6 percent effective October 2011.

There are 19 separate classes of health care services and providers that are eligible to be taxed. In 1984, Florida became one of the first states in the nation to impose a provider assessment on hospitals. Currently, 46 and the District of Columbia states impose provider assessments on at least one category of health care services and providers. The four states that do not have providers assessments are Alaska, Delaware, Hawaii, and Wyoming. The most frequently taxed are hospitals, nursing facilities, and intermediate care facility services for the developmentally disabled and the mentally retarded (ICF/MR-DD). States generally use provider assessments in times of fiscal crisis because it allows the Legislature to free up general revenue and replace it with revenue collected through the assessment, thus maintaining the level of services provided.

Nursing home and ICF/DD Assessment: In response to the economic recession, the 2009 Legislature enacted an industry supported quality assessment on nursing homes and ICF/MR-DDs. The nursing home and ICF/MR-DD assessment is currently assessed at 5.5 percent, which means the Legislature can only consider increasing the assessment to the 6 percent maximum.

Hospital Provider Assessment: Florida imposes a 1.5 percent assessment of hospital inpatient services net operating revenues and a 1.0 percent assessment of hospital outpatient services net operating revenues. This revenue is deposited into the Public Medical Assessment Trust Fund and is used as the state share of the Medicaid program.

In FY2010-11, 34 states impose provider assessments on hospitals. This past year, eight states increased or adopted new hospital assessments. Florida could increase the hospital assessments incrementally up to the maximum allowable amount. If the hospital assessment was increased by 1 percent, an estimated annual savings of $111.9 million in general revenue for hospital inpatient services and $61 million in general revenue for hospital outpatient services could be generated in FY2012-13 and replaced with revenue collected through the increased assessment.

4 National Conference of State Legislatures, “
HMO Provider Assessment: Currently, 11 states impose a provider assessment on managed care organizations (Arizona, Maryland, Minnesota, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, and Texas). Federal law originally defined the managed care organization class to be Medicaid only but was changed to broaden the definition to those of all managed care organizations, effective July 1, 2009. Florida has not implemented a provider assessment on managed care organizations and could implement an HMO assessment incrementally up to the maximum allowable amount. If a 1 percent assessment was established, an estimated annual savings of $71.5 million in general revenue could be generated from the prepaid health plan services category in FY2012-13 and replaced with revenues collected through the assessment.

Recommendation: The state should explore opportunities to increase provider assessments up to the maximum allowable cap and establish a managed care provider assessment to generate revenues to support the state share of the Medicaid program. Increasing or establishing assessments could be used as an alternative to provider rate reductions and allow providers to maintain the level of services while achieving cost savings for the state.

B. Medicaid co-payments

Increased cost-sharing, or requiring Medicaid beneficiaries to pay more for medical care, has been implemented by most states as a way to reduce Medicaid costs and promote “personal responsibility”. A total of 45 states have copayment requirements in their Medicaid program. Nominal copayments may be charged Medicaid beneficiaries that range between 50 cents and $3 per service for most services but may not be charged to children, pregnant women or institutionalized individuals. The amount of the copayment is deducted from reimbursement to the provider. The Medicaid program, in accordance with s. 409.9081, F.S., requires Medicaid recipients to pay a nominal copayment for the following Medicaid services.

**Figure 5: Florida Medicaid Required Copayments**

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Centers</td>
<td>$2.00 per day, per provider, per recipient for gynecological services</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>$1.00 per day, per provider, per recipient</td>
</tr>
<tr>
<td>Community Behavioral Health</td>
<td>$2.00 per day, per provider, per recipient</td>
</tr>
<tr>
<td>Federally Qualified Health Center</td>
<td>$3.00 per day, per provider, per recipient</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>$2.00 per day, per provider, per recipient</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>5% coinsurance up to the first $300 of Medicaid payment for each visit in the Emergency Room for non-emergency services, not to exceed $15.00</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>$3.00 per admission fee</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>$3.00 per visit</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>$1.00 per day, per provider, per recipient</td>
</tr>
</tbody>
</table>
Non-Emergency Transportation  | $1.00 per trip each way  
Nurse Practitioner           | $2.00 per day, per provider, per recipient  
Optometrist                   | $2.00 per day, per provider, per recipient  
Physician                     | $2.00 per day, per provider, per recipient  
Physician Assistant           | $2.00 per day, per provider, per recipient  
Podiatrist                    | $2.00 per day, per provider, per recipient  
Portable X-Ray Company        | $1.00 per day, per provider, per recipient  
Prescription Drugs            | 2.5% of Medicaid cost of drugs with cap of $7.50 per drug  
Rural Health Clinic           | $3.00 per day, per provider, per recipient  
Registered Nurse First Assistant | $2.00 per day, per provider, per recipient  

In 2010, Arizona implemented a new $2.30 co-payment for prescription drugs and Massachusetts increased their generic and over-the-counter drugs co-payment from $2.00 to $3.00 (with some exceptions). In 2011, The Legislature passed House Bill 7109, which requires a copayment of $100 for non-emergency services provided in a hospital.

