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An Evaluation:

Family Care

Department of Health Services

April 2011

Report Highlights

FY 2009-10 program expenditures were $936.4 million.

Increases in the number of high-cost participants contribute to funding concerns.

Less than 1 percent of all functional eligibility determinations completed in FY 2009-10 were made in error.

Assessments and care plans for participants are generally complete and timely.

Efforts by DHS to measure the quality of care have been mixed.

Family Care is a long-term care program for low-income adults who have developmental or physical disabilities or are frail and elderly. As of June 2010, it was administered in 53 Wisconsin counties and served 28,885 participants. The program is intended to provide cost-effective, comprehensive, and flexible services tailored to participants' needs and to serve as an alternative to institutional care. The Department of Health Services (DHS) is responsible for its oversight, but services are delivered under the direction of nine public or nonprofit managed care organizations (MCOs) that work with participants to develop individual care management plans and contract with providers for the delivery of program services.

In July 2010, the Joint Legislative Audit Committee directed us to complete a comprehensive evaluation of the Family Care program. In completing our work, we reviewed:

- program expenditures and participation for the five-year period from fiscal year (FY) 2005-06 through FY 2009-10;
- services provided to program participants and how their needs are assessed;
- the process for setting capitation rates that control payments to the MCOs for care management and paying provider claims;
- the financial solvency of the nine MCOs that currently participate in Family Care, as well as financial and program oversight by DHS; and
- quality-of-care indicators.

Key Facts and Findings

In June 2010, the Family Care program operated in 53 of Wisconsin's 72 counties.

Nearly 60 percent of program participants reside in their own homes.

Under Family Care's capitation system, MCOs assume some financial risk if their costs to provide services exceed the capitation rates they are paid.

Expenditures for prescription drugs, emergency room visits, and other acute care services provided to Family Care participants on a fee-for-service basis were $80.0 million in FY 2009-10.

DHS shares responsibility for financial oversight of the MCOs with the Office of the Commissioner of Insurance.

The cost-effectiveness of Family Care is difficult to assess.

Expenditures and Services

Family Care expanded from 5 to 53 counties during the five-year period we reviewed, and program expenditures increased from $248.4 million in FY 2005-06 to $936.4 million in FY 2009-10. Federal Medical Assistance funding supported 68.9 percent of program expenditures in FY 2009-10.

More than 90 percent of program expenditures have been payments to MCOs that reflect the capitation rates they are paid for each enrolled participant. In FY 2009-10, DHS paid nine MCOs $892.4 million for care management and other contracted services.

Participants' care needs vary widely, as do the services they receive. In FY 2009-10, 55.7 percent of the MCOs' expenditures were for health and supportive services such as assistance with daily activities, care management, and specialized transportation.

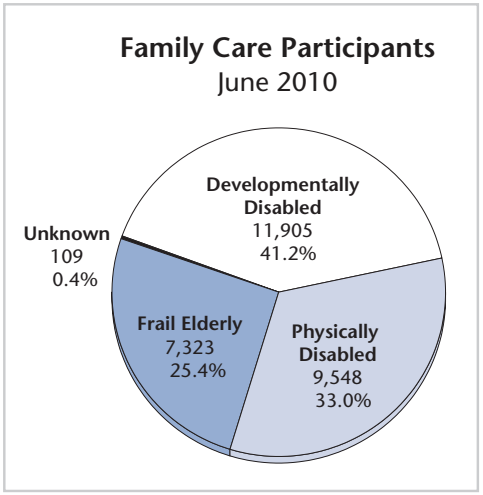
Nearly 60 percent of program participants receive care in their own homes. Most others receive residential services in small, community-based facilities or adult family homes. Residential services costs represented 44.3 percent of the MCOs' expenditures in FY 2009-10.

DHS is planning to establish uniform residential rates for participants with similar needs within and across counties. However, the proposed residential rate-setting methodology has become controversial, and the ability or willingness of residential care providers to accept the rates DHS has proposed is not clear.

MCOs' administrative expenditures for salaries, supplies and services, and rent and facilities costs more than tripled during the period we reviewed and were $53.2 million in 2010. Executive compensation varied considerably, but we found four cases of salaries exceeding $200,000, excluding fringe benefits.

Costs per Participant

Most of the 28,885 individuals who received Family Care benefits in June 2010 were either developmentally or physically disabled, and 96.8 percent qualified for comprehensive care.



In FY 2009-10, average monthly service costs ranged from $1,800 to $2,800 per participant for individuals who were physically

disabled or elderly, and from $2,900 to $4,600 per participant for individuals who were developmentally disabled. Newer MCOs spent more per participant, on average, than the five MCOs that operated during the program's pilot phase.

