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Justification Review

January 2003 Report No. 03-02

Brain and Spinal Cord Injury Program Reports Meeting Goal, Could Recover Additional Revenues

at a glance

The Department of Health's Brain and Spinal Cord Injury Program helps people with traumatic brain or spinal cord injuries return to their homes or other community-based living. We found

- that, although the program reported meeting its Legislative performance goal, it lacks reliable data to assess performance accurately;
- however, other data reveals that clients are generally satisfied with services; and
- the program should improve efficiency and effectiveness by modifying case management reimbursement practices for Medicaid clients. In addition the program should shift all case management functions for waiver clients from program employees to Medicaid support coordinators.

We estimated that the program would recover an additional $238,000 per year in federal funds by filing for Medicaid reimbursement for adult clients as well as reduce trust fund costs of $59,900 for children's services. The program could also avoid the cost of $309,000 in its 2003-04 Legislative Budget Request for seven additional positions.

Purpose

Section 11.513, *Florida Statutes,* directs the Office of Program Policy Analysis and Government Accountability to complete a program evaluation and justification review for each state agency that is operating under a performance-based program budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs. See Appendix A, page 9, for summaries of our conclusions in each of the nine issue areas that by law OPPAGA is directed to consider as part of this review.

This report is one of three that reviews the Health Care Practitioner and Access Program administered by the Department of Health. This report addresses the performance of Florida's Brain and Spinal Cord Injury Program. In two other reports we address the performance of the Division of Medical Quality Assurance and the Bureau of Emergency Medical Services.

Background

The Brain and Spinal Cord Injury Program's purpose is to provide services to help people who have sustained a traumatic brain or spinal cord injury return to their homes or other community-based living arrangements, thus avoiding nursing home or

other institutional care. Literature indicates that early and appropriate medical rehabilitation increases the likelihood that survivors will return to the community or be employed, which should reduce the long-term cost of health care and public assistance for these individuals.

State law requires that public and private health and social agencies report to a central registry anyone experiencing a traumatic brain or spinal cord injury.[1] The number of referrals to the Central Registry varies annually. In Fiscal Year 2001-02, 3,239 were referred to the Central Registry. Most people with traumatic brain or spinal cord injuries are white, male, and between the ages of 26 and 45. Motor vehicle accidents and falls are the leading causes of injuries.

In Fiscal Year 2001-02, the program accepted 931 new clients. The program serves people who are referred through the Central Registry and meet certain eligibility criteria. As defined in state law, the injured person must have a motor deficit, a sensory deficit, bowel and bladder dysfunction, or cognitive or behavioral deficits.[2] In addition, the person must be

- a legal resident of Florida;
- medically stable, which means that they are not in a coma and do not require life support or other extensive medical services; and
- able to benefit from program services as determined by program case managers.

There is no financial or means test for eligibility. The types and levels of services the program pays for vary according to the client's individual coverage. The program is intended to be a payer of last resort, meaning that it seeks to recover costs from available private insurance, Medicaid, and/or Worker's Compensation insurance.

[1] Section 381.74, *F.S.*

[2] Section 381.745, *F.S.*

The program provides a range of services that include case management services, acute care, inpatient and outpatient rehabilitation, transitional living, assistive technology, home and vehicle modifications, home and community-based services, and long-term community-based supports.

As of October 17, 2002, the program served 3,714 clients. All clients receive case management services, which include identifying the individual's rehabilitative needs and programs or facilities that can provide those services. Clients typically complete all of planned services within two years, although some need additional long-term care.

In a 1996 review, OPPAGA recommended that the program seek a Medicaid home and community-based waiver to secure federal funds for client services.[3] In 2000, after receiving a Medicaid Waiver, the program began providing long-term care services for up to 200 clients who faced imminent risk of nursing home admission.[4] The waiver extends the duration of client services and allows services as long as clients need help to help avoid nursing home or other institutional care. The federal government extended the waiver program in July 2002 and approved it to serve 300 clients.

