oppaga

# Special Report

**January 2002** **Report No. 02-04**

# Children's Medical Services Privatization Is Feasible; Could Save Over $18 Million, But Barriers Must Be Overcome

## *at a glance*

The Children's Medical Services (CMS) Program within the Department of Health (DOH) purchases and coordinates health care for low-income children with special health care needs. The Florida Legislature directed OPPAGA to determine whether CMS can be fully privatized. We found that the current CMS Program is mostly privatized, but administrative inefficiencies exist that could be addressed through further privatization. However, barriers limit the program's ability to fully privatize. Overcoming these barriers will require a long-term effort.

The department should take the following actions to address concerns related to implementing these privatization initiatives:

- release a request for proposals (RFP) for privatizing its information and claims processing system;
- proceed with efforts to create capitated contracts with Integrated Care Systems (ICS);
- include care coordination in the Integrated Care Systems contracts; and
- consolidate or eliminate regional CMS offices as these contracts are implemented for all CMS clients across the state because they would no longer be necessary for claims processing or support for care coordination.

With full implementation of these initiatives, and assuming that care coordination could be included in the ICS structure, overall reductions could total over $18 million in cost reductions from salaries and operating expenses.

## Purpose

OPPAGA examined this program at the request of House fiscal staff. This report

- describes the current structure of the CMS program;
- examines the current level of privatization;
- identifies inefficiencies in the current program;
- examines internal and external privatization initiatives; and
- recommends steps to address barriers to additional privatization.

## Background

The Children's Medical Services (CMS) program within the Department of Health is a private/public partnership that purchases and coordinates health care for low-income children with special health care needs. Appendix A lists eligibility criteria.[1] The program's

[1] Children with special health care needs include children under age 21 who have serious and chronic physical conditions that require extensive medical care, beyond that required by typically healthy children.

mission is to provide a family-centered, coordinated system of care for children with special health care needs and to provide essential preventive, evaluative, and early intervention services for at-risk children.

## *CMS is a private/public partnership that delivers direct health care services to patients*

The CMS program is provided through both private sector providers and state employees. Private medical providers under contract deliver most direct health care services while CMS employees provide care coordination and program administration.

### *Private Sector Partners*

Private contracts are grouped into two main divisions, the CMS Network division and the Prevention and Intervention division. Both of these divisions are described in this section, but the question of further privatization only concerns the CMS Network division because the Prevention and Intervention division is already more than 97% privatized.

The ***CMS Network*** division consists of contracts with over 7,000 private providers (e.g., physicians, hospitals, etc.). These private providers deliver preventive, ambulatory, and hospital care for eligible children. Services are provided on both an outpatient (in the physician's office or a local clinic) and inpatient (in the hospital) basis. CMS Network physicians provide all medically necessary health care to these children.

The Legislature appropriated $236.9 million to the CMS Network in Fiscal Year 2001-02 to serve approximately 50,000 children. Exhibit 1 describes these children by funding source.

**Exhibit 1**
**Most CMS Network Patients Are Served Using Medicaid Funds**

| Category of Funding | Patients |
|---|---|
| Medicaid (Title XIX) | 35,003 |
| CHIP (Title XXI) | 8,514 |
| Safety Net (General Revenue/Block Grants) | 14,270 |
| **Total Patients [1]** | **57,787** |
| Less patients served by multiple sources | 9,799 |
| **Total Unduplicated Patients** | **47,988** |

[1] The sum of the funding source enrollments is greater than the actual unduplicated counts of clients due to movement between funding sources.

Source: Florida Department of Health, CMS Division.

The ***Prevention and Intervention*** division consists of contracts with private firms to provide specialized prevention, identification, and early intervention services. These programs are designed to identify and avoid illnesses particularly affecting children at high-risk for serious medical or developmental problems. These contracts include those described below.

- ***Early intervention.*** This contract provides services to prevent or ameliorate disabling conditions to ensure that children grow, develop, and benefit from future educational opportunities.
- ***Preventive services.*** These contracts provide intensive medical services to prevent and treat specific disabling conditions. These services include Pediatric HIV/AIDs, Regional Perinatal Intensive Care Centers, Sickle Cell Screening, and the Poison Control Centers.
- ***Medical services to abused/neglected children.*** These contracts include the Child Protection Team program and the Sexual Abuse Treatment program.

In Fiscal Year 2000-01, the Prevention and Intervention division provided direct services to 83,113 clients, with another 170,883 assisted through the Poison Control telephone programs.[2] The Legislature appropriated $64.7 million to the division for Fiscal Year 2001-02.

## CMS employees

State employees of CMS provide two major functions—care coordination and administrative/support. In Fiscal Year 2001-02, the Legislature authorized 751 FTEs for these functions. Appendix B describes these FTEs by function and location.

***Care coordination*** primarily uses registered nurses to provide direct case management for patients. Licensed social workers also provide coordination, in conjunction with nurses, for patients with severe psychosocial needs. Case management includes

- conducting evaluations of each patient's health status;
- helping each child adhere to his or her physician's treatment plan (e.g., checking to make sure medication is taken appropriately, physical therapy schedule is maintained, etc.);
- coordinating the provision of ancillary services (e.g., wheelchairs, etc.);
- coordinating care needs with other non-medical entities (e.g., schools); and
- providing education to the patient and family.

Care coordination services are provided in the patient's home, in hospitals and clinics, and over the telephone. For Fiscal Year 2001-02, there are 373.5 FTEs providing care coordination.

The second function provided by the state is administration and support for the two main divisions. ***Administrative staff*** (173 FTEs) includes program managers, nursing directors, and computer systems analysts. These individuals conduct oversight of contracts and service delivery, supervise care coordinators, and manage the data/information system. ***Support personnel*** (204.5 FTEs) include secretaries, data entry personnel, and financial assistants. These individuals provide claims processing, eligibility determinations, and other support functions.

