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Follow-Up Report on the Children's Medical Services Program As Administered by the Department of Health

Abstract

- **Pursuant to the recommendations in our prior report, Children's Medical Services is implementing a managed care process for children with special health care needs.**
- **However, Children's Medical Services has not established per capita pre-paid fees and continues to operate on a fee-for-services basis.**

Purpose

In accordance with s. 11.45(7)(f), F.S., this follow-up report informs the Legislature of actions taken by the Department of Health and Rehabilitative Services in response to our Report No. 95-02, which we issued July 25, 1995. This report presents our assessment of the extent to which the Department has addressed the findings and recommendations included in our report. Specifically, we sought to determine the status of Children's Medical Services (CMS) becoming a managed care provider.

Background

CMS serves children who have serious or chronic physical or developmental conditions and need extensive preventative and maintenance health care beyond that required by healthy children. CMS promotes, plans and coordinates medical and social support services provided either by CMS staff or through contracts with private providers. Services are provided by a statewide network of 22 CMS local clinics as well as physician offices, hospitals, regional centers, and medical tertiary care centers. In fiscal year 1996-97, CMS was appropriated $120,163,788. During fiscal year 1995-96, CMS served approximately 54,000 children with special health care needs.

At the time of our review, the Children's Medical Services Program was in the Department of Health and Rehabilitative Services (DHRS). Effective January 1, 1997, the Legislature created the Department of Health and transferred CMS to the new Department.

Prior Findings

Our prior report contained three principal findings. First, Children's Medical Services had not developed a system to evaluate its cost effectiveness in producing desired outcomes. Second, CMS had not pursued Medicaid waiver options that could enable it to increase federal funding for services. Finally, current trends in managed care, including the potential for private providers emerging to serve children with special health care needs, indicated that CMS's role is likely to diminish and a state run program may no longer be needed to serve this population. Our recommendations were intended to position CMS to become a private Medicaid health maintenance organization for children with special health care needs and enable CMS to become more competitive in Florida's emerging health care environment. Specifically, we recommended that:

- The Legislature require CMS to develop and begin implementing a plan to enable it to become a Medicaid health maintenance organization (HMO) for children with special health care needs and eventually privatize.
- The Secretary of DHRS give the CMS Program Office the authority it needs to perform functions needed for it to become an HMO.

- CMS successfully operate under fixed monthly fees for a period of time such as two years before becoming privatized, due to the financial risks associated with establishing per capita fees for children with special health care needs.

Current Status

Medicaid HMO. Instead of implementing the recommendations we made in our report, CMS has implemented alternative solutions to the problems we identified. These alternatives were in response to 1996 legislation creating an alternative services network, which satisfies the intent of our recommendation that CMS operate under a system of managed care. As a result of this legislation, CMS assigns a primary care provider from its network who controls client access to more expensive services provided by specialists or hospitals. This additional control should help to reduce unnecessary use of more costly services and is a key component of managed care.

Additional Authority. CMS placement within the Department of Health has strengthened its authority to perform the functions needed for it to become an HMO. Because of the risks associated with pre-paid health plans, to become a health maintenance organization, CMS will need to exercise careful control over its budget. At the time of our review, DHRS program offices had little budgetary control because districts were authorized to move resources between programs. The transfer of CMS to the Department of Health should resolve this budgetary control issue. Under Department of Health protocols, CMS budget operations will be centralized within the Department's Division of Administration.

Fixed Fees. CMS has not developed or operated a pre-paid rate reimbursement arrangement and is not planning to do so at this time. Pursuant to the 1996 legislation, CMS uses a fee-for-service reimbursement method. A fee-for-service payment arrangement appears appropriate for now. To establish pre-paid rates, historical data must be developed to determine the cost of serving this population, which may take several years. We believe that CMS should continue to develop this data.

A pre-paid managed care arrangement creates a financial incentive for the managed care organization to provide cost-effective services. Pre-paid managed care plans also offer the administrative flexibility to manage chronic and high cost medical conditions that are not available through fee-for-services reimbursement arrangements. In many of Florida's Medicaid HMOs and pre-paid health plans, providers receive fixed payments for every client served. Payments are determined by calculating the average costs of serving their client population.

An alternative to CMS privatizing and using a per capita pre-paid fee arrangement would be to solicit private provider networks willing to operate on this basis to serve children with special health care needs. Florida statutes authorize the Agency for Health Care Administration to issue requests for proposals to providers outside of the CMS network to serve Medicaid eligible children with special health care needs. At the time of our prior review, several providers had expressed interest in becoming specialty HMOs for chronically ill children. Using private provider networks, in addition to CMS, will allow the state to inject competition into this health care area and test the comparative cost and quality of pre-paid versus fee-for-service plans.

Summary and Recommendations

CMS is implementing a managed care process for children with special health care needs, as recommended in our report. However, CMS has not established per capita pre-paid fees but continues to operate on a fee-for-service basis. We continue to recommend that the Agency for Health Care Administration solicit private pre-paid providers to serve this population. This would allow families and children a choice of providers and also comparisons of quality and costs of fee-for-service versus pre-paid plans.

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (904/488-1023 or 800/531-2477), by FAX (904/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302). Web site: http://www.state.fl.us/oppaga/

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