Organization. Since January 2000, the Department of Health has administered the Brain and Spinal Cord Injury Program formerly administered by the Department of Labor and Employment Security.[5] The Brain and Spinal

[3] *Review of the Brain and Spinal Cord Injury Program Within the Division of Vocational Rehabilitation of the Department of Labor and Employment Security*, Report No. 95-23, January 1996.

[4] The waiver is also used to help people with brain and spinal cord injuries living in nursing homes who could return to the community with appropriate services.

[5] The Legislature established a central registry in 1974 within the former Department of Health and Rehabilitative Services for people with severe disabilities. In 1987, the Legislature transferred the program to the Department of Labor and Employment Security's Division of Vocational Rehabilitation. The 1999 Legislature reassigned the program to the Department of Health (effective January 1, 2000) when it abolished the Department of Labor and Employment Security.

Cord Injury Bureau within the Division of Emergency Medical Services and Community Health Resources manages the program. The bureau establishes policies and procedures, provides training for community-based waiver support coordinators, and provides oversight of community-based providers. The program employs case management and technical support staff who are assigned to five regions throughout the state. Case managers develop service plans for clients, help coordinate client care, and make necessary changes to service plans. Program technicians help case managers with processing of invoices.

The department's Children's Medical Services (CMS) Division serves children with traumatic brain and spinal cord injuries through an intra-agency agreement with the Brain and Spinal Cord Injury Bureau. As of October 17, 2002, Children's Medical Services served a total of 411 Brain and Spinal Cord Injury Program clients.

Program Resources. Revenues for the program were $16.4 million in Fiscal Year 2001-02. The program has two sources of funding. Most (88%) funding originates from the Brain and Spinal Cord Injury (BSCI) Trust Fund, which was created by the Legislature in 1988. Revenues accrue from civil penalties including for speeding, drunk driving, and boating violations. Federal match for the Medicaid Waiver Program provided another $1.7 million in Fiscal Year 2001-02.

Because state law requires the program to be the payer of last resort, the program seeks reimbursement for services from various sources including private insurance companies, Medicaid, and lawsuit settlements.[6] The program recovered $307,119 in Fiscal Year 2001-02.

For Fiscal Year 2002-03, the Legislature appropriated $16,511,654 and authorized 62 full-time equivalent positions (FTEs). Ten positions are assigned to the central program office in Tallahassee. In addition, there are 5 regional managers, 21 case managers, 20 program technicians, and 6 support staff located throughout the state.

Findings

Although the program lacks reliable data to assess effectiveness in achieving legislative goals, program consumers appear to be reasonably satisfied with services. However, the program should improve its efficiency and effectiveness by modifying its case management reimbursement practices for Medicaid clients and shifting all case management functions from program employees to Medicaid support coordinators.

The program lacks reliable data to assess its impact in helping clients stay in the community

The program's goal is to reintegrate clients into the community. Reintegration occurs when a client receives all the services outlined in their case plans without being institutionalized. The Legislature has established a goal to reintegrate 83% of clients into the community. To accomplish this goal, the program provides case management and direct services and assists clients in accessing services they will need to live in the community.

While the program reported that it met the Legislature's goal, the data it uses to measure its performance is not reliable.[7] The program could not provide us with an unduplicated count of clients and could not provide supporting documentation for the data on client reintegration reported to the Legislature in Fiscal Years 1999-00 and 2000-01.

The program is acting to resolve data problems. It hired a private contractor to upgrade the information system and is devoting program staff time to eliminating duplicate client records.

[6] Section 381.785, *F.S.*

[7] The program reported that 91% of its clients were reintegrated in Fiscal Year 2000-01.

The program anticipates having an unduplicated count of clients for its Fiscal Year 2001-02 annual report due in March 2003.

A weakness in the program's outcome measure is that it only assesses whether clients remain in the community while they are receiving services. However, these services are typically completed within a two-year period. If clients cannot remain in the community after completing these services, the program is not accomplishing its reintegration goal. Information on whether clients stay out of nursing homes or other institutions after completing the program for specified periods, such as two and five years, would enable the program to determine with more precision whether the services offered are effective in helping clients stay in the community in the long term.

