REPORT NO. 95-02

STATE OF FLORIDA

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

PERFORMANCE REVIEW

OF

CHILDREN'S MEDICAL SERVICES

AS ADMINISTERED BY THE
CHILDREN'S MEDICAL SERVICES PROGRAM OFFICE
WITHIN THE

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

July 25, 1995

The Office of Program Policy Analysis and Government Accountability was established by the 1994 Legislature to play a major role in reviewing the performance of state agencies under performance-based budgeting and to increase the visibility and usefulness of performance audits. The Office was staffed by transferring the Program Audit Division staff of the Auditor General's Office to the Office of Program Policy Analysis and Government Accountability. The Office is a unit of the Office of the Auditor General but operates independently and reports to the Legislature.

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- Whether a program is effectively serving its intended purpose;
- Whether a program is operating within current revenue resources;
- Goals, objectives, and performance measures used to monitor and report program accomplishments;
- Structure and design of a program to accomplish its goals and objectives; and
- Alternative methods of providing program services or products.

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State of Florida

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

JAMES L. CARPENTER

July 25, 1995

The President of the Senate,
the Speaker of the House of Representatives,
and the Legislative Auditing Committee

I have directed that a performance review be made of Children's Medical Services as administered by the Children's Medical Services Program Office within the Department of Health and Rehabilitative Services. The results of the review are presented to you in this report. This review was conducted at the request of the Joint Legislative Auditing Committee. This review was conducted by Ms. Joyce Copeland under the supervision of Ms. Martha G. Wellman.

We wish to express our appreciation to the staff of the Department of Health and Rehabilitative Services for their cooperation during this review.

Respectfully yours,

James L. Carpenter
Interim Director

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Contents

Summary

Performance Review of Children's Medical Services

Purpose

This review focuses on Children's Medical Services (CMS) as administered by the Children's Medical Services Program Office within the Department of Health and Rehabilitative Services (DHRS). The purpose of the review was to determine:

- Whether the CMS Program Office has implemented a system to assess its cost-effectiveness;
- Whether the CMS Program Office has examined alternatives for maximizing Medicaid funding for services provided to CMS clients; and
- How CMS will function in the emerging health care environment.

Conclusions and Recommendations

CMS has a long history of providing health services to children with special health care needs and is recognized for providing quality care. It has not developed, however, the systems needed to determine the cost-effectiveness of its services in reaching desired outcomes. Nor has it pursued options to increase Medicaid coverage for its clients and services.

CMS's Traditional Role Is Changing

In addition, due to changes in Florida's health care environment and Medicaid Program, CMS's historical role in serving children with special health care needs has diminished. For example, in the past, CMS paid for the services provided to its clients, but now, Medicaid is the primary payer for CMS services. Furthermore Medicaid is in the process of shifting from a fee-for-services system to a managed care system. In the future, private managed-care providers that are willing and able to provide medical and social services to these children are likely to emerge.

If this occurs, CMS's role is likely to further diminish and a state-operated program may no longer be needed to serve this population. Furthermore, maintenance of a state-operated program supported in part by general revenue

could encourage private providers to avoid costs by encouraging children who require extremely expensive care to go into the state-operated program. In addition, a state-operated program may not be able to effectively compete with private health maintenance organizations (HMOs) which have more operational flexibility than state agencies in areas such as purchasing or personnel management.

Medicaid HMOs Provide Viable Options for Services to Children With Special Health Care Needs

Two viable options exist for moving the delivery of medical services for children with special health care needs from a state-operated, fee-for-service program to Medicaid HMOs. One option would be to phase out CMS as new providers emerge. The other option would be for CMS to position itself to become a private Medicaid HMO for children with special health care needs. Under either option, the state would need to develop controls to ensure that the children served meet medical and financial eligibility requirements and receive quality care.

Both options share advantages inherent to the use of competing prepaid health care plans. First, since prepaid health providers are not reimbursed for every service they provide, they are not constrained to providing only those services for which Medicaid will reimburse. Consequently, they have greater flexibility to provide services that will meet the needs of their clients than fee-for-service providers. Secondly, prepaid providers have a financial incentive to closely monitor and control the cost-effectiveness of their services. Finally, in a competitive system, clients can choose between alternative providers. When clients are able to chose their providers, their satisfaction and willingness to comply with prescribed treatments is likely to increase.

However, the option of phasing out CMS has disadvantages not shared with the option of transforming it into a private specialty HMO. First, if CMS were phased-out, the children it serves may need to be moved to new providers or social workers. This could be disruptive and break the continuity of care for those children. Second, much of the knowledge and expertise CMS staff and providers have in providing services to children with special health care needs could be lost. Third, because specialty HMOs for children

with special health care needs are likely to develop in urban areas, without CMS, children living in rural areas may have difficulty finding providers.

CMS Should Become Medicaid HMO

Therefore, we recommend that the Legislature require CMS and the Agency for Health Care Administration to develop and begin implementing a plan to enable CMS to become a Medicaid HMO for children with special health care needs and eventually privatize. This process will take several years and involve a variety of changes to CMS operations. For example, CMS will have to develop a system to evaluate the cost-effectiveness of its services in reaching desired client-outcomes and examine ways of increasing Medicaid coverage of its clients and services. These changes are likely to improve CMS operations and make better use of state resources. Thus, they should be beneficial even if CMS does not privatize. However, some of the changes will require the CMS Program Office to exercise stronger controls over its programs. For example, district offices control the budget for most DHRS programs. If CMS were to become an HMO, it would need budgetary control. The Secretary of DHRS should give CMS the authority it needs to exercise centralized controls necessary to the operation of an HMO. In exercising this authority, the CMS Program Office should strive to give the districts as much operational flexibility as possible.

Agency Response

The Acting Secretary of the Department of Health and Rehabilitative Services concurred with our recommendations and attached comments to our description of steps needed to transform Children's Medical Services into a Medicaid Health Maintenance Organization.

Performance Review of Children's Medical Services

CHAPTER I Introduction: Purpose of Review

Purpose and Scope

The Office of Program Policy Analysis and Government Accountability conducts performance reviews as part of its responsibility to provide the Legislature with information it can use to improve programs and allocate limited resources. In this review, we evaluated Children's Medical Services (CMS) within the Department of Health and Rehabilitative Services. The purpose of the review was to:

- Determine whether the CMS Program Office has implemented a performance evaluation system to assess its cost-effectiveness;
- Determine whether the CMS Program Office has examined alternatives for maximizing Medicaid funding for services provided to CMS clients; and
- Determine how CMS will function in the emerging health care environment.

Our review was made in accordance with generally accepted government auditing standards and applicable evaluation standards. Our fieldwork was conducted from April 1994 to February 1995. During that time, we interviewed central office staff responsible for overseeing the individual CMS programs and reviewed program policy and procedures manuals as well as applicable reports, data collection instruments, and budget documents. We also reviewed literature discussing methods for measuring program outcomes and effectiveness in order to evaluate CMS's ability to assess and demonstrate the effectiveness of its programs.

To determine whether CMS has examined alternatives for increasing Medicaid coverage of its clients and services, we interviewed staff at the Agency for Health Care Administration and CMS program managers. We also

obtained information about Medicaid waiver programs in other states. In order to obtain information regarding Children's Medical Services' role in the emerging health care environment, we also reviewed information concerning trends and developments in the health care environment, particularly in relation to caring for children with special health care needs. In addition, we interviewed staff from six state agencies currently coordinating with CMS, private health care consultants, and representatives of managed care providers. We also examined the advantages and disadvantages of policy alternatives concerning the future role of CMS (see Appendix A).

