

An Evaluation

Family Care

Department of Health Services

2011-2012 Joint Legislative Audit Committee Members

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Response

From the Department of Health Services



STATE OF WISCONSIN

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Janice Mueller
State Auditor

April 27, 2011

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

We have completed an evaluation of the Department of Health Services' (DHS's) Family Care program, as requested by the Joint Legislative Audit Committee. As of June 2010, Family Care operated in 53 counties and served 28,885 elderly and disabled participants. Program expenditures totaled \$936.4 million in fiscal year (FY) 2009-10, including \$892.4 million paid to nine public and nonprofit organizations that arrange and manage participants' long-term care and pay the providers who deliver medical care, assist with the activities of daily living, and provide other services.

Several of the managed care organizations (MCOs) have incurred operating deficits as the program expanded from 5 pilot counties to 53 counties as of June 2010. DHS and the Office of the Commissioner of Insurance, which share financial oversight of the MCOs, have identified three that are at an increased risk of insolvency. Despite increases in the capitation amounts they are paid, the MCOs contend that capitation amounts are not sufficient to pay for all necessary services, in part because of increasing numbers of participants with high-cost needs. High-cost participants represented 16.9 percent of the total caseload in FY 2009-10, and the number of participants with developmental disabilities, who tend to require more expensive care, represented 41.2 percent of the total caseload at the end of that fiscal year.

Our analysis indicates that the program has improved access to long-term care, ensured thorough participant care planning, and provided participants with choices tailored to their individual needs. However, its cost-effectiveness remains difficult to assess, 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.

The Governor's 2011-13 biennial budget proposal caps Family Care enrollment at existing levels, pending results of this evaluation. We include a number of questions for the Legislature to consider as it debates the future of the Family Care program.

We appreciate the courtesy and cooperation extended to us by DHS, the MCOs, and county staff in completing this evaluation. DHS's response follows the appendices.

Respectfully submitted,

Janice Mueller
State Auditor

JM/PS/ss

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.

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.

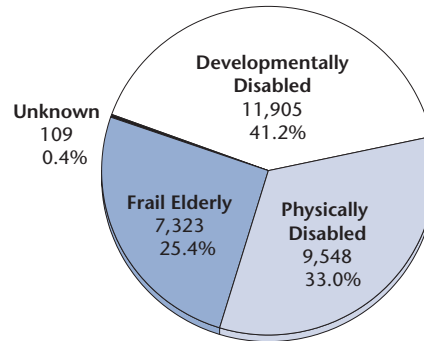
MCOs' administrative expenditures for salaries, supplies and services, and rent and facilities costs more than tripled during the period we reviewed and were \$53.2 million in 2010. Executive compensation varied considerably, but we found four cases of salaries exceeding \$200,000, excluding fringe benefits.

Costs per Participant

Most of the 28,885 individuals who received Family Care benefits in June 2010 were either developmentally or physically disabled, as shown in Figure 1, and 96.8 percent qualified for comprehensive care.

Figure 1

Family Care Participants
June 2010



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*).

■ ■ ■ ■

Introduction ■

Family Care makes long-term care available to low-income adults who are developmentally disabled, physically disabled, or frail and elderly.

Family Care was established in 1998 to make comprehensive and flexible long-term care available to low-income adults who are unable to safely or adequately care for themselves. Participants include:

- people with longstanding cognitive or developmental disabilities, such as cerebral palsy or Down Syndrome;
- people with physical disabilities that limit their ability to care for themselves, such as multiple sclerosis; and
- other adults who are 60 years or older in Milwaukee County and 65 years or older in other counties and have a disabling cognitive or physical condition, such as dementia.

The program's goals include:

- offering participants choices about where they will live and the services that will best meet their needs;
- improving access to health and supportive services;

- improving service quality by focusing on participants' health and social outcomes; and
- creating a cost-effective system by delivering long-term care services in home and community-based settings.

Family Care seeks to replace county-administered Medical Assistance programs that operate under federal waivers, such as the Community Integration Program (CIP) and Community Options Program (COP), which also provide home and community-based, long-term care services. Under the Family Care program, services are arranged and provided through two types of organizations:

- Aging and disability resource centers (ADRCs) are the point of entry for Family Care services, providing prospective participants with information on available long-term care options and assistance in assessing their appropriateness; accepting applications for program enrollment; and evaluating applicants' functional eligibility for program services.
- Managed care organizations (MCOs) are responsible for arranging and managing the services provided to Family Care participants, and for paying service providers.

ADRCs are operated by individual counties, groups of counties, or tribes. MCOs include private nonprofit organizations, counties, or public long-term care districts established under s. 46.2895, Wis. Stats., as local units of government created to administer services under the Family Care program.

To participate in Family Care, an individual must be at least 18 years old and meet Medical Assistance financial eligibility requirements, which generally involve having assets and income of no more than \$2,000, excluding a primary residence and personal vehicle. Financial eligibility is determined by county staff. In addition, s. 46.286(1)(a)1m, Wis. Stats., requires that the applicant have a long-term or irreversible condition that is expected to last at least 90 days or result in death within 12 months.

Applicants are also required by statute to meet certain functional eligibility standards. Within 14 days of a prospective participant's application, an ADRC is required to collect clinical and behavioral information using a "functional screen" assessment tool to evaluate whether his or her needs are consistent with a "nursing home level of care."

Two levels of care are provided: comprehensive and intermediate.

Family Care services are provided at two levels: comprehensive and intermediate. Section DHS 10.33(2), Wis. Adm. Code, specifies that individuals eligible for comprehensive care will be unable to safely or appropriately perform:

- activities of daily living such as bathing, dressing, and eating;
- instrumental activities of daily living such as managing medications, preparing meals, and transportation; or
- activities to meet their own needs because of developmental disabilities, impaired cognition, self-neglect, or their need for frequent medical or social interventions.

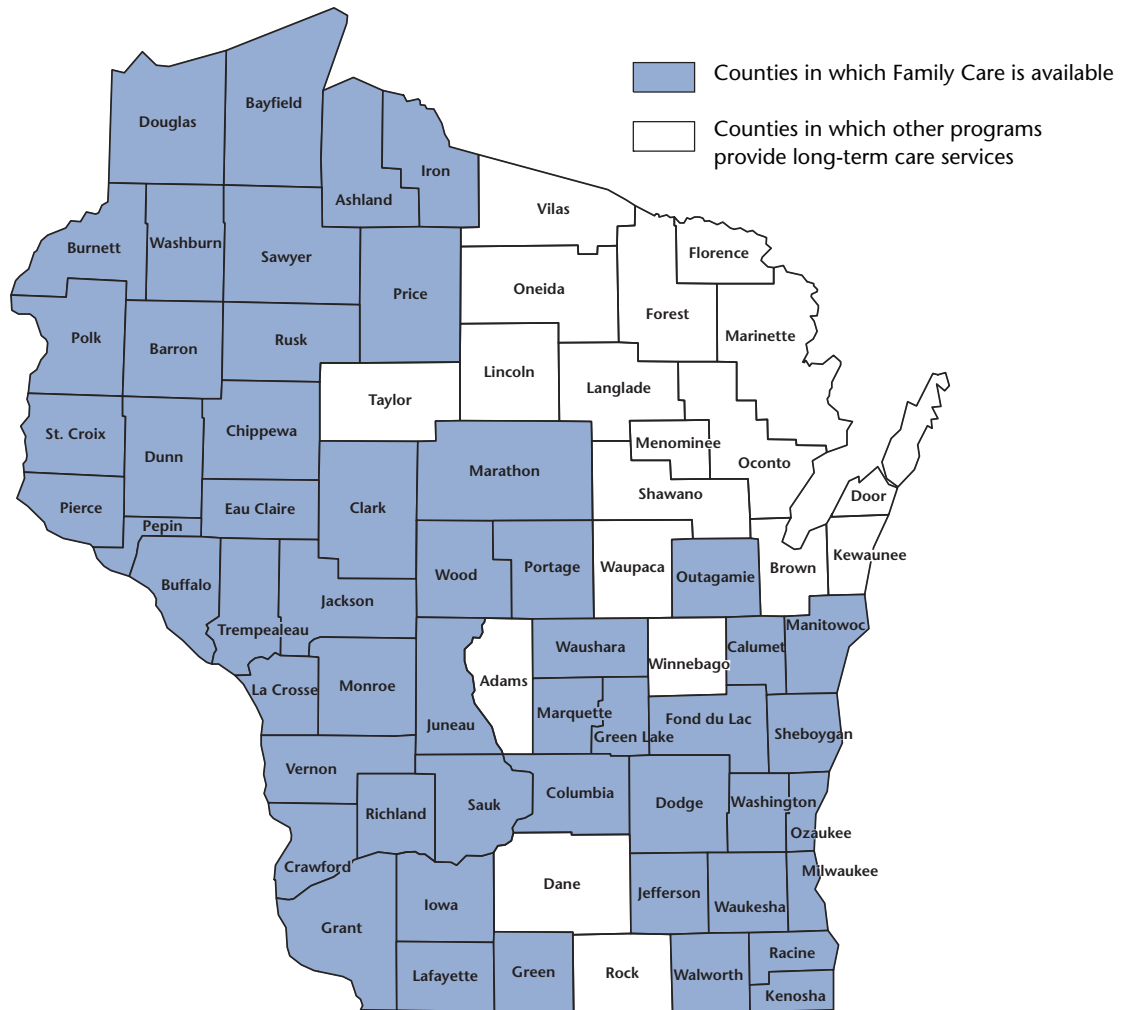
Intermediate care consists of more limited services and is available to participants with less-severe clinical or behavioral care needs, whom statutes define as individuals at risk of losing independence or functional capacity without assistance and having a condition that is expected to last at least 90 days or to result in death within 12 months of the date of application.

As of June 2010, the Family Care program operated in 53 counties.

As of June 2010, DHS had contracted with nine MCOs to provide Family Care services to individuals in the 53 counties shown in Figure 2.

Figure 2

Family Care Counties
June 2010



Most counties are served by only one MCO. However, as shown in Table 1, three counties—Milwaukee, Washington, and Waukesha—are served by two. A list of the 35 ADRCs and the counties they served as of June 2010 is Appendix 1.

Table 1
Managed Care Organizations
 June 2010

Managed Care Organization	Organization Type	Counties Served
Care Wisconsin First, Inc.	Nonprofit Organization	Columbia, Dodge, Green Lake, Jefferson, Marquette, Washington, Waukesha, Waushara
Community Health Partnership, Inc.	Nonprofit Organization	Chippewa, Dunn, Eau Claire, Pierce, St. Croix
Community Care of Central Wisconsin	Public Long-Term Care District	Marathon, Portage, Wood
Community Care, Inc.	Nonprofit Organization	Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Sheboygan, Walworth, Washington, Waukesha
Lakeland Care District	Public Long-Term Care District	Fond du Lac, Manitowoc
Milwaukee County Department of Family Care	County	Milwaukee
NorthernBridges	Public Long-Term Care District	Ashland, Barron, Bayfield, Burnett, Douglas, Iron, Polk, Price, Rusk, Sawyer, Washburn
Southwest Family Care Alliance	Public Long-Term Care District	Crawford, Grant, Green, Iowa, Juneau, Lafayette, Richland, Sauk
Western Wisconsin Cares	Public Long-Term Care District	Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon

As shown in Table 2, the two largest MCOs—Milwaukee County Department of Family Care and Community Care, Inc.—served almost one-half of all participants in June 2010. Appendix 2 shows the number of developmentally disabled, physically disabled, and frail elderly participants served by each MCO at that time.

DHS is required by s. 46.284(3), Wis. Stats., to certify that MCOs have and maintain the capacity to administer Family Care before they begin delivering services and each year thereafter. Therefore, DHS ensures that the MCOs have qualified staff, a sufficient network of providers to meet participants' needs, and the means to collect financial and operational data.

Table 2

Family Care Enrollment
June 2010

Managed Care Organization	Participants
Milwaukee County Department of Family Care	7,469
Community Care, Inc.	5,929
Western Wisconsin Cares	3,283
Care Wisconsin First, Inc.	3,053
Community Care of Central Wisconsin	2,671
NorthernBridges	1,855
Southwest Family Care Alliance	1,718
Lakeland Care District	1,627
Community Health Partnership, Inc.	1,115
Unknown	165
Total	28,885

Under a federal waiver, DHS is required to offer a fee-for-service alternative to Family Care applicants.

DHS is required under a waiver from the federal government to offer a fee-for-service alternative to applicants seeking home and community-based long-term care. Therefore, in July 2008 it created the Include, Respect, I Self-Direct (IRIS) program, which allows enrollees to manage their own long-term care services with monthly funding in an amount established by DHS, based in part on the severity of their needs as measured by the functional screen assessment. DHS contracts with a private nonprofit organization—The Management Group, Inc.—to assist IRIS participants in developing their care plans, and with another private nonprofit organization—the Milwaukee Center for Independence—for assistance in claims processing and ensuring that payments are made only for services specified in a care plan.

Program Participants and Care Provided

Table 3 provides demographic information on program participants in June 2010. The majority were white and female; 52.5 percent were between the ages of 18 and 64 and 47.5 percent were 65 and older; and most were either developmentally or physically disabled.