Clients are generally satisfied with the services they receive

While not a legislative performance measure, limited data has been collected by the program that indicates that its clients are generally satisfied with services. A March 2002 client satisfaction survey found that clients seem to be satisfied with program services.[8] Eighty-two percent of clients reported that they had adequate access to needed services, and 88% felt that service providers treated them with respect. Nearly 80% reported that they were satisfied with their community re-entry plans and 77% were satisfied with the follow-up services when they returned home from the hospital or a rehabilitation center.

Program officials have revised the survey instrument and methodology based on the preliminary results. Program managers said that they have revised and clarified some questions and changed the survey response categories to allow a three-point response for clients with brain injuries who might need a simplified set of response choices.

The program is now surveying clients on a monthly basis and including client comments in the survey results. Some of the comments made by dissatisfied clients include that they were not informed about services, were not assigned case managers, and did not receive the help they were promised. The program also plans to expand the survey to include clients who declined services or who dropped out prior to completing their plan of care.

The program would recover additional funds by changing case management practices

One of the program's primary functions is to provide case management for clients. In practice, there are three client populations that receive case management services: adult clients who receive case management from 21 case managers; children age 18 and under who receive case management from 12 nurse case managers through the department's Children's Medical Services (CMS) program; and Medicaid Waiver clients who receive case management through the program's case managers and through private provider support coordinators.

To maximize program resources, the program should take the following actions:

- begin billing Medicaid for case management services provided to clients who are Medicaid-eligible, resulting in a potential reduction in state cost and an increase in federal funds for the program of $238,000 per year;
- use Medicaid reimbursements received by CMS for providing case management to children to offset the program's costs, resulting in a potential reduction in BSCI trust fund costs of $59,900 per year; and
- transfer the case management functions for Medicaid Waiver clients from program case managers to private providers as required in

[8] The consumer satisfaction pilot project surveyed 100 BSCIP clients who completed their service plans in December 2001 and January 2002. The Brain Injury Association of Florida and the Florida Spinal Cord Injury Resource Center carried out the survey for the program.

the waiver. This would avoid the need to create seven additional positions at a cost of $309,000, as requested in the program's Fiscal Year 2003-04 Legislative Budget Request.

Filing for reimbursement for case management for Medicaid-eligible adult clients. State law requires the Brain and Spinal Cord Injury Program to be the payer of last resort.[9] This means that the program is required to identify any benefits (e.g., Medicaid, private insurance) available to fund the needed service. However, the program has not sought changes to the Medicaid State Plan that would allow it to bill Medicaid for case management services provided to Medicaid-eligible adult clients. As a result, the program is not maximizing program resources.

Program officials told us that they have not pursued case management reimbursement because the steps necessary to comply with Medicaid rules would burden its case managers. According to program managers, in order to file for reimbursement, program case managers would have to track the time spent with each client and whether that client was Medicaid-eligible. Currently case managers do not track the time they spend with clients. However, the program has not conducted any systematic analysis of the time it would take to file for Medicaid reimbursement or the associated costs.

We believe that it is feasible for the program to begin filing for Medicaid reimbursement without disrupting its case management activities. With its implementation of the Medicaid Waiver in July 2000, the program has established a process for filing for Medicaid reimbursement. Medicaid Waiver providers bill the Brain and Spinal Cord Program that in turns pays the cost of the service. Program employees then complete the process and bill Medicaid through the state's Medicaid fiscal agent that reimburses the program's costs. Consequently, the program already has a system in place to process Medicaid claims.

In addition, other state and local programs have developed alternative cost reimbursement methods for case management and other services. The department's CMS program is developing a new system that bases reimbursement on the results of a sampling of case managers' actual hours spent on tasks. This alternative would provide a more efficient method of determining reimbursements and thus reducing the burden on case managers.