CHAPTER II Background

Program Design

Chapter 391, Part 1, F.S., authorizes Children's Medical Services (CMS). CMS is composed of a number of programs and services intended to provide medical services to needy children with chronic, crippling or potentially crippling, or physically handicapping diseases and conditions so that each child can develop to his or her full potential. To accomplish this, the CMS is to provide leadership and direction in promoting, planning, and coordinating children's medical services and may provide services directly or through hospitals, clinics, or provider centers that emphasize quality care.

Since CMS's inception in 1929, the client groups it serves have expanded. CMS originally was designed to serve crippled children, but it now serves children with other medical disabilities including cerebral palsy, heart disorders, hearing or speech disorders, spinal bifida, leukemia, cystic fibrosis, and kidney disease and infants or toddlers who have conditions that may lead to developmental delay. CMS also serves children in neonatal intensive care units and women with high-risk pregnancies.

To become eligible for CMS services, children must be under the age of 21 and medically in need of services. Women may be of any age but must have a high-risk pregnancy. Both women and children usually must also meet the financial eligibility standards shown in Exhibit 1. However, some children, such as children who received CMS services prior to their adoption or children designated as having special needs, are categorically eligible for care. In addition, other children who do not meet financial eligibility standards may become eligible for services if the cost of providing them care would reduce their families's incomes to the CMS financial eligibility criteria. In these cases, the families generally must agree to pay a portion of the costs of the services. CMS resources are to be used as a last resort: CMS does not pay for services covered by

Medicaid or other third-party payers. Approximately 70% to 80% of CMS clients are eligible for Medicaid.

Exhibit 1: Children's Medical Services Financial Eligibility Standards

Age	Criteria
Pregnant Women and Infants (Birth to 1 Year)	Eligible without financial participation with family incomes at or below 185% of the federal poverty level. (Same as Medicaid.)
Children Aged 1 to 6 Years	Eligible without financial participation with family incomes at or below 133% of the federal poverty level. (Same as Medicaid.)
Children Aged 6 to 21 Years	Eligible without financial participation with family incomes at or below 100% of the federal poverty level. (Children aged 6 to 11 years with these family incomes are covered by Medicaid; older children are not unless they meet the criteria below.)
Children Birth to 21 Years	Eligible without financial participation if on Social Security Income or Aid to Families with Dependent Children; designated as "special needs child," or adopted and previously received CMS services. (Most of these are the same as Medicaid.)

Source: Florida Department of Health and Rehabilitative Services, "The Children's Medical Services Program. An Integrated System of Health Care for Children 1991-92."

Organization

Children's Medical Services is administered by the Department of Health and Rehabilitative Services. The Department is headed by a Secretary, who is appointed by the governor and confirmed by the Senate. H. James Towey served as Secretary from July 16, 1993, to June 30,

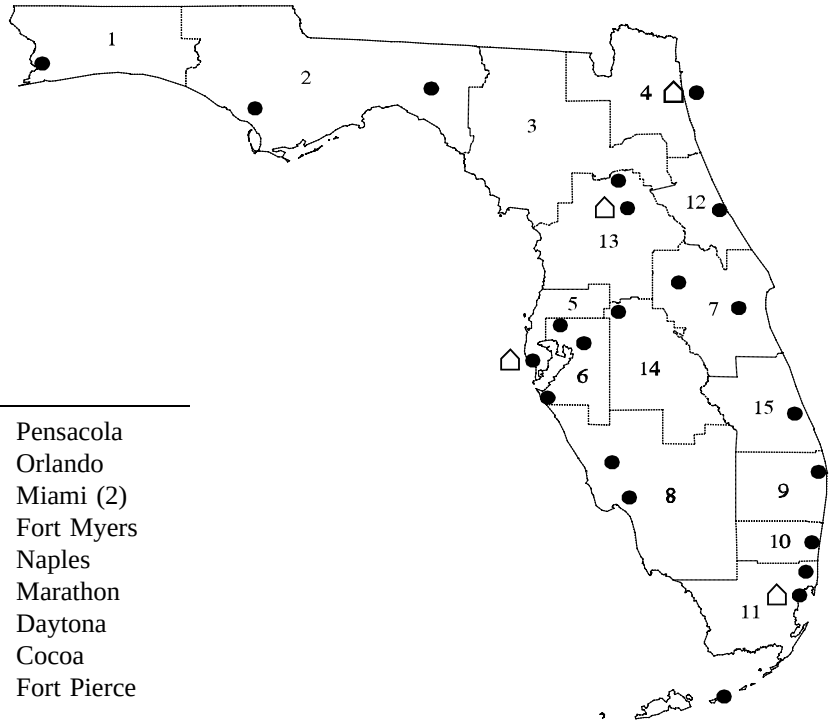
1995. Edward A. Feaver was appointed Acting Secretary on June 13, 1995.

The Secretary appoints a Deputy Secretary who acts in his absence and three Deputy Secretaries who head the major offices of the Department. Under the Deputy Secretary for Health, the Children's Medical Services Program Office is responsible for administering CMS programs and services. In addition, the CMS Program Office administers the health-related portions of other programs designed to serve children with certain needs, such as children who have been abused or who are at risk of developmental delay.

Central CMS Program Office staff are responsible for providing guidance to and overseeing CMS operations. Their specific duties include planning, developing, and monitoring the programs assigned to the office; ensuring that services meet quality standards; providing training and technical assistance; and managing resources and program data.

The Secretary also appoints District Administrators to head the Department's offices in 15 service districts. Under each District Administrator, a CMS Medical Director is responsible for overseeing the delivery of CMS services. Services are provided to clients either directly by CMS staff or by providers contracted by CMS. Services are delivered through a statewide network composed of 22 CMS local clinics as well as physician offices, hospitals, regional centers, and medical tertiary care centers. (See Exhibit 2.) At least 4,500 private providers participate in the CMS service network. The types of services provided include medical and nursing care as well as social, educational, and family services. Each family is assigned a CMS nurse case manager whose responsibilities include direct nursing care and family consultation related to prescribed home-based care and arranging for, coordinating, and monitoring services and treatment based on needs identified through screenings and assessments. Also, each CMS district has a social worker responsible for providing social services to families with multiple social problems. During fiscal year 1993-94, CMS served approximately 56,300 clients.

Exhibit 2: Site Locations of Children's Medical Services' Clinics and Regional Centers



⌂ ***Regional Centers***

Gainesville
Jacksonville
Tampa
Miami

● ***Clinic Sites***

Gainesville (2)	Pensacola
Jacksonville	Orlando
Fort Lauderdale	Miami (2)
Panama City	Fort Myers
St. Petersburg	Naples
Tampa (2)	Marathon
West Palm Beach	Daytona
Tallahassee	Cocoa
Sarasota	Fort Pierce
Lakeland	

Source: Department of Health and Rehabilitative Services.

Program Resources

In fiscal year 1994-95, CMS was appropriated approximately $112 million. Funding for CMS comes mainly from state general revenue, federal funds, and third-party income. Exhibit 3 shows the funding sources, amounts, and percentages for the 1994-95 fiscal year. Exhibit 4 shows 1994-95 appropriations broken down by program.