Table 3
Characteristics of Family Care Participants
 June 2010

Description	Number	Percentage	Description	Number	Percentage
Age			Level of Care		
18-25	2,168	7.5%	Comprehensive	27,980	96.8%
26-44	4,971	17.2	Intermediate	739	2.6
45-64	8,025	27.8	Unknown	166	0.6
65-74	4,547	15.7	Total	28,885	100.0%
75-84	4,739	16.4	Participant Type		
85 and Over	4,435	15.4	Developmentally Disabled	11,905	41.2%
Total	28,885	100.0%	Physically Disabled	9,548	33.0
Gender			Frail Elderly	7,323	25.4
Female	17,381	60.2%	Unknown	109	0.4
Male	11,504	39.8	Total	28,885	100.0%
Total	28,885	100.0%	County of Residence		
Race or Ethnicity			Milwaukee	8,284	28.7%
White	20,324	70.4%	La Crosse	1,951	6.7
African American	3,382	11.7	Waukesha	1,272	4.4
Hispanic/Latino	750	2.6	Fond du Lac	1,120	3.9
Asian/Pacific Islander	386	1.3	Kenosha	1,083	3.8
American Indian	148	0.5	Racine	978	3.4
Other	76	0.3	Other	14,197	49.1
Unknown	3,819	13.2	Total	28,885	100.0%
Total	28,885	100.0%			

Nearly 60 percent of Family Care participants resided in their own homes in June 2010.

As shown in Table 4, 59.1 percent of participants resided in their own homes in June 2010. The remainder received residential services or short-term institutional care while, for example, recuperating in a nursing home from surgery or receiving care for health issues that could not be adequately treated elsewhere. Residential services are provided in:

- community-based residential facilities, where five or more participants reside in a group home–like setting;
- adult family homes, where up to four participants may reside; and
- residential care apartment complexes, where five or more participants reside in separate apartments, each with its own entrance, kitchen, bedroom, and living room.

Table 4
Residential Arrangements of Family Care Participants
June 2010

	Number	Percentage
Home	17,095	59.1%
Residential Services		
Community-Based Residential Facility	5,507	19.1
Adult Family Home	3,934	13.6
Residential Care Apartment Complex	744	2.6
Subtotal	10,185	35.3
Institutional Care		
	1,605	5.6
Total	28,885	100.0%

DHS licenses three- and four-bed adult family homes, community-based residential facilities, and residential care apartment complexes. Licensing is not required for one- and two-bedroom adult family homes, but they are required to be certified by MCOs. The number and percentage of developmentally disabled, physically disabled, and frail elderly participants in each residential arrangement are shown in Appendix 3.

Nearly all Family Care participants receive care management services provided by MCO staff. As shown in Table 5, more than one-third of participants in June 2010 received medical supplies and equipment and assistance with daily activities, such as bathing, eating, and walking, while more than one-quarter received specialized transportation. Appendix 4 shows the number and percentage of developmentally disabled, physically disabled, and frail elderly participants who received various health and supportive services in June 2010.

Table 5
Health and Supportive Services Provided to Family Care Participants
June 2010

Service	Participants	Percentage
Care Management	27,662	95.8%
Medical Supplies and Equipment	12,786	44.3
Assistance with Daily Living Activities	11,221	38.8
Specialized Transportation	9,037	31.3
Financial Management	6,564	22.7
Employment Services	5,042	17.5
Day Center Services	3,483	12.1
Meal Services	2,578	8.9
Home Health Care	1,961	6.8
Counseling and Therapy	1,935	6.7
Adult Day Care	1,336	4.6
Respite Care	1,084	3.8
Other ¹	890	3.1
Skilled Nursing Services	644	2.2
Recreational Activities	278	1.0
Day Treatment—Medical	49	0.2

¹ Includes consumer education, energy and housing assistance, health screening, and other allowable services.

In October 2010, 8,464 individuals were waiting to receive Family Care benefits in 47 counties.

Statutes governing Family Care entitle all eligible individuals within a participating county to receive program benefits 36 months after the start of county participation. Because the number of individuals who would like to enroll in Family Care can be large, waiting lists are established until all who are interested can be enrolled. As of October 2010, 8,464 individuals were waiting to receive Family Care benefits in 47 counties in which the program was operating at that time, including 3,585 developmentally or physically disabled individuals in Milwaukee County. Individuals on waiting lists receive long-term care services under the Medical Assistance fee-for-service program. In counties that do not participate in Family Care, home and community-based long-term care services are provided through the CIP and COP Medical Assistance waiver programs to the extent funding is available.

During FY 2009-10, 3,756 participants were disenrolled from the Family Care program, including 2,162, or 57.6 percent, who died during the year. The remaining 1,594 participants were disenrolled for some other reason. During our audit period, neither ADRCs nor MCOs tracked reasons for disenrollment other than death.

DHS Expenditures and Staffing

In June 2010, nine MCOs provided care to 28,885 participants.

As shown in Table 6, the program expanded from 7 counties and six MCOs providing care for 11,344 participants in June 2007 to 53 counties and nine MCOs providing care for 28,885 participants in June 2010.

Table 6

Program Expansion

	June 2007	June 2008	June 2009	June 2010
Participating MCOs	6	8	9	9
Participating Counties	7	14	38	53
Program Participants	11,344	13,950	22,998	28,885

DHS expenditures for the Family Care program increased from \$248.4 million in FY 2005-06 to \$936.4 million in FY 2009-10, or by 277.0 percent over the five-year period shown in Table 7. Federal support increased from 55.9 percent of program costs in FY 2005-06

to 68.9 percent in FY 2009-10, primarily because of \$90.9 million in additional Medical Assistance funding received in FY 2009-10 under the federal American Recovery and Reinvestment Act of 2009. These funds are available through June 2011. Program revenue includes payments from counties that participate in the Family Care program, as required by statutes. Appendix 5 shows county contributions for FY 2009-10.

Table 7

DHS Expenditures by Funding Source¹
(in millions)

	FY 2005-06		FY 2009-10	
	Amount	Percentage	Amount	Percentage
Federal Revenue	\$138.8	55.9%	\$645.0	68.9%
General Purpose Revenue	109.5	44.1	249.1	26.6
Program Revenue ²	0.1	<0.1	42.3	4.5
Total	\$248.4	100.0%	\$936.4	100.0%

¹ Primarily payments to MCOs for program services and administration. Does not reflect MCO expenditures.

² Includes required contributions from counties based on a percentage of their spending for long-term care services before Family Care implementation.

***Under Family Care's
capitation system, MCOs
assume some financial risk
if costs exceed revenues.***

The majority of DHS expenditures represent payments to MCOs in fixed monthly amounts that are the same for each enrolled participant. Under the economic model by which MCOs operate, these capitation payments may exceed the cost of providing services to some participants and be less than the cost of providing services for others, but MCOs assume the financial risk of service costs exceeding their revenues from DHS.

DHS is required to follow guidelines established by the federal Centers for Medicare and Medicaid Services to calculate Family Care capitation rates, and since 2006 it has contracted with a private accounting firm—PricewaterhouseCoopers, LLP—to do so each year and to verify that the rates are actuarially sound. Separate rates are calculated for each MCO, and rates differ for comprehensive and intermediate levels of care.

We interviewed staff from PricewaterhouseCoopers and DHS who are responsible for calculating the capitation rates and reviewed

their data sources and methodology for 2010 rates. In that year, the capitation rate for the comprehensive level of care was calculated using information from a number of sources, but primarily:

- the most recently available functional characteristics of all Family Care participants as contained in the functional screen assessments prepared for each participant; and
- actual 2008 service expenditures reported by the five pilot counties, adjusted for inflation to reflect 2010 costs.

The monthly capitation rates established by DHS vary by MCO and level of care.

As shown in Table 8, 2010 monthly capitation rates for comprehensive care varied from \$3,542 per participant enrolled in Community Care, Inc., in Milwaukee County to \$2,627 per participant enrolled in Lakeland Care District. Monthly capitation rates for intermediate care varied between \$627 and \$681. Five-year trends in capitation rates for comprehensive care are shown in Appendix 6.

Table 8

**Monthly Capitation Rates
2010**

Managed Care Organization	Comprehensive Level of Care	Intermediate Level of Care
Care Wisconsin First, Inc.	\$3,305	\$672
Community Care of Central Wisconsin	3,041	655
Community Care, Inc.		
Kenosha and Racine counties	3,225	642
Milwaukee County	3,542	642
Ozaukee, Sheboygan, Walworth, Washington, and Waukesha Counties	3,114	642
Calumet, Outagamie, and Waupaca ¹ Counties	3,481	642
Community Health Partnership, Inc.	3,391	672
Lakeland Care District	2,627	646
Milwaukee County Department of Family Care	2,689	665
NorthernBridges	3,088	672
Southwest Family Care Alliance	2,885	681
Western Wisconsin Cares	2,783	627

¹ Began providing Family Care Services in July 2010

As shown in Table 9, payments to MCOs have accounted for more than 90 percent of DHS program expenditures during the period we reviewed. In FY 2009-10, they included:

- \$851.3 million in capitation payments;
- \$29.0 million in risk-sharing payments, which are additional payments related to program expansion that are made to assist new MCOs or those beginning to provide services in additional counties; and
- \$12.1 million in adjustments to capitation rates, such as supplemental payments for participants with high-cost medical needs.

Table 9

DHS Expenditures by Type
(in millions)

	FY 2005-06		FY 2009-10	
	Amount	Percentage	Amount	Percentage
MCO Contract Services	\$230.8	92.9%	\$892.4	95.3%
ADRC Contract Services ¹	13.1	5.3	34.9	3.7
DHS Administration	4.5	1.8	9.1	1.0
Total	\$248.4	100.0%	\$936.4	100.0%

¹ Includes payments related to eligibility determination for the Family Care program and other available long-term care programs and for providing information on long-term care services.

In FY 2009-10, expenditures for ADRC contract services funded functional eligibility determinations for participants in all available long-term care programs, including Family Care, as well as advice and counseling provided to those seeking information on long-term care options.

Approximately 71 FTE state and private employees administer the Family Care program at the state level.

Expenditures for DHS administration in FY 2009-10 include staffing costs related to 55.85 full-time equivalent (FTE) state staff positions and 15.55 FTE positions staffed by three contractors. In addition, DHS paid:

- \$2.3 million to MetaStar, Inc., a health care consulting firm, for external quality reviews that are required under the federal waivers allowing operation of the Family Care program;
- \$577,200 to Hewlett Packard Enterprise Services for information technology services;
- \$563,100 to Disability Rights Wisconsin for Family Care ombudsman services such as mediation, investigating participants' complaints about the program, and assisting Family Care and IRIS participants in filing appeals; and
- \$451,500 to PricewaterhouseCoopers for actuarial and other related services.

Fee-for-service expenditures for Family Care participants totaled \$80.0 million in FY 2009-10.

Program participants make co-payments for some of the services they receive and the State incurs Medical Assistance costs for services provided on a fee-for-service basis, including prescription drugs and certain acute care services, such as inpatient and outpatient hospital stays and emergency room visits. As shown in Table 10, fee-for-service expenditures for Family Care participants totaled \$80.0 million in FY 2009-10, including \$37.3 million for inpatient and outpatient hospital care and \$22.4 million in prescription drugs.

Table 10

Fee-for-Service Expenditures for Family Care Participants
 FY 2009-10
 (in millions)

	Amount	Participants ¹
Inpatient and Outpatient Care	\$37.3	19,407
Prescription Drugs	22.4	20,713
Physicians, Clinics, and Other Professional Services	17.9	28,199
Dental Services	2.4	10,183
Total	\$80.0	

¹ Includes the number of Family Care participants who received a service in a category at any point in the year. Some participants received services in more than one category.

MCO Expenditures and Financial Stability ■

Operating deficits reported by MCOs during expansion of Family Care have raised concerns about the program's financial stability, including whether the MCOs receive adequate funding and whether the expansion of the program is cost-neutral, as required by s. 49.281(1g)(b), Wis. Stats. To address these concerns, we analyzed spending on program services and administrative costs; the methods DHS uses to calculate its payments to MCOs, including supplemental funding; and the MCOs' financial solvency.

Service Expenditures

MCOs spent \$932.1 million to provide long-term care services to Family Care participants in FY 2009-10.

As shown in Table 11, MCOs reported spending \$932.1 million to provide services to Family Care participants in FY 2009-10. That amount exceeds the \$892.4 million paid by DHS, in part because it includes participants' co-payments for certain services.

Contracts with DHS stipulate that MCOs' payments to providers cannot exceed Medical Assistance fee-for-service rates. However, Medical Assistance has not established fee-for-service rates for some services available under Family Care, including residential services. MCOs negotiate their payments for those services with providers.

Table 11

Expenditures for Family Care Services by MCO
 FY 2009-10
 (in millions)

Managed Care Organization	Amount ¹	Percentage
Milwaukee County Department of Family Care	\$225.3	24.2%
Community Care, Inc.	185.6	19.9
Care Wisconsin First, Inc.	121.8	13.1
Western Wisconsin Cares	102.0	10.9
Community Care of Central Wisconsin	93.2	10.0
NorthernBridges	67.4	7.2
Community Health Partnership, Inc.	52.8	5.7
Southwest Family Care Alliance	46.1	4.9
Lakeland Care District	37.9	4.1
Total	\$932.1	100.0%

¹ Includes participants' co-payments for services, and certain other adjustments.

As shown in Table 12, 55.7 percent of MCOs' FY 2009-10 expenditures were for health and supportive services, including care in their own homes that was provided to 59.1 percent of program participants. Residential services represented 44.3 percent of total expenditures, and community-based residential facilities represented the single largest expenditure.

DHS is planning to establish uniform rates for residential services to program participants.

The rate-setting process for residential services is therefore an important component of Family Care funding. Under the CIP and COP waiver programs, payment rates for residential care varied by county, but DHS is planning to establish uniform residential rates for Family Care participants with similar needs within and across counties. Under DHS's most recent proposal, which was developed in 2010, residential care rates would increase for five MCOs and be reduced for the other four. For example, Lakeland Care District would be required to pay residential care providers an average of \$7 more per day, which would be a 7.4 percent increase to its current daily rate, while Community Health Partnership would be required to pay an average of \$26 less, which would reduce its current daily rates by 15.6 percent. Average daily rates for all adult family homes would be reduced by \$5 per day, while daily rates for other residential care providers would increase. DHS indicated the final rates may differ from those that it has proposed.