We estimated that the program would generate an additional $238,000 per year in federal funds if it filed for Medicaid reimbursement of case management costs for these clients.[10] The program could use the trust fund dollars it is already spending on case management positions as the state's match. The federal funds could be used to expand services for these clients such as in-patient rehabilitation services. While program management has not quantified the extent to which additional services are needed, they assert that clients need more services.

Reimbursement for children's case management. The program funds 12 nurse case managers in the department's Children's Medical Services (CMS) program to serve about 400 children age 18 and under.[11] Until October 2002, CMS billed Medicaid for targeted case management services it provided to Medicaid-eligible children who are clients of the program. In Fiscal Year 2001-02, CMS was reimbursed $59,900 in federal dollars for case management

[9] Section 381.785, *F.S.*

[10] The program served an estimated 288 Medicaid eligible adult clients for services in Fiscal Year 2000-01. We used the CMS program's average monthly cost of $117 per month to provide case management to program clients under the age of 18 to estimate that the program could have billed Medicaid for an estimated $404,352 in Fiscal Year 2000-01. Of the total the federal match is an estimated $238,000.

[11] The agreement between Brain and Spinal Cord Injury Program and CMS provides a total of 15 positions, 12 nurse case managers, and 3 support positions. The cost of the positions, travel and other administrative totaled $915,015 for the Fiscal Year 2001-02.

services provided for program clients age 18 and under.

To increase the amount Medicaid reimburses for case management services, the Legislature directed CMS to implement a different method for recovering federal funds. In October 2002, the CMS program discontinued billing Medicaid targeted case management and implemented administrative claiming.

Administrative claiming allows the program to recoup direct care and indirect (administrative) expenditures based on an estimate of how much time case managers spend serving Medicaid clients. [12] Since CMS just began the new administrative claiming, it will not have information on actual reimbursement amounts until January 2003.

We estimated CMS could recover $274,504 for salaries, benefits and expenses associated with Brain and Spinal Cord Program clients. [13] To ensure that the BSCI Trust Fund monies are used efficiently, the BSCI Program should ensure that any federal funds recovered by CMS are used to offset the program's annual payment to CMS.

Shifting case management for Medicaid Waiver clients. The program has not transferred case management functions from its case managers to Medicaid Waiver support coordinators. When program clients enroll in the Medicaid Waiver Program, they are assigned a support coordinator to provide ongoing monitoring of services to these clients. The program pays support coordinators $120 per client per month. However, our survey of program case managers in October 2002 and a January 2002 federal compliance review found that program case managers were amending and updating clients' plans of care for 163 clients enrolled in the Medicaid Waiver Program. [14] The provisions of the Medicaid Waiver require support coordinators to take over this function after the case manager establishes the initial plan of care.

Case managers also perform other functions that waiver support coordinators could perform, such as authorizing payment for services, making interim changes to plans of care, and entering data into the program's information system. In other waiver programs, such as Developmental Disabilities, support coordinators handle all case management functions. We surveyed program case managers and found that waiver clients compose 13% of their caseloads and take 25% of their time each week. [15]

Continuing to be responsible for Medicaid Waiver clients is inefficient because waiver support coordinators could provide these services. As a result, program case manager workload has increased by 12%. Case managers serve an average of 70 clients (based on our survey of case managers), including the waiver clients. Discontinuing this service duplication would reduce case manager workload and avoid the need for creating additional positions. To relieve the additional workload of providing case management to waiver clients and other community-based initiatives, the program has requested $309,000 for seven additional FTEs (five nurse case managers and two additional positions). We concluded that the program would not need these additional positions, thus could avoid spending $309,000, if it shifted case management functions for Medicaid Waiver clients to private support coordinators. In addition, by freeing up the time they currently spend on waiver clients, program case managers could use their time to serve their

[12] The administrative claiming formula is based on a survey of a sample of CMS's 373 case managers including the 12 who serve BSCI clients.