If Florida implemented a $2.00 co-payment on prescribed drugs, an estimated $8.9 million in total savings and $3.9 million in general revenue funds could be saved in FY2012-13.

**Recommendation:** *The Legislature should explore the option of implementing a co-payment on prescribed services to encourage personal responsibility similar to other co-payments established on other services in the Medicaid program.*

3. **Mitigate effect of Medicaid provider rate reductions**

If provider rate reimbursement reductions are going to be considered, the Legislature should also explore implementing changes reducing providers’ costs, thereby mitigating the negative effects of a rate cut.

   **A. Limit malpractice liability for Medicaid providers**

   The litigation crisis is affecting patients, physicians, hospitals, and nursing homes and impacts health care quality. The patients’ ability to get care is affected not only because many physicians find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price.

   **Recommendation:** *If provider reimbursement rates are reduced, such a reduction should also explore meaningful litigation reform to help ensure access to health care, including extending limited sovereign immunity for Medicaid providers against liability for Medicaid patients.*

   **B. Medicaid Nurse Staffing Requirements**

   Florida had been a recognized national leader in nursing home quality and has one of the highest nursing homes staffing ratios in the nation. Over the past several years, the required nursing
staffing ratios have increased from 1.7 hours to 2.3 hours in January 2002, to 2.6 hours in January 2003, and to 2.9 hours in January 2007. The 2010 Legislature modified the nursing home staffing requirements to allow for a combined direct care staffing requirement of 3.9 hours per resident per day, effective July 1, 2010. The 2011 Legislature lowered the nursing staff ratio to 3.6 hours via Senate Bill 2144. Over this same time period, there has also been a commitment from the Legislature to improve nursing home quality through increased Medicaid funding in the direct care cost component of Medicaid reimbursement to pay for new staffing, rigorous enforcement of standards, increased fines when facilities do not comply with standards, tort reform and public reporting requirements. If the nursing staffing ratio was reduced to 2.6 hours, an estimated $27.6 million in total funds and $11.05 million in general revenue funds could be saved in FY2012-13.

Recommendation: If the Legislature should contemplate provider rate reductions to nursing homes, it should consider reducing the required nursing staff ratio from 3.6 hours to 2.6 hours per resident per day.

4. Medicaid optional services

The Medicaid program is a federal-state partnership and states design and administer their own programs within broad federal guidelines. Medicaid covers a wide range of benefits and states may elect to offer many “optional” services, such as prescription drugs, dental care, durable medical equipment, and personal care services. All Medicaid services, including those considered optional for adults, must be covered for children. Several states have recently eliminated optional services. Examples include:

- Nevada - eliminated coverage of non-medical vision services for adults (2009).
- Utah – eliminated dental coverage (2010); eliminated audiology and hearing services, physical, occupational and speech therapies, and eyeglasses and chiropractic services for adults (2009).
- California – eliminated acupuncture, dental, audiology and speech services, optometry and optician services, podiatry, psychology services, and chiropractic services (2010).

If Florida eliminated dental, visual, hearing, podiatry, and chiropractic services for adults, estimated annual savings of $55.3 million in total funds and $23.9 million in general revenue funds could be saved in FY2012-13.
Figure 6: Proposed Medicaid Optional Service Reductions FY2012-13

<table>
<thead>
<tr>
<th>Service</th>
<th>General Revenue</th>
<th>Trust</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dental Services</td>
<td>($13,224,957)</td>
<td>($17,296,409)</td>
<td>($30,521,366)</td>
</tr>
<tr>
<td>Adult Visual Services</td>
<td>($6,368,178)</td>
<td>($8,474,942)</td>
<td>($14,843,120)</td>
</tr>
<tr>
<td>Adult Hearing Services</td>
<td>($1,478,093)</td>
<td>($1,905,044)</td>
<td>($3,383,137)</td>
</tr>
<tr>
<td>Podiatry –Adult</td>
<td>($2,135,669)</td>
<td>($2,768,128)</td>
<td>($4,903,797)</td>
</tr>
<tr>
<td>Chiropractic – Adult</td>
<td>($704,376)</td>
<td>($911,583)</td>
<td>($1,615,959)</td>
</tr>
<tr>
<td>Total</td>
<td>($23,911,273)</td>
<td>($31,356,106)</td>
<td>($55,267,379)</td>
</tr>
</tbody>
</table>

Recommendation: If the Legislature should contemplate provider rate reductions, the Legislature should consider eliminating certain optional Medicaid services.