Table 12

Expenditures for Family Care Services by Type
 FY 2009-10
 (in millions)

Service	Amount	Percentage of Total
Residential Services		
Community-Based Residential Facility	\$192.2	20.6%
Adult Family Home	190.7	20.5
Residential Care Apartment Complex	29.6	3.2
Subtotal	412.5	44.3
Health and Supportive Services		
Assistance with Daily Living Activities	140.6	15.0
Care Management	110.8	11.8
Nursing Homes and Other Institutional Care	82.7	8.9
Day Center Services	37.6	4.0
Home Health Care	31.7	3.4
Employment Services	31.1	3.3
Specialized Transportation	23.9	2.6
Medical Supplies and Equipment	19.7	2.1
Adult Day Care	13.2	1.4
Meal Services	6.2	0.7
Respite Care	6.1	0.7
Counseling and Therapy	5.4	0.6
Financial Management	5.1	0.6
Skilled Nursing Services	3.3	0.4
Day Treatment—Medical	0.7	0.1
Recreational Activities	0.4	<0.1
Other ¹	1.1	0.1
Subtotal	519.6	55.7
Total	\$932.1	100.0%

¹ Includes consumer education, energy and housing assistance, health screening, and other allowable services.

The proposed rate-setting methodology has become controversial.

The proposed residential rate-setting methodology has become controversial because, for example, it will either limit the ability of some MCOs to negotiate lower rates with providers or prevent them from paying higher rates to address participants' specific care needs.

Some MCOs have also asserted they need flexibility to pay higher rates for participants who require significant supervision, and the proposed rates may disproportionately affect adult family home providers who typically care for participants with those needs.

The proposed methodology's effect on the Family Care program—including the ability or willingness of providers to accept the rates that are offered—is not clear. No specific date has yet been established for implementation. However, if DHS chooses to implement a uniform rate-setting methodology, it will need to closely monitor both that appropriate services continue to be provided to participants and that program costs are appropriately controlled.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on the status of its proposed changes to the provider residential rate-setting methodology.

Administrative Expenditures

MCOs' administrative costs more than tripled from 2006 to 2010.

As shown in Table 13, MCOs' expenditures related to management and staffing costs, supplies and services, rent and facilities costs, and other administrative costs more than tripled over the past five years, from \$16.0 million in 2006 to \$53.2 million in 2010. Appendices 7 and 8 provide additional information on administrative and other expenditures in 2009 and 2010.

As shown in Table 14, expenditures for the salaries and fringe benefits of executive, administrative, and care management staff who coordinate the delivery of services to Family Care participants represented 57.2 percent of total administrative expenditures.

Table 13

Administrative Expenditures by MCO

Managed Care Organization	2006	2007	2008	2009	2010 ¹
Care Wisconsin First, Inc.	–	–	\$ 3,175,100	\$ 8,414,800	\$ 8,530,800
Community Care of Central Wisconsin	\$ 1,007,800	\$ 783,500	2,668,300	4,690,600	4,685,700
Community Care, Inc.	–	2,706,800	4,001,500	6,306,600	8,824,100
Community Health Partnership, Inc.	–	–	822,300	2,359,400	2,385,100
Lakeland Care District	1,633,500	1,596,200	1,753,300	1,888,600	3,695,800
Milwaukee County Department of Family Care	11,404,000	7,567,800	7,032,200	8,570,100	13,355,500
NorthernBridges	–	–	–	2,470,900	3,476,000
Southwest Family Care Alliance	746,000	747,300	1,113,100	2,640,000	3,367,900
Western Wisconsin Cares	1,214,900	1,545,700	2,641,800	4,144,500	4,858,900
Total	\$16,006,200	\$14,947,300	\$23,207,600	\$41,485,500	\$53,179,800

¹ Based on unaudited financial statements.

Table 14

MCO Administrative Expenditures by Type¹
2010

Type	Amount	Percentage
Salaries and Fringe Benefits	\$30,437,200	57.2%
Third-Party Administrators	5,822,200	10.9
Other Professional Services	2,319,300	4.4
Rent	1,958,600	3.7
Contracted IT Development	1,230,300	2.3
Other Contracted Services	743,000	1.4
Other	10,669,200	20.1
Total	\$53,179,800	100.0%

¹ Based on unaudited financial statements.

In four cases, executive salaries exceeded \$200,000, excluding fringe benefits.

We obtained the 2010 annualized salaries of MCO staff, including executives, managers, and care management staff and excluding fringe benefit costs. As shown in Table 15, the salaries of chief executive officers or directors of the MCOs varied considerably, but in two cases exceeded \$200,000, excluding fringe benefits. The two highest-paid chief executives also administer smaller state- and federally funded long-term care programs, and at one of those firms the chief financial officer and the chief operating officer each were also paid more than \$200,000 annually. We found that for other managerial staff—excluding those with care management responsibilities—salaries ranged from an average of \$67,500 for three individuals at the Milwaukee County Department of Family Care to an average of \$55,600 for four individuals at Southwest Family Care Alliance.

Table 15

**Salaries for MCO Executives
2010**

Managed Care Organization	Chief Executive Officer or Director	Chief Financial Officer	Chief Operating Officer
Community Care, Inc.	\$323,300 ¹	\$230,000	\$260,000
Care Wisconsin First, Inc.	247,000 ¹	170,000	186,100
Community Health Partnership, Inc.	182,000 ¹	131,900	98,000
NorthernBridges	145,000	85,000	–
Community Care of Central Wisconsin	130,000	108,000	108,000
Southwest Family Care Alliance	114,500	90,700	85,600
Lakeland Care District	110,400	98,000	81,400
Western Wisconsin Cares	107,300	94,400	87,300
Milwaukee County Department of Family Care ²	95,300	–	–

¹ Includes amounts charged to Family Care and two other long-term care programs.

² Milwaukee County Department of Family Care contracts with a private organization for chief financial officer and chief operating officer duties, and that entity declined to provide us with specific salary information.

Salaries for nurse care managers, who are responsible for assessing and monitoring the health of Family Care participants and determining the medical effectiveness of authorized services, ranged from an average of \$70,300 for 7 staff at the Milwaukee County Department of Family Care to \$45,900 for 36 staff at Southwest Family Care Alliance.

As shown in Table 16, the average caseload for nurse care managers varied significantly among the eight MCOs that rely primarily on their own staff to perform care management functions. One reason for that variation may be differences in their definitions of the optimal caseload for nurse care managers. For example, the Lakeland Care District attempts to maintain a caseload of approximately 50 participants per nurse care manager, while other MCOs have established caseloads of approximately 80 participants per nurse care manager.

Table 16

Caseloads of Employees with Care Management Responsibilities¹
June 2010

Managed Care Organization	Nurse Care Managers		Social Service Coordinators	
	Number	Average Caseload	Number	Average Caseload
Care Wisconsin First, Inc.	40	76.3	79	38.6
Community Care of Central Wisconsin	47	56.8	77	34.7
Community Care, Inc.	78	76.0	133	44.6
Community Health Partnership, Inc.	12	92.9	25	44.6
Lakeland Care District	44	37.0	48	33.9
NorthernBridges	25	74.2	45	41.2
Southwest Family Care Alliance	36	47.7	32	53.7
Western Wisconsin Cares	45	73.0	85	38.6

¹ Excludes Milwaukee County Department of Family Care, which contracts for most of its care management functions.

Milwaukee County contracts with 26 social service organizations for most care management functions.

Five of the eight MCOs seek to maintain an average caseload of approximately 40 participants per social service coordinator. Their actual caseloads for June 2010 averaged from 33.9 participants per coordinator at Lakeland Care District to 53.7 participants per coordinator at Southwest Family Care Alliance. Salaries for social service coordinators, who are responsible for assessing the social needs of participants and developing participants' care plans, ranged from an average of \$53,200 for 7 staff at the Milwaukee County Department of Family Care to \$41,000 for 79 staff at Care Wisconsin First. Because Milwaukee County contracts with 26 social service organizations for most of its care management functions, its average caseloads and staffing levels are not shown in Table 16.

Caseload variation for care management functions raises questions about the MCOs’ allocation of resources, the adequacy of service coordination, and their ability to properly control costs. Given the large disparity, additional attention is warranted.

☑ Recommendation

We recommend the Department of Health Services review caseloads of managed care organization staff and report to the Joint Legislative Audit Committee by September 1, 2011, on its efforts to ensure that caseloads are appropriate.

Adequacy of Capitation Payments

The financial statements each MCO is required to submit to DHS each year generally show improvements in their financial conditions from 2009 to 2010. As shown in Table 17, five MCOs reported surpluses in 2010 after running deficits during 2009; however, three MCOs continued to report deficits, including Community Care, Inc., which reported the largest deficit of \$3.8 million.

Table 17

Family Care MCOs’ Total Operating Surplus or Deficit

Managed Care Organization	December 2009 ¹	December 2010 ²
Care Wisconsin First, Inc.	\$ (2,756,600)	\$ 780,100
Community Care, Inc.	(4,277,900)	(3,750,800)
Community Care of Central Wisconsin	(2,286,700)	444,800
Community Health Partnership, Inc.	(4,617,800)	13,800
Lakeland Care District	(1,775,300)	(833,700)
Milwaukee County Department of Family Care	201,400	2,786,800
NorthernBridges	(603,600)	(631,400)
Southwest Family Care Alliance	(680,200)	4,635,200
Western Wisconsin Cares	(1,269,900)	4,790,900
Total	\$(18,066,600)	\$8,235,700

¹ Based on audited financial statements, except for Lakeland.

² Based on unaudited financial statements.

Because it takes time to develop effective management of participant services, DHS expects MCOs will initially operate in a deficit situation.

Reported deficits do not necessarily mean that MCOs will be unable to operate over the long term. In fact, DHS expects those with more limited Family Care experience to initially report operating deficits because it takes time to develop strategies for identifying unnecessary or undesired participant services, reducing service costs by negotiating lower rates with providers, and identifying administrative efficiencies. Moreover, the capitation payments from DHS are based on program expenditures in counties that are experienced in administering Family Care, and DHS financial staff indicated it takes up to three years for new MCOs' expenditures to be consistent with that experience. Finally, MCOs are able to maintain their operations by borrowing funds through lines of credit they maintain with financial institutions, transferring surpluses from other programs they operate, and using reserve funds, as well as through capitation rate adjustments provided by DHS to help them fund program expansion or care provided to participants with high-cost needs.

Continuing deficits have, however, raised concerns about long-term fiscal sustainability, and in 2010 DHS contracted with APS Healthcare—a consulting firm—to assess certain financial elements of the program, including whether MCOs may need more than three years to align their expenditures with available resources. In February 2011, the consulting firm reported that DHS may need to provide newer MCOs with up to five years of additional payments for risk-sharing, as well as other capitation adjustments to ensure their financial stability, primarily because the participants they serve are sufficiently different from those in pilot counties and typically have more costly care needs.

To evaluate whether the spending patterns of new MCOs differ from those operating in the five pilot counties, we analyzed average monthly expenditures per participant. As shown in Table 18, the four newest MCOs had the highest average monthly expenditures per participant receiving comprehensive care. Community Health Partnership, which is included in the group, had significantly higher average monthly expenditures per participant than any other MCO, in part because it serves a large number of individuals who are developmentally disabled and who typically have more costly care needs.

Table 18

**Average Monthly Expenditures per Participant Receiving Comprehensive Level of Care
FY 2009-10**

Managed Care Organization	Average Monthly Expenditures	Years Administering Family Care
Community Health Partnership, Inc.	\$4,100	2.0
NorthernBridges	3,100	1.1
Care Wisconsin First, Inc.	3,100	2.3
Community Care, Inc.	3,100	3.4
Community Care of Central Wisconsin	2,800	10.2
Overall Average	2,800	
Southwest Family Care Alliance	2,600	9.4
Western Wisconsin Cares	2,500	10.2
Lakeland Care District	2,400	10.3
Milwaukee County Department of Family Care	2,400	9.9

The number of developmentally disabled participants with higher-cost needs has increased significantly since June 2006.

As shown in Table 19, average monthly expenditures for developmentally disabled participants significantly exceeded those for elderly and physically disabled participants. Individual MCOs spent from \$2,900 to \$4,600 per participant per month to provide care for the developmentally disabled, compared to \$1,800 to \$2,800 per participant per month for care for the physically disabled and elderly. Because the Family Care managed care funding model depends on the ability of MCOs to offset expenditures for higher-cost participants with unspent capitation payments for participants with less-expensive care needs, MCOs contend that substantial increases in the number of participants with higher-cost needs have resulted in capitation amounts that are insufficient. For example, the number of developmentally disabled participants has increased substantially over the past five years, from 1,779 individuals and 17.8 percent of the total caseload in June 2006 to 11,905 individuals and 41.2 percent of the total caseload in June 2010.

Table 19

Average Monthly Expenditures by Participant Type¹
FY 2009-10

Managed Care Organization	Developmentally Disabled	Physically Disabled	Frail Elderly
Community Health Partnership, Inc.	\$4,600	\$2,800	\$2,700
Milwaukee County Department of Family Care	3,900	2,200	2,100
NorthernBridges	3,800	2,800	2,300
Community Care, Inc.	3,700	2,400	2,200
Care Wisconsin First, Inc.	3,700	2,500	2,000
Community Care of Central Wisconsin	3,400	2,400	2,200
Western Wisconsin Cares	3,300	1,800	1,900
Lakeland Care District	3,000	2,000	1,900
Southwest Family Care Alliance	2,900	2,400	2,300
Program Average	3,600	2,300	2,100

¹ Average monthly expenditures per participant receiving comprehensive level of care.