CMS employees work out of 22 area offices, with the program's headquarters located in Tallahassee.[3] Care coordinators operate solely out of the area offices, while administrative and support personnel are located in both the area offices and headquarters.

# Federal and state dollars fund the program, with 19% coming from state general revenue

The CMS program is funded by both federal and state dollars. The main funding sources include Medicaid (Title XIX), Children's Health Insurance Program (CHIP or Title XXI), general revenue, and block grants (which fund services for the safety net population).[4]

For Fiscal Year 2001-02, the Legislature appropriated $347.7 million for CMS. Of this amount, $67.3 million (19%) is state general revenue. Exhibit 2 shows appropriations by funding category for Fiscal Year 2001-02.

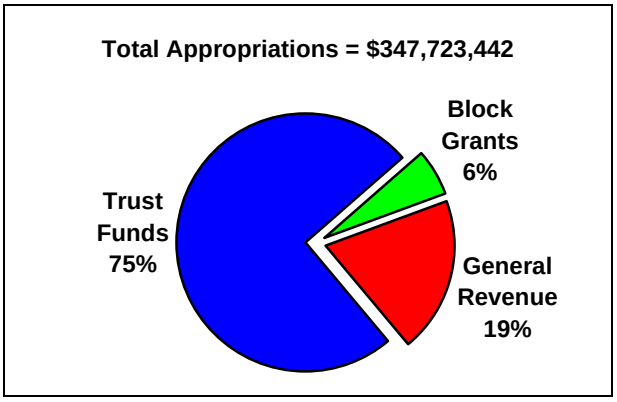
[2] The 83,113 children served in the Prevention and Intervention division include 32,282 in the Early Intervention program (which has some overlap in the CMS network counts), 36,199 in the Child Protection Team program, 1,020 in the Sexual Abuse Treatment program, 11,449 high risk neonates and OB patients in the Regional Perinatal Intensive Care Centers program, and 2,118 newborns in the Infant Screening program.

[3] Offices are located in Daytona Beach/DeLand, Fort Lauderdale, Fort Myers, Fort Pierce, Gainesville, Jacksonville, Lakeland, Marathon, Miami (two facilities), Naples, Ocala, Orlando, Panama City, Pensacola, Rockledge, Sarasota, St. Petersburg (two facilities), Tallahassee, Tampa and West Palm Beach.

[4] The safety net population includes: persons who do not qualify for Title XIX or XXI; patients awaiting enrollment verification; patients from Title XXI who miss their premium payment for more than 60 days and must leave CHIP/Healthy Kids (although they are likely to return to the program); the underinsured; and uninsured non-citizens.

Appropriations include $150 million transferred from Medicaid to CMS. These funds are still officially included in the Medicaid services budget, as well as the CMS budget. CMS has budgetary authority to spend these funds on a new initiative that capitates CMS providers through Integrated Care Systems. This initiative will be discussed in greater detail later in this report.

**Exhibit 2**
**The Program Is Supported Primarily by Trust Funds**




Source: OPPAGA analysis of data provided by Department of Health staff. Appropriations for Fiscal Year 2001-02.

# Findings

We found that the current program is mostly privatized, but administrative inefficiencies exist that hinder program management and greater privatization. The department is considering some privatization initiatives, but these inefficiencies may limit their feasibility and ultimate success. With full implementation of these initiatives, and assuming care coordination could be included in the new system, overall reductions could total more than $18 million in cost reductions from salaries and operating expenses.

## *Although substantially privatized, the program has administrative inefficiencies*

The CMS program is already substantially privatized in terms of the percentage of funds outsourced to private partners. In Fiscal Year 2001-02, 87% of appropriations (equaling $301.6 million) will be paid directly to private medical providers to deliver health care services. The remaining CMS appropriations (13% or $46.2 million) are maintained within the department for salaries, benefits, and operating expenses of staff performing direct services or administration.

However, despite this substantial level of privatization, our review found that several administrative inefficiencies exist that hinder effective program management. These inefficiencies include

- an information system unable to track performance outcomes and costs;
- a decentralized, manual claims processing system;
- duplicative administrative functions in the area offices that increase program overhead; and
- care coordination provided without a system for determining the appropriate level of care based on the severity of the child's condition.

### *CMS information system is antiquated, unstable, and a fiscal liability*

To effectively manage any public program, a reliable computer information system is necessary to track program performance and client outcomes. In general, the system must be able to identify who received what services, at what cost, and with what results. More specifically, to meet current CMS business needs, the information system must be able to be used as an electronic medical record and be

able to efficiently bill multiple payers with minimal errors.

Contrary to these requirements, the Case Management Data System (CMDS) is antiquated, unstable, does not meet current business needs, and is not compliant with federal regulations effective in 2002.[5] These problems are more fully described below.

- It is increasingly difficult to modify CMDS to function in newer versions of the Microsoft Windows operating system found on most computers (CMDS uses the DOS operating system). Because of this, staff reports that there are few people in the department familiar enough with the software to provide technical support on an ongoing basis. The department must contract with an outside consultant to support the existing system.
- The CMDS system is unstable because of previous staff attempts to configure the system to operate in newer versions of Windows. This has resulted in frequent errors and lost data within the system. System users are frustrated by these problems and find it a barrier to efficiency.
- The system cannot track patient outcomes or determine unit costs.
- Because of its age, CMDS is not in compliance with new federal regulations. The system does not use standard data formats or have the appropriate security standards required under the regulations. Under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, all electronic medical information must be in specific formats and have certain safety and security measures in place. Entities that produce or use electronic health information must comply with the first of these standards by May 2002, or face federal fines up to $25,000 per single violation category. More importantly, CMS may be unable to transfer information to others in the health care system because the law allows individuals and corporations to refuse electronic information not in the appropriate format.

