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Progress Report

May 2004 **Report No. 04-35**

Children's Medical Services Working to Expand Privatization and Reduce Administrative Inefficiencies

at a glance

Since our 2002 report, the Children's Medical Services Program has taken steps to implement our recommendations. However, the program encountered problems developing a new information system, and it currently plans to merge data into another system that is not expected to be completed until June 2005. While the program expanded privatization by establishing a new Integrated Care System contract, all client groups are still not covered, and data limitations continue to impede full implementation. The program has consolidated administrative functions from 22 area offices into 8 regional offices, thus reducing duplication and producing annual cost savings of $700,000.

Purpose

In accordance with state law, this progress report informs the Legislature of actions taken by the Department of Health (DOH) in response to a 2002 OPPAGA report on the Children's Medical Services Program.[1, 2] This report presents our assessment of the extent to which the department has addressed the findings and recommendations included in our report.

Background

The Children's Medical Services (CMS) Program within the Department of Health is a public/private partnership that purchases and coordinates health care for low-income children with special health care needs. The program's mission is to provide a family-centered, coordinated system of care for children with special health care needs and to provide essential preventative, evaluative and early intervention services for at-risk children.

Florida's Children's Medical Services Program operates through two main divisions

- **Prevention and Intervention.** This division contracts with private firms to provide specialized prevention,

[1] Section 11.45(7)(f), *F.S.*

[2] *Special Report: Children's Medical Services Privatization Is Feasible; Could Save Over $18 Million, But Barriers Must Be Overcome*, OPPAGA Report No. 02-04, January 2002.

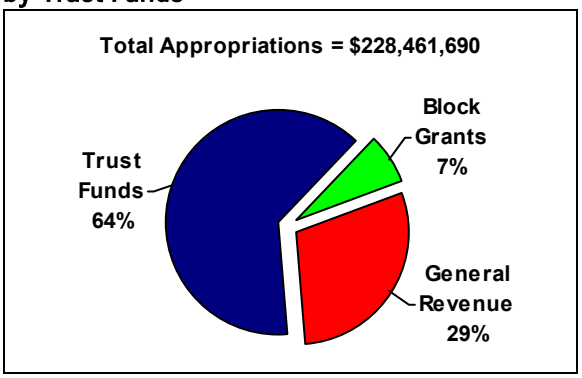
identification, and early intervention services. In Fiscal Year 2002-03, the Prevention and Intervention division provided direct services to 23,738 clients, with another 113,972 assisted through the Poison Control telephone programs.

- **CMS Network.** This division contracts with over 7,000 private providers (e.g., physicians, hospitals). These private providers deliver preventive, ambulatory, and hospital care for eligible children. CMS Network physicians provide all medically necessary health care to these children. The program estimates it will serve approximately 115,549 children in Fiscal Year 2003-04.

For Fiscal Year 2004-05, the Legislature authorized 751 full-time equivalent (FTE) positions and appropriated $228.5 million to the program. CMS employees provide program administration and care coordination functions. The program has 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.

As shown in Exhibit 1, funding for the CMS program comes from various sources. The main funding sources include Medicaid (Title XIX), Children's Health Insurance Program (SCHIP or Title XXI), general revenue, and block grants (which fund services for the safety net population). [4]

Exhibit 1
The CMS Program Is Supported Primarily by Trust Funds



Source: OPPAGA analysis of Conference Report on House Bill 1835 – FY 2004-2005.

Prior Findings

In our 2002 report, we concluded that while the program was mostly privatized, administrative inefficiencies existed that could be addressed through further privatization. However, barriers such as the program's inadequate information system and functional duplication in area offices limited the program's ability to fully privatize. We recommended that the department address these issues which would require a long-term effort. We estimated that full privatization would save over $18 million in cost reductions from salaries and operating expenses.

CMS information system was antiquated; needed replacement to increase efficiency

The CMS information system, Case Management Data System, was outdated, did not meet business needs, and was not compliant with federal privacy regulations. We recommended that the department release a Request for Proposals or Invitation to Negotiate to privatize its information and claims processing systems.

[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 SCHIP/Healthy Kids (although they are likely to return to the program); the uninsured; and uninsured non-citizens.

Integrated Care Systems had the best potential to increase privatization, but barriers could hinder its full implementation

We concluded that CMS could become almost totally privatized through full implementation of private, capitated arrangements. The department had begun an initiative to pay for all CMS services through capitated arrangements with Integrated Care System providers.[5] If CMS fully implemented these arrangements for all client populations, no services would be provided through the current structure of contracts. Consequently, there would be no need for claims processing and internal information technology services as these functions would be provided by the providers.

However, potential providers were reluctant to cover all CMS populations in their contracts because they lacked reliable data on client service costs. Providers were willing to contract for the SCHIP (Title XXI) population, for which information was available through other sources, but were hesitant to enter into contracts for either the Medicaid (Title XIX) or safety net populations.[6] The Agency for Health Care Administration had contracted with an actuary to determine a valid capitation rate for the Medicaid population.