In FY 2009-10, high-cost participants represented 16.9 percent of MCOs' caseloads.

As shown in Table 20, 16.9 percent of the 31,117 individuals who received Family Care benefits in FY 2009-10 were “high-cost” participants, based on the \$4,500 average monthly service cost threshold DHS used in its analysis of participant costs. The caseload of Community Health Partnership, a newer MCO that serves western Wisconsin, included the largest percentage of high-cost participants. The Milwaukee County Department of Family Care had the smallest percentage of high-cost participants. Individuals with developmental disabilities represented 74.2 percent of high-cost Family Care participants in FY 2009-10.

Table 20

**High-Cost Participants as a Percentage of Caseload
FY 2009-10**

Managed Care Organization	High-Cost Participants ¹	Family Care Participants	Percentage
Community Health Partnership, Inc.	386	1,119	34.5%
Community Care, Inc.	1,414	6,390	22.1
Care Wisconsin First, Inc.	695	3,344	20.8
NorthernBridges	376	2,007	18.7
Community Care of Central Wisconsin	468	2,847	16.4
Southwest Family Care Alliance	270	1,754	15.4
Lakeland Care District	261	1,722	15.2
Western Wisconsin Cares	517	3,465	14.9
Milwaukee County Department of Family Care	867	8,469	10.2
Total	5,254	31,117	16.9

¹ Participants whose service costs averaged \$4,500 or more per month.

35 high-cost participants had average monthly costs of more than \$20,000.

Our review of paid claims for services indicated that in FY 2009-10, 35 high-cost participants had average monthly claims costs of more than \$20,000, including 1 physically disabled individual with average claims costs of more than \$55,000 per month and 6 participants with average claims costs of more than \$30,000 per month. Of the 35 participants, 28 had developmental disabilities and 7 had physical disabilities; all typically had significant care needs. For example:

- all 35 participants received overnight care by a paid staff person;
- 24 participants received regular interventions for behavioral needs, including 13 participants who required five or more interventions per day from professional staff to prevent or limit violent or self-injurious behavior; and
- 10 participants were ventilator-dependent.

Table 21 shows care needs that are more frequently associated with high-cost participants. For example, in FY 2009-10, 68.4 percent of the 361 participants who needed three or more interventions per day to prevent or limit self-injurious behavior had high service costs.

Table 21

Care Needs Associated with High-Cost Participants¹
FY 2009-10

	All Family Care Participants with Specified Care Need or Condition ²	High-Cost Participants with Specified Care Need or Condition	High-Cost Participants as a Percentage of Those with Specified Care Need or Condition
Behavioral Care Needs			
Three or more interventions per day for self-injurious behaviors	361	247	68.4%
Three or more interventions per day for violent behaviors	652	425	65.2
Two to six interventions per week for self-injurious behaviors	905	554	61.2
Five or more daily interventions for behavioral needs	1,239	705	56.9
Other Care Needs or Conditions			
Ventilator dependent	51	29	56.9
No ability to communicate	1,916	979	51.1
Prader-Willi Syndrome	62	31	50.0
Tracheotomy	116	58	50.0

¹ Based on electronic functional screen assessment and paid claims data for Family Care participants maintained by DHS. High-cost participants are those whose service costs averaged \$4,500 or more per month.

² Participants may be included in more than one category because they may have more than one care need.

It is difficult to assess whether MCOs could better manage expenditures associated with high-cost participants.

It is difficult to assess whether MCOs could better manage expenditures associated with high-cost participants. For example, medical professionals may disagree on whether certain services are necessary or whether the most cost-effective or lowest-cost services were chosen. Nevertheless, DHS has acknowledged that the capitation amounts, including adjustments, do not fully fund services for certain high-cost participants. Therefore, beginning with 2010 capitation rates, DHS significantly changed its practice to first calculate a baseline rate for each of the three types of Family Care participants—developmentally disabled, physically disabled, and elderly—and then, using data from the functional screen assessments, to adjust that amount based on the costs associated with certain functional characteristics of the participants an MCO serves. Finally, a weighted average amount for each MCO is created using the three rates and the proportion of each type of participant the MCO serves.

Changes to the method used to calculate capitation rates were intended to provide fiscal relief to MCOs with large numbers of high-cost participants. However, disputes about the sufficiency of the rates will likely continue because DHS and some MCOs do not agree that changes to the capitation rates have been adequate. As a result, DHS has asked MCOs to provide it with documentation on the actual services provided to their high-cost participants. In its February 2011 report, APS Healthcare recommended that DHS continue to review its capitation rate calculation methods for high-cost participants and consider additional changes to the rate calculation methodology to better account for the costs of providing care to these participants.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on the status of its efforts to analyze whether additional adjustments to the Family Care capitation rates are needed.

Enhancing MCO Financial Solvency

For the program to remain sustainable, MCOs must be financially solvent and provide all necessary services at appropriate rates.

Managing long-term care can involve more financial risk for MCOs than providing other types of managed care because the population served will not, by definition, include a large number of individuals with limited service needs, and changes in participants' health or behavioral care needs can quickly and significantly affect MCOs' finances. Ensuring that MCOs are financially solvent and providing all necessary services at appropriate rates, taking steps to identify MCOs with significant financial risk, and making corrections are necessary to ensure the program remains sustainable.

DHS and OCI share responsibility for financial oversight of MCOs.

DHS provides financial oversight of MCOs in part by reviewing their audited financial statements on an annual basis. In addition, in recognition of the financial oversight needs of the rapidly expanding program, 2009 Wisconsin Act 28, the 2009-11 Biennial Budget Act, authorized 3.0 FTE financial examiner positions at the Office of the Commissioner of Insurance (OCI) to provide additional oversight of participating MCOs' financial operations and to help ensure consistency in the oversight of other managed care organizations. In January 2010, DHS and OCI finalized a memorandum of understanding granting OCI responsibility for ensuring that financial audits are conducted and assessing the insolvency risks of each Family Care MCO.

Since the program began, DHS 10.42, Wis. Adm. Code, has required MCOs to demonstrate financial solvency and stability as a condition of their annual recertification by DHS. Since June 2009, s. 648.05, Wis. Stats., has required MCOs to also obtain an annual permit from OCI that demonstrates they are managing their finances appropriately and can ensure they are able to continue to pay providers for all participants' services. DHS and OCI base their approvals on an annual review of business plans submitted by each MCO, including financial projections to demonstrate that an MCO can match its spending to projected revenue. Both agencies annually approve each MCO after verifying that its projections are calculated accurately and include reasonable assumptions.

To analyze Family Care MCOs, OCI has adapted two primary indicators of solvency that it uses in monitoring other health care organizations. The first is an analysis of net assets as recorded in the annual financial statements, which are a measurement of the difference between an MCO's total liabilities and total assets. This analysis is more comprehensive than analyzing a cash surplus or deficit because it includes all short and long-term liabilities and assets. As of December 2010, three MCOs had negative net assets:

- Community Health Partnership had negative net assets of \$6.0 million;
- Care Wisconsin First had negative net assets of \$2.3 million; and
- NorthernBridges had negative net assets of \$800,000.

OCI's second indicator is MCOs' maintenance of separate funds to protect against insolvency. Under its contract with DHS, each MCO must use its revenue from capitation payments to contribute to:

- a central solvency fund maintained by the Department of Administration, to which each MCO must make a one-time deposit of \$750,000 that can be used to fund the costs of transferring the responsibility of care of participants from an insolvent MCO to another MCO, if needed; and
- a restricted reserve fund, also to protect against insolvency, that is maintained by each MCO and ranges in size from \$1.4 million for Community Health Partnership to \$3.4 million for the Milwaukee County Department of Family Care.

As of December 2010, five MCOs owed a total of \$4.6 million to their reserve funds, and four MCOs owed a total of \$2.0 million to the State’s solvency fund.

As shown in Table 22, as of December 2010, five MCOs owed a total of \$4.6 million to their reserve funds, and four MCOs also owed a total of \$2.0 million to the solvency fund. Community Health Partnership, NorthernBridges, and Care Wisconsin First had shortages in both funds largely because their negative net assets prevented them from making contributions to either. Southwest Family Care Alliance’s shortages in both funds can be attributed in part to its recent expansion to several counties. OCI has worked with each of the four MCOs to establish contribution plans for full solvency fund deposits by FY 2011-12 and reports that it will work to establish similar plans for the restricted reserve.

Table 22
Amounts Owed by MCOs to Solvency and Reserve Funds
 December 2010

Managed Care Organization	Solvency Fund Amount Outstanding	Restricted Reserve Amount Outstanding	Total Amount Outstanding
Community Health Partnership, Inc.	\$ 750,000	\$1,131,400	\$1,881,400
Southwest Family Care Alliance	500,000	1,174,000	1,674,000
NorthernBridges	250,000	1,198,400	1,448,400
Care Wisconsin First, Inc.	500,000	563,400	1,063,400
Western Wisconsin Cares	0	489,300	489,300
Community Care, Inc.	0	0	0
Community Care of Central Wisconsin	0	0	0
Lakeland Care District	0	0	0
Milwaukee County Department of Family Care	0	0	0
Total	\$2,000,000	\$4,556,500	\$6,556,500

OCI has identified Care Wisconsin First, Community Health Partnership, and NorthernBridges as “financially hazardous,” its most serious classification for managed care organizations, because their ongoing negative net assets and difficulty in funding their reserves place them at greater risk for insolvency. For example, if a large number of new participants with costly health or behavioral care needs enroll, these MCOs may not have sufficient revenue to pay for participants’ services.

DHS established corrective action plans in late 2010 with Community Health Partnership and NorthernBridges to address certain management issues it identified as contributing to their financial losses. For example, Community Health Partnership's plan requires enhanced efforts to transfer participants to lower-cost residential services. We were also informed shortly before the publication of our report that Community Health Partnership would be subject to a heightened level of monitoring by DHS.

OCI states that it will make initial evaluations of the MCOs' progress in mid-2011. To further enhance oversight, OCI issued permits that require a review of their updated financial projections in June 2011. In 2010, an interagency workgroup was established by DHS and OCI to define the types of progressive sanctions it could use for MCOs that fail to comply with a corrective action plan, as well as the criteria for concluding that an MCO has become insolvent. The group's work remains ongoing.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on:

- *the solvency status of each Family Care managed care organization and the actions it has taken to address insolvency risks;*
- *the criteria established for identifying a managed care organization as insolvent; and*
- *the sanctions the Department of Health Services and the Office of the Commissioner of Insurance have developed for managed care organizations that do not comply with corrective action plans.*

Payment Processing and Program Integrity

Under their contracts with DHS, MCOs must pay at least 90 percent of all accurate and complete claims for authorized services within 30 days of receipt, and all accurate and complete claims within 180 days of receipt. DHS does not monitor the timeliness of claims payments, and the claims information it maintains was not sufficient for us to complete an independent analysis.

Claims for authorized services are generally paid promptly.

During our interviews with MCOs, advocacy groups, and providers, we identified only one instance of a significant delay in claims processing, which resulted from the actions of a third-party claims administrator. Care Wisconsin First is one of six MCOs that contract with third-party administrators for Family Care claims processing. In 2009, it contracted with a claims administrator that did not have experience with long-term care claims processing. DHS staff became aware of payment claims delays in January 2010 and developed a corrective action plan that established deadlines and identified claims that needed immediate attention. As of November 2010, DHS reported that claims submitted to Care Wisconsin First are being processed in a timely manner.

Improper Payments

DHS requires MCOs to prevent and identify improper or potentially fraudulent payments.

DHS requires MCOs to prevent and identify improper or potentially fraudulent payments, and each of the five we visited established internal controls to do so. For example, their contracts with providers define allowable types and amounts of service and deny payment for any unauthorized services. However, uniform controls have not been established.

DHS also requires quarterly reports identifying all potentially fraudulent payments, as well as the actions taken in those cases. The quarterly reports from FY 2005-06 through FY 2009-10 included nine instances of potentially improper payments reported by MCOs. For example:

- Community Care of Central Wisconsin reported that from 2008 through 2009, an employee of a supportive home care provider received \$36,400 for undelivered services; however, the provider reimbursed the full amount to the MCO and terminated employment of the responsible individual.
- Community Care, Inc., reported that from 2007 through 2009, an adult family home provider received at least \$16,000 by double-billing the MCO and a participant for room and board payments; however, the contract has been terminated, and reimbursement is being pursued.
- Care Wisconsin First reported that in 2008, a personal care provider received at least \$16,400 for services that were instead being provided by the participant's family. Provider reimbursements have been discontinued, but recovery of the improper payments has not been sought.

No reports of potentially fraudulent payments were filed by MCOs for the first six months of 2010. Given the rapid expansion of the Family Care program, the self-reported instances of potentially fraudulent payments continue to be important to help ensure that improper or potentially fraudulent payments are minimized.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on potentially fraudulent payments identified by managed care organizations in 2010.

■ ■ ■ ■

Care Planning ■

ADRCs and MCOs perform assessments that determine individuals' eligibility to participate in the Family Care program, the level of care participants receive, and particular services for which they are eligible. We analyzed the eligibility determination process and reviewed a random sample of health and social assessments and participant care plans to evaluate the timeliness, consistency, and completeness of care planning, as well as the appeals process available to individuals who believe they have been inappropriately denied eligibility or services.

Functional Eligibility Determination

A “functional screen” assessment tool is used to evaluate eligibility for Family Care services.

Federal rules governing Family Care require the entity that determines initial eligibility for program services to be separate from the entity responsible for service delivery so that financial interests do not inappropriately affect decisions related to participants' care needs. Since 2001, DHS has required ADRC staff to complete their initial assessment of applicants' needs for long-term care services using a Web-based screening tool it developed with the assistance of health care providers. This “functional screen” assessment tool has been approved by the federal Centers for Medicare and Medicaid Services.

