

State of Wisconsin  
Department of Health Services

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Scott Walker, Governor  
Dennis G. Smith, Secretary

September 1, 2011

Senator Robert Cowles  
Co-Chair Joint Legislative Audit  
Bureau Committee  
Room 118 South, State Capitol  
P. O. Box 7882  
Madison, WI 53707-7882

Representative Samantha Kerkman  
Co-Chair Joint Legislative Audit  
Bureau Committee  
Room 315 North, State Capitol  
P. O. Box 8952  
Madison, WI 53708-8952

Dear Senator Cowles and Representative Kerkman:

This letter and the attached report are in response to the Legislative Audit Bureau's (LAB) comprehensive evaluation of the Family Care program dated April 2011, and its recommendations that the Department of Health Services provide certain information to the Joint Legislative Audit Committee by September 1, 2011.

As stated in the response to the evaluation, 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.

The LAB highlighted the need for additional oversight and monitoring of certain aspects of the Family Care program management and financial solvency. The Department concurred with these recommendations and with the request to 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.

Accordingly, the Department has carefully reviewed each of the ten recommendations highlighted in the LAB report for which a response was requested by September 1, 2011. The Department's response highlights both the work completed since the evaluation and the status of each of the items referenced in the recommendations. Where possible, updated information, analysis and options for future consideration are provided; however, further efforts remain in process in some areas.

In closing, I would like to express the Department's gratitude to the Legislative Audit Bureau management and staff for their diligence and efforts and for their recommendations to improve the management and oversight of the Family Care program.

Sincerely,

A handwritten signature in cursive script that reads "Dennis G. Smith".

Dennis G. Smith  
Secretary

Attachment

# Department of Health Services Report to the Joint Legislative Audit Committee On the Status of Family Care Oversight and Management

September 1, 2011

## Introduction

In its evaluation of the Family Care program, which was released in April 2011, the Legislative Audit Bureau (LAB) highlighted the need for additional oversight and monitoring of certain aspects of Family Care program management and financial solvency. The Department of Health Services (DHS) concurred with the recommendations in the evaluation and agreed to provide information to the Joint Legislative Audit Committee by September 1, 2011, as recommended in the evaluation.

This report, from the Department of Health Services, provides the additional information, status updates and potential options to streamline and improve the efficiency and operation of the Family Care program. In 2010, Family Care supported 31,256 individuals at a cost of \$975.8 million. In addition to the direct cost of Family Care, the state spent \$94.8 million to provide other Medicaid services to these individuals. Moreover, a vast majority of these individuals are also covered by Medicare (“dual eligibles”). Improving coordination between Medicare and Medicaid, which will lower costs, will be a high priority of the Department.

Each section of this report is organized to include the Legislative Audit Bureau’s recommendation, noted in italics, followed immediately by the Department’s update on the status of each recommendation. On occasion, additional supporting materials are included as attachments.

## Recommendation #1: Residential Rate-Setting Methodology

*The Department of Health Services should 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.*

As noted in the LAB report, DHS had been working with managed care organizations (MCOs) and stakeholders to develop a statewide residential rate-setting method that would incorporate member acuity and facility cost in determining the reimbursement rate for community substitute care settings. The project was in the analytical stage during the audit.

Since that time, several MCOs have developed and implemented rate-setting methodologies that reflect regional and geographic differences in local provider networks, encourage capacity and innovation through market competition, and support care delivery in the most integrated and cost-effective settings. Consequently, DHS is committed to building on this growing expertise and is not currently pursuing plans to implement a residential rate-setting methodology for statewide use by the Family Care MCOs.

It is the Department's position that a statewide rate-setting methodology would hamper innovative, and creative contracting methods at the MCO level, and would not resolve all of the underlying challenges to move beyond the past practices, culture and expectations for residential care. The Department's efforts will focus on developing the capacity to provide care in the most integrated, cost-effective and consumer-directed manner. Policy initiatives that support members in their own home will be emphasized so that out-of-home placement, funded by public funds, should only be pursued when other more integrated, home-like settings are not feasible to support the member's health and safety. Approaches which incentivize the provision of care in a member's own home are critical to the program's continued cost effectiveness and long-run fiscal sustainability.