In recognition of these problems, CMS staff and external stakeholders agree that the system must be replaced. However, there is considerable debate over whether the system should be updated internally or if the entire system should be privatized. In the interim, CMS staff is trying to include additional data fields to better meet business needs and will continue to pay outside consultants to prevent a systemwide collapse.

## *Manually processing claims for non-Medicaid patients is labor intensive and time-consuming*

Timely and accurate claims processing is also important for administering a health care program. Automated, error-free processing saves money both in labor costs and payment accuracy (i.e., only paying for services actually delivered). Most health programs and payers use electronic billing systems to ensure efficiency.

However, CMS has a manual claims processing procedure and cannot process claims electronically. After treating non-Medicaid CMS patients, providers must submit paper claims for payment directly to the program through the area offices.[6] CMS staff manually processes these claims in the area offices. Claims must be entered into two different data systems that produce electronic copies.

[5] CMDS is the department's computer software application used to process claims, schedule appointments and clinic visits, collect demographic information, and track non-billable services. It operates in a "stand alone" environment, which means that the software is used on computers in each of the 22 area offices with no communication among computers or with headquarters.

[6] Providers submit claims directly to Consultec (the Medicaid fiscal intermediary) for those CMS patients enrolled in Medicaid. If Medicaid does not cover the child, the provider submits the claim directly to the CMS program as if the patient was not enrolled in Medicaid.

In turn, electronic claims files are produced that are sent, along with copies of the paper claims, to headquarters for payment using overnight mail.

As a result, non-Medicaid claims processing is labor intensive and time-consuming as illustrated in Appendix C. For example, for the week of September 17-21, 2001, CMS processed over 7,100 claims among its area offices, which equates to an estimated 370,000 claims per year. Although CMS employs over 150 FTEs to process these paper claims and to bill third party payers, it may take several months for a claim to move through the entire payment process. [7]

This outdated manual claims processing is an artifact of CMS's previous placement in the former Department of Health and Rehabilitative Services. That department's policy was to decentralize services for greater local control. However, this resulted in a loss of economies of scale and isolated the CMS program from technological developments occurring in other areas of the department. CMS has retained this decentralized claims processing structure despite its transfer to the Department of Health in 1997. CMS functions, in general, were not included in the consolidation of administration services when the department was created because the area offices were also used for providing care coordination. [8]

CMS managers report that they have considered trying to automate the claims processing system and/or contracting with a third-party administrator. However, they believe that both alternatives would be more costly than the current system, although they could not provide information supporting this statement.

## *Area offices perform duplicative functions, increasing program overhead*

The decentralized administration of CMS is another administrative inefficiency. CMS is administered through 22 area offices distributed across the state, which is also an artifact of the program's prior placement in the Department of Health and Rehabilitative Services. [9] All area offices perform the same basic functions and serve as the base of operations for care coordination, claims processing, provider relations, and general program administration. There are redundancies in several functions of the area offices; claims processing and general administration are functions with the greatest overlap among offices. Each office also includes clinics where patients receive some direct physician services.

The department is aware that these functions can be consolidated for greater efficiency. Recently, CMS consolidated the administration of multiple offices in three service areas under one medical director per area. These service areas are

- Tampa, St. Petersburg, and Lakeland;
- Pensacola and Panama City; and
- West Palm Beach, Fort Lauderdale, and Fort Pierce.

However, there was no change in the actual number of area offices associated with these administrative consolidations. Departmental staff believes the single administrative reporting structure of one medical director will be more efficient. CMS plans to continue this process as the new privatization initiatives are implemented.

[7] Based on an analysis of positions devoting more than 50% of their time to these activities.

[8] For more information concerning regionalization of administrative services see *Agencies Are Following Through by Consolidating Administrative Services,* OPPAGA Report No. 00-14, October 2000.

[9] The majority of these offices are housed in leased facilities, so further privatization would not require closing a large number of state-owned buildings.

### *Care coordination is provided without a system for determining the appropriate level of care, which results in an inefficient use of resources*

While the CMS care coordination staff varies some service levels based on the needs of their clients, the program lacks a systematic means to do so. As a result, care coordination efficiency is reduced, and program costs can be increased.

Currently, most CMS care coordinators are registered nurses.[10] Staff has substantial expertise that is very useful in dealing with clients' complex medical conditions. However, this level of expertise may not always be necessary for treating some patients who have limited needs. For example, some clients with complex medical conditions such as spina bifida may need continuous in-home service, while a child with well-controlled asthma may only need occasional telephone follow-up.

The care coordinators do vary their patient interaction based on the severity of individual patient need, but this could be done more efficiently. For example, clients with minimal needs, or who have well-controlled conditions, could receive case management from non-RN staff [e.g., licensed practical nurses (LPNs) or licensed social workers (LSWs)] without compromising quality of care. Establishing a more diversified care coordination staff would be less costly and would better match the varying needs of program clients.

CMS is acting to improve management of care coordination resources. In July 2001, CMS updated its care coordination guidelines. The new guidelines require the case manager to assess, with input from the family, whether the child should receive comprehensive or periodic care coordination. Comprehensive care coordination includes continuous assistance and support from the nurse case manager, while periodic care coordination involves the family in the role of primary care coordination. CMS staff believes the new guidelines will better match services to need as determined by the family. They also believe that this will allow CMS to use nursing staff more efficiently. However, at both levels, registered nurses will still provide all services instead of using less expensive staff (i.e., LPNs, LSWs). This reduces the program's ability to achieve greater efficiencies.

[10] There are 41 social workers that are included in the care coordination function. These care coordinators work in conjunction with nurse case managers and do not provide case management independent of the nurse.

## *Additional privatization initiatives are being considered; however, barriers currently limit feasibility*

The department is considering several initiatives that may increase privatization of the CMS system. These initiatives include

- privatizing the information system;
- paying for most CMS services through private, capitated arrangements; and
- continued consolidation of administration in the area offices.