Exhibit 3: CMS Funding Sources for Fiscal Year 1994-95

Source	Amount	Percent
General Revenue	$ 71,933,114	63.9%
Maternal/Child Health Block Grant	9,246,356	8.2%
Title XX Social Services Block Grant Trust Fund	4,610,860	4.1%
Donation Trust Fund [1]	25,664,789	22.8%
Grants and Donations	1,042,947	1.0%
Total	**$112,498,066**	**100.0%**

[1] This is a Department-wide trust fund into which monies received from private contributions and reimbursements from Medicaid and insurance companies are deposited. The figure does not include a $470,000 appropriation for service to refugees because the appropriation was contingent upon federal funds that were not subsequently received.

Source: Children's Medical Services Program Office, Department of Health and Rehabilitative Services.

Exhibit 4: CMS Funding by Program for Fiscal Year 1994-95

Program	Appropriations 1993-94
Regional Perinatal	$ 1,973,642
Genetic Services	1,351,654
Sickle Cell Screening	525,751
Primary Care	5,785,806
Kidney Disease	880,865
Catastrophic Medical Services	2,000,000
Cleft Lip/Palate	198,196
Contracted Services	6,036,609
Master Contracts	6,422,000
Purchasing of Client Services - Clinic/Field Services [1]	16,891,293
Rheumatic Fever	93,550
Children's Cardiac	372,400
Poison Information Center Network	2,760,638
Early Intervention/Infant Hearing Impairment	26,525,095
Services for Abused/Neglected Children	8,381,096
Infant Toddler Stepdown	602,673
Administration (includes salaries of CMS nurses and other personnel who work in field clinics)	31,696,798
Total	**$112,498,066**

[1] Does not include salaries of personnel who work in field clinics.

Source: Children's Medical Services Program Office, Department of Health and Rehabilitative Services.

CHAPTER III Findings and Recommendations

Introduction

The purpose of the Children's Medical Services (CMS) is to enable needy children with handicapping diseases or conditions to develop to their full potential by providing them medical services. To achieve this goal, the CMS Program Office has:

- Entered into contracts or agreements with a network of health care providers to serve children with complex medical conditions;
- Developed a thorough review process to ensure that its clients receive quality care;
- Integrated the provision of medical services with the provision of social services designed to enable families to properly care for children with special health care needs in home settings; and
- Coordinated its activities with other programs in Florida including those serving dependent children and developmentally disabled individuals.

As a result, CMS is nationally recognized for providing quality care and does not duplicate functions performed by other state entities.

However, the CMS Program Office could do more to ensure that it is providing services in a cost-effective manner and maximizing available federal funding for services. In addition, due to changes in Florida's health care environment and Medicaid, CMS's role in serving children with special health care needs has diminished.

This section contains our findings in these areas. Because the issues are related, our recommendations are presented at the end of the report.

Finding 1

Children's Medical Services has not developed a system to evaluate its cost effectiveness in producing desired outcomes.

CMS has not developed a system that would enable it to routinely monitor the cost-effectiveness of its programs in achieving desired results. Like many other state organizations, CMS has focused its attention on service outputs, not outcomes. CMS has structured its programs around the different types of services it provides and routinely monitors service quality. It also tracks its expenditures by program. However, most CMS clients receive services from more than one CMS program, and the effect of individual services or programs on client outcomes cannot be separated or measured. The CMS central office does not routinely track the combined effect of its programs on client outcomes or collect per-client costs. As a result, it cannot assess its cost-effectiveness in achieving desired outcomes.

CMS Outcome Measures Cannot Be Used to Assess Its Effectiveness in Meeting Client Needs

As part of the Department's strategic planning process, CMS has developed broad measures to gauge the general impact and public benefit of its services. These outcomes are typically expressed in terms of broad societal effects such as the percentage of children with physical impairments who are mainstreamed in the classroom. While useful, broad societal indicators are often influenced by external factors and cannot be used to determine the effectiveness of CMS in meeting client needs. Additionally, broadly stated measures do not provide information needed for CMS to manage its programs and services.

Client Progress Depends on a Combination of CMS Services

CMS comprises a large network of services and treatments provided either by CMS staff or purchased from physicians and health care organizations. Most CMS services are part of a continuum of care that is designed to serve children with special health care needs. CMS nurse case managers or primary care physicians assess clients and their families to determine the medical and social services they need to

achieve desired outcomes. Nurse case managers also help coordinate care and ensure that clients and families receive prescribed services. Client progress in achieving intended outcomes depends on the combination of services: for example, if a client needs surgery to alleviate health problems, his or her improvement depends not only on the hospital services provided but also upon the pre- and post-hospitalization services provided in local CMS clinics or doctors' offices. Thus, to determine its cost-effectiveness, CMS would need information on the cost of all services it provides clients and the impact of those services on client and family functioning.

CMS Clients Have Divergent Needs and Anticipated Outcome for These Clients Vary

Further, due to the variation among CMS clients, CMS would need to gather outcome and service cost information by the type of child it serves. Currently CMS uses information about a child's medical condition and family's ability to support the treatment effort to classify its clients into four groups. As shown in Exhibit 5, children are classified as medically involved, multiply involved, medically complex, and medically fragile. The expected outcomes and treatment costs for children in these four groups varies widely. For example, medically involved children may have relatively short-term problems that require relatively inexpensive surgical intervention and follow-up but are not expected to develop into chronic conditions. Conversely, medically fragile children have chronic conditions and often need extremely expensive care, such as life-sustaining medical technology and close monitoring by trained professionals. Due to wide variation in the anticipated outcomes for and costs of serving these clients, CMS cannot assess the cost-effectiveness of its services without considering the types of children served.

Exhibit 5: Categories of Medically Eligible Children

Category	Description	Severity of Case
Medically Involved	Children who have an illness or health care condition that affects their normal functioning and requires more than routine and basic care.	Lowest
Medically Complex	Children who have more than one illness or health care condition and require more than one type of specialist. Children generally have multiple treatment recommendations.	Medium - Low
Multiply Involved	Children who have a chronic illness that affects one or more body systems and are affected by other factors such as developmental problems, family functioning, and economic problems.	Medium - High
Medically Fragile	Children who rely upon life-sustaining medical technology and devices and may rely upon ongoing care and monitoring by trained professionals.	Highest

Source: Children's Medical Services Program Office.

CMS Program Structure Impedes Outcome and Cost-Effectiveness Assessment

The way CMS currently organizes its programs and services is not conducive to client outcome evaluation. CMS organizes programs not by the types of clients it serves but by the types of services it provides. According to CMS administrators, CMS contains 17 different programs. As shown in Exhibit 6, 10 of these 17 programs, comprising about 75% of CMS's budget, provide different types of social or medical services designed to enable special health needs children to achieve their full potential. [1] These children need a combination of services provided by multiple programs; therefore the effect of an individual program on client outcomes cannot be easily measured. Consequently, CMS has evaluated these programs by focusing on the number of clients they serve and the extent to which services meet quality standards.

[1] The remaining programs serve the general public at large or clients, such as abused and neglected children, who may not have special health care needs or have different purposes, such as the prevention of developmental delay, that are not directly related to providing health care to special needs children.