The Department will work with MCOs that have advanced purchasing and contracting practices in this area to expand those practices to all MCOs on a regional basis. As Family Care implementation and MCO maturity varies across the State, the Department will continue to ensure enhanced technical assistance and administrative oversight on residential purchasing initiatives and will foster the dissemination of best practices among MCOs. This work will focus on the underlying principles associated with these best practices, as opposed to specific technical or methodological approaches.

The residential services initiative has been a longstanding project within the Division of Long Term Care and has made steady progress over the years in improving equity, consistency, and clarity in the purchase of quality substitute care services at a fair price. The most recent resurgence of this project has been successful in furthering that objective with a number of improvements, including: (i) clarification of instructions for defining a member's obligation for contribution to room and board and cost share; (ii) standardization of instructions for room and board; and (iii) targeted remediation with at-risk MCOs to further align their residential service purchasing practices with individual members' needs.

The Department will continue to work with MCOs and residential services providers to improve service purchasing practices, communication, inter-organization collaboration, and informed decision-making. A forum for assisted living industry representatives, MCOs, and DHS staff to work on these important issues has already been established. Some of the primary objectives of the residential rate-setting project were to improve transparency, equity, objectivity, and alignment with both cost and acuity in the service purchasing practices that are used across the State. Those objectives remain a focus of Family Care's program administration efforts and will be pursued with MCOs through targeted initiatives within each region, rather than through a specific statewide payment formula.

**Recommendation #2: Care Management Caseload Staffing**

*The Department of Health Services should 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.*

The Department of Health Services reviewed the processes used by MCOs to set caseload sizes for their members in order to assure that they are appropriate. The following is a summary of those findings in response to the Legislative Audit Bureau (LAB) study of the Family Care program.

Under Family Care, MCOs receive a monthly capitated rate for each member. Capitation rates are grounded in the experience of the five pilot counties, in particular their experience with managing service costs in a manner that enables Family Care enrollees to receive the services that meet the long term care outcomes they have identified. The adoption of a managed care is distinctly different from the method used in the prior long term care programs, which relied on fee-for-service payments for each service provided. Care management is critical to ensure access to quality supports and services that are effective and cost-efficient.

The MCOs manage the cost and effectiveness of all services and supports by using the Resource Allocation Decision (RAD) method. The RAD method helps to define the goals or outcomes that each member wants to achieve and how this relates to his or her long term care needs. The care management team from the MCO works with the member to determine the possible ways to address those needs, including the use of paid long term supports and services. The RAD method defines an approach for the team to determine the most cost-efficient and effective choice available to meet the member's goals or outcomes. The most economical option might be a purchased service, but it might also be an informal support, a volunteer service or a service provided by another, non-Medicaid program.

The transition process from the legacy waivers to Family Care resulted in some of the variances noted in the LAB report. MCOs were at various stages within the transition process when LAB reviewed care management staffing ratios during June 2010. Staffing ratios fluctuated fairly significantly at that time because MCOs hired and trained care managers in advance of expected enrollment as Family Care started in new areas. Care managers have subsequently transitioned to the new managed care model, and variable staffing ratios experienced during the expansion period have stabilized.

Additionally, staffing ratios vary among MCOs, even during stable enrollment, for a variety of factors. These factors include:

- Staff in MCOs serving rural areas require significant driving time because care managers meet with members face-to-face.
- Automation and technology has helped some MCOs to create efficiencies; this includes the use of distance communication tools.
- Certain MCOs may employ specialized staff who do not have a caseload. Rather, these staff perform related tasks such as: assessments for the purchase of durable medical equipment; assistance to set up self-directed services; assistance with mental health and behavioral support needs; and coordination of benefits related to Medicare.