Some stakeholders believe that privatization of the care coordination function should also be considered.

Our review of these initiatives found that there are barriers that limit their successful implementation. Without overcoming these limitations, additional privatization of the program is unfeasible and will ultimately result in increased costs to provide the same level of service. These initiatives, their potential limitations, and the barriers to their implementation are discussed below; detailed discussions of these initiatives are included in Appendix D.

### *Privatizing the information system would increase efficiency*

There is widespread agreement among stakeholders that the program's information

technology system, Case Management Data System (CMDS), is antiquated and in serious threat of failure. Replacing the current system, either through internal updates or privatization, is a priority for the department. Privatizing the system could be accomplished in several ways including contracting with a third party administrator like Medicaid's fiscal intermediary, Consultec, or contracting with a research center at one of Florida's universities.

Any new system should be a web-based application to allow providers to submit claims electronically through the Internet. The system must be able to process claims to several funding sources and allow for the tracking of patient outcomes. In general, the system should be able to indicate who received what services, at what cost, and with what results.

According to the department, an improved information system, whether it is upgraded internally or privatized, would result in a 10% increase in general efficiency, a 50% to 75% reduction in the time to process new clients and other data entry, and a 75% reduction in the time it takes to transfer data from one system to another. Privatizing the system would result in greater efficiency and the reduction of up to 150 FTEs within the department. [11]

However, the most significant barrier to privatizing or updating the current system may be the cost. CMS staff estimates that the cost of converting the current system would require approximately $5 million in one-time funding, with an additional $1 million to $2 million in operating costs annually thereafter.

At this time, it costs about $1.2 million to maintain and operate the current system. It also costs approximately $3 million for the manual claims processing needed because of weaknesses in the current system. Thus, reducing operating costs to between $1 million and $2 million annually by increasing efficiency and eliminating the manual claims processing function would allow the department to pay for a new $5 million information system in less than five years.

However, our review found that this cost estimate is probably too low. Companies with experience converting to similar types of systems, and some CMS staff, believe that actual costs to implement such a system may be over $10 million. [12] They also believe that operating costs would be higher than estimated. They suggest that by moving to this new system, the department or private information technology provider must provide funds for technical support for system users (e.g., primarily physicians and hospitals). Without technical support, health care providers trying to use the system may become frustrated and return to submitting paper claims. This would reduce overall administrative efficiencies created by the new system, and the department would have to scramble to re-create the manual payment system.

The department is moving forward with this initiative and has submitted a legislative budget request for Fiscal Year 2002-03. The budget request is for $5.3 million, and CMS states that it will need $1 million to $2 million in operating costs annually.

## *Capitated arrangements have the most potential to increase privatization, but have significant barriers to their successful implementation*

The department has started an initiative to pay for all CMS services through private, capitated arrangements. Integrated Care Systems (ICSs) are health care firms being approached for this

[11] CMS has over 150 FTEs devoted to claims processing, data entry, and third party collections, based on an analysis of positions descriptions where at least 50% of time was designated for these activities. Using the entry wage for each of these FTEs, we estimate that current salary costs are at least $3 million annually.

[12] CMS staff reports that initial discussions with an outside computer company suggested that it would cost over $10 million to implement a new web-based information system.

initiative. ICSs are hospitals, and other entities, that specialize in pediatrics and contract with local pediatricians, specialists, medical equipment providers, and other ancillary services to provide comprehensive care to CMS patients under a capitated fee arrangement. All health care is provided through the ICS for this prearranged payment amount.

CMS could become almost totally privatized through full implementation of these capitated contracts. Full implementation means that all CMS populations, by funding source and geography, would be included in the ICS contract service areas and no services are provided through the current structure of contracts. With these systems in place, there would be no need for claims processing and internal IT services as currently structured. These functions would be provided by the ICS under the capitated arrangement.

Moreover, assuming that the care coordination function could be included in the ICS contracts, 373.5 FTEs related to care coordination could be eliminated from the public sector. The salaries and benefits associated with these positions ($13.7 million) would likely need to be transferred to the ICSs as part of a higher capitation rate and would not result in any savings.

If there were no care coordination function in the public sector, there would no longer be a need for the CMS area offices because they mainly house administrative and support staff associated with this activity. However, administrative and support staff would need to remain in Tallahassee for program oversight. As a result, full implementation of the ICS initiative for all CMS populations across the state and the transfer of care coordination into ICS capitated arrangements would reduce current public sector administration and service costs between $32.1 million and $36.1 million.

We estimated the reduction in public sector administration and service cost based on staff reductions in the area offices of 45.5 administrative FTEs ($1.3 million), 102 support FTEs ($2.1 million), 152 claims processing and third-party liability FTEs ($3.1 million), and all area office OPS positions ($2.3 million).[13] We then subtracted area office operating expenses of $9.6 million. We calculated that these reductions alone could generate over $18 million in savings. Finally, we estimated that $13.7 million associated with care coordination would need to be transferred into the ICS arrangements to provide this function. In total, these cost reductions and transfer of care coordination funds would reduce program administrative costs from $46.2 million to between $10.1 million and $14.1 million (see Exhibit 3).

**Exhibit 3**
**Changes in CMS Structure Would Result in Over $18 Million in Cost Savings**

| Cost Saving / Fund Transfer Activities | Minimum (million) | Maximum (million) |
|---|---|---|
| Elimination of Area Office Administrative Staff | $ 1.3 | $ 2.3 |
| Elimination of Area Office Support Staff | 2.1 | 3.3 |
| Elimination of Area Office Claims Processing and Third Party Liability Staff | 3.1 | 4.6 |
| Elimination of Area Office OPS Staff | 2.3 | 2.3 |
| Elimination of Area Office Operating Expenses | 9.6 | 9.9 |
| **Total Cost Savings** | **$18.4** | **$22.4** |
| Transfer of Care Coordination Funds | $13.7 | $13.7 |
| **Total Savings Plus Transfer of Funds = Total Reduction in Public-Sector Administrative and Service Costs** | **$32.1** | **$36.1** |

[1] Calculations are based on salary ranges for all FTEs providing a particular function.
Source: OPPAGA calculations.