[13] The total cost of the BSCI agreement is $915,015. In Fiscal Year 2001-02, 60% of CMS clients were Medicaid clients. The reimbursement rate for administrative claiming is 50%. Based on this, we estimate that CMS could recover one-half of the 60% ($549,009) spent on case management or $274,504.

[14] *Compliance Report on the Traumatic Brain Injury/Spinal Cord Injury Waiver,* Centers for Medicare and Medicaid Services, January 22, 2002.

[15] We received completed surveys from 71% of BSCI case managers.

primary clients and recruit needed service providers.

Program officials said that case managers are doing some of the work that support coordinators are responsible for because the Medicaid Waiver is relatively new and has not yet been fully implemented. Program managers oppose transferring all case management functions to support coordinators because it would result in a lack of control over program resources, client service plans, and provider billing.

Continuing to be responsible for case management is inefficient, is inconsistent with provisions of the Medicaid Waiver, and should be discontinued.

Recommendations

While the program reports that it met its legislative goal, the program continues to have several deficiencies in its accountability system that impedes its ability to provide meaningful and accurate performance information. We found that the program has substantial validity problems with the data including duplicate records and unverifiable data. To ensure the accuracy of data on its key outcome measure reported to the Legislature, we recommend that the program continue to work to upgrade the information system and ensure that duplicate records are eliminated. The program should also begin maintaining records necessary to verify program performance.

To provide more meaningful information to the Legislature on the long-term effects of program services, we recommend that the program establish a mechanism for tracking clients that have been successfully reintegrated at the time of program completion for one year.

We also recommend that the program modify its case management practices in order to use its limited resources more efficiently and economically. State law requires that the program be the payer of last resort, which means that it needs to actively pursue other funding sources such as Medicaid. However, we found that the program does not seek Medicaid reimbursement for case management services it provides for Medicaid-eligible adult clients. The program also has not implemented a recommendation from a 1996 OPPAGA report that it deduct trust fund payments to the Children's Medical Services (CMS) program for the amount that CMS is reimbursed by Medicaid for those same services. [16] Finally, the program needs to transfer case management functions to Medicaid Waiver Program support coordinators as required by the Medicaid Waiver. Continuing to assign program case managers responsibility for waiver clients is inefficient and has caused an increase in case managers' workload.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes,* a draft of our report was submitted to the Secretary of the Department of the Health for his review and response.

The Secretary's written response is reprinted herein beginning on page 11.

[16] *Review of the Brain and Spinal Cord Injury Program within the Division of Vocational Rehabilitation of the Department of Labor and Employment Security,* Report No. 95-23, January 1996.

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Appendix A

Statutory Requirements for Program Evaluation and Justification Review

Section 11.513*, Florida Statutes,* provides that OPPAGA Program Evaluation and Justification Reviews shall address nine issue areas. Out conclusions on these issues as they relate to the Brain and Spinal Cord Injury Program are summarized in Table A-1.

Table A-1
Summary of the Program Evaluation and Justification Review of the Health Care Practitioner and Access Program