Other factors that are important to consider include:

- Most MCOs now directly employ care management staff as this has been determined to be more efficient than subcontracting.
- Some MCOs have developed caseload specifications, but travel time may prevent the use of

these ratios in rural areas.

- Some MCOs have identified care management responsibilities that can be handled by staff who are not human service or nursing professionals.
- There is no apparent correlation between caseload sizes and MCO fiscal performance.

DHS collaborates with MCOs to: develop and share best practices for care management; monitor care management processes and results through annual on-site quality reviews; and determine the efficiency of care management by oversight of MCO utilization and fiscal performance. The Department is developing performance measures related to care management results, and has conducted management studies to monitor and improve the results for Family Care members.

Further details of this evaluation are included in *Attachment 1: Care Management Caseload Staffing in Family Care*.

### **Recommendation #3: Family Care Capitation Rates**

*The Department of Health Services should 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.*

Each year, DHS seeks to strengthen the rate-setting model for Family Care capitation payments. As MCOs gain experience offering the Family Care benefit in new counties, the Department analyzes the effectiveness of their efforts to determine whether the service model has stabilized to the point where their baseline data may be used to set capitation rates. In the 2010 rate-setting process, DHS combined the cost and service delivery experience of Racine and Kenosha with the data from the five pilot counties. The determination of whether to include a county in the baseline data involves an analysis of a variety of factors, including a comparison of the actual performance of an MCO as compared to what may be expected under the model, given actual enrollments.

This approach underlies the development of rates for the program's benefit package that serves as the basis for the capitation rate paid to the MCOs. The rate is grounded in the experience of the five pilot counties and their experience with managing service costs in a manner that enables Family Care enrollees to receive the services that meet the outcomes they have identified. The adoption of a managed care model departs from the method used in the prior long-term care programs, which relied on fee-for-service payments for each service provided. As a result, service providers and MCOs with experience in fee-for-service programs require time to transition to this new policy environment.

Collectively, MCOs ended calendar year 2010 in a surplus position. However, four MCOs closed the year with a deficit. At the end of the first quarter of 2011, six of the nine MCOs reported a surplus, while two more MCOs will also have a surplus once capitation payments are adjusted to reflect the actual experience of serving a population with greater care needs than assumed in their initial rate. The financial situation of the MCOs is becoming stronger and more stable with increased experience.

Over the past several years, the Family Care program has examined a number of strategies to modify the payment model in a manner that would better predict the costs associated with enrollees with the greatest acuity. The Department worked collaboratively with the Family Care MCOs and the Department's contracted actuarial firm in 2011 to assess whether or not the capitation rate methodology requires additional adjustment. Balancing costs across high-cost and low-cost enrollment populations to operate within a single capitated rate is a fundamental expectation of an MCO. It is the Department's responsibility to ensure that the formula used to set the capitation rate is sensitive to a number of different cost drivers that might lead to legitimate cost variations across MCOs.

Most recently, a project was initiated to determine whether or not there are cost drivers associated with complex program enrollees that are not currently reflected in the payment formula. For example, actual service costs were higher than those that were expected, as measured by the funding formula. The Department provided a list of program enrollees for whom the capitation appeared to be most out-of-line with service costs to further explore this potential issue. Recognizing that there may be other reasons for this lack of alignment than simply the payment formula, this list was shared with MCOs along with a request to review case files and generate data elements to supplement the analysis. The Department's actuarial firm was then tasked with analyzing whether introducing these data elements into the payment formula improved its overall accuracy of the capitated rate.

This project represented a substantial investment of Department and MCO resources. Over 2,600 members (roughly 8% of 2010 program enrollment) were identified by the Department for inclusion in this study. MCO staff, or their contractors, reviewed member files, or other records, for each of these members, representing between 5% - 12% of a given MCO's enrollment to provide information to the Department on a very rapid-cycle response basis.