Functional assessments are designed to collect information about participant demographics and care needs.

If an applicant is determined to be eligible, the assessment information is made available to the MCO that will arrange for and manage his or her services. Contracts with DHS require MCOs to complete a second functional assessment after a participant's enrollment if the initial assessment was conducted more than 12 months previously, or if staff want to include additional information not recorded in the initial assessment. At least every 12 months thereafter, MCOs are contractually required to assess each participant's ongoing functional eligibility.

The functional assessments performed by ADRCs and MCOs are designed to collect demographic information, as well as information about participants' particular health and social needs. They address:

- diagnoses of developmental or physical disabilities, frailties of aging, chronic and acute illnesses, and substance abuse;
- frequency and amount of assistance needed to manage wandering or violent behavior, administer and manage medications, and manage other clinical or behavioral conditions;
- need for and frequency of assistance with basic activities such as bathing, toileting, dressing, meal preparation and eating and the need for overnight care;
- ability to communicate and cognitive capacity;
- current and preferred living arrangements;
- employment status and need for assistance if working; and
- risk of abuse or neglect.

As shown in Table 23, the majority of Family Care participants were eligible for comprehensive care in both FY 2005-06 and FY 2009-10.

The care needs of participants vary widely.

As shown in Table 24, of the 30,425 participants assessed in FY 2009-10, those who were developmentally disabled were more likely to need assistance with tasks such as money and medication management, while those who were physically disabled and elderly were more likely to need assistance with mobility and physical tasks such as laundry.

Table 23

Family Care Participants' Level of Care¹
FY 2005-06 and FY 2009-10

	FY 2005-06		FY 2009-10	
	Number	Percentage	Number	Percentage
Comprehensive	13,153	97.6%	29,517	97.0%
Intermediate	320	2.4	908	3.0
Total	13,473	100.0%	30,425	100.0%

¹ Includes the level-of-care determination for only those participants screened during the fiscal year.

Table 24

Common Care Needs of Family Care Participants
FY 2009-10

Care Need	Developmentally Disabled		Physically Disabled		Frail Elderly	
	Number	Percentage	Number	Percentage	Number	Percentage
Money Management	11,859	97.9%	6,825	66.8%	6,805	84.0%
Transportation	11,759	97.1	9,200	90.1	7,798	96.3
Meal Preparation	11,365	93.9	9,545	93.4	7,836	96.7
Laundry	11,010	90.9	9,937	97.3	8,004	98.8
Medication Management	9,909	81.8	7,687	75.2	7,062	87.2
Bathing	8,680	71.7	8,055	78.8	6,982	86.2
Dressing	7,355	60.7	6,440	63.0	5,548	68.5
Overnight Care	7,461	61.6	4,021	39.4	4,246	52.4
Telephone Use	5,799	47.9	1,774	17.4	2,754	34.0
Eating	5,233	43.2	2,816	27.6	2,620	32.3
Use of Restroom	5,196	42.9	4,235	41.5	3,809	47.0
Mobility	2,499	20.6	4,125	40.4	3,539	43.7

We found that most functional eligibility determinations were made correctly within criteria established in administrative code.

To determine whether functional eligibility determinations are made correctly, we compared the results of all 30,425 functional screen assessments completed in FY 2009-10 with the functional eligibility criteria in DHS 10.33(2), Wis. Adm. Code, which identifies conditions that prevent individuals from safely or appropriately performing specified activities of daily living, such as bathing, dressing, and eating, are eligible for comprehensive care. We found that functional eligibility determinations were correct in most cases, but 87 participants who should have been found eligible for comprehensive care were instead found eligible for intermediate care. We did not find any instances of individuals being inappropriately denied services because of having been erroneously found ineligible for care under the Family Care program.

DHS has acknowledged that a variance exists between the eligibility criteria in administrative code and the rules encoded in the software for the electronic functional screen assessment. DHS indicated that in 2010, Disability Rights Wisconsin, an advocacy and ombudsman group for Family Care participants, raised concerns similar to our findings and that the agency is drafting administrative rules to reconcile the discrepancy.

3.0 percent of the care determinations we reviewed resulted in a decrease in the level of care.

As shown in Table 25, we also analyzed the extent to which level-of-care determinations made by ADRC staff were increased or decreased following the first functional assessment completed by MCO staff. We found relatively little change among all 9,304 participants whose first MCO assessment was completed in FY 2009-10. MCO staff identified more needs in 1.1 percent of participants, which increased the level of care available to 103 individuals, and they identified fewer needs in 3.0 percent of participants, which decreased the level of care available to 275 individuals. On average, 7.5 months elapsed between the two assessments.

Table 25

**Differences in Level-of-Care Determinations
FY 2009-10**

	Number	Percentage
Increased Following Assessment by MCO	103	1.1%
No Change	8,926	95.9
Decreased Following Assessment by MCO	275	3.0
Total	9,304	100.0%

Among the 275 participants whose level of care decreased, 35 were determined no longer eligible for program services based on their health care needs. Seven of those individuals had received services from Community Health Partnership; six had received services from Care Wisconsin First; and six had received services from Community Care, Inc.

As shown in Table 26, we also analyzed the extent to which level-of-care determinations changed between participants' first and second functional assessments by MCOs. We again found relatively little change. More needs were identified in 2.3 percent of participants, which increased the level of care available for 204 individuals, and fewer needs were identified for 1.9 percent of participants, which decreased the level of care available to 171 individuals. On average, 7.9 months elapsed between the two assessments.

Table 26

**Differences in Level-of-Care Determinations by MCOs
FY 2009-10**

	Number	Percentage
Increased from First to Second Assessment	204	2.3%
No Change	8,610	95.8
Decreased from First to Second Assessment	171	1.9
Total	8,985	100.0%

Of the 171 participants whose level of care decreased, 15 were determined no longer eligible for program services. Three of those individuals had received services from Community Care, Inc.; three had received services from Western Wisconsin Cares; and two had received services from the Milwaukee County Department of Family Care. As shown in Table 27, all but one of the nine MCOs had participants whose level of care decreased.

Table 27

Decreases in Ongoing Level-of-Care Determinations by MCO
FY 2009-10

Managed Care Organization	Participants with a Decreased Level of Care	Number of Assessments Completed	Percentage
Community Care of Central Wisconsin	44	1,557	2.8%
Western Wisconsin Cares	28	1,129	2.5
NorthernBridges	13	555	2.3
Community Health Partnership, Inc.	14	763	1.8
Southwest Family Care Alliance	9	499	1.8
Milwaukee County Department of Family Care	23	1,332	1.7
Community Care, Inc.	21	1,217	1.7
Care Wisconsin First, Inc.	19	1,760	1.1
Lakeland Care District	0	173	-
Total	171	8,985	1.9

DHS reported that it completes checks on at least a quarterly basis to identify potential instances of inappropriate or incorrect functional screen assessments by reviewing all results that are appealed by participants or their guardians. In addition, it reviews 30 functional assessments at two ADRCs each month to ensure “clinical consistency” throughout the program and requires ADRCs and MCOs to discuss any significant differences in the results of assessments that each performed within 90 days of the other.

Most functional screen assessments are completed on a timely basis.

We also analyzed whether MCOs were timely in completing their required annual functional screen assessments. As shown in Table 28, most were. However, completing 16 assessments took 16 months or more. One of the 16 was completed 23.6 months later than required, and another was completed 21.1 months later than required.

Monitoring of Certified Screeners

Staff who complete the functional screens are required to receive training and be tested.

Functional screen assessments should be complete and accurate because of their importance in determining program eligibility and developing care plans for participants, and because they can provide valuable data for analyzing and planning program services. DHS requires individuals who will administer these assessments to

Table 28

Timeliness of Most Recent Functional Screen Assessment¹
FY 2009-10

Months to Completion	Number	Percentage
Less than 3	6,300	23.9%
3 to 6	5,162	19.4
7 to 9	2,956	11.1
10 to 12	7,483	28.2
13 to 15	4,629	17.4
16 or more	16	<0.1
Total	26,546	100.0%

¹ Measured from the date of each participant's most recent functional screen assessment.

complete an online training course and score 80 percent or higher on a certification exam, and it requires certified screeners to have a registered nurse's license or a bachelor's degree, preferably in a health or human services field, as well as experience working with one of the three Family Care target populations. In addition, its contracts require that certified screeners complete continuing skills testing, which is also referred to as inter-rater reliability testing. However, DHS has no written policies that require testing on a regular basis, and it did not administer tests in 2006, 2008, and 2009.

We analyzed the results of a multiple-choice test DHS administered in 2010 and found that 153 certified screeners, including 4.7 percent of the 320 employed by ADRCs and 14.9 percent of the 928 employed by MCO staff, scored below 80 percent. Two of these individuals had not completed required remedial training, but they continued to administer functional assessment screens.

Recommendation

We recommend the Department of Health Services develop policies to administer assessment skills tests to all certified screeners at aging and disability resource centers and managed care organizations on a regular basis and report to the Joint Legislative Audit Committee by September 1, 2011, on these efforts.

Care Planning

DHS requires MCOs to schedule a face-to-face comprehensive health and social assessment within ten days of a new participant's enrollment. Nurse care managers assess existing health and behavioral conditions, health risks, and treatment needs and options, while social service coordinators complete assessments that address the participant's education, employment, caregivers, daily routine, and living situation.

DHS staff review all comprehensive assessment tools used by MCOs.

The comprehensive assessment is designed to collect sufficient information to identify each participant's preferences for social interaction and integration, necessary and desired health and social services, employment preferences, and preferred living situations, as well as the availability and stability of care that can be provided by friends, family members, and guardians. To avoid significant or arbitrary differences in the types and amounts of services provided, DHS requires MCOs to use a standard process to determine participants' desired health and social outcomes and to identify how services to meet those outcomes can be delivered in the most cost-effective manner. DHS staff review all assessment tools used by MCOs to ensure sufficient information is collected to best address participants' needs.

Section DHS 10.44(2)(j), Wis. Adm. Code., requires completion of a comprehensive assessment within 30 days of the participant's enrollment, and development of a care plan within 60 days of enrollment. However, in its 2010 contract with all MCOs, DHS extended the allowable time for completing assessments and care plans to within 90 days of enrollment, in part to improve assessment quality. DHS is currently drafting a revision to administrative code to reflect these extended time lines.

Participants may choose to have the MCO arrange all services included in their care plans, or they may choose to manage a specific, budgeted amount to purchase services from providers of their choice. In such cases of self-directed services, the MCO continues to provide care management services.

Participants may not receive some services they believe are necessary or desirable if care management staff question the effectiveness of those services.

It should be noted that participants may not receive all of the services they or their guardians believe are necessary, or that they would like to obtain, if care management staff do not believe those services to be the most effective for meeting participants' desired health and social outcomes. MCOs must, however, receive approval from either the participant or his or her guardian before implementing the care plan. Unless requested by the participant, DHS does not require MCO social service coordinators to include parents, adult children, or legal guardians in care planning discussions, but care management staff at the five MCOs we visited indicated that they regularly do so, particularly if cognitive or

speech impediments make it difficult to discern a participant's needs and desired outcomes. MCOs do not regularly include service providers in the care planning process, largely out of concern that providers may have a financial interest in advocating for specific goods or services.

MCOs are required to monitor participants' ongoing health and social well-being by conducting face-to-face visits at least quarterly and by updating both comprehensive assessments and care plans every six months, or more frequently if a participant's health or social needs change.

In most cases we reviewed, comprehensive assessments met the timeliness standards established by DHS.

We reviewed the most recent assessments and care plans for a random sample of 10 case files from each of the five MCOs we visited, including 15 case files for elderly participants, 20 case files for developmentally disabled participants, and 15 case files for physically disabled participants. We found that in all but three of these case files, comprehensive assessments had been completed every six months, as required. One assessment conducted by the Milwaukee County Department of Family Care exceeded the deadline by one month, and another exceeded the deadline by two months. One assessment conducted by Western Wisconsin Cares was completed 16 months later than required. In all but 2 of the 50 case files we reviewed, care plans had also been updated appropriately. However, the Milwaukee County Department of Family Care completed two plans two months later than required.

It does not appear from our review that delays in completing assessments or care plans negatively affected the care provided to participants. Moreover, although each of the MCOs used slightly different health and social assessment forms and care plan templates, all case files that we reviewed appeared to contain sufficient information about a participant's health and social needs and services, and they were typically completed in a thorough manner.

Each of the five MCOs we visited also employ staff specialists in areas such as rehabilitation and occupational therapy to help determine the appropriateness of service delivery decisions. Two MCOs—Community Care, Inc., and Western Wisconsin Cares—provide written guidelines to help social service coordinators determine the quantity of certain services, such as supportive home care services. Lakeland Care District has staff dedicated to creating a list of the lowest-cost providers of a given good or service, while Care Wisconsin First indicated that a committee reviews all service authorizations over \$2,000 to determine whether alternatives are available at a lower cost.

Nevertheless, assessing whether all services provided to Family Care participants are appropriate and necessary is difficult. Moreover, some service providers have raised concerns that they could potentially be sanctioned by state or federal regulators for not providing additional services that they believe a participant needs, but that have not been approved by an MCO. However, we did not identify any instances in which providers had been cited or fined.

Appeals

Participants may file appeals with three separate entities.

