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Progress Report

September 2004 **Report No. 04-66**

Brain and Spinal Cord Injury Program Improves Data Reliability, But Should Increase Medicaid Reimbursements

at a glance

Since our 2003 report, the Brain and Spinal Cord Injury Program has improved its performance data reliability by eliminating duplicate client records and retaining documentation for performance measures. However, its efforts to assess client outcomes one year after service completion have been unsuccessful.

The program should take additional steps to recover allowable costs from Medicaid by

- **billing Medicaid for case management services provided to eligible adults,**
- **recouping case management fees paid by Medicaid to the Children's Medical Services (CMS) Program once the federal government approves CMS's new billing system, and**
- **pursuing Medicaid reimbursement for costs allowable under the Medicaid waiver when it privatizes oversight and billing.**

Scope

In accordance with state law, this progress report informs the Legislature of actions taken by the Department of Health in response to the OPPAGA report on the Brain and Spinal Cord Injury Program issued in 2003.[1,2] This report assesses the extent to which the department has addressed the findings and recommendations included in our prior report.

Background

The Department of Health's Brain and Spinal Cord Injury program assists people with traumatic brain or spinal cord injuries to return home or to other community-based living arrangements and avoid nursing homes or other institutional care. The program serves people who meet certain eligibility criteria, although there is no financial or means test for eligibility.

Program services vary according to the client's needs and can include case management, acute care, inpatient and outpatient rehabilitation, and home and community-based services. In Fiscal Year 2003-04, the program served 1,672 clients (1,318 adults and 354 children). Most clients receive services for up to two years following injury. For clients needing longer-term services, the program has a Medicaid home and community-based care waiver to provide long-term care services to a maximum of 300 clients. In Fiscal Year 2003-04, the program served 238 individuals under its Medicaid Waiver.

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. In Fiscal Year 2003-04, the program's revenue sources totaled $20.7 million, with 78% of these funds from the

[1] Section 11.51(6), *F.S.*

[2] *Justification Review: Brain and Spinal Cord Injury Program Reports Meeting Goal, Could Recover Additional Revenues* OPPAGA Report No. 03-02, January 2003.

Brain and Spinal Cord Injury Rehabilitation Trust Fund. Trust Fund revenues accrue from civil penalties for violations such as speeding tickets and driving or boating under the influence. Federal match for the Medicaid Waiver accounted for 20% of funds, while other third party or subrogated funds contributed to 2% of program resources.

Prior Findings

Our 2003 report concluded that while the program was meeting its legislative goal of reintegration, data reliability problems impeded its ability to provide meaningful and accurate performance information.[3] The program had validity problems with its information system that resulted in duplicate client counts. Moreover, the program could not provide supporting documentation for data on client reintegration reported to the Legislature. We recommended that the program continue to work to eliminate duplicate client records and begin maintaining records necessary to verify program performance.

The program also lacked data to assess its long-term effectiveness in helping clients remain in the community. The program's legislative outcome measure only assessed 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 community reintegration goal. Collecting 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. We recommended that the program establish a mechanism for tracking clients who have been successfully reintegrated for one year after completing program services.

We also concluded that the program needed to modify its case management practices in order to use its limited resources more efficiently. The program did not seek Medicaid reimbursement for case management services it provided for Medicaid-eligible adult clients. In addition, program management had not implemented a 1996 OPPAGA recommendation to deduct trust fund payments to the Children's Medical Services (CMS) Program for the amount CMS is reimbursed by Medicaid for those same services, which would maximize program funds. Further, program case managers were amending and updating plans of care for clients enrolled in the Medicaid Waiver Program and performing other functions that the Medicaid Waiver required be performed by waiver support coordinators.

To maximize program resources, we recommended that the program

- bill 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 program trust fund costs of $59,900 per year; and
- transfer case management functions for Medicaid Waiver clients from program case managers to private providers as required in the waiver.

Current Status

Although the program has improved its data reliability, it has not been successful in efforts to measure its long-term effectiveness. Also, the program should take additional steps to recover allowable costs from Medicaid

While the program improved its data reliability; its long-term effectiveness remains uncertain

The program has improved performance data reliability. The program has made two improvements in data reliability. First, it eliminated duplicate client records by modifying its database and revising data entry procedures. The program is now using personal details from the database such as date of injury and Social Security number to better match individuals, to prevent duplicate entries. The program also eliminated duplicate records by no longer

[3] Reintegration is defined as successfully completing the services and goals outlined in the case plan without being institutionalized.

reentering individuals into the database when transferring from program to waiver services.

Second, the program can now provide supporting documentation to verify the accuracy of the data for the program's one legislative outcome measure (the percentage of clients who are successfully reintegrated into the community). The modified database can now calculate this performance measure and produce a record to verify the calculation.

In addition to improving data reliability, the program is also making better use of information to manage the program. The program has established new internal measures and uses this information to monitor and revise its practices. [4] For example, during the third quarter of Fiscal Year 2003-04, program administrators noticed a decrease in referrals and traced the decrease to a particular hospital. Program employees discussed concerns with hospital staff and anticipate that referrals will return to expected levels.