Exhibit 6: Children's Medical Services Programs and Services

Children With Special Health Care Needs	■ *Regional Perinatal Centers* - Provides medical and case management services to high risk pregnant women in clinics and neonatal intensive care services to sick and low birth weight babies. ■ *Primary Care* - Provides primary care services to children with special health care needs through contracts with community pediatricians and MediPass physicians. Also provides case management services through CMS nurse case managers. ■ *Kidney Disease* - Provides inpatient/outpatient medical services, dialysis, transplants, and other support services to children with kidney disease. ■ *Catastrophic Medical Services* - Provides additional funding for medical services to districts for children whose medical expenses exceed $25,000. ■ *Cleft Lip/Palate* - Provides services to children with cleft lip and palate disorders. ■ *Contract Services* - Provides a variety of medical services through contracts with health providers at regional and local clinics or facilities. For example, hematology/oncology services, diabetes/endocrine services, and pediatric urology services. ■ *Master Contracts* - Provides hospital-based inpatient and outpatient professional services through contracts with the medical schools at the Universities of Florida, South Florida, and Miami. ■ *Purchased Clinic/Field Services* - Provides care by specialty physicians, medical supplies and equipment, medications, and various therapists' services to children with special health care needs. CMS contracts with local physicians to provide services at CMS clinics or at the physician's private office. ■ *Children's Cardiac* - Provides cardiac surgical services to children with cardiac conditions. ■ *Administration* - Provides all nursing and case management services, central and district program staff, program administrators, and other support staff to operate the CMS programs.
General Population	■ *Poison Information Network* - Provides 24-hour emergency assistance to individuals exposed to poisonous substances over the phone and also provides information to health professionals and consumers about poisonous substance and treatment. ■ *Genetic Services* - Provides screening, evaluation, and diagnosis for people at risk for or suspected of having genetic disorders as well as people at risk of parenting children with genetic disorders. ■ *Sickle Cell Screening* - Provides follow up screening and diagnosis for children identified by the state lab as possibly having sickle cell disease.
Developmental Delays	■ *Early Intervention/Infant Hearing Impairment* - Identifies, evaluates, and coordinates care for children with special health care needs and those at risk for developmental delays. Services are provided at the Regional Perinatal Centers and clinics.
Research and Other	■ *Infant Toddler Stepdown* - Provides services to children during the transition between inpatient care and going home. This program is specific to District 11. CMS has no administrative or oversight responsibilities related to this program. ■ *Rheumatic Fever* - Provides screening, diagnosis, and treatment for strep throat and education regarding the importance of early detection of the illness to prevent the development of rheumatic fever.
Abused and Neglected Children	■ *Medical Services for Abused and Neglected Children* - Provides Child Protection Teams that assist the Department of Health and Rehabilitative Services abuse investigative staff by providing medical and psychological evaluations, treatment for families, and court testimony when required.

Source: Office of Program Policy Analysis and Government Accountability analysis of Children's Medical Services program structure.

CMS Expenditure Data Does Not Include the Cost of Services Covered by Medicaid

CMS has gathered cost information primarily by tracking its expenditures for each of its programs rather than the cost of serving individual clients. However, CMS expenditure information does not include information about the cost of CMS services that are covered by Medicaid and thereby understates the total cost for medical care provided CMS clients. Most CMS children are eligible for Medicaid. CMS encourages its providers to directly bill Medicaid for services provided to these children and does not receive information about the number, type, and cost of these services. Without this information, CMS cannot determine the total cost of the services its clients receive.

Because of its program structure and lack of information on services billed to Medicaid, CMS has not developed a system to track the services each of its clients receive, the total cost of those services, or their impact on client outcomes. Without this information the CMS Central Office cannot routinely monitor the number and types of services clients are receiving and identify clients or providers who may be under- or over-utilizing certain services. Nor can it link service costs to client outcomes to evaluate its cost-effectiveness. By routinely monitoring client-specific information on service costs and outcomes, CMS managers can quickly identify problems and take action to contain costs or improve the effectiveness of its services. Without this information, however, they cannot ensure that CMS services are being used in a cost-effective manner in attaining desired outcomes.

CMS Is Gathering Information That Could Be Used to Assess Outcomes

Although CMS has not developed a system to monitor the cost-effectiveness of its programs, it is gathering information that could be used to build such a system. In April 1994, CMS implemented a minimum data system to collect information on the number and types of services it provides to clients. Since CMS typically pays Medicaid rates, the data system can be used to calculate the cost of all CMS services, even those paid by Medicaid.

In addition, CMS has implemented a procedure to assess changes in its clients medical conditions and family functioning. Since a client's family plays a central role in the success or failure of medical intervention, one of

CMS's primary objectives is to provide families the training and education needed to improve their ability to manage their children's care and access the necessary health care and social services. When children first come to CMS, they are assigned to a nurse case manager, who completes an assessment instrument containing 12 outcome-oriented performance measures that establish baseline information on each child's physical and emotional condition and the family's ability to manage the child's care (see Exhibit 7). Over time, the nurse case manager uses the same instrument to reassess and document changes in the child's medical condition and family functioning. For families who are not improving as anticipated, CMS staff can analyze the situation to identify possible reasons for the lack of improvement and modify the service plan accordingly. [2]

However, CMS's service cost and client outcome information is of limited use to program managers for a number of reasons. First, the client progress information currently remains in individual client files and is not aggregated and reported to the CMS central office. Secondly, the service cost information is not collected by individual client or linked with client outcomes. Finally, CMS has not established quantified goals or benchmarks it could use to determine whether its clients have made satisfactory progress within reasonable time frames or have been served at a reasonable cost. However, if it developed systems to aggregate existing client progress and service cost information and developed benchmarks, CMS program managers could then use this information to routinely monitor the cost-effectiveness of its services.

[2] Possible reasons for lack of client improvement include client limitations that must be addressed before progress can take place, ineffective providers, or inadequate assessment or case management by CMS staff.

Exhibit 7: Children's Medical Services Outcome Evaluation System

CMS nurse case-managers assess each family's knowledge and abilities in the 4 areas defined below. Within each area, 3 aspects of client functioning is assessed for a total of 12 measures of outcome.

ENVIRONMENTAL

- Knowledge: What the client's family knows about finding, obtaining or maintaining adequate food, shelter, and other resources to meet basic needs.
- Behavior: What the client's family is currently doing to address environmental concerns.
- Status: The severity of the problems.

PSYCHOSOCIAL

- Knowledge: What the client's family knows about community resources such as counseling, parent education, or support groups, the family can use to meet social or psychological needs.
- Behavior: What client's family is currently doing about the concern.
- Status: The severity of the need.

PHYSIOLOGICAL

- Knowledge: What client's family knows about child's condition, symptoms, and illness.
- Behavior: What the patient/family is willing to care for the child.
- Status: The severity of physiological signs and symptoms.

HEALTH RELATED BEHAVIORS

- Knowledge: Family's/patient's knowledge of behaviors that maintain health and wellness, such as following prescribed diets, and medication/immunization regimens.
- Behavior: What health and wellness behaviors the client's family is currently willing and able to practice.
- Status: The severity of the present status of patient/family in relation to wellness behaviors.

Source: Condensed by Office of Program Policy Analysis and Government Accountability from CMS's Problem Rating Scale.

Finding 2

The Children's Medical Services Program Office has not pursued Medicaid waiver options that could enable it to increase federal funding for services.

Some CMS Clients and Services Are Not Eligible for Medicaid

Children's Medical Services receives general revenue funds to pay for services not covered by Medicaid and services provided to non-Medicaid eligible children. Approximately 20% to 30% of CMS clients are categorically or financially not eligible for Medicaid. Medicaid also does not cover certain services provided to Medicaid-eligible CMS clients, such as respite care, home modifications, and caregiver training, and only covers a portion of the cost of medical equipment and other services, such as hearing and dental services.