However, a significant barrier hinders the full implementation of this initiative. The inability of the department's data system to produce reliable data on client service costs has led to reluctance on the part of the ICSs to cover all

[13] These savings are conservative. They are based on the low end of the salary range for each position in the analysis and exclude benefits.

CMS populations in their contracts. ICSs are willing to contract for the CHIP (Title XXI) population, but are hesitant to enter into contracts for either the Medicaid (Title XIX) or safety net populations. [14, 15]

ICS representatives believe that the claims experience of the Medicaid and safety net populations will exceed the capitated payment under the contract. In lieu of the needed program data, department staff has contracted with a federal actuary to determine a valid capitation rate for the Medicaid population. Staff hopes that this will provide the information necessary to alleviate ICS concerns. But, ICS representatives indicate they still want to see whether the first ICS in Miami can be successful before considering an arrangement with the state.

This issue must be resolved in order for the ICS initiative to be successful. The department is attempting to develop a better capitation rate and improve its data system. However, even if these issues are addressed, we believe it will take several years for the department to implement ICS contracts for all CMS populations across the state. [16] This is because the ICSs do not want to cover all populations or all geographical areas until they see the outcome of the first arrangement in Miami. Thus, the current infrastructure will need to remain in place and there will be few reductions in FTEs until the ICSs are confident of these outcomes and sign contracts with CMS.

[14] A separate ICS contract will be required for each of the three CMS populations in a particular ICS service area because of federal eligibility requirements.

[15] The department signed the first ICS contract in December 2001, with Jackson Memorial Hospital in Miami. The initial contract will only cover the Title XXI population (about 15% of the CMS population) in only two counties, Dade and Monroe.

[16] CMS staff indicates that the safety net population may take more than five years to include in the ICS contracts.

## *Consolidation of area offices would increase efficiency and reduce some administrative and support staff positions*

The CMS program is beginning to consolidate certain administrative functions (primarily medical directors) in the 22 area offices. The department intends to accelerate this consolidation as it moves forward with the implementation of ICS contracts. Full implementation of the ICS contracts could eliminate the need for all area offices, but previously discussed problems are preventing this from occurring.

Potential FTE reductions due to consolidation are minimal without the implementation of ICS contracts or privatization of the claims processing system. Continued consolidation of administration in area offices, as is currently being conducted, will most significantly affect high-level administrative positions and their direct support staff. Since care coordination functions continue to be provided through these offices, full consolidation to the state level is unlikely.

## *The care coordination function must be privatized to achieve full privatization of the CMS program*

Stakeholders have advocated privatizing the care coordination function. Since this activity is the largest single function provided by public employees in the CMS program, full privatization of CMS as a whole is unfeasible without privatizing care coordination.

The preferred method for privatizing care coordination is to include it in the Integrated Care System arrangement since these are the primary privatization initiatives being considered. This would involve increasing the capitated payment to cover the expense of providing case management nurses. The increase in rates would probably need to equal current expenditures for case managers in the

public sector.[17] Although inclusion of care coordination in the ICS initiative has been discussed, there is currently no agreement on incorporating the activities into these capitated arrangements.

Privatization of care coordination could also be accomplished by contracting with a private firm such as a disease management organization (DMO), Health Maintenance Organization (HMO), or home health agency to provide case management. However, contracting with these entities raises concerns over cost and quality. As is the case with including care coordination in the ICS initiative, privatizing this function with another entity would likely cost as much to provide the same service. We also have concerns about the quality of care provided by these organizations. In an OPPAGA report examining the disease management initiative in Florida's Medicaid program, we found that these initiatives have difficulty demonstrating improved patient outcomes and cost savings.[18]

# Conclusions and Recommendations

The CMS program is significantly privatized. For Fiscal Year 2001-02, 87% percent of program funds will be paid directly to private health care providers. However, the program has several administrative inefficiencies, including an outdated information system, a decentralized and inefficient manual claims processing system, duplicate administrative functions in area offices, and a case management system that lacks flexibility to meet the varying needs of clients.

The department is pursuing several initiatives to address these inefficiencies, and external stakeholders have suggested other options. Together, these initiatives and options could produce savings of over $18 million annually by entering into capitated arrangements, eliminating manual claims processing, consolidating regional offices, and privatizing the care coordination function. While these initiatives could further privatize the CMS program, barriers currently limit their feasibility.

The department should take the actions described below to address barriers related to implementing these initiatives.

- **The department should release a request for proposals, or invitation to negotiate, for privatizing its information and claims processing systems.** This is important because additional privatization of the CMS program is contingent upon the ability of the department to identify unit costs and track performance and outcome information.

  In order to meet current CMS business needs, the information technology system should allow providers to submit claims electronically over the Internet. The system must also be able to process claims to several funding sources and allow for the tracking of patient outcomes. In general, the system must be able to indicate who received what services, at what cost, and with what results.

  In moving to this new system, the department or private information technology provider must provide technical support for system users (e.g., physicians and hospitals). Without technical support, health care providers may become frustrated trying to use the system and return to submitting paper claims.

  Finally, if the information system is privatized, clear propriety rights should be established to ensure that ownership of the data remains within the department. The department would need to regulate all access to the information to protect patient confidentiality.

[17] In Florida, private sector nursing salaries range from $41,253 to $45,974 annually. The average salary for nurse care coordinators serving the CMS population is $46,300.