The number of developmentally disabled participants with high-cost needs grew significantly during the period we reviewed. MCOs contend that the capitation payments they receive to fund care for these participants are insufficient. DHS has made some rate adjustments, but disputes will likely continue.

DHS and the Office of the Commissioner of Insurance have identified three MCOs whose ongoing negative net assets and reserve fund shortages place them at greater risk for insolvency: Care Wisconsin First, Inc., Community Health Partnership, Inc., and NorthernBridges.

DHS established corrective action plans with Community Health Partnership and NorthernBridges late in 2010, and shortly before the publication of our report we were informed that Community Health Partnership would also be subject to a heightened level of monitoring.

Eligibility Determinations

A "functional screen" assessment tool is used to evaluate participants' eligibility for Family Care services. We compared the results of all 30,425 functional screen assessments completed in FY 2009-10 with eligibility rules established in administrative code and found errors in functional eligibility determinations for less than 1 percent. Those 87 participants were eligible for comprehensive care but were erroneously found eligible for more limited services.

MCOs are required to annually reassess participants' eligibility. We did not find patterns to suggest that MCOs were systematically decreasing participants' level of care in order to limit their own costs.

Care Planning

MCO care management staff complete comprehensive health and social assessments every six months and work with participants and their families to develop a plan of care to meet desired health and social outcomes. We reviewed the most recent assessments and care plans for a random sample of 50 participants and found that comprehensive assessments had been completed as frequently as required in all but three cases. All but two care plans had also been updated appropriately.

Quality of Care

As required by federal law, DHS contracts for annual reviews of each MCO's compliance with federal and state program rules. In FY 2009-10, a private contractor found that MCOs complied with most of the 129 regulations and requirements the contractor was asked to assess. DHS also measures participants' personal outcomes, such as their ability to choose their daily routine and living arrangements and their achievement of certain goals. A private contractor was hired in 2006 to develop a new system for measuring participants' personal outcomes, and DHS began using the new system in October 2010.

DHS did not formally evaluate the personal outcomes of Family Care participants while the new system was being developed and tested. However, more than 80 percent of participants surveyed by the MCOs expressed satisfaction with Family Care in 2009.

Future Considerations

The 2011-13 biennial budget proposal appropriates $1.4 billion in each year of the next biennium to continue Family Care, but it caps enrollment to June 2011 levels and prohibits DHS from further program expansion pending results of this evaluation.

Our findings indicate the program has improved access to long-term care, ensured thorough care planning, and provided choices tailored to participants' individual needs. However, we could not definitively determine its cost-effectiveness, in part because the type and quality of services available under Family Care may be prompting enrollment by some

individuals who would otherwise not seek public assistance.

Given the program's increasing enrollment and costs, substantial public interest in long-term care services, and the increased authority that DHS may be granted to promulgate administrative rules governing programs funded by Medical Assistance, the future of Family Care is likely to be debated in the current legislative session.

To assist the Legislature in framing its debate, we have provided a series of questions related to sustainability, rate-setting, long-term care strategies, and the provision of acute care services in a managed care model. We also include a series of recommendations to improve program administration and ensure the Legislature is in a position to assess the effects of any program changes DHS may put in place in the near future.

Recommendations

We recommend that DHS report to the Joint Legislative Audit Committee by September 1, 2011, on:

- ☑ rate-setting, including any proposed changes in methodology or adjustments to capitation rates *(pp. 26 and 36)*;
- ☑ its oversight of service delivery, including the caseloads of MCO staff, the testing of certified functional assessment screeners, the appeals process available to participants, and how the personal outcome data provided by MCOs will be used to improve service quality *(pp. 30, 49, 55, and 62)*;
- ☑ financial oversight, including the solvency of participating MCOs and available sanctions for noncompliance with corrective action plans, as well as potentially fraudulent payments identified by each MCO in 2010 *(pp. 39 and 41)*; and
- ☑ its own performance measurement and evaluation efforts, including plans to develop regional long-term care committees *(pp. 63 and 64)*.

We also recommend that DHS report to the Joint Legislative Audit Committee by August 31, 2012, on:

- ☑ the status of the Family Care program at that time, including any changes in participation rates and costs, as well as how any administrative rules it has promulgated or any statutory changes enacted as part of the 2011-13 biennial budget have affected the program and the individuals it serves *(p. 70)*.

Additional Information

For a copy of report 11-5, which includes a response from the Department of Health Services, call **(608) 266-2818** or visit our Web site:

www.legis.wisconsin.gov/lab

Address questions regarding this report to:

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