Medicaid Waiver Options Could Increase Medicaid Coverage of CMS Clients and Services

The federal government offers waiver options that would enable Children's Medical Services to obtain Medicaid coverage for services and children that currently are not covered by Medicaid. These options include a home and community-based waiver and a waiver under the Tax Equity and Fiscal Responsibility Act (TEFRA). Exhibit 8 contains a description of these waivers. Both options are intended to target the population of children that have or are at risk of having conditions that require long term care in hospitals, skilled nursing facilities, or other institutions. Medicaid generally only pays for services to these children if the services are provided in an institutional setting.

Exhibit 8: Federal Medicaid Waiver Options for Children With Special Health Care Needs

Home and Community-Based Waiver:

- Application must be made with the Health Care Financing Administration.
- The population receiving services must be defined and limited to a specific number of participants.
- Allows Medicaid coverage for services not already covered by Medicaid.
- The application can include a provision that allows the parent's income to be separated from the child's, so that children not eligible for Medicaid because of income restrictions can become eligible.

Tax Equity and Fiscal Responsibility Act (TEFRA):

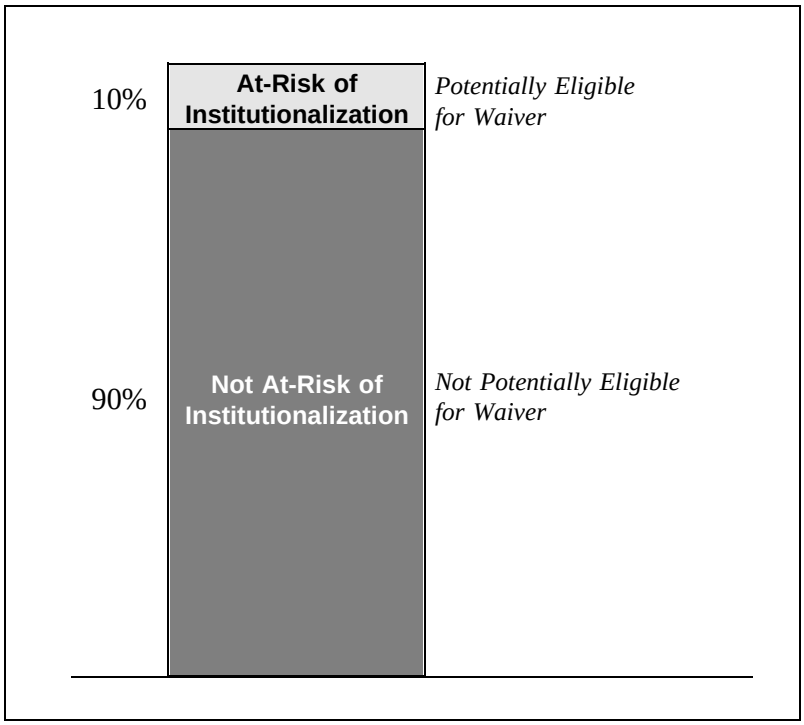
- Participation is indicated on the state's Medicaid Plan, so no application is required.
- The population receiving services cannot be limited, so all children meeting the eligibility requirements can receive services.
- Only pays for services already covered under the state's Medicaid program.
- Allows the parent's income to be separated from the child's, so that children not eligible for Medicaid because of income restrictions can become eligible.

Source: National Governor's Association bulletin entitled "Medicaid Home Care Options for Disabled Children: The State of the States," 1990.

Approximately 10% of CMS children who are not already eligible for Medicaid are at risk of institutionalization and could potentially be covered by the waiver options. (See Exhibit 9.) Currently, the state pays 100% of the cost of the services provided to these children. Under the waiver option, 56% of this cost would be paid by the federal government. The home and community-based waiver option would also expand Medicaid coverage to include services that would allow all Medicaid-eligible CMS clients at risk of institutionalization to remain in the home or in a community-based setting. The TEFRA option does not

expand Medicaid coverage to include additional services, but it makes more children eligible to receive the existing services covered by Medicaid. Under both options, cost of providing services in the home or community setting may not exceed the cost of providing those services in an institution.

Exhibit 9: Potential Medicaid Waiver Eligibility for CMS Clients Not Currently Covered by Medicaid (20% to 30% of All CMS Clients)



Source: Children's Medical Services Program Office estimates.

Although both waiver options allow the state to increase Medicaid funding for CMS clients and, consequently, to obtain federal matching funds for 56% of the cost of caring for these clients, they may also increase total state expenditures by expanding the number of children eligible for services. The risk of increased expenditures is greater with the TEFRA option than with the home and community-based waiver option because no limit is set on the number of children that are allowed to participate.

More states have chosen the home and community-based waiver. According to a 1990 National Governor's Association survey, 23 states have home and community based waiver programs, 4 states have TEFRA waiver programs, and 13 states have both.

CMS Has Not Pursued Available Waiver Options

Because Children's Medical Services and the Agency for Health Care Administration, which operates the Medicaid Program, have been working on other priorities, neither has pursued available options for increasing federal funding for children with special health care needs. However, both CMS and the Agency support the idea of evaluating the waiver options to determine their potential impact on the state's cost of caring for this population of children.

Finding 3

Due to changes in Florida's health care environment and Medicaid, Children's Medical Services' role in serving children with special health care needs has diminished and in future years a state-run program may not be needed.

Historically CMS Has Served Poor Children With Special Health Care Needs

Historically, CMS has performed four essential functions in providing health care services to poor children with special health care needs:

- CMS directly paid for the services provided to its clients. Prior to the inception of the Medicaid Program in 1970, CMS paid for services provided to all of its clients. Even after the creation of Medicaid, CMS remained as the primary payer for services provided to poor children with special health care needs. [3] This occurred because until the late 1980s, Medicaid eligibility was tied to Aid to Families With Dependent Children (AFDC) income criteria, which in Florida, is about one-third of the federal poverty

[3] For the purposes of the report, we are defining poor children as children whose families meet Medicaid financial eligibility criteria or have incomes under the federal poverty level.

level. [4] Consequently, about two-thirds of poor children in Florida were not covered by Medicaid, and CMS continued to pay for the care provided to those poor children with special health care needs;

- CMS attracted physicians and other health care providers willing to serve its clients. After the creation of Medicaid, many health care providers were unwilling to serve Medicaid clients due to low reimbursement rates and complex billing requirements. CMS worked to attract health care providers willing to serve its clients by building close relationships with medical schools and physician associations, entering into contracts that assured providers reasonable volumes of business, and helping providers bill Medicaid;

- CMS managed the care provided to its clients. CMS pre-authorized the services provided to its clients to ensure that the services were necessary and appropriate; and

- CMS integrated the provision of medical and social services to ensure that families were able to properly care for children with special health care needs. CMS nurse case managers visited clients' homes to monitor the home care provided to its clients and to teach families how to manage their children's medical needs. In addition, when necessary, CMS social workers helped families access other social services that would help them better provide for their children.

Changes in the Health Care Environment and Medicaid Have Diminished CMS's Historical Role

However, due to changes in Florida's health care environment and the Medicaid Program, the importance of CMS's role in providing three of these four functions has diminished. For example, due to changes in the Medicaid Program, Medicaid now serves as the primary payer for services provided to CMS children. In the late 1980s the federal government first permitted, then mandated expansion of Medicaid to cover more poor women and

[4] Supplemental Security Income clients were also eligible for Medicaid, however, most children become eligible through AFDC.

children. Currently Medicaid covers all poor pregnant women and children aged 11 years or less and, by 2002, Florida law requires Medicaid coverage to be extended to poor children aged 19 years or less. [5] CMS staff estimate that approximately 70% to 80% of CMS clients are covered by Medicaid, and this percentage may increase if Medicaid coverage expands to include nearly all poor children.