[18] *Justification Review: Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed*, Report No. 01-27, May 2001.

- **The department should proceed with efforts to create capitated contracts with Integrated Care Systems (ICSs).** In order to address barriers to the successful implementation of the ICS initiative, the department should expedite the upgrade of its computer information system. This would allow the department to obtain the unit cost information needed to require that all CMS populations be included in the ICS contracts.

  Without these contractual requirements, a large number of patients would remain in the traditional CMS program and the current CMS infrastructure would need to be maintained indefinitely to serve any population not in the ICS. This would prevent the program from realizing program efficiencies and cost savings.

  In fact, the gradual implementation of these contracts for select populations (i.e., the children funded by CHIP dollars) will result in a slow decline in any current economies of scale and higher program costs. This is because many children will need to remain in the current infrastructure for their care, while others move into the ICS system.

- **The care coordination function should be included when implementing the Integrated Care Systems.** This action alone would result in the reduction of 373.5 FTEs in the public sector, although salaries and benefits related to this function would need to be used to increase the capitated contracts.

  Until this occurs, the department could maintain the current system or privatize the care coordination function by using another type of health care company (e.g., a disease management organization, health maintenance organization, etc.). But, we have concerns that privatization through the use of one of these entities would produce few cost savings as appropriations previously used for CMS nurse care coordinators' salaries and expenses would be needed to fund the private contracts.

  We also have concerns about the quality of care provided by these organizations. In an OPPAGA report examining the disease management initiative in Florida's Medicaid program, we found that these initiatives have difficulty demonstrating improved patient outcomes and cost savings. [19]

  Regardless of how care coordination is privatized, the department should maintain some public nursing staff at the state level for oversight purposes. This oversight function mainly would ensure that patients are receiving all medically necessary care.

- **As ICS contracts become fully operational, regional CMS offices should be eliminated.** Until ICS contracts are fully operational, the department should continue its efforts to consolidate administrative functions in the area offices, although this will likely result in reductions of only a few high-level administrative positions (i.e., medical directors).

# Agency Response

In accordance with the provisions of s. 11.45(7), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Department of Health to review and respond.

The Secretary's written response is printed herein on page 19.

[19] *Justification Review: Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed*, Report No. 01-27, May 2001.

# *Appendix A*

# CMS Eligibility Criteria

Children's Medical Services (CMS) provides health care to low-income children with special health care needs. These children often need complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings.

Most CMS children are identified for referral to the CMS Network based on a single question on the KidCare application. Once referred, CMS staff contacts the family and proceeds with a medical eligibility determination. This determination is based on a multi-tiered screening tool that has the following elements.

**Table A-1**
**CMS Eligibility Criteria**

| Tier | Information Used for Determination | Description |
|---|---|---|
| **Tier IA** | **Medical Diagnoses** | A child is automatically eligible for CMS if one of the following conditions is present: AIDS/HIV, Cancer (if treated and has been in remission for less than five years), Congenital Adrenal Hypoplasia, Cystic Fibrosis, Diabetes, Galactosemia, Hemophilia, Hepatitis, Hypothyroidism, Juvenile Myasthenia Gravis, Juvenile Rheumatoid Arthritis, Kidney Disease (with dialysis), Leukemia (if treated and has been in remission for less than five years), Muscular Dystrophy, Phenylketonuria, Quadriplegia/tetraplegia, Sickle Cell Anemia, Spina Bifida, or Tuberculosis. |
| **Tier IB** | **Behavioral Health/ Substance Abuse** | Children are also screened for behavioral health conditions during the initial CMS medical eligibility determination. If potential problems are identified, the patient may be referred to the Behavioral Health Specialty Network, within CMS. The patient may be referred to more than one assistance program based on whether there is a behavioral health problem in conjunction with a major medical condition, or just a behavioral health condition alone. Behavioral health conditions include Bipolar Disorder, Classification of Severe Emotional Disturbance by the School System, Major Depression, Schizophrenia, and/or Substance Abuse. |
| **Tier II** | **Screening Questions** | Children referred to CMS are screened using a standard assessment tool. This questionnaire asks guardians to describe any long-standing medical conditions. If the parent answers "Yes" to all of the first three questions, then the child is deemed eligible to participate in CMS. These questions ask whether the child requires additional supervision, medical equipment and/or assistance in activities of daily living (dressing, eating, etc.) because of a medical condition. If any of these questions are answered "No," then there are additional questions used to ascertain the child's medical history. Based on these answers, the child may be determined eligible, or additional information may be requested from medical records. |
| **Tier III** | **Medical Records** | If there is insufficient information from the screening tool to make an eligibility determination, CMS staff will request a Medical Release of Information from the guardians. With this release, CMS staff obtains medical records from the child's physician. Staff reviews these records to make an eligibility determination. |
| **Tier IV** | **Physical Exam** | Direct medical exams by a licensed physician are the final method for determining eligibility. |

Source: Florida KidCare Evaluation, Year 2: Fiscal Year 2000. Institute for Child Health Policy.

# *Appendix B*

# CMS Staff by Function and Location, Fiscal Year 2001-02

State employees of CMS provide two major functions—care coordination and administrative/support. In Fiscal Year 2001-02, the Legislature authorized 751 FTEs to provide these functions. The table below describes these FTEs by type and location.