Family Care participants who believe an MCO has inappropriately denied, limited, reduced, or terminated authorized services; inappropriately determined that they are ineligible for program services; developed an unacceptable care plan; or calculated their co-payment amount incorrectly may file appeals with DHS, the Department of Administration’s Division of Hearings and Appeals, and the MCOs’ internal appeals committees required by contracts with DHS. A decision by the Division of Hearings and Appeals is accepted by DHS or the internal appeals committee as the final decision, but participants may pursue appeals with all three agencies simultaneously. Appeals must be filed within 45 days, and s. DHS 10.56, Wis. Adm. Code, requires MCOs to continue providing program services at the pre-appeal level to participants who request them pending outcome of the appeal.

From FY 2005-06 through FY 2009-10, participants filed 1,047 appeals related to eligibility, services, or care plans.

We analyzed all appeals filed with DHS and the Division of Hearings and Appeals from FY 2005-06 through FY 2009-10 and conducted a more limited analysis of appeals to MCOs, because of differences in how information is maintained. As shown in Table 29, from FY 2005-06 through FY 2009-10, participants filed 1,047 appeals, including 119 appeals of the same issue filed with both agencies.

Table 29

Appeals by Family Care Participants FY 2005-06 through FY 2009-10

Filed with	Number ¹
DHS	403
Division of Hearings and Appeals	644
Total	1,047

¹ Includes 119 cases that were appeals to both DHS and the Division of Hearings and Appeals.

As shown in Table 30, most appeals were related either to eligibility issues or to the provision of services, including service reduction, suspension, termination, or denial. The Milwaukee County Department of Family Care, which served 25.9 percent of all Family Care participants in FY 2009-10, accounted for 49.2 percent of 415 appeals filed in that year.

Table 30

Type of Participant Appeals Filed with State Agencies
FY 2005-06 through FY 2009-10

Appeal Type	Number ¹	Percentage
Eligibility Appeals		
Determination of co-payment	220	21.0%
Termination of eligibility	167	16.0
Denial of eligibility	81	7.7
Delay of eligibility	28	2.7
Recovery of incorrectly paid benefits	1	0.1
Subtotal	497	47.5
Service Appeals		
Reduction, suspension, or termination of services	212	20.2
Denial of services	135	12.9
Denial of payment of services	54	5.2
Failure to provide services in a timely manner	18	1.7
Limited authorization of services	16	1.5
Subtotal	435	41.5
Care Plan–Related Appeals		
Plan includes requirement to live in a location unacceptable to enrollee	18	1.7
Plan does not provide sufficient services	12	1.1
Plan requires acceptance of unwanted services	11	1.1
Plan requires acceptance of care, treatment, or support that is unnecessarily restrictive	1	0.1
Subtotal	42	4.0
Other²	73	7.0
Total	1,047	100.0%

¹ Includes 119 cases that were appeals to both DHS and the Division of Hearings and Appeals.

² Includes failure of MCOs to resolve appeals in a timely manner and miscellaneous complaints.

DHS and the Division of Hearings and Appeals use different methods to resolve disputes, and they report appeal outcomes differently. Outcomes of appeals reported by DHS include whether an MCO and participant were able to resolve their disagreement. Alternatively, outcomes of appeals to the Division of Hearings and Appeals include whether an administrative law judge decided in favor of an MCO, a participant, or whether the case was resolved through a compromise between the parties.

From FY 2005-06 through FY 2009-10, 403 appeals were filed with DHS.

As shown in Table 31, participants and MCOs agreed to a resolution in 187 of the appeals filed with DHS from FY 2005-06 through FY 2009-10, while no resolution was reached in 162 appeals and 4 were withdrawn. Data maintained by DHS did not contain the outcomes of 50 appeals.

Table 31

Outcome of Appeals Filed with DHS
FY 2005-06 through FY 2009-10

Outcome	Number	Percentage
Resolution agreed upon	187	46.4%
No resolution reached	162	40.2
Withdrawn by participant	4	1.0
Unknown	50	12.4
Total	403	100.0%

As shown in Table 32, 135 appeals filed with the Division of Hearings and Appeals were resolved in favor of the MCO, while 62 were decided in favor of participants, and participants abandoned or withdrew 341 appeals from FY 2005-06 through FY 2009-10.

Table 32

Outcomes of Appeals Filed with the Division of Hearings and Appeals
FY 2005-06 through FY 2009-10

Outcome	Number	Percentage
Appeal abandoned or withdrawn	341	53.0%
Decision in favor of MCO	135	21.0
Decision in favor of participant	62	9.6
Resolved through compromise	22	3.4
Unknown	84	13.0
Total	644	100.0%

In FY 2009-10, participants filed 316 appeals with MCOs' internal committees, including 140 filed with the Milwaukee County Department of Family Care. Participants withdrew 150 of those appeals, 99 were decided in favor of the MCO, and 54 were decided at least partly in favor of the participant. The outcomes of 13 appeals could not be determined from information maintained by the MCOs. DHS requires MCOs to decide all appeals they receive within 20 business days, although the deadline may be extended up to 30 business days if requested by the participant or if the MCO internal appeals committee determines that delaying a decision is in the participant's interest. Resolution of only 14 of the 316 appeals we reviewed took more than 45 business days.

We heard few complaints about the appeals process during the course of our fieldwork, which suggests it is working largely as intended. However, DHS could consider streamlining a process that allows simultaneous appeals to three different agencies. For example, participants could be required to bypass DHS and appeal directly to the Division of Hearings and Appeals, as is done for certain other public assistance programs, such as Wisconsin Works.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on options for streamlining the appeals process without adversely affecting participants' rights to a fair hearing.

Quality of Care ■

Statutes grant DHS broad authority to monitor the operations of MCOs and the quality and effectiveness of the services they provide, and to:

- create standards for their performance;
- evaluate compliance with those standards;
- create regional long-term care committees for the evaluation of both MCOs and ADRCs; and
- assist those committees in their evaluation efforts, in monitoring participant grievances and appeals, and in long-term planning for the Family Care program.

MCO Administrative Processes

A private contractor seeks to ensure that MCOs meet quality-of-care requirements.

Since 2002, DHS has contracted with a health care consulting firm—MetaStar—to complete annual reviews of MCOs' compliance with federal regulations and contract requirements for program administration. In FY 2009-10, MetaStar reviewed 129 regulations and requirements, including:

- 42 related to the options and processes for appealing decisions by MCOs;
- 32 related to the actions of MCOs in assisting participants in understanding their rights to services;

- 23 related to participants’ access to sufficient services for their health and social needs and their desired outcomes;
- 18 related to MCOs’ policies and procedures for delivering services and complying with contractual obligations; and
- 14 related to MCOs’ policies and procedures for maintaining and improving their quality of care.

MCOs complied with most of the 129 regulations and requirements the contractor assessed.

We reviewed MetaStar’s findings in each annual compliance review from FY 2005-06 through FY 2009-10. As shown in Table 33, MCOs fully met between 87.1 and 89.5 percent of all standards in each year we reviewed. However, MetaStar found that:

- in FY 2006-07, Western Wisconsin Cares did not meet its requirement to protect participants’ privacy rights because some care management staff included personally identifiable information in e-mail communications with participants;
- in FY 2008-09, Southwest Family Care Alliance did not have procedures in place to adequately monitor whether contracted care management staff were carrying out their responsibilities; and
- in FY 2009-10, NorthernBridges had not developed clinical guidelines to inform service providers of best practices for participant care.

Table 33

MetaStar Compliance Review Results

Fiscal Year	MCOs Reviewed ¹	Percentage of Standards Met	Percentage of Standards Partially Met	Percentage of Standards Not Met
2005-06	5	89.5%	7.7%	2.8%
2006-07	5	87.3	11.7	1.0
2007-08	6	88.3	11.6	0.1
2008-09	6	87.1	12.4	0.5
2009-10	9	87.3	11.9	0.8

¹ Includes reviews of MCOs that have been operating for at least one year.

MCOs generally completed all required care plans and authorized services in a timely manner.

MetaStar is also contractually required to analyze a random sample of case files to evaluate whether MCOs' care planning practices address participants' safety and health, identify their desired health and social outcomes, and make appropriate service authorizations. In its FY 2009-10 case file reviews, MetaStar found that care plans were generally completed and services were generally authorized in a timely manner, although some shortcomings were identified. For example:

- five MCOs did not include participants in final service decisions related to their care plans, as required;
- four MCOs required some participants to pay for covered services, such as supportive home care and medical supplies;
- four MCOs did not document care planning outcomes that clearly reflected participants' personal goals; and
- three MCOs did not always use the required comprehensive assessment tools to identify participants' needs.

We identified only one case in which an MCO did not meet a standard in more than one annual compliance review: the Milwaukee County Department of Family Care did not have procedures in place to ensure its care management decisions were consistent with its clinical practice guidelines in FY 2005-06 and FY 2006-07. However, MetaStar found that it had fully met the requirement by FY 2007-08.

Participant Outcomes

In 2000, a private contractor measured 14 outcomes related to participants' experience with Family Care.

DHS staff indicated that the primary purpose of Family Care services is to support participants in achieving personal health and social outcomes to achieve quality of life, and it has developed administrative code requiring the measurement of related outcomes. For example, from 2000 through 2005, DHS contracted with a private, nonprofit organization—the Council on Quality and Leadership—to measure 14 outcomes related to whether the program was protecting participants' health and safety, supporting positive personal experiences, and ensuring participants choose their own activities and living arrangements. Until the contract's termination in 2005, the Council conducted annual interviews with a statistically significant random sample of Family Care participants

or their guardians and also interviewed MCO staff to assess whether they had identified and provided appropriate services to achieve each outcome. As shown in Table 34, the Council's final interviews in FY 2004-05 found generally positive results. For example, 88.7 percent of participants reported that they felt safe, and MCO staff reported that they had provided appropriate services to protect participants' safety 86.3 percent of the time.

Table 34

Personal Outcomes and MCO Support¹
FY 2004-05

Outcome	Participants Reporting Outcome Was Met	Reported Support for Meeting This Outcome
I choose where and with whom to live.	72.3%	82.5%
I achieve my employment objectives.	77.1	78.7
I am satisfied with my services.	82.9	89.6
I choose my daily routine.	85.6	90.5
I have privacy.	90.1	90.0
I participate in the community.	62.3	72.7
I have personal dignity and respect.	84.9	88.8
I choose my services.	62.7	76.9
I have personal support networks.	82.5	91.1
I feel safe.	88.7	86.3
I am treated fairly.	76.7	85.6
I have the best possible health.	64.4	90.5
I am free from abuse and neglect.	92.1	84.1
I have continuity and security in my life.	68.8	79.0

¹ Based on a survey of 292 randomly sampled participants and their care management staff.

In 2006, DHS contracted with the University of Wisconsin's Center for Health Systems Research and Analysis to develop a new interview system—the Personal Experience Outcomes Integrated Interview and Evaluation System—that measures 12 outcomes adapted from those measured by the Council. After nearly four years of development and testing, DHS began using the new system in October 2010. Its methodology is similar to that developed by the Council, and the 12 personal outcomes it is designed to measure are shown in Appendix 9.

More than 80 percent of participants surveyed in 2009 expressed satisfaction with Family Care.

Although DHS did not formally evaluate the personal outcomes of Family Care participants during the period in which the new system was being developed, it has collected information on participants' satisfaction with their care management services through surveys conducted by the MCOs. In 2009, a statistically valid random sample of 3,606 Family Care participants responded to those surveys. As shown in Table 35, more than 80 percent agreed with each survey statement "always" or "most of the time." It should be noted, however, that the MCOs are allowed to use their own methods both for sampling participants and for conducting the surveys, which limits the consistency and usefulness of the data collected.

Table 35

**DHS Family Care Participant Satisfaction Survey Results¹
2009**

Survey Statement	Always or Most of the Time	Sometimes	Never or Almost Never
I am satisfied with the work my care team does for me.	94.1%	4.6%	1.3%
I participate in planning and making decisions about the services I will receive.	88.7	8.6	2.5
I would recommend this program to a friend.	90.9	6.1	3.0
My care manager listens to my concerns.	94.0	4.7	1.3
My nurse listens to my concerns.	94.9	3.5	1.3
I get help from my care manager when I need it.	93.2	5.1	1.6
I get help from my nurse when I need it.	93.4	4.6	1.6
My care manager talks to me so I can understand.	90.9	7.8	1.3
My nurse talks to me so I can understand.	91.8	4.8	1.3
I feel comfortable asking my care manager questions about my care.	92.4	5.6	1.9
I feel comfortable asking my nurse questions about my care.	92.7	5.1	1.8
I can select the people who help me with my personal care.	81.1	8.8	6.3
I am happy with the services I receive.	93.9	4.7	1.4
I get the equipment or additional help that I need in a timely manner.	87.9	6.4	2.4

¹ Results for some statements do not add to 100 percent because of nonstandard responses or MCO data recording errors.

Implementation of its new interview system should allow DHS to resume measuring personal outcomes that address participants' quality of life. However, participants' satisfaction or dissatisfaction does not necessarily reflect the quality of service provided by MCOs. It may therefore be difficult for DHS to use personal outcome information to effectively identify and address concerns about the quality of service delivery under the Family Care program.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on its plans to use personal outcome data to help it identify ways to improve the quality of services provided by managed care organizations.

Administrative code requires DHS to measure five clinical and functional outcomes.

Five clinical and functional outcomes are required to be measured under DHS 10.46(3), Wis. Adm. Code:

- number of preventable hospitalizations and emergency room visits;
- incidence of pressure sores;
- medication management outcomes;
- influenza vaccination rates; and
- changes in participants' ability to carry out activities of daily living.