5. **Enhance eligibility screening for Medicaid applicants**

Improving eligibility screening for Medicaid can reduce fraud by identifying ineligible applicants at enrollment before benefits have been assigned and payments have been made. Implementing an electronic matching process (tied to national database information) for Medicaid eligibility determination is one option that would generate significant savings opportunities for the state by reducing payments for healthcare services provided to individuals who are not eligible for Medicaid.

Data resources such as identity and address information, household composition, and financial status are gathered utilizing browser-based tools to validate the self-reported information submitted by applicants. A comprehensive screening system would provide state officials with the information they need to approve or refuse eligibility with confidence and justification.

Denial of ineligible claims represents significant savings to Florida, as just 74 indictments issued in 2007 in Miami alone uncovered over $400 million in fraudulent billings to Medicare. Although Medicare is entirely funded by Federal tax dollars, this case provides insight into the vast amount that Florida could be losing from Medicaid payouts to ineligible recipients.

Assuming that 2 percent of a program’s total beneficiaries are actually ineligible (a very conservative estimate given that experts estimate that the typical state averages between 3.5 and 5 percent), then an estimated 59,400 individuals within Florida Medicaid’s population of approximately 2.97 million beneficiaries could therefore be determined ineligible and claims made on their behalf would be appropriately denied. The average cost of Medicaid per member

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5. Although exact number of beneficiaries is difficult to pin down, there are approximately 2.97 million beneficiaries. According to AHCA website, (http://ahca.myflorida.com/Medicaid/about/about2.shtml, accessed on January 21, 2011) “Florida's average monthly eligibles is currently approximately 2.4 million Medicaid recipients.” According to the “Number of Medicaid eligibles by program-group by county as of 12/31/2009,” there were 2,679,941 eligibles in December 2009 and 2,727,362 eligibles in November 2009 – therefore, the 2.5 million is likely an underestimate.
per month (PMPM) was $530.28 in July 2011, although distribution of usage is not linear. This equates to an average annual cost per member of $6,363.36. If only 10 percent of average service usage spent on the 2 percent of beneficiaries estimated to be ineligible were appropriately denied benefits through eligibility screening, the Medicaid program would save more than $37.8 million\(^6\) which would result in a savings to Florida of approximately $16.62 million annually beginning in FY2012-13 (not including implementation costs or cost sharing if provided through outsourcing)\(^7\).

**Recommendation:** The Legislature should direct the Department of Children and Families to enhance the applicant eligibility screening and benefit determination program, either internally or by contract with a private provider.

6. **Conduct durable medical equipment audits**

Estimated expenditures show that the Florida Medicaid program will spend $91,338,452 in on “durable medical equipment” (DME), which include medical supplies such as wheelchairs.\(^8\) As with other aspects of Medicaid, the annual DME billings likely include some “aberrant claims” (i.e., fraud, waste, and abuse), such as billings for services that were never administered or billings that violate the provider agreement. Implementing a DME audit process would help identify such claims and could significantly reduce the cost of the Medicaid program.

According to a leading service provider, the distinguishing factor of a successful audit process is that a qualified medical professional conducts chart reviews at the actual provider site. This on-site approach is less burdensome on the provider than typical off-site or “desk” audit reviews, which require the provider to photocopy reams of documentation for the auditors. In contrast, on-site reviews require access to the files and a small workspace to conduct the review.

The on-site approach also allows for a full review of each page of the patient chart. The auditor can easily compare doctors’ orders, nurses’ notes, compounding records, and dispensing records to the amount billed to the plan.

Specific examples of the success of DME audits in other states provide useful insight into the potential value of this process for Florida. DME audits have uncovered such practices as a provider that frequently included the leasing of durable medical equipment in perpetuity. Whether it was a set of $50 crutches, or a $1,500 infusion pump, the company could lease the equipment for a monthly rate, but would bill well beyond the point when the insurer had met the purchase price (or agreed “cap”). In one instance, an infusion pump valued at $2,500 was leased

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\(^6\) Assuming 2 percent of 2.94 million beneficiaries (59,400 individuals) multiplied by the average annual per member cost ($6,363.36) equals $377.983 million, 10 percent of which is $35 million.