**Table B-1**
**CMS Staff By Location**

| Location | Care Coordinators | Administration | Support Personnel | Total FTEs |
|---|---|---|---|---|
| Headquarters/ Statewide | 0 | 60 | 3 | 63 |
| Pensacola | 23 | 7 | 11 | 41 |
| Tallahassee | 20.5 | 5.5 | 11.5 | 37.5 |
| Panama City | 13.5 | 5 | 9.5 | 28 |
| Gainesville/Ocala | 44.5 | 9 | 22.5 | 76 |
| Daytona/DeLand | 13.5 | 3 | 9 | 25.5 |
| Jacksonville | 14 | 7 | 10 | 31 |
| St. Petersburg | 29 | 3 | 16 | 48 |
| Tampa | 29 | 10 | 14 | 53 |
| Lakeland | 18 | 6 | 14 | 38 |
| Fort Pierce | 18.5 | 4 | 8 | 30.5 |
| Orlando | 24 | 7 | 12.5 | 43.5 |
| Rockledge | 12 | 3 | 7 | 22 |
| Fort Myers | 17 | 6.5 | 7.5 | 31 |
| Sarasota | 11 | 4 | 6 | 21 |
| Naples | 2 | 0 | 0 | 2 |
| West Palm Bch | 24 | 11 | 15 | 50 |
| Fort Lauderdale | 23 | 10 | 10 | 43 |
| Miami North | 24 | 8 | 9 | 41 |
| Miami South | 11 | 3 | 8 | 22 |
| Marathon | 2 | 1 | 1 | 4 |
| **Total** | **373.5** | **173** | **204.5** | **751** |

Source: Department of Health, Children's Medical Services.

# *Appendix C*

# CMS Manual Claims Processing Procedure

Another administrative inefficiency preventing full privatization is the program's manual claims processing system. After treating non-Medicaid CMS patients, providers must submit paper claims for payment directly to the program; CMS is not able to accept claims electronically from providers. CMS staff manually processes these claims in the area offices before sending them to headquarters for payment. This results in a complex, labor-intensive process. Table C-1 describes a simplified version of this procedure.

**Table C-1**
**Manual Claims Processing Procedure**

| Step | Description |
|---|---|
| 1 | A CMS provider sees a patient. If Medicaid covers the CMS patient, the provider submits a claim for service directly to Consultec, the Medicaid fiscal intermediary. If not, the provider produces a paper claim and sends it to the local CMS office. |
| 2 | The local CMS area office receives the claim. |
| 3 | The claim is manually examined for errors and proper codes are transcribed onto the claim if they are needed (i.e., pharmacy charges are not in the computer system, so they must be manually identified from a spreadsheet and put on the claim). |
| 4 | The claim is manually entered separately into CMDS. |
| 5 | An electronic file is produced from these claims and it is sent, along with a paper copy of the original claim, to Department of Health Finance and Accounting (DOH F&A) in Tallahassee by overnight mail. |
| 6 | Finance and accounting receives the electronic file. |
| 7 | The files are uploaded into a software program called the Fiscal Invoice Processing Batch Upload System (FIPBUS). This software reorganizes the payment information and adds some fiscal identifying information necessary for payment purposes and then exports a text file in a new format. This text file is then sent to the Department of Children and Families to be processed by another software called the Vendor Payment System (VPS). This software validates the clients, the services billed, and the amounts billed for those services. The outputs of this process are 1) updates to a data file known as the Master Expenditures File (MEF); 2) another text file that is forwarded to DOH F&A; and 3) error reports for the payment information that do not pass the edits. DOH F&A then take the file and sends it to the Comptroller's Office for payment processing. |
| 8 | The Comptroller processes the electronic file and sends a payment voucher back to Finance and Accounting. |
| 9 | Finance and Accounting staff manually compares the payment voucher to the original claim. |
| 10 | If payment voucher and claim reconcile, the payment is sent to the provider. |

# *Appendix D*

# Privatization Initiatives

The department is pursuing several initiatives to address certain administrative inefficiencies, and external stakeholders have suggested other options. Together, these initiatives and options could save over $18 million annually by entering into capitated arrangements, eliminating manual claims processing, consolidating regional offices, and removing the care coordination function from the public sector. While these initiatives could further privatize the CMS program, barriers currently limit their feasibility. These initiatives and barriers to their implementation are discussed below.

## *Integrated Care Systems (ICS)*

The main privatization initiative is the creation of Integrated Care Systems (ICS). Patients may only go to a provider outside of the assigned ICS by permission; otherwise, the care will not be covered. CMS patients are assigned to the ICS based on their funding source and geographic location.

Separate capitated ICS contracts will be required for each of the three funding sources (Title XIX, Title XXI, and safety net) due to federal and state eligibility requirements. Care coordination, mental health, dental, transportation and pharmaceutical benefits will not be included in the capitated arrangements. In addition, ICSs will not be held at medical risk for the first three years of the contract. This means that if actual expenditure requirements exceed what Medicaid would have paid, the state will cover the additional costs.

Department staff believes that creation of ICS will result in long-term efficiencies and lower program costs. CMS staff is currently estimating potential cost savings and position reductions that may occur with the introduction of ICSs, but they are not available at this time.

The implementation of the ICS arrangements has just started. The department recently received permission from the federal government through a Medicaid waiver to enter into ICS contracts. The first ICS contract is with Public Health Trust of Miami-Dade County and routed through Jackson Memorial Hospital Health Plan. The contract will cover the Title XXI population only and serve Dade and Monroe counties. The department signed the contract in December 2001. Another ICS was in negotiation with the department is Shands Health Care System in Gainesville. Shands vice president for Managed Care proposed a four-year phase-in for the Title XXI population in Areas 3 and 13. [20] Based on the success of this contract, Shands would have expanded to other areas of the state. However, at the time of

[20] Counties in these areas include: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union.

this report, Shands has withdrawn from negotiations. Contract negotiations were contingent upon the creation of a provider network called the Baycare Health Network, but this effort has recently collapsed. Other discussions have been with providers in the Tampa/St. Petersburg area.