Issue	OPPAGA Conclusion
The identifiable costs of the program	For Fiscal Year 2002-03, the Legislature appropriated $16,511,654 and authorized 66 full-time equivalent positions to the program.
The specific purpose of program, as well as the specific public benefit derived therefrom	The purpose is to provide services to help people who have sustained a traumatic brain or spinal cord injury return to their homes or other community-based living arrangements, thus avoiding nursing home or other institutional care.
Progress toward achieving the outputs and outcomes associated with the program	While the program reported that it met the Legislature's goal, the data it uses to measure its performance is unreliable.[1]
An explanation of circumstances contributing to the department's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in s. 216.011, *F.S.*, associated with the program	The Brain and Spinal Cord Injury Program reports exceeding the legislative standard to reintegrate 83% of clients into the community. For Fiscal Year 2000-01, the program reported 91% of clients successfully reintegrated, an increase from 1999-00 when 80% of clients were reintegrated. Program officials attribute their improved performance to the increased skill and expertise of their case managers in appropriately identifying clients who will benefit from program services.
Alternative courses of action that would result in administering the program more efficiently or effectively	To maximize program resources, the program should take the following actions: ▪ begin billing Medicaid for case management services provided to clients who are Medicaid-eligible, resulting in a potential cost savings for the program of $238,000 per year; ▪ use Medicaid reimbursements received by CMS for providing case management to children to offset the program's costs, resulting in a potential reduction in BSCI trust fund costs of $59,900 per year; and ▪ transfer the case management functions for Medicaid Waiver clients from program case managers to private providers. This would avoid the need to create seven additional positions at a cost of $309,000, as requested in the program's Fiscal Year 2003-04 Legislative Budget Request.
The consequences of discontinuing the program	Providing community-based services to people who experience traumatic brain or spinal cord injuries costs less than serving them in institutions. People who experience a traumatic spinal cord injury may require extensive rehabilitation and help with activities of daily living such as bathing, dressing, and moving from a bed to a chair. Those who experience a traumatic brain injury may experience memory loss or other cognitive deficits that affect their daily living. Without the Brain and Spinal Cord Injury Program, some clients with traumatic injuries would require more costly nursing home care.

Issue	OPPAGA Conclusion
Determination as to public policy; which may include recommendations as to whether it would be sound public policy to continue or discontinue funding the program, either in whole or in part	Early and appropriate medical rehabilitation increases the likelihood that survivors will return to the community or be employed, which should reduce the long-term cost of health care and public assistance for these individuals.
Whether the information reported pursuant to s. 216.031(5), *F.S.*, has relevance and utility for evaluation of the program	A weakness in the program's outcome measure is that it only assesses whether clients remain in the community while they are receiving services. However, these services are typically completed within a two-year period. If clients cannot remain in the community after completing these services, the program is not accomplishing its reintegration goal. Information on whether clients stay out of nursing homes or other institutions after completing the program for specified periods, such as two and five years, would enable the program to better determine whether the services it offers are effective in helping clients stay in the community in the long-term.
Whether state agency management has established control systems sufficient to ensure that performance data are maintained and supported by state agency records and accurately presented in state agency performance reports.	The program could not provide us with an unduplicated count of its clients and could not provide supporting documentation for the data on client reintegration reported to the Legislature in Fiscal Years 1999-00 and 2000-01.

Source: OPPAGA analysis.

Appendix B

Jeb Bush
Governor

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

December 23, 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:

Thank you for the opportunity to respond to the Office of Program Policy Analysis and Government Accountability's [OPPAGA] justification review, *Brain & Spinal Cord Injury Program Reports Meeting Goal, Could Recover Additional Revenues.*

Please find enclosed our response to the report recommendations made to the Legislature, and our response to statements in the report narrative that we found to be in need of clarification or explanation.

We appreciate the opportunity to comment. If you have questions, please contact us.

Sincerely,

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

JOA/mhb
Enclosure

Preliminary and Tentative Findings Response

OPPAGA Justification Review, Brain & Spinal Cord Injury Program Reports Meeting Goal, Could Recover Additional Revenues.