We recommended that the department proceed with efforts to create capitated contracts with Integrated Care System providers. To address barriers to the initiative, the department needed to expedite the upgrade of its computer information system to obtain the unit cost information needed to require that all CMS populations be included in the provider contracts. We also recommended that the care coordination function be included in contracts to further reduce inefficiencies and increase cost savings.

Area offices performed duplicative functions; consolidation would increase efficiency

We identified redundancies in several functions of the area offices. The claims processing and general administration functions had the greatest overlap among offices. The department had begun consolidating certain administrative functions (primarily medical directors), and intended to accelerate consolidation while implementing integrated care system contracts. We recommended that the department eliminate regional CMS offices as contracts became fully operational. Until contracts become fully operational, the department needed to continue its efforts to consolidate administrative functions in the area offices, but this would likely result in reductions of only a few high-level administrative positions (i.e., medical directors).

Current Status

Although the program has taken steps to implement our recommendations, opportunities exist to expand CMS privatization and to further reduce administrative inefficiencies. Since our prior report, the program has continued working on developing a new information system, but it has encountered problems, and currently plans to merge data into another existing information system that is expected to be completed by June 2005. In addition, the program made strides to increase privatization by establishing a new integrated client services contract.

[5] Integrated Care Systems are hospitals and other entities that specialize in pediatrics and contract with local providers for all health care services for a prearranged payment amount. The department signed the first contract in December 2001, with Jackson Memorial Hospital in Miami. The initial contract only covered the Title XXI population (about 15% of the CMS population) in two counties, Dade and Monroe.

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

However, neither of the two existing contracts covers all client groups, and data limitations continue to present the obstacles to full managed care implementation. The program also has consolidated administrative functions by regionalizing its area offices, which has produced cost savings.

The program has experienced problems developing a new information system

After years of preparation, the program completed an initial Invitation to Negotiate for obtaining a new information system in the fall of 2003. However, the Legislature's Technology Review Workgroup recommended that the program amend the invitation and supporting documents to more specifically define system requirements and their acquisition strategy. Subsequently, the program hired a contractor to rework the invitation and issued a Request for Information to obtain a cost estimate of a new system. The program planned to issue a final Invitation to Negotiate in May 2004.

However, in April 2004 the Technology Review Workgroup stated that it would not recommend funding for a stand alone CMS information system. Instead, the workgroup recommended support of the CMS system as an extension of the Department of Health's Public Health Management System. As a result, the Department of Health recommended that CMS stop moving forward on the Invitation to Negotiate process.

The Public Health Management System is designed to replace the outdated technology systems used by county health departments. The department expects that the system will be completed by the end of the 2004-05 fiscal year. The CMS program office is to meet with department project managers to design a new project timeline and begin to determine what elements of the system are compatible with its needs.

The program established a new Integrated Client Services contract in July 2003, but it only covers a small portion of the CMS client population

In July 2003, the program entered into a second Integrated Care System contract with the University of Florida in Gainesville, which began enrolling clients in November 2003. The contract serves Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union counties. The new Gainesville and the existing Miami Integrated Care System contracts currently cover only the SCHIP (Title XXI) client population which represents 5.4% of the CMS client population; neither covers the Medicaid (Title XIX) or safety net populations.

One of the primary barriers to fully covering all CMS client populations continues to be a lack of reliable data on the cost of providing services for these other client groups. In an effort to obtain more specific information, the Agency for Health Care Administration contracted with an actuary in 2002 to determine a valid capitation rate for the Medicaid population. However, the study did not produce proposed Medicaid rates. CMS program staff reported they cannot move forward with Medicaid capitation until rates have been determined by the agency. Until this information is available providers may be hesitant to cover the Medicaid and safety net populations. However, program officials seem optimistic about the prospect of providers entering into integrated client services contracts for the SCHIP population, in part, due to the experiences of the Miami and Gainesville providers.

Evaluation results on the Miami contract are mostly positive. The Institute for Child Health Policy has conducted two evaluations of the contract, assessing demographics, client satisfaction, provider

satisfaction, and service utilization.[7] The first evaluation found some problems with families accessing specialty care, difficulties in building a primary care provider network, confusion about the role of CMS nurse coordinators, and nursing staff turnover. Program staff attributed these difficulties as issues that occur with any large-scale system change. By the second evaluation in June 2003, many of these problems had been resolved. For example, families had fewer problems accessing specialty care and interviews with providers and nurses found that they were satisfied with the program and their interactions with each other.

The program does not plan to include care coordination in future contracts

In our prior report, we recommended that the care coordination function be included when implementing Integrated Care System contracts. However, program officials believe that care coordination should not be moved into a capitated arrangement in order to provide for outside quality control monitoring. Consequently, the program has decided not to include care coordination in current or future Integrated Care System contracts.

The program has consolidated administrative functions into regions, reducing duplication and achieving cost savings

Since our prior report, the program has reduced duplication by consolidating administrative functions from 22 area offices into eight regions (see Exhibit 2). As of April 2004, the program had completed its consolidation efforts in all regions except for regions II and VI.