DHS does not collect or analyze information related to pressure sores or medication management. However, it measures three outcomes and publishes the results of its analyses in annual reports. For example, from its analysis of paid claims for all hospitalizations and emergency room visits by Family Care participants in 2009, DHS found that 1,654 participants had been hospitalized with diagnoses that could have been avoided through preventative care, and that 1,956 emergency room visits by participants were preventable. In addition, based on analyses by a contractor, DHS reported that more than 70 percent of participants served by either the Milwaukee County Department of Family Care or Community Care of Central Wisconsin received influenza vaccinations in 2009, as shown in Table 34. Only 15.3 percent of participants served by NorthernBridges received vaccinations, in part because it had only begun providing services in May 2009.

Table 36

**Participant Influenza Vaccination Rates by MCO
2009**

Managed Care Organization	Vaccination Rate
Milwaukee County Department of Family Care	71.4%
Community Care of Central Wisconsin	70.9
Lakeland Care District	68.0
Western Wisconsin Cares	56.7
Community Care, Inc.	54.8
Southwest Family Care Alliance	54.7
Community Health Partnership, Inc.	46.0
Care Wisconsin First, Inc.	34.4
NorthernBridges	15.3

DHS indicates that it has not consistently used available clinical and functional data to identify or address concerns with program quality or improvement because of its focus on the certification process during program expansion, as well as staffing constraints. However, within the limitations of available resources, DHS would benefit by prioritizing efforts to further develop and analyze clinical and functional outcomes based on standard medical definitions. Such an approach would be more effective than relying on personal outcome data provided by the MCOs for comparing their results over time and for identifying and addressing any quality concerns.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on its plans to:

- *collect and report all required performance measures; and*
- *enhance program oversight using data it already collects on clinical and functional outcomes.*

Regional Long-Term Care Committees

Statutes require the creation of regional long-term care committees to evaluate the performance of MCOs and ADRCs.

When Family Care was authorized to expand statewide in 2007, s. 46.2825, Wis. Stats., required the creation of regional long-term care committees to evaluate the performance of MCOs and ADRCs, monitor grievances and appeals from participants, and conduct long-term planning for the program. Statutes also required DHS to provide information and staff assistance to support committee activities.

DHS initially began to develop a map of committee regions and to discuss issues such as membership and organizational structure, but it discontinued these efforts because the committees defined in statutes required more funding and administrative assistance than it believed was available. As of September 2010, DHS had developed but not implemented four alternatives that it believes will meet the intent of statutes without creating additional oversight structures that require administrative assistance:

- arranging with selected statewide advocacy groups to conduct forums on consumer satisfaction with Family Care and other long-term care programs;
- contracting to conduct focus groups with selected stakeholders;
- continuing to conduct participant satisfaction surveys; and
- convening annual regional meetings of ADRC representatives to discuss their challenges and suggestions for system changes.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on the status of its plans for using regional long-term care committees to oversee the performance of aging and disability resource centers and managed care organizations.

■ ■ ■ ■

Future Considerations ■

Since June 2010, Family Care has expanded to assist more than 30,000 participants in obtaining home- and community-based services, but some MCOs have continued to face financial challenges. As changes to the program are considered, it will be important for DHS and the Legislature to balance budgetary considerations, the needs of low-income adults statewide who have disabilities or are frail and elderly, and the quality of available services.

2011-13 Biennial Budget Proposal

The Legislature authorized the statewide expansion of Family Care in 2007 Wisconsin Act 20, the 2007-09 Biennial Budget Act. However, before Family Care expansion to any new county can occur, statutes require DHS to submit a proposal to the Joint Committee on Finance providing the names of the counties that wish to participate and the agency's estimates of the costs of expansion. Statutes require that each expansion be cost-neutral, which DHS has defined as limiting total Family Care expenditures to an amount no greater than what the Legislature has budgeted for the program in that biennium. An expansion proposal is approved if no member of the Committee objects within 14 days of submission.

The proposed budget appropriates \$1.4 billion in each year of the 2011-13 biennium to continue Family Care operations.

2011 Senate Bill 27 and Assembly Bill 40, the 2011-13 biennial budget bills, appropriate \$1.4 billion in each year of the biennium to continue Family Care. They also include two changes to the Family Care program. First, they would cap enrollment in each county currently operating the program to the number of participants enrolled as of June 2011 or the date on which the final bill is enacted, whichever is earlier. Second, they would prohibit DHS from expanding Family Care into any other counties unless it determines that implementing Family Care would be “more cost-effective” than continuing to provide long-term care under existing programs.

Our audit findings indicate that the Family Care program has improved access to long-term care by allowing participants to avoid institutional care, and in many instances to remain in their own homes; that it has focused on participants’ health and social outcomes by requiring thorough care planning and the provision of services by trained, qualified staff; and that it has provided choices tailored to a wide range of participants’ individual needs. The implementation of this large, complex program has generally proceeded as planned, and our analyses found no evidence to suggest a pattern of MCOs denying participant eligibility or reductions to participants’ levels of care.

The program’s cost-effectiveness is difficult to assess.

However, because the cost-effectiveness of the Family Care program is much more difficult to assess, it will be significantly more challenging to determine how best to continue the provision of long-term care to low-income adults who have developmental or physical disabilities or are frail and elderly. For example, a 2005 study completed by APS Healthcare, Inc., a health services consulting firm under contract with DHS, estimated that providing long-term care services to Family Care participants cost \$452 less per participant per month than providing these services to a comparison group of non-Family Care participants in the Medical Assistance program. However, the data used in the study are now more than seven years old, and the Family Care program has grown and changed in the interim. Further, although the federal government has been satisfied with the State’s ability to demonstrate cost neutrality as required under the terms of the Family Care waiver, meeting federal waiver requirements demonstrates only that no more is being spent per participant for long-term care services provided on a managed care basis than would have been spent on a fee-for-service basis.

We independently attempted to determine cost-effectiveness in two ways. First, we analyzed per participant expenditures and found they increased from \$24,900 in FY 2005-06 to \$32,400 in FY 2009-10. That increase averages 6.5 percent per year and compares favorably to national cost increases for comparable Medical Assistance services, which averaged 7.9 percent per year from 2005 through

2009. Our comparison relied on data maintained by the Centers for Medicare and Medicaid Services for residential, home health, and other services similar to the primary services available under Family Care.

The type and quality of Family Care services may encourage enrollment by some individuals who would not otherwise seek Medical Assistance–funded services.

Second, we analyzed reasons for growth in the program’s costs. Family Care expenditures increased by 277.0 percent from FY 2005-06 through FY 2009-10, largely because of the program’s expansion to additional counties. However, what cannot be readily determined from available data is whether the types or quality of services available through Family Care may be encouraging enrollment by individuals who would not otherwise have received Medical Assistance–funded services.

In FY 2009-10, approximately 1,200 of the 9,500 newly enrolled participants had not received any Medical Assistance–funded services during at least the previous 12 months. Some of these individuals would have sought and received Medical Assistance–funded services in the absence of the Family Care program, but others may have enrolled in Family Care in response to the efforts of ADRCs to promote the program.

Continued Provision of Long-Term Care Services

Given the cost of the Family Care program, the substantial amount of public interest that exists in the provision of long-term care services, especially as Wisconsin’s population ages, and the increased authority that DHS may be granted to promulgate administrative rules that could supersede current statutes in modifying Medical Assistance–funded programs, the program’s future will likely be debated in the current legislative session, and a range of options will likely be considered. As it deliberates these options, the Legislature may wish to consider the following questions:

1. Can the program be sustained over the long term?

It will be important for DHS to continue closely monitoring the financial condition of the MCOs, especially the three that are at increased risk for insolvency, not only to assess whether additional funding is needed but also to ensure the uninterrupted delivery of services to participants. As was noted, shortly before the publication of this report, we were informed that one of these MCOs would be subject to a heightened level of monitoring by DHS.

Efforts could also be made to reduce administrative costs associated with the MCOs' operations. As noted, the large disparity in caseloads among social service coordinators and nurse care managers suggests some efficiency could be gained through closer review and greater standardization of caseload size. In addition, the salaries of some MCO executives may warrant closer attention.

2. *Are rates sufficient to maintain an effective provider network for long-term care services?*

We found evidence of increasing provider dissatisfaction with service rates and the promptness of payments. For example, among the providers we spoke to:

- five reported reductions in rates, such as a change from \$29 to \$19 per hour in the 2011 payment rate for one-to-one supervision of participants who are developmentally and physically disabled;
- four reported delays in service authorizations that delayed both the provision of care to participants and payments to providers; and
- three reported their payment rates were reduced without notice or on short notice, such as a provider being informed by an MCO on October 27, 2010, that lowered rates would take effect on November 1 of that year.

Given recent statements by some providers concerning discontinuing their participation in the Family Care program, strong disagreement about the sufficiency of rates is expected to continue.

3. *Should Wisconsin have a single long-term care strategy, or should it continue to administer a variety of programs for adults who have developmental or physical disabilities or are frail and elderly?*

Currently, the State administers five other long-term care programs in addition to Family Care: Family Care Partnership, the Program for All-Inclusive Care for the Elderly (PACE), IRIS, CIP, and COP. Streamlining may be desirable to reduce both unnecessary administrative costs that result from the operation of multiple programs with similar purposes, and the potential for confusion among participants and family members who are seeking long-term care services.

For the purposes of streamlining, the Legislature may wish to consider whether to discontinue participation in the federal PACE program and eliminate Family Care Partnership, which was formerly known as the Wisconsin Partnership program. PACE provides managed long-term and acute care services primarily in Milwaukee County to individuals who are 55 and older. In June 2010, it provided services to 834 individuals. Family Care Partnership was implemented in 1995 as an alternative to PACE. It provides managed long-term care and acute care services to elderly and physically disabled individuals and in June 2010 provided services to 3,511 individuals, most of whom reside in counties in which the Family Care program is also available. Combined expenditures for these two programs totaled \$173.2 million in FY 2009-10.

Increasing the number of individuals who self-direct their long-term care services has been discussed.

Increasing the number of individuals who self-direct their long-term care services has also been discussed. Such an approach would be similar to the IRIS program, the fee-for-service alternative that DHS was required to develop under the federal waiver authorizing the expansion of Family Care. As noted, IRIS participants are responsible for developing their own care plans and for self-directing their own long-term care services with monthly funding in an amount established by DHS. The proposal is likely to reduce Family Care administrative costs, which totaled \$53.2 million for all MCOs in 2010, and could increase participants' choices related to both the types of services they receive and their service providers. When participants have adequate information and adequate cognitive capabilities or family support, this approach could work well. However, several MCO staff and advocates we spoke with indicated it could also be problematic because participants may not make choices that best meet their short- or long-term health care needs, and because it would make participants responsible for identifying providers and negotiating the costs of their care.

If such an approach were to be implemented, policymakers would first have to determine how monthly benefits budgets would be established and how they would be adjusted in subsequent years. In addition, we believe additional attention will need to be given to fraud prevention related to payment made for services provided by family members. For example, we have heard anecdotal examples of payments to family members for services that in some instances may not have been provided at all or that were not provided to the extent for which payments were received.

IRIS participation has increased from 1,137 in January 2010 to 2,392 in August 2010.

During the course of our audit, we found that IRIS participation increased significantly, from 1,137 participants in January 2010 to 2,392 participants by August 2010. DHS had projected a maximum IRIS enrollment of 1,500 by June 2011. During the same eight-month period, DHS's monthly program expenditures more than doubled, increasing from \$2.5 million to \$5.7 million. If the program's expansion is to continue, it will be important to implement safeguards to ensure the appropriate expenditure of state and federal funds.

4. *Should acute care services provided to Family Care participants on a fee-for-service basis be incorporated in the managed care model?*

As noted, fee-for-service acute care expenditures for Family Care participants totaled \$80.0 million in FY 2009-10. Including acute care services as part of the Family Care program would have the advantage of providing these services under a managed care framework, which could help limit future Medical Assistance expenditures.

Assessing Programmatic Changes

For the Legislature to comprehensively assess the effects of any changes to the Family Care program put in place by DHS in the near future, DHS will need to provide updated information on the Family Care program's size and cost-effectiveness, the rates paid to providers, and providers' ability and willingness to accept rates that are offered.

Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by August 31, 2012, on:

- *the status of the Family Care program at that time, including data on changes in participation and program costs; and*
- *how any statutory changes enacted as part of the 2011-13 biennial budget and any administrative changes instituted by the Department of Health Services have affected the Family Care program and the individuals it serves.*

Appendix 1

Aging and Disability Resource Centers¹

June 2010

Name	County	Name	County
ADRC of the North	Ashland, Bayfield, Iron, Price, Sawyer	ADRC of Jefferson County	Jefferson
ADRC of Barron, Rusk, and Washburn Counties	Barron, Rusk, Washburn	ADRC of Kenosha County	Kenosha
ADRC of Brown County	Brown	ADRC of Manitowoc County	Manitowoc
ADRC of Buffalo, Clark, and Pepin Counties	Buffalo, Clark, Pepin	ADRC of Central Wisconsin	Marathon Wood
ADRC of Northwest Wisconsin	Burnett, Polk	Aging Resource Center of Milwaukee County	Milwaukee
ADRC of Calumet, Outagamie and Waupaca Counties	Calumet, Outagamie, Waupaca	Disability Resource Center of Milwaukee County	Milwaukee
ADRC of Chippewa County	Chippewa	ADRC of Ozaukee County	Ozaukee
ADRC of Columbia County	Columbia	ADRC of Pierce County	Pierce
ADRC of Southwest Wisconsin—North	Crawford, Juneau, Richland, Sauk	ADRC of Portage County	Portage
ADRC of Dodge County	Dodge	ADRC of Racine County	Racine
ADRC of Douglas County	Douglas	ADRC of St. Croix County	St. Croix
ADRC of Dunn County	Dunn	ADRC of Sheboygan County	Sheboygan
ADRC of Eau Claire County	Eau Claire	ADRC of Trempealeau County	Trempealeau
ADRC of Fond du Lac County	Fond du Lac	ADRC of Walworth County	Walworth
ADRC of Forest County	Forest	ADRC of Washington County	Washington
ADRC of Southwest Wisconsin—South	Grant, Green, Iowa, Lafayette	ADRC of Waukesha County	Waukesha
ADRC of Green Lake, Marquette, and Waushara Counties	Green Lake, Marquette, Waushara	ADRC of Winnebago County	Winnebago
ADRC of Western Wisconsin	Jackson, La Crosse, Monroe, Vernon		

¹ ADRCs operate in some counties that do not participate in Family Care.