Changes in Medicaid

Other changes in the Medicaid Program and health care environment have lessened the need for CMS to attract providers willing to serve poor children with special health care needs. Medicaid rates have increased substantially and its billing forms and procedures are more compatible with those of other third-party health care payers. In addition, insurance companies and other third-party payers have implemented health care purchasing practices that have reduced the prices they pay for health care services. As a result, Medicaid rates are more attractive than they were. This, coupled with the large number of people covered, has increased the number of providers who are willing to serve Medicaid clients. Thus, the need for CMS to actively solicit providers willing to serve its clients has lessened.

The Growth of Managed Health Care Delivery Systems

Finally, CMS is no longer unique in its role as a managed care provider. In reaction to rising concerns over escalating health care costs, many private and public third-party payers are turning to managed health care delivery systems to control costs. Under a managed care system, a primary care physician controls client access to more expensive services provided by specialists or hospitals by pre-authorizing the clients' use of those services. This helps reduce unnecessary use of more costly services. In some managed care systems, services are reimbursed on a fee-for-service basis. In others, providers such as Health Maintenance Organizations (HMOs) receive fixed payments for every client they serve. These payments are determined by calculating the average cost of serving their client population. When HMO clients receive more expensive services provided by hospitals or specialists, the HMOs pay for those services. This creates an incentive for the HMO to provide services in the most cost-effective manner

[5] Section 409.903, F.S.

possible. Most HMOs have developed a network of specialists and other providers who will provide specialty services to their clients for discounted fees.

In Florida, both private and public third-party health care payers are turning to managed care systems. Since 1990, enrollment in Florida's commercially licensed HMOs has increased from 1.5 to 2.7 million. In addition, Medicaid is in the process of transforming from a fee-for-service to a managed care system. To accomplish this goal, Medicaid has recruited HMOs and other prepaid health plans willing to serve Medicaid clients. In addition, Medicaid is implementing Medipass, a mandatory fee-for-service managed care program for clients who do not choose to enroll with HMOs. Under Medipass, clients are being assigned to a primary care physician responsible for managing their care and controlling their access to more expensive specialty services. As of January 31, 1995, 57% of Medicaid's AFDC and AFDC-related clients were enrolled in a prepaid health plan or Medipass, and by December 31, 1996, the Agency for Health Care Administration expects all Medicaid clients to be enrolled in a managed care system.

Although Medipass physicians and Medicaid prepaid health plans could serve CMS clients, they are unlikely to do so currently. Medipass physicians offer primary care, but may not be trained to provide the specialty care needed by CMS clients. Medicaid has not specifically recruited a network of specialists to whom Medipass physicians can refer patients, and in 1993, over half of the Medipass physicians responding to a survey reported difficulty in locating specialists for their Medipass clients.[6] CMS has implemented procedures to inform Medipass physicians that CMS will provide specialty care to all poor children with special health care needs. Consequently, Medipass physicians are likely to refer these children to CMS.

[6] University of South Florida, Florida Public Health Information Center "Implementation of MediPass; An Evaluation." March 10, 1993. The survey instrument was mailed to all physicians participating in the four-county pilot of Medipass. Of the 250 physicians in the implementation area, 132 or 48.9% responded to the survey.

Medicaid prepaid health plans have developed networks of specialists and some probably have the medical capability to serve children with special health care needs. However, traditional prepaid health care plans generally do not provide the extensive social services needed to ensure that poor families are able to properly care for their children with special health care needs. Further, due to the high cost of providing medical care to children with special health care needs, prepaid health plans have little incentive to keep these children as their clients. Medicaid HMOs and other prepaid health plans that serve the general AFDC population have had difficulty providing quality care to individuals who have special health care needs.

The Development of Specialty HMOs

Because general-population HMOs have not always been able to provide quality health care to individuals with special health care needs, other states have begun to develop specialized HMOs to serve these individuals. These specialty HMOs generally operate in a manner similar to that of CMS: clients are treated by health care teams composed of specialists, primary care physicians, nurses, and social workers who provide a wide range of medical and social services designed to ensure that their clients receive quality care in non-institutional settings. Like general HMOs, specialty HMOs receive fixed monthly payments for each client they serve. However the monthly payments are based on the Medicaid's average cost of providing health care to clients with special health care needs similar to those who are served by the specialty HMOs and thus are much higher than the average per capita payments general HMOs receive. In addition, due to high probability that some of their clients will need extremely costly services, specialty HMOs usually enter into some type of risk-sharing agreement with the state's Medicaid agency. Nevertheless, the per capita payment system gives specialty HMOs the incentive to closely monitor the cost-effectiveness of the services they provide. In addition, because they receive a fixed monthly fee per client instead of a reimbursement for each service they provide, specialty HMOs have the flexibility to provide services that would not ordinarily be covered by Medicaid but will help clients meet their medical goals.

It is likely that in the near future, Florida will also be developing specialty HMOs for Medicaid clients. According to Agency for Health Care Administration staff, the agency has been examining the feasibility of developing prepaid plans for several groups of individuals with special health care needs, including children, and several providers have expressed interest in becoming Medicaid HMOs for chronically ill children. The Agency is beginning to work on technical issues that need to be resolved before it can begin to contract with specialty HMOs. These include developing per capita payment rates, contract standards, and quality control monitoring procedures for specialty HMOs. However, once these issues are resolved, the Agency may be likely to seek out providers willing to become HMOs for children with special health care needs.

If specialty Medicaid HMOs for children with special needs are developed, CMS may no longer be needed to serve this population. Faced with this possibility, CMS and the Agency for Health Care Administration explored the option of CMS becoming a state-run, specialty Medicaid HMO. However, this option was not pursued for two reasons. First, the Secretary of the Department of Health and Rehabilitative Services did not believe that CMS has the capability to function as an HMO because it lacks the systems needed to closely manage the cost-effectiveness of the services provided to its clients. Second, the Agency for Health Care Administration believed that developing private sector HMOs rather than public HMOs would be more consistent with the current direction of health care reform. However, these objections may be overcome if CMS's transformation into a specialty HMO is carefully planned and implemented over several years, and if CMS becomes privatized and competes with other specialty providers.

Conclusions and Recommendations

CMS has a long history of providing health services to children with special health care needs and is recognized for providing quality care. However, it has not developed systems needed to evaluate the cost-effectiveness of its services in reaching desired outcomes. CMS also has not pursued options to increase Medicaid coverage for its clients and services.

In addition, due to changes in Florida's health care environment and Medicaid Program, CMS's historical role in serving children with special health care needs has diminished. If current trends continue and private managed-care providers emerge that are willing and able to provide medical and social services to special health care needs children, CMS's role is likely to further diminish and a state-operated program may no longer be needed to serve this population. Furthermore, maintenance of a state-operated program supported in part by general revenue could encourage private providers to avoid costs by encouraging children who require extremely expensive care to go into the state-run program. In addition, a state-operated program may not be able to effectively compete with private HMOs which have more operational flexibility than state agencies in areas such as purchasing or personnel management.