The program has had limited success in assessing client outcomes one year after service completion. To better gauge its long-term impact, the program contracted with the Florida Spinal Cord Injury Resource Center and the Brain Injury Association of Florida in 2003 to survey former clients one year after they had reintegrated into the community. However, surveyors could not locate 68% of the 258 former clients they had attempted to contact between January and July 2004. Of the 82 individuals the surveyors reached, 4% were living in alternate settings. [5] However, the survey response rates are too limited to draw conclusions about the program's long-term effectiveness. As a result, it is unknown whether most program clients were still successfully living in a community-based arrangement or had moved to an institutional setting.

Program administrators did find the survey results to be a useful tool for developing strategies to improve program services. Most of the former clients who continued to live in the community had support from family and friends, adequate housing, and access to needed medications. In addition, more than half of these individuals were not employed or in school.

The program is using the survey results to improve access to employment and educational opportunities. For example, the program is establishing relationships with vocational rehabilitation service providers and has obtained $100,000 in grant funds to assess brain-injured individuals' work-readiness skills and vocational training needs. [6] Obtained in May 2004, the grant, Project RESULTS (Realistic Employment Strategies Ultimate Long Term Success), is funded through the federal 1996 Traumatic Brain Injury Act.

The program needs to take additional steps to recover Medicaid costs for case management services

State law requires that the program be the payer of last resort, meaning that the program should actively pursue other funding sources such as Medicaid. However, the program needs to modify its case management practices in order to use its limited resources more efficiently. [7]

The program is not billing Medicaid for case management services provided to Medicaid-eligible adults. Program managers do not have a formal plan to bill Medicaid for case management services provided to eligible adults. [8] At the time of our original report, program managers said that they had not pursued Medicaid reimbursement for case management because the steps necessary to comply with Medicaid rules would be too burdensome for their case managers.

Our 2003 report estimated that billing Medicaid would result in a potential reduction in state cost and an increase in federal funds for the program of $238,000 per year. The department's county health departments use a method called administrative

[4] Examples of new measures include referrals to the central registry and number of care plans written.

[5] Family members often responded on behalf of the client and reported placement in settings such as assisted living facilities or prisons.

[6] The Brain Injury Association of Florida is implementing the project and is providing an additional $57,000 as local match to meet project goals.

[7] There are three client populations that receive case management services from the program: adult clients who receive case management from program case managers; children under 18 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.

[8] Program managers have reviewed the Time Direct system. This is an electronic employee timesheet and does not include the specific client information needed to bill Medicaid.

claiming to receive Medicaid reimbursements. Administrative claiming bases reimbursement amounts on a sampling of case managers' actual hours spent on tasks. The department's Children's Medical Services Program is awaiting approval from the federal government to use administrative claiming. CMS administrators expect to receive approval in the near future. Given the potential cost savings, we continue to recommend that the program take the steps needed to obtain federal approval to adopt a similar strategy for billing Medicaid.

The program should recover payments from the Children's Medical Services Program when CMS's new billing system receives federal approval. In our prior report, we estimated that the program could save $59,900 by deducting trust fund payments to the CMS program for the amount that CMS is reimbursed by Medicaid for those same services. As discussed above, the CMS program is awaiting approval from the federal government to adopt an administrative claiming system for Medicaid. In the meantime, the state and the federal government have a temporary agreement for billing case management.

Calculating the program's share of case management fees under CMS's current temporary billing arrangement and then recalculating that share under administrative claiming or other negotiated method would likely be more costly to implement than can be recovered in one year. However, once the final billing system is adopted, the program should work with CMS to ensure that it recoups program Medicaid expenses.

The program has taken steps to transfer Medicaid-waiver clients' case management functions to support coordinators, but needs to pursue Medicaid reimbursement when it privatizes oversight and billing. In June 2003, the program directed case managers to shift responsibility for updating care plans and other case management activities to support coordinators. In addition, the program plans to issue a competitive bid by December 2004 to privatize administrative oversight of the waiver. For an estimated additional cost of $450,000 to $540,000 per year, the selected vendor will recruit, train, and monitor providers, removing these responsibilities from case managers. The vendor also will complete client assessments and care plans, enter this information into the program database, and oversee support coordinator activities. The program is also in the process of centralizing the provider payment function to further reduce case manager workload. Two regions have centralized provider payment, and the other three regions will be centralized by October 2004. [9]

Program administrators plan to pay for oversight and centralized billing using the program's trust fund. They expect to offset these costs by billing Medicaid for allowable administrative costs. However, given that the program has not implemented our recommendations to bill Medicaid for eligible case management services, the program needs to ensure that it will proactively seek Medicaid reimbursement for case management costs allowable under the waiver. Otherwise, using trust fund dollars for oversight and centralized billing will result in greater costs for the state.

[9] In contrast to some waivers where providers directly bill Medicaid, the program pays providers directly with trust fund dollars and then bills Medicaid for reimbursement for services.

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