OVERVIEW OF CONTRACTING AND FISCAL REGULATION FOR THE DEPARTMENT OF HEALTH SERVICES' FAMILY CARE PROGRAM

Intent: The intent of this document is to provide an understanding of the Department of Health Services (the Department) contracting and fiscal regulatory requirements for the Family Care Managed Care Organizations. Statewide expansion of the Family Care program represents a major system change to support the transition of the county operated Medicaid waiver programs to a Medicaid managed care model in order to ensure all eligible Wisconsin adult citizens with long-term care needs have equal access to in-home, community-based, and institutional care resulting in the elimination of waiting lists. This document describes the procurement process that is designed to ensure program consistency and safeguards through structured contracting requirements. This document also describes ongoing review of managed care organization fiscal operations for the new contracted service delivery system.

Procurement

The procurement of a contract with the Department as a Family Care Managed Care Organization begins with a rigorous Request for Proposal (RFP) process.

- Planning groups with County and private entity participation have been exploring statewide expansion since 2006. Entities interested in submitting proposals for Family Care expansion are committed to the Department's care management and service delivery model and must submit a proposal to the Department's RFP.
- Response to the RFP is a comprehensive submission that is managed under the consistent standards dictated by the State Department of Administration.
- The RFP process awards a potential Managed Care Organization (MCO) the opportunity to enter into the initial certification process rather than a contract. The certification process requires the MCO demonstrate readiness to operate the Family Care program with systems that will support a risk-based managed care contract.
- Multiple MCOs could enter the initial certification process to serve members in the same region.

➢ Link to a Family Care expansion RFP: https://vendornet.wi.gov/Bid.aspx?NewBid=true&Id=8726501f-a07e-e611-80f7-0050568c7f0f

Initial Certification

An MCO begins the initial certification process after successfully competing through the RFP process. Certification is a rigorous process of Department review and demonstration by the MCO that all required systems are in place and operational to satisfy the Family Care contract requirements and to support enrollment and the provision of services for the proposed membership.

The eight broad areas of operation included in the certification process are:

- Basic requirements- board of directors
- Provider network

- Medicaid certification
- Appeals and grievances
- Marketing consumer information
- Quality management
- Care management expertise and process
- Fiscal
- Information systems capacity

The initial certification requirements document is available upon request.

During certification the MCO's policies and procedures undergo rigorous formal review and site visits are conducted to ensure the MCO is prepared to operationalize the approved policies and procedures as written. The remainder of this document focuses on the fiscal certification and oversight processes. This document does not address certification or oversight activities related to other areas of MCO functioning/operations.

Fiscal Certification

The following fiscal policies and procedures are included in the certification process:

- Member obligation, third party billing and collections
- Claims processing
- Enrollment and capitation reconciliation
- Financial reporting
- Investment
- IBNR
- Cost allocation

In addition, the MCO develops a three-year business plan demonstrating an enrollment plan that is consistent with the County transition plan submitted to DHS and taking into account other enrollment options a member may elect such as a competing MCO or the IRIS program. The assumed capitation rates and projected service costs are validated and administrative costs, cost allocation across related entities, organizational structure of related parties and service cost rate setting where arms length transactions cannot be achieved are re-evaluated.

The development of rates for services provided directly by the MCO must be submitted to the Department to allow full review of the underlying direct costs and allocated costs as well as the assumed units of service to result in a unit rate that can be certified. Since service costs are the source for capitation rate setting the Department must insure consistency of the internal MCO rate development process and validate the costs and service units built into the rate development.

MCO Funding and Contracting for Services

The Family Care MCO contract with DHS is a risk-based contract to serve all enrolled members under an actuarially sound and certified per member per month (PMPM) capitation rate(s). The MCO cannot withhold member services due to MCO financial position concerns and is motivated by the nature of the funding mechanism to ensure the outcome-based care plan is achieved in a cost-effective manner.

The MCOs are required to pay Medicaid rates where one is established or to negotiate a rate, established through market analysis and evaluation of the provider financial information where a Medicaid rate does not exist.

The nature of the contract creates a financial incentive to establish cost-effective provider rates that are not in excess of the market rate for those services, and an incentive to ensure there is not duplication or over utilization of required services.

- Links to the Family Care Contract and Capitation Rate Reports
  https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm

Fiscal Monitoring

Fiscal monitoring of the Family Care MCO results is a shared oversight model between DHS and the Office of the Commissioner of Insurance (OCI). The MCOs are required to submit interim financial reporting in the DHS/OCI reporting format on a Generally Accepted Accounting Principles (GAAP) basis. The reporting identifies the financial results for each contracted Family Care program and identifies other programs and operations conducted in addition to the Family Care program by each entity. MCOs with related organizations are also required to submit consolidated financial reporting that presents the results of each entity and the consolidating entries to achieve the final consolidated results. Finally, the Family Care MCOs are required to provide a report from their financial institution that demonstrates the existence of the restricted reserve funds. The OCI monitors the Family Care MCO submissions and supporting documents to ensure compliance with the MCO's capital requirements and ongoing solvency.

The OCI also receives financial reporting from the Family Care Partnership/PACE MCOs submitted on a statutory of accounting basis monitors and regulates the solvency requirements of those plans as licensed HMOs.

- The Family Care required financial reporting template is available upon request.

In addition to structured financial reports, there is ongoing communication with the MCOs to clarify and support the understanding of the MCOs financial position, trends and leading indicators. The fiscal oversight team and a DHS managed care section team for each MCO meet to support an integrated regulatory structure.

Financial results are summarized and shared with the MCOs and external stakeholders in order to provide transparency and accountability of the Family Care program. The comparative results support ongoing development of benchmarking, best practice, and program improvement initiatives.

Financial Audit

The financial audit requirements for Family Care are defined in Wisconsin State Statute, the DHS Family Care contract, and in the Statute of authority for the OCI. Those requirements are comprehensive and independent external auditors are expected to conduct their field work in a manner that satisfies the requirements of the program.

The MCOs undergo an annual audit by an independent Certified Public Accounting firm following Generally Accepted Audit Standards in accordance with GAAP. The audit reports include:

a. Financial statements other than audit schedules and reports required for the type of financial audit necessary for the MCO entity;
b. A report on the internal control environment of the MCO;
c. A report describing the system of cost allocation for shared overhead and direct services between programs or lines of business as required;
d. A supplemental financial report that demonstrates the financial results and segregated reserves of the MCO business for each state program contract where the organization serves members under multiple Medicaid managed care contracts and/or other lines of business. The report shall be in columnar format for the various programs as required;
e. Letter(s) to Management as issued or written assurance that a Management Letter was not issued with the audit report; and
f. Management responses/corrective action plan for each audit issue identified in the audit report and/or Management letter.

Financial audits of contracts should include procedures outlined in the Family Care Audit Guide.

- Link to the Family Care Audit Guide https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm

That audit guide describes the audit of systems unique to the Family Care programs including but not limited to the enrollment and capitation reconciliation, member obligation, and incurred but not reported (IBNR).

An MCO operated by a County is included in the County Single Audit as a program of that County. One County-based MCO is contracted to operate a Family Care program during 2010.

MCOs operating the Family Care Partnership and PACE programs include acute and primary services, as well as long-term care services, and must operate under licensed HMOs and comply with the regulatory and audit requirements for insurance companies as directed by the OCI.

Recertification

Annual re-certification includes submission of a comprehensive three-year business plan including full program narrative and financial projections.

Annual certifications are conducted to ensure consistency of program system operations applied by independent organizations and the ongoing fiscal health and success of the program.

- The business plan requirements are available upon request.