Two viable options exist for moving the delivery of medical services for children with special health care needs from a state-operated, fee-for-service program to Medicaid HMOs.[7] One option would be to phase out CMS as new providers emerge. The other option would be for CMS to position itself to become a private Medicaid HMO for children with special health care needs. Under either option, the state would need to develop controls to ensure that the children served meet medical and financial eligibility requirements and receive quality care.

Both options share advantages inherent to the use of competing prepaid health care plans. First, since prepaid health providers are not reimbursed for every service they provide, they are not constrained to providing only those services for which Medicaid will reimburse. Consequently, they have greater flexibility to provide services that will meet the needs of their clients than fee-for-service providers. Secondly, prepaid providers have a financial incentive to closely monitor and control the cost-effectiveness of their services. Finally, in a competitive system, clients can choose between alternative providers.

[7] Other options exist, but are not considered viable. (See Appendix A.)

When clients are able to chose their providers, their satisfaction and willingness to comply with prescribed treatments is likely to increase.

However, the option of phasing out CMS has disadvantages not shared with the option of transforming it into a private specialty HMO. First, if CMS were phased-out, the children it serves may need to be moved to new providers or social workers. This could be disruptive and break the continuity of care for those children. Secondly, much of the knowledge and expertise CMS staff and providers have in providing services to children with special health care needs could be lost. Thirdly, because specialty HMOs for children with special health care needs are likely to develop in urban areas, without CMS, children living in rural areas may have difficulty finding providers.

Therefore, we recommend that the Legislature require CMS and the Agency for Health Care Administration (AHCA) to develop and begin implementing a plan to enable CMS to become a Medicaid HMO for children with special health care needs and eventually privatize. This process will take several years and require CMS and AHCA to take a number of steps. For example, CMS will have to develop a system to evaluate the cost-effectiveness of its services in reaching desired client outcomes and examine ways of increasing Medicaid coverage of its clients and services. (A more detailed description of some of the steps CMS and AHCA would need to take appears in Appendix B.)

These changes are likely to improve CMS's operations and make better use of state resources. Thus, they should be beneficial even if CMS does not privatize. However, some of these changes will require the CMS Program Office to exercise stronger controls over its programs than the other Department of Health and Rehabilitative Services' (DHRS) Program Offices. For example, districts control the budgets for most DHRS programs. To become a Medicaid HMO, the CMS Program Office would need centralized budget controls. It also would need to develop a centralized, integrated billing and claims review system to enable it to monitor and control expenditures for CMS services. Finally, it will need to continue to closely monitor the

quality of CMS services. We recommend that the Secretary of the DHRS give the CMS Program Office the authority it needs to perform the functions needed for it to become an HMO. In exercising this authority, the CMS Program Office should strive to give districts the flexibility to tailor services to best meet client needs. In addition, due to the financial risks associated with establishing per capita fees for children with special health care needs, we recommend that CMS successfully operate under fixed monthly fees for a period of time such as two years before becoming privatized. This will enable it to test the adequacy of the fixed payments and its ability to control costs before operating as a private entity. A longer phase-in timeframe will also allow CMS to adjust to other changes that may occur in the Medicaid Program due to the actions of the federal government.

List of Appendices

Appendix A
Analysis of Policy Alternatives for Providing Care to Children With Special Health Care Needs

Policy Alternative	Advantages	Disadvantages	Feasibility
Do Nothing, Retain CMS as It Currently Exists	■ Maintains state capability to provide care to children with special health care needs ■ Retain CMS's expertise and network of providers ■ Keeps continuity of care for CMS children	■ CMS may gradually disappear as private specialty HMOs begin operations ■ CMS may be left caring for only those children who need extremely expensive services ■ Without HMO flexibility, CMS may continue to need general revenue appropriations to pay for services that Medicaid will not cover on a fee-for-service basis ■ CMS will continue to have difficulty controlling the costs of services reimbursed by Medicaid and other third-party payers	■ Feasible
Keep CMS as a State-Operated HMO	■ Maintains state capability to provide care to children with special health care needs ■ Retains CMS's expertise and network of providers ■ Strengthens CMS's ability to ensure cost-effectiveness ■ Gives CMS HMO flexibility to provide services that Medicaid would not pay for on a fee-for-service basis ■ Keeps continuity of care for CMS clients	■ State bears all insurance risks for children with special health care needs ■ CMS may not be competitive with private HMOs due to the constraints government agencies have regarding purchasing, personnel, etc. ■ CMS may be left caring for only those children who need extremely expensive services	■ Feasible, although time will be needed to develop per capita rates and resolve other technical issues
CMS Becomes a Private HMO	■ Retains CMS Network ■ Strengthens CMS's ability to ensure cost-effectiveness ■ Gives CMS HMO flexibility to provide services that Medicaid would not pay for a fee-for-service basis ■ State shares insurance risk for children with special health care needs with private HMOs ■ CMS not restrained by government purchasing or personnel procedures ■ Keeps continuity of care for CMS children	■ State loses capability for caring for children with special health care needs ■ State will need to carefully monitor the quality and costs of services providers	■ Feasible-although time will be needed to develop per capita rates and resolve other technical issues
Phase Out CMS as Private Providers Emerge	■ Private specialty HMOs have the flexibility and incentive to provide cost-effective services ■ State shares the insurance risks for children with special health care needs with private HMOs	■ State loses capability to care for children with special health care needs ■ State will need to carefully monitor the quality and costs of service providers ■ Loss of CMS experts and network of providers ■ Possible loss of continuity of care for CMS children ■ Private providers may not offer services in rural areas	■ Feasible, although transition problems may be expected
CMS Becomes a Provider of Specialty Service Under Contract With HMOs	■ State shares insurance risks for children for special health care needs with private HMOs ■ Retains CMS expertise network of providers ■ Gives CMS HMO flexibility to provide services that Medicaid would not pay for on a fee-for-service basis	■ HMOs would manage the services provided by CMS, thereby creating the potential for disputes over the care that should be provided ■ Most HMOs have their own network of providers and would not use CMS ■ Possible loss of continuity of care for CMS clients	■ Probably not feasible given potential conflicts between CMS and HMOs

Source: Office of Program Policy Analysis and Government Accountability analysis of Department of Health and Rehabilitative Services' records.

Appendix B
Description of Steps Needed to Transform Children's Medical Services into a Medicaid Health Maintenance Organization

This describes in greater detail some of the steps Children's Medical Services (CMS) and the Agency for Health Care Administration (AHCA) would need to take to transform CMS into a Medicaid health maintenance organization (HMO):

- CMS will need to identify which of its programs and activities involve the provision of health care services to special needs children and could be supported by Medicaid monthly fees. For example, some CMS programs, such as the Poison Control Centers, serve the general population and would not be supported by Medicaid fees. In addition, not all CMS activities involving children with special health care needs can be privatized. At a minimum, the state will need to monitor the quality of care clients receive and ensure that clients are eligible to receive services. After identifying the activities and programs that could be performed by an HMO, CMS should then reorganize to consolidate them into one organizational entity. Consolidating these programs will help CMS prepare to privatize them. CMS could continue to operate its other programs or transfer them to other state entities with similar functions. For example the Poison Control Centers could be transferred to the State Health Office;

- CMS and AHCA will need to examine available federal waiver options that would increase Medicaid coverage for the services CMS currently uses general revenue to provide. If it appears that the waiver options would increase federal financial support for CMS services without greatly increasing the number of children eligible for services, CMS and AHCA should seek legislative approval for obtaining a waiver. If the waiver options do not extend Medicaid coverage to all CMS clients, the Legislature will have to consider whether or not to continue to provide general revenue to serve the remaining clients;