\(^7\) This figure is based on the FY2012-13 Federal Medical Assistance Percentages (FMAP) that will take effect on October 1, 2011 and last through September 30, 2013. State share = 43.96% and federal share = 56.04%. Sharing agreement information provided by AHCA, July 2011.

\(^8\) Florida Agency for Health Care Administration, “Florida Medicaid” presentation by Roberta K. Bradford to the Florida House, January 2011.
at the monthly rate of $720. At the time of the audit, payments of over $10,000 were identified for the infusion pump. Upon discovery through the audit, the provider repaid the overcharges.

DME audits are especially important in Florida. National media reports have explicitly shown that DME billings have become excessive in some parts the state, as noted in a 60 Minutes investigative report on Medicare fraud perpetrated by DME providers in South Florida. Specifically reported was a tiny medical supply company that billed Medicare almost $2 million in July and, in August, while 60 Minutes was there, billed $500,000; but there was never anybody inside the company and phone calls were never returned. One interviewed DME ‘provider’ indicated that he never provided any service; he simply purchased readily available recipient billing ID’s and billed for unfilled services on their behalf.

Also, the state can take a proactive approach to ensuring that the most blatant violators are removed as providers of medical services under the program. Since Medicare shares many of the same issues that Florida Medicaid is facing with this service category, these audit efforts could be coordinated with the Medicare program and the other program should target referrals from either party.

Given the annual DME spending of more than $90 million, every 1 percent fraud reduction would yield more than $900,000. A leading audit service provider uses 8 percent in estimating savings based on DME spending: for the Florida Medicaid program in FY2009-10, that would produce a savings of $7,307,076. Assuming a 20 percent revenue sharing arrangement with the outsourced provider (to avoid any upfront cost to the state), the state could achieve a savings of $5.8 million in the first year.

Whatever the percentage of aberrant claims identified or the revenue-sharing ratio, the savings for Florida are likely to be significant given the increasing utilization of DME services in medical care and the recent revelations of the prevalence of unscrupulous billing practices.

Recommendation: The Legislature should direct AHCA to explore implementation of an on-site durable medical equipment audit program, either internally administered or outsourced through a revenue sharing arrangement (to avoid upfront costs).

7. Medicaid Waiver Program administrative service support

Implementing an electronic system to provide administrative support of the Medicaid Home and Community-Based Long-term Care Services (HCBS) Waiver Programs can produce significant savings through a reduction in claim loss in three categories: 1) reduction in losses attributable to eligibility-related reporting errors/inaccuracy; 2) misrepresentation of service units provided; 3) data input errors); and 3) through a reduction in waiver administration costs (e.g., reduction in paper processes, process improvements in case management and point of care authorization.

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functions, reporting accuracy and efficiencies, and enhancements in electronic billing and claim control).

Florida’s HCBS Waivers serve nearly 70,000 participants, expending more than $1.14 billion in health and social services, through 14 different waivers, in three different departments. Additionally, there are waiting lists with more than 30,000 potential eligible clients of which many are receiving some services while on waiting lists. However, all of the individual waiver programs are managed through various systems, disparate applications, and paper processes. There is very little coordination between waivers and no enterprise management of the waivers. This includes both those in the waiver programs and those on waiting lists.

Because of the nature of the current, primarily manual, administration of the HCBS programs in Florida, there are unquantified losses or additional unnecessary costs related to both the claim process and the administrative support. Implementing the administrative support components for the HCBS Waiver programs could control these losses and unnecessary costs.

South Dakota has implemented a similar program. Other states are contemplating this type of administrative support, including Texas, New Hampshire, and Hawaii.

Assuming a 1 percent loss due to duplicate payments, unauthorized services, and overpayments (i.e., aberrant claims), the state losses approximately $11 million annually due to lack of coordination in administration of waivers. Outsourced systems are available that could reduce these losses. Assuming a 20 percent revenue share with the vendor on 1 percent losses avoided, the state would save $8.8 million in FY2012-13 and annually thereafter (assuming no additional upfront or implementation costs).

**Recommendation:** The Legislature should consider the implementation of an enterprise-wide Medicaid Home- and Community-Based Long-term Care Services (HCBS) Waiver programs administrative support system.