There are several other problems associated with this initiative. The most significant problem is that it is unlikely that all CMS populations will be covered, either because of geography or funding source. As previously stated, one ICS is close to entering a contract but it will only cover the Title XXI population in two counties. The majority of counties in the state will not be covered under current negotiations. ICSs are reluctant to enter into capitated arrangements for any CMS population other than the Title XXI (CHIP) population. ICS representatives interviewed expressed doubt that a valid capitation rate could even be developed for the Title XIX population, which is the majority of children in CMS.[21] The safety net population is a particular problem because its size and composition fluctuates throughout the year making it more difficult to determine a unit cost and, thus, create a reasonable capitation rate. Any population not covered under the ICS will need to obtain care through the current CMS infrastructure.

### *Privatizing care coordination*

Privatizing the care coordination function has been discussed as a way to decrease the number of FTEs in the CMS program. Care coordinators and their supervisors account for 399.5 FTEs in the current program, most of whom are registered nurses (RNs).

As with the ICS initiative, the privatization of the care coordination function has a number of barriers. No request for proposals (RFP) has ever been issued to evaluate the concept, and it is unclear whether there is a private firm interested in providing this service.

Furthermore, it is likely that a contract requiring the same level of case management with the same level of expertise (i.e., registered nurses) would be at least as expensive as current services.[22] In order to provide care coordination at a comparable cost, level of service or expertise will need to be reduced. This will mean either reducing the frequency of personal visits to the patient or the use of licensed practical nurses, licensed social workers, or certified nursing assistants in place of RNs. Many stakeholders interviewed believe that this would be at the detriment of the CMS population. They believe that the medical complexity of these children is such that an RN is required.

Stakeholders are also concerned about the inclusion of the care coordination function within ICSs. They believe that the interest of the care coordinator would shift from that of serving the child to maintaining fiscal limits on care. They strongly believe that the care coordination function should be kept

[21] The department has contracted with a federal actuary to develop the Title XIX capitation rate.

[22] In Florida, private sector nursing salaries range from $41,253 to $45,974 annually. The average salary for nurse care coordinators serving the CMS population is $46,300.

separate for additional oversight of the ICSs. Conversely, ICS representatives stated that they did not believe the care coordination function is necessary. They argue that the very nature of their system ensures greater coordination among providers in the network and that the physician is actually the best advocate for the child.

### *Additional consolidation/regionalization of area offices*

Although the department is actively consolidating high-level administrative functions, staff has not conducted any studies to determine total possible reductions in FTEs or facilities. Implementation of the ICS initiative and the provision of care coordination limit greater regionalization. This is because the most significant staff reductions (primarily claims processing and contract management staff) will only occur as the ICS initiative is successfully implemented. On the other hand, care coordinators are based out of the area offices and geographic limitations (e.g., distance a case manager can efficiently travel to provide care) necessitate a multitude of area offices spread across the state.

Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

John O.Agwunobi, M.D., M.B.A.
Secretary

January 9, 2002

John W. Turcotte, Director
Office of Program Policy Analysis
& Government Accountability
111 West Madison Street, Room 312
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

This letter serves to document the Department of Health's response to the Office of Program Policy Analysis and Government Accountability's (OPPAGA) program review entitled:

**Children's Medical Services Privatization Is Feasible, Could Save Over $18 Million, But Barriers Must be Overcome**

We concur with the findings related to the outdated information system and its resulting inability to provide sufficient information to track service use, cost, and outcomes in an efficient and reliable manner. We feel that this is the greatest barrier to increased efficiency in the Children's Medical Services (CMS) Program.

We do not agree that care coordination should be moved into a capitated arrangement. We believe keeping it outside of a capitated arrangement allows for quality control and monitoring of the potential to restrict necessary services. Additionally, we recognize that disciplines other than nursing can be used for care coordination, however CMS uses registered nurses because they also provide direct nursing services that cannot be provided by other disciplines.

It is important to note that the barriers to additional privatization of Children's Medical Services outlined by OPPAGA staff are significant. In fact, there are no fully privatized children with social health care needs programs operating under Title V of the Social Security Act in the nation because of the barriers noted in this report. Those barriers include the following.

- Adequacy of current Medicaid rate.
- Willingness of providers to accept risk for an adversely selected population without adequate rates including administrative overhead.
- Adequacy of current information systems.
- Privatization of care coordination functions may increase costs.

Thank you for the opportunity to comment. If you have any questions, please contact us.

Sincerely,

/s/
John O. Agwunobi, M.D., M.B.A.
Secretary, Department of Health

JOA/psd
cc: Jean Gonzalez, Legislative Planning

***The Florida Legislature***

# *Office of Program Policy Analysis and Government Accountability*

Visit the *Florida Monitor*, OPPAGA's online service. See http://www.oppaga.state.fl.us. This site monitors the performance and accountability of Florida government by making OPPAGA's four primary products available online.

- OPPAGA publications and contracted reviews, such as policy analyses and performance reviews, assess the efficiency and effectiveness of state policies and programs and recommend improvements for Florida government.
- Performance-based program budgeting (PB²) reports and information offer a variety of tools. Program evaluation and justification reviews assess state programs operating under performance-based program budgeting. Also offered are performance measures information and our assessments of measures.
- Florida Government Accountability Report (FGAR) is an Internet encyclopedia of Florida state government. FGAR offers concise information about state programs, policy issues, and performance. Check out the ratings of the accountability systems of 13 state programs.
- Best Financial Management Practices Reviews of Florida school districts. In accordance with the *Sharpening the Pencil Act*, OPPAGA and the Auditor General jointly conduct reviews to determine if a school district is using best financial management practices to help school districts meet the challenge of educating their students in a cost-efficient manner.

Subscribe to OPPAGA's electronic newsletter, Florida Monitor Weekly, a free source for brief e-mail announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

*Florida Monitor:* http://www.oppaga.state.fl.us/

Project supervised by Frank Alvarez, Staff Director (850/487-9274)

Project conducted by Michael Garner, Policy Analyst (850/487-9252)

John W. Turcotte, OPPAGA Director