- CMS will need to develop a system to collect information on the health care and social services it provides to each of its special health care needs clients. It should use this information to determine, among other things, its cost of providing services to Medicaid eligible clients that were not reimbursable by Medicaid as well as its cost of serving clients who were not eligible for Medicaid. This information would be useful in estimating possible effects of various Medicaid waiver alternatives. It also would be helpful in determining the monthly fees CMS would need to receive if it became a Medicaid HMO;

- CMS and AHCA will need to develop a methodology to establish the fixed monthly fees HMOs would need to serve children with special health care needs. These monthly fees should also be used for any CMS clients who are covered by the state without Medicaid participation. In developing the fees, CMS costs for providing non-Medicaid reimbursable services to Medicaid-eligible children should be considered. If this is not possible given Medicaid rules, the monthly fees should not be implemented until a waiver is in effect. Otherwise the fees may not be sufficient to cover the costs of serving special needs children. In addition, due to the variation in the cost of serving clients with different medical conditions, the Agency should consider creating separate monthly payments for the different types of clients CMS serves;

- CMS and AHCA will also need to work out an arrangement for sharing the financial risks associated with serving children with special health care needs. Currently Florida's Medicaid HMOs bear all the risks of financial losses due to unexpectedly high health care costs. However, with a special needs population, these risks are higher than they are for healthier client groups. Consequently Medicaid agencies need to develop some means for sharing the risks with specialty HMOs; and

- Finally, CMS will need to develop a system for routinely monitoring the cost-effectiveness of its services in achieving desired client outcomes. The CMS central office should collect the client outcome data currently maintained in client records as well as the cost of services provided each client and aggregate this information by the client groups served. In addition, CMS should adopt strategies used by HMOs to contain costs. HMOs track the number and types of services being provided to their clients and use historical service use patterns to identify clients or providers that appear to be overusing services. The HMO can then take steps to ensure that services are being used appropriately. A system that links actual costs with outcomes will provide the Legislature information, in addition to broader societal outcome measures, to assist it in allocating limited resources. Such a system will also allow CMS to better manage its programs by more closely monitoring expenditures to avoid overuse of services. In addition, local CMS managers can identify services that are not effective and modify or eliminate the services accordingly.

Appendix C
Response From the Department of Health and Rehabilitative Services

In accordance with the provisions of s. 11.45(7)(d), F.S., a list of preliminary and tentative audit findings was submitted to the Secretary of the Department of Health and Rehabilitative Services for his review and response.

The Acting Secretary's written response is reprinted herein beginning on page 34.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

June 30, 1995

James L. Carpenter
Interim Director
111 W. Madison Street
Room 312, Claude Pepper Building
Tallahassee, Florida 32302

Dear Mr. Carpenter:

I am responding to your May 30 letter regarding the preliminary and tentative findings of your performance review of Children's Medical Services within the Department of Health and Rehabilitative Services. Our responses to your recommendations, and our comments to your description of steps needed to transform Children's Medical Services into a Medicaid Health Maintenance Organization are attached.

Thank you for the opportunity to respond to this review. We appreciate the work of your staff and will diligently pursue correction of outstanding deficiencies.

Sincerely,

Edward A. Feaver
Acting Secretary

Enclosure

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICE

RESPONSE TO OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY (OPPAGA) PERFORMANCE REVIEW OF CHILDREN'S MEDICAL SERVICES

RECOMMENDATION 1

The Legislature require Children's Medical Services (CMS) and the Agency for Health Care Administration to develop and begin implementing a plan to enable CMS to become a Medicaid HMO for children with special health care needs and eventually privatize.

RESPONSE:

Department management concurs with the recommendation.

RECOMMENDATION 2

The Secretary of the DHRS give the CMS Program office the authority it needs to perform the functions needed for it to become an HMO.

RESPONSE:

Department management concurs with the recommendation and appreciates your recognition that the districts need the flexibility to tailor services to best meet client needs.

RECOMMENDATION 3

CMS successfully operate under fixed monthly fees for a period of time such as two years before becoming privatized.

RESPONSE:

We also concur with this recommendation, provided that it is intended to include all fees that Medicaid pays for services rendered to children with special health care needs. Furthermore, it is important that monthly fees are not discounted during this period in order to determine sound actuarial capitation rates for children with special care needs. We must also point out that priority needs to be given to the development of a sound data management and information system.

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

RESPONSE TO OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY (OPPAGA) PERFORMANCE REVIEW OF CHILDREN'S MEDICAL SERVICES

The following comments address the Description of Steps Needed to Transform Children's Medical Services into a Medicaid Health Maintenance Organization, Appendix B, pages 30-32 of the report.

Children's Medical Services is in the process of developing and implementing a minimum data set in order to track costs for CMS patients across multiple program components, contractors, and providers. It should be noted that the department has entered into outcome measurements that are based on societal indicators. This is not unique to CMS. Furthermore, the department recognizes that there are multiple variables that affect societal indicators and has developed measures for contributing factors that directly influence these variables. Contributing factors are directly influenced by the inputs produced or provided through departmental programs such as CMS. For example, the implementation of programs to serve high-risk pregnant women 'n their communities has had a direct impact on infant mortality as a societal measure.

It should also be noted that CMS has long advocated for an adequate data system to capture important and necessary output and outcome information that is client rather than program specific information. Resources for this data system are prioritized within the department. In order for CMS to effectively track cost-effective outcomes, priority needs to be placed on the development of a data system that measures costs across a variety of programs and also has the capability to measure opportunity or indirect costs. The prioritization of data system needs is beyond the scope of CMS, but rests within the department.

Children's Medical Services has reviewed the possibility of pursuing Medicaid waiver options. In fact, CMS is pursuing a waiver option for the provision of Early Intervention Services.

While the Tax Equity and Fiscal Responsibility Act (TEFRA) may be an option, we are addressing a relatively small sample of children who qualify for TEFRA. If 10% of the CMS patients (n=56,000 x .10 or 5600) are uninsured and of these 10% are at risk for institutionalization, we are,addressing 560 children. Because currently CMS financial eligibility limits mirror Medicaid policies, most of these children will become eligible for Medicaid through the year-by-year phase in until all children under the age of 19 with family incomes below poverty will be Medicaid eligible.

Home and community-based waivers are also options, however, the report correctly states that we must set limits on the population. Furthermore, the waiver will only provide services that Medicaid does not cover, such as home adaptation, parent training, etc. We currently have a very comprehensive Medicaid benefit package for children and funding for other services is generally sought through community agencies. Both TEFRA and Home and Community Based Waivers would also create increased Medicaid expenditures in a time when there is uncertainty about caps in the Medicaid Program.

It should not be assumed that physicians are more willing to become Medicaid providers and serve children with chronic medical problems. our experience, and results of a provider survey conducted by USF College of Public Health indicate that providers are not as willing to serve children with chronic illnesses, because of the child's condition, the time involved to see the child, the liability fear factor, and the current low level of reimbursement for office visits.

We do concur that the role of CMS may be diminished as Medicaid HMOs and other managed care options have developed. However, these managed care arrangements do not appropriately risk adjust for chronically ill children, nor do they contain standards of care and referral criteria that address the long-term needs of chronically ill children. It is erroneous to assume that without

changes in the managed care environment, chronically ill children will. have access to quality care. In fact, studies and qualitative reviews indicate that chronically ill children are compromised under managed care environments which operate under annual financial statements in lieu of long-term systems of care.