The results from this project are just now being reported to the Department and still require further analysis and review. Along with the data, the Department has sought feedback from MCOs and other stakeholders on additional opportunities to enhance community stabilization and crisis response for complex, high cost enrollees. The Department's work in this area will continue into early September to discern whether the 2012 capitation rate formula or other provisions of the Family Care program should be modified as a result of this analysis, or whether 2013 is a more practical time frame for potential change.

The Department remains committed to investing in the programmatic review, data systems, internal analytic capacity, contracted actuarial services, transparent funding principles, and collaborative approach to refine and improve payment formulas and to ensure quality, access and cost-effective long term care supports and services for Family Care enrollees.

**Recommendation #4: MCO Financial Solvency**

*The Department of Health Services should 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.*

***Solvency Status***

Each Family Care MCO is currently solvent based on the Family Care program’s financial oversight standard. This assessment is based on the most current financial information about each organization, which is the financial reporting period that ended June 30, 2011. However, some MCOs remain at higher risk for insolvency.

The following table illustrates the amounts owed by the MCOs to the Solvency and Reserve Funds at the time of the Family Care Evaluation Report in December, 2010 as compared to the most recent data as of June 30, 2011. As the table shows, several of the MCOs significantly reduced the outstanding amounts owed in the last six months. Two additional MCOs, Southwest Family Care Alliance and Western Wisconsin Cares, are now in compliance with reserve requirements. Over this time period, the total outstanding amounts owed to solvency and reserve funds have been reduced by approximately 50%, from \$6.6 million to \$3.3 million.

**Amounts Owed by MCOs to the Solvency and Reserve Funds**

Managed Care Organization	December 2010			June 30, 2011		
	Amounts Outstanding			Amounts Outstanding		
	Solvency Fund	Restricted Reserve	Total	Solvency Fund	Restricted Reserve	Total
Community Health Partnership, Inc.	\$750,000	\$1,131,400	\$1,881,400	\$600,000	\$1,277,300	\$1,877,300
Care Wisconsin First, Inc.	500,000	563,400	1,063,400	250,000	577,700	827,700
NorthernBridges	250,000	1,198,400	1,448,400	0	620,500	620,500
Southwest Family Care Alliance	500,000	1,174,000	1,674,000	0	0	0
Western Wisconsin Cares		489,300	489,300	0	0	0
Community Care of Central Wisconsin	0	0	0	0	0	0
Community Care, Inc.	0	0	0	0	0	0
Lakeland Care District	0	0	0	0	0	0
Milwaukee County Dept of Family Care	0	0	0	0	0	0
<b>Total</b>	<b>\$2,000,000</b>	<b>\$4,556,500</b>	<b>\$6,556,500</b>	<b>\$850,000</b>	<b>\$2,475,500</b>	<b>\$3,325,500</b>

With respect to each of the program's capital requirements, which are additional metrics of MCO financial health, the following data emerge from the MCOs' financial reporting:

- Three of the nine organizations are in compliance with the working capital requirement and another is close to compliance.
- Six of the nine organizations are in compliance with the restricted reserve requirement and two more are close to compliance.
- Seven of the nine organizations are in compliance with the solvency fund requirement and another is close to compliance.
- In the aggregate, MCOs meet 91% of the restricted reserve and 87% of the solvency fund requirement.

Additional work is needed to further stabilize the MCOs, particularly in the area of MCOs' working capital. However, the metrics shown above compare favorably with December 2010, demonstrating that the program has begun to stabilize after the initial and rapid expansion period which caused widespread challenges. At that point in time in December 2010, the comparable figures indicated that:

- Two of the nine organizations were in compliance with the working capital requirement.
- Five of the nine organizations were in compliance with the restricted reserve requirement.
- Three of the nine organizations were in compliance with the solvency fund requirement.

One important lesson that has emerged over the course of the past year is that experienced MCOs tend to outperform those organizations that are new to the Family Care program. This learning highlights the importance of sharing best practices across the state. The Department is now working with MCOs in a number of targeted areas to facilitate that sharing, and this will continue to be a program management tool that will be used to stabilize distressed MCOs.