Finding	*Recommendation*	*Management's Response*	*Corrective Action Plan*
The program lacks reliable data to assess effectiveness in achieving the legislature's goal to reintegrate 83% of clients into the community	To ensure the accuracy of data on its key outcome measure reported to the legislature, we recommend that the program continue to work to upgrade the information system and ensure that duplicate records are eliminated. The program should also begin maintaining records necessary to verify program performance	Since transferring to the Department of Health in January 2000, the Brain and Spinal Cord Injury Program has contracted with Marquis Software Development, Inc., to develop a data system to specifically meet the needs of the program. Working with BSCIP staff, duplication of data entry has been identified and rectified so that only one referral is being entered into the data system for services through the regular program or the Medicaid Waiver Program. Ongoing refinements to ensure that the data duplication is avoided include identifying clients by social security number and funding source; only one referral for the same injury will be entered in RIMS, referrals to the Medicaid Waiver Program waiting list are now captured through the funding source in special projects; and the Medicaid Waiver cases will remain open in special projects in RIMS until the death of these clients or they are institutionalized.	A. The BSCIP will provide ongoing systematic monitoring for duplication via its statewide RIMS workgroup under the direction of Becky Robinson. B. Training on data system enhancements is ongoing and will be provided to all staff to ensure the accuracy of the data and that program performance is systematically assessed throughout the state. C. The BSCIP will add an annual review as an enhancement to RIMS for each client closed as successfully reintegrated into the community or referred to VR. D. The BSCIP will monitor the quarterly regional statistical reports and discuss at its bi-weekly teleconferences and quarterly face-to-face meetings with headquarters administrators and regional managers.
The program has not sought changes to the Medicaid State Plan that would allow it to bill Medicaid for case management services provided to Medicaid-eligible adult clients. As a result, the program is not maximizing program resources.	We recommend that the program modify its case management practices in order to use its limited resources more efficiently and economically. The program should take the following actions: 1) Begin billing Medicaid for case management services provided to clients who are Medicaid-eligible, resulting in a potential reduction in state cost and an increase in federal funds for the program of $238,000 per year; 2) Use Medicaid	The BSCIP does not have the authority to seek changes to the Medicaid State Plan, but will collaborate with the Agency for Health Care Administration, Medicaid Program Office, to explore the feasibility of utilizing targeted case management or administrative claiming to seek Medcaid reimbursement for case management services provided to Medicaid eligible clients. The program questions the assumptions upon which the Medicaid reimbursement projections of $238,000 per year were derived. The program has a contract for the development of a five-year	The BSCIP will contract with a consultant to provide a cost benefit analysis and evaluation of the three recommendations made by the OPPAGA surveyors.

Finding	*Recommendation*	*Management's Response*	*Corrective Action Plan*
	reimbursements received by CMS for providing case management to children to offset the program's costs, resulting in a potential reduction in BSCI trust fund costs of $59,900 per year; and, 3) Transfer the case management functions for Medicaid waiver clients from program case managers to private providers as required in the waiver. This would avoid the need to create seven additional positions at a cost of $309,000, as requested in the program's FY 2003-04 LBR.	strategic plan for the Medicaid Waiver Program to address the increasing demands for long-term community supports and identify the most cost effective ways to administer the program and address the needs of the individuals the program serves. We believe that OPPAGA's conclusion that transferring all case management functions to the community support coordinators for the Medicaid Waiver Program is premature and that this issue deserves further consideration in the development of the five-year strategic plan. Over the past year the program has made significant progress in identifying, training, approving, and transitioning individuals to community support coordinators. To date, only a few waiver clients in limited areas of the state lack community support coordinators. Currently, the support coordinators do not have authority to access the RIMS or FIMIS systems to initiate vendor payments. The issues involved in providing RIMS and FIMIS access to the support coordinators include: confidentiality of program data, cost of providing all support coordinators with the necessary hardware and software and training, and the loss of administrative control of the budget and services. The support coordinators are primarily responsible for coordinating and ensuring the provision of care. The case managers and rehabilitation technicians are responsible under the Medicaid agreement for monitoring of the clients' budget, payment processing, and performance of the community support coordinators to ensure the provision of timely and quality services. The BSCIP does not feel that transferring the functions of the case managers/waiver coordinators to the community support coordinators relinquishes the need to establish seven additional positions requested in the program's FY 2003-2004 LBR. These additional positions would be assigned specifically to the Waiver and will assume the responsibilities currently performed by the BSCIP case managers and technicians. The five case managers/waiver coordinators would be R.N.s eligible for 75% Medicaid reimbursement. The other two positions requested would provide administrative support and would be eligible for 50% reimbursement from Medicaid. The increased funding request will come from the Brain and Spinal Cord Injury Trust Fund. No general revenue will be required. These additional positions will enhance the waiver accountability, billing, monitoring, and training, as well as position the program to more effectively and efficiently address the long-term needs of the clients served by the waiver.	