Through regionalization, the program was able to consolidate positions and functions. Each region adopted a standard organization chart with a regional nursing director and assistant regional nursing director overseeing nurse supervisors in each of the area offices. Previously, each area office had its own nursing director. Through consolidation, the program downgraded the area office nursing director position to the lower pay grade nurse supervisor. In addition, regionalization enabled the program to consolidate some administrative functions. For example, regions can obtain items like medical supplies in bulk or lease office equipment at a reduced rate.

Although the program did not reduce the number of area offices or personnel, program managers report that the primary benefit is the redirection of cost savings into client services. Savings could be used to fund any CMS service, such as physician, hospital inpatient and outpatient visits, pharmacy, lab, x-ray, and medical equipment. Funds also could be used to supplement staffing to address care coordination needs due to increased caseload. The program was unable to provide statewide cost savings information, but did provide us with information from region VII, which comprises the Fort Pierce, West Palm Beach, and Fort Lauderdale area offices. As of March 2004, the region estimated savings of almost $600,000 and projected annual recurring savings of over $700,000. The region produced these savings, in part, through bulk purchasing, regionalization of legal services, and the renegotiation or discontinuation of contractual agreements. The region redirected these funds into client services.

[7] *The Integrated Care System in Miami-Dade and Monroe Counties: Baseline Report.* Institute for Child Health Policy, June 2003 and *The Integrated Care System in Miami-Dade and Monroe Counties: Follow-Up Report.* Institute for Child Health Policy, December 2003.

Exhibit 2
CMS Has Consolidated Administrative Functions for 22 Area Offices into Eight Regions

Region I

(Pensacola) Escambia, Santa Rosa, Okaloosa, Walton counties
(Panama City) Bay, Calhoun, Gulf, Holmes, Jackson, Washington counties

Region II

(Tallahassee) Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla counties

Region III

(Gainesville/Ocala) Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union counties
(Jacksonville) Baker, Clay, Duval, Nassau, St. Johns counties
(Daytona) Flagler, Volusia counties

Region IV

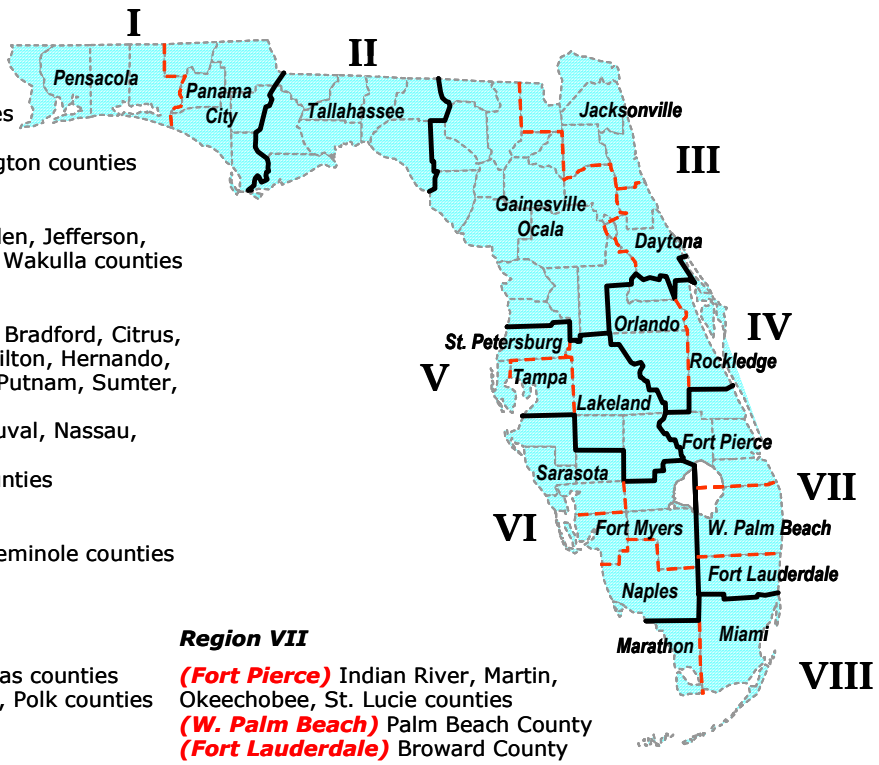
(Orlando) Orange, Osceola, Seminole counties
(Rockledge) Brevard County

Region V

(Tampa) Hillsborough County
(St. Petersburg) Pasco, Pinellas counties
(Lakeland) Hardee, Highlands, Polk counties

Region VI

(Sarasota) Charlotte, DeSoto, Manatee, Sarasota counties
(Fort Myers) Glades, Hendry, Lee counties
(Naples) Collier County



Region VII

(Fort Pierce) Indian River, Martin, Okeechobee, St. Lucie counties
(W. Palm Beach) Palm Beach County
(Fort Lauderdale) Broward County

Region VIII

(Marathon) Monroe County
(Miami North, Miami South) - Dade County

Source: OPPAGA analysis of Department of Health data.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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