Appendix 2

Number of Family Care Participants by MCO
June 2010

Managed Care Organization	Developmentally Disabled	Physically Disabled	Frail Elderly	Unknown Participant Type	Total
Milwaukee County Department of Family Care	1,267	4,161	2,024	17	7,469
Community Care, Inc.	3,248	1,452	1,214	15	5,929
Western Wisconsin Cares	1,351	1,133	792	7	3,283
Care Wisconsin First, Inc.	1,747	562	735	9	3,053
Community Care of Central Wisconsin	1,203	597	867	4	2,671
NorthernBridges	877	443	533	2	1,855
Southwest Family Care Alliance	790	456	465	7	1,718
Lakeland Care District	650	466	509	2	1,627
Community Health Partnership, Inc.	740	226	146	3	1,115
Unknown	32	52	38	43	165
Total	11,905	9,548	7,323	109	28,885

Appendix 3

Residential Arrangements of Family Care Participants¹

June 2010

Residential Arrangement	Developmentally Disabled		Physically Disabled		Frail Elderly	
	Number	Percentage	Number	Percentage	Number	Percentage
Home	6,487	54.4%	6,916	72.5%	3,583	48.9%
Residential Services						
Community-Based Residential Facility	1,837	15.4	1,279	13.3	2,391	32.7
Adult Family Home	3,412	28.7	350	3.7	172	2.3
Residential Care Apartment Complex	31	0.3	265	2.8	448	6.1
Subtotal	5,280	44.4	1,894	19.8	3,011	41.1
Institutional Care	138	1.2	738	7.7	729	10.0
Total	11,905	100.0%	9,548	100.0%	7,323	100.0%

¹ Excludes 109 participants because DHS's information did not identify whether they were developmentally disabled, physically disabled, or elderly.

Appendix 4

Health and Supportive Services Provided by MCOs¹

June 2010

Service	Developmentally Disabled		Physically Disabled		Frail Elderly	
	Number	Percentage	Number	Percentage	Number	Percentage
Care Management	11,387	95.6%	9,275	97.1%	6,998	95.6%
Employment Services	4,855	40.8	175	1.8	12	0.2
Specialized Transportation	4,651	39.1	2,975	31.2	1,411	19.3
Financial Management	4,364	36.7	1,527	16.0	672	9.2
Day Center Services	3,354	28.2	118	1.2	11	0.2
Assistance with Daily Living Activities	3,232	27.1	5,188	54.3	2,800	38.2
Medical Supplies and Equipment	3,206	26.9	5,572	58.4	4,007	54.7
Respite Care	870	7.3	118	1.2	96	1.3
Counseling and Therapy	679	5.7	963	10.1	293	4.0
Home Health Care	640	5.4	917	9.6	404	5.5
Adult Day Care	640	5.4	376	3.9	320	4.4
Other ²	398	3.3	284	3.0	208	2.8
Recreational Activities	246	2.1	27	0.3	5	0.1
Meal Services	165	1.4	1,437	15.1	976	13.3
Skilled Nursing Services	132	1.1	315	3.3	197	2.7
Day Treatment—Medical	27	0.2	22	0.2	0	0.0

¹ Excludes 109 participants because DHS's information did not identify whether they were developmentally disabled, physically disabled, or elderly.

² Includes consumer education, energy and housing assistance, health screening, and other allowable services.

Appendix 5

County Contributions to Family Care¹
 FY 2009-10

County	Amount
Ashland	\$ 315,800
Barron	444,700
Bayfield	524,300
Buffalo	228,700
Burnett	194,300
Calumet	588,300
Chippewa	716,800
Clark	973,100
Columbia	1,545,500
Crawford	324,700
Dodge	1,209,600
Douglas	781,400
Dunn	699,400
Eau Claire	1,605,100
Grant	75,700
Green	218,000
Green Lake	493,800
Iowa	29,500
Iron	65,400
Jackson	533,400
Jefferson	1,734,900
Juneau	111,600
Kenosha	1,925,100
Lafayette	410,500
Manitowoc	289,700
Marathon	3,205,000
Marquette	184,700
Milwaukee	1,959,900
Monroe	663,400
Outagamie	627,200
Ozaukee	1,652,500
Pepin	119,700
Pierce	327,700

County	Amount
Polk	\$ 606,800
Price	362,700
Racine	1,106,200
Rusk	366,800
Sauk	1,115,200
Sawyer	80,600
Sheboygan	1,896,500
St. Croix	2,192,000
Trempealeau	467,000
Vernon	493,600
Walworth	765,700
Washburn	570,400
Washington	2,105,200
Waukesha	3,910,800
Waushara	369,800
Wood	1,060,700
Total	\$42,249,400

¹ Counties are required by statutes to make contributions during their first five years of program participation.

Appendix 6

Capitation Rates for Comprehensive Level of Care

Managed Care Organization	2006	2007	2008	2009	2010
Care Wisconsin First, Inc.	-	-	-	\$2,927	\$3,305
Community Care of Central Wisconsin	\$2,411	\$2,506	\$2,496	2,846	3,041
Community Care, Inc.					
Kenosha and Racine Counties	-	2,670	2,957	3,031	3,225
Milwaukee County	-	-	-	-	3,542
Ozaukee, Sheboygan, Walworth, Washington, and Waukesha Counties	-	-	-	2,993	3,114
Calumet, Outagamie, and Waupaca Counties	-	-	-	-	3,481
Community Health Partnership, Inc.	-	-	-	3,489	3,391
Lakeland Care District	2,158	2,233	2,324	2,441	2,627
Milwaukee County Department of Family Care	2,055	2,093	2,221	2,400	2,689
NorthernBridges	-	-	-	2,699	3,088
Southwest Family Care Alliance	2,140	2,256	2,361	2,695	2,885
Western Wisconsin Cares	2,023	2,186	2,238	2,564	2,783

Appendix 7

2009 MCO Expenditures
(in millions)

Managed Care Organization	Participant Services	Care Management	Administration	Other Adjustments	Total Expenditures
Milwaukee County Department of Family Care	\$181.7	\$ 27.1	\$ 8.6	\$ 1.3	\$218.7
Community Care, Inc.	141.2	17.9	6.3	0.7	166.1
Care Wisconsin First, Inc.	109.7	12.0	8.4	–	130.1
Western Wisconsin Cares	87.7	13.0	4.1	(0.8)	104.0
Community Care of Central Wisconsin	80.1	11.9	4.7	(0.1)	96.6
Community Health Partnership, Inc.	47.8	5.1	2.4	(3.7)	51.6
NorthernBridges	32.9	6.1	2.5	–	41.5
Southwest Family Care Alliance	32.0	5.3	2.6	<0.1	39.9
Lakeland Care District ¹	28.1	4.4	1.9	0.5	34.9
Total	\$741.2	\$102.8	\$41.5	\$(2.1)	\$883.4

¹ Based on unaudited financial statements.

Appendix 8

2010 MCO Expenditures¹
(in millions)

Managed Care Organization	Participant Services	Care Management	Administration	Other Adjustments	Total Expenditures
Community Care, Inc.	\$227.8	\$ 25.0	\$ 8.8	\$1.0	\$ 262.6
Milwaukee County Department of Family Care	218.2	29.2	13.4	0.5	261.3
Care Wisconsin First, Inc.	117.1	11.3	8.5	(0.2)	136.7
Western Wisconsin Cares	91.3	14.1	4.9	(0.5)	109.8
Community Care of Central Wisconsin	86.0	12.5	4.7	0.7	103.9
NorthernBridges	63.1	9.2	3.5	0.9	76.7
Lakeland Care District	63.9	8.7	3.7	(0.4)	75.9
Community Health Partnership, Inc.	49.0	5.7	2.4	1.3	58.4
Southwest Family Care Alliance	46.1	7.5	3.3	0.3	57.2
Total	\$962.5	\$123.2	\$53.2	\$3.6	\$1,142.5

¹ Based on unaudited financial statements.

Appendix 9

**Current Personal Outcome Measures
for Family Care Participants¹**

Choice Outcomes

I decide where and with whom I live.

I make decisions regarding my supports and services.

I decide how I spend my day.

Personal Experience Outcomes

I have relationships with family and friends I care about.

I do things that are important to me.

I am involved in my community.

My life is stable.

I am respected and treated fairly.

I have privacy.

Health and Safety Outcomes

I have the best possible health.

I feel safe.

I am free from abuse and neglect.

¹ Results are not available because the system developed to measure these outcomes was first used in October 2010.



State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

April 22, 2011

Janice L. Mueller, State Auditor
Wisconsin Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

This letter is in response to the Legislative Audit Bureau's (LAB) comprehensive evaluation of the Family Care program. I appreciate the opportunity to comment on the evaluation and to share our plan to address the critical questions posed in the evaluation report on the fiscal sustainability, cost-effectiveness and options to strengthen the Family Care program and the long term care system in Wisconsin.

The Department of Health Services is committed to ensuring that the Family Care program demonstrates excellence in ensuring access to quality, cost-effective long term care services for the elderly and persons with disabilities, that participants are provided choice and the ability to self-direct their care, and that the managed care organizations which administer services have sound program and financial management practices. Moreover, we strive to ensure that the programs which support and complement Family Care, including the Aging and Disability Resource Centers (ADRCs) and the federally required Include, Respect, I Self-Direct (IRIS) program, are efficient, effective and well-managed.

The Department appreciates the considerable amount of time and effort that the LAB devoted to the evaluation, to the complexity and number of program and financial areas reviewed, and to the framework for the outstanding questions that need additional review. The courtesy and professionalism of the LAB staff throughout the evaluation process are also truly appreciated. I am confident that the Family Care program will improve as a direct result of this evaluation.

The Department is pleased that the LAB found that Family Care has largely met program goals to improve access to long term care, provide thorough care planning for enrollees, and offer people choices tailored to their individual needs. The principle of self-determination is basic to Wisconsin's long term care programs, and is seen in both the ability of people in Family Care to design a person-centered, community-based plan and in the development of the IRIS waiver program for people choosing to self-direct their care.

However, as noted in its evaluation, the LAB highlights the need for additional oversight and monitoring of certain aspects of Family Care program management and financial solvency. We concur with the recommendations in the report and will provide the Joint Legislative Audit Committee with additional information, status updates, and potential options to streamline and improve the efficiency and operation of the Family Care program, as recommended in the report.

While significant effort has occurred to date, we know that additional initiatives, analysis and options must be undertaken by the Department to address issues identified in the LAB report, including:

- The significant variations in the cost of care per participant, including the nature and extent of services in alternative community settings within Family Care, and compared with costs in non-Family Care counties, IRIS, PACE and Partnership;
- The enhanced ability of ADRCs to help individuals remain in their own homes for as long as possible;

Ms. Janice Mueller
April 22, 2011
Page 2

- The continued growth and adequacy of managed care organization (MCO) capitation rates;
- The increasing number of participants with high cost needs;
- The variation and cost of provider residential rates;
- Oversight of service delivery, including MCO staff caseloads, functional assessment screener testing, and the use of quality data to improve long term care outcomes;
- MCO administrative costs, including compensation of executives; and
- MCO operating deficits and the risk of MCO insolvency.

As noted in the evaluation, three Family Care MCOs had negative net assets as of December 2010, and are at risk of insolvency. The Department is working jointly with the Office of the Commissioner of Insurance to review data on fiscal solvency. The Department has required a corrective action plan and enhanced oversight, and each MCO is monitored closely. We continue to provide intensive technical assistance to help MCOs attain compliance with program and financial requirements, including the development and implementation of a comprehensive business plan required for MCO certification.

Like other states, Wisconsin is facing significant growth in persons needing long term care. Finding solutions now that can be sustained for years to come is a priority for the Department. The Governor's recommended enrollment cap on Family Care and related long term care programs in the 2011-13 biennium is designed to give this Department and state policymakers an opportunity to explore strategies and identify options that are fiscally sustainable and cost-effective.

The LAB report identifies critical questions on the fiscal sustainability and cost-effectiveness of the Family Care program that were not answered by its evaluation. In addition, the LAB report questions whether there are opportunities to reduce costs, increase efficiency and improve outcomes through long term care program consolidation or through integration of primary and long term care.

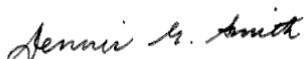
To address these critical and fundamental questions on the fiscal sustainability and cost-effectiveness of Family Care, I am committed to completing a comprehensive analysis to:

- Evaluate the nature and cost of services provided by Family Care and its related programs;
- Provide a comprehensive comparison of Family Care and non-Family Care counties, including services actually used by participants;
- Review screening and eligibility processes to enroll in the State's long term care programs; and
- Develop options to increase the use of consumer-directed care in an individual's own home.

I concur with the need to review the overall strategic approach to long term care, and I am confident that the recent approval of \$1 million for the "Virtual PACE" grant will be an integral component of this approach. Through this federal grant, our goal is to design a coordinated system of primary, acute and long term care for elderly and disabled adults who wish to receive care in the community, coordinating care now provided through Medicare and Medicaid funding.

Again, we appreciate the time, effort and professionalism of the LAB Audit Team in performing this evaluation. Thank you for your consideration of our comments.

Sincerely,



Dennis G. Smith
Secretary