### ***Criteria for Insolvency***

The program's standard for insolvency is an organization's inability to meet its day-to-day financial obligations, when operating from a negative equity position and lacking a source of new, additional capital.

### ***Sanctions/Corrective Action Plans***

The Department has worked closely with the Office of the Commissioner of Insurance (OCI) to establish a more formal and transparent financial oversight trajectory for the Family Care MCOs. This trajectory recognizes that financial distress does occur within a risk-based managed care environment and that, ultimately, the State also bears responsibility in ensuring continuity and access to quality care for enrollees with long-term care needs. A robust financial oversight process, given this unique structure, must be able to detect that distress as early as possible and promote rapid actions at the MCO level that will mitigate the risk(s). The State has an increasingly important role in this trajectory, as the overall level of risk increases.

This joint state agency work has resulted in the creation of a procedure, detailed in ***Attachment 2: Family Care Financial Oversight and Sanctions Procedure***, which describes how an MCO may enter, and exit, various levels of Department-imposed sanctions. ***Attachment 3: Family***



*Care Financial Monitoring and Corrective Action Tiers*, shows the series of stages in which a distressed MCO may be placed and a description of the specific sanctions. This structure, in conjunction with other important programmatic changes, should lead to the long-run financial viability of a well-run MCO.

#### **Recommendation #5: Payment Processing and Program Integrity**

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

The Department addresses any report of fraud or abuse within the Medicaid program in a serious and prompt manner, regardless of the dollar amount that is involved. In general terms, this function is delegated to MCOs, within the managed care environment. The Department, however, maintains an important oversight role.

Historically, the activities in this area have included the following Department activities:

- Completing an annual review of the MCO's Program Integrity Plan.
- Investigation and monitoring of potential fraud and abuse.
- Communication to, and from, the MCOs regarding reported provider fraud and abuse.
- Review of MCO operational policies and procedures.

*Attachment 4: Family Care Summary of Improper Payments in 2010*, provides a summary of improper payments under Family Care in 2010, including a detailed description of potentially fraudulent payments in that year. In total, four reports of potentially fraudulent activities were reported, two with full recoveries, one with a minor report (under \$20.00), and one report where the dollar amount could not be determined. Family care capitation payments in 2010 were approximately \$990 million.

The Division of Long Term Care is involving the MCOs in a wide-ranging program integrity initiative as detailed in *Attachment 5: Enhancement of MCO Program Integrity Plans*. The goals of the initiative are to improve awareness, ensure compliance with the provisions of the Deficit Reduction Act, which originally implemented fraud and abuse protections, as well as the Patient Protection and Affordable Care Act, which enacted additional requirements. Activities are anticipated to include additional training and resources to MCOs, sharing of best practices across MCOs, and potential language to strengthen the Department's contract with MCOs.

#### **Recommendation #6: Functional Screen Assessment Skills Testing**

*The Department of Health Services should 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.*

DHS policy is to conduct skills testing for all certified screeners every two years. The Department had delayed, by six months, the testing during the timeframe evaluated by the LAB, in order to create a more robust and valid Continuing Skills Testing process related to the Long Term Care Functional Screen tool. The Department subsequently implemented Continuing Skills Testing. All screeners with test results of less than 80% were required to complete an individual Plan of Correction. This Plan of Correction needed to be successfully completed in order to retain access to the Long Term Care Functional Screen (LTC FS) web-based application and to continue as a certified screener. Agencies that have systemic issues related to quality are required to complete an agency-level Plan of Correction in addition to the individual plans.

The description of the Continuing Skills Testing and Plan of Correction Policy and accompanying procedure are included as *Attachment 6: Continuing Skills Testing for Functional Long Term Care Screeners* and *Attachment 7: Long Term Care Functional Screener Plan of Correction*. These are regularly reviewed and revised as necessary by the Division's LTC Functional Screen Governance Committee. The next skills testing will be conducted during February 2012, and planning for this process is underway. DHS has recently created a unit dedicated to oversight and management of the LTC Functional Screen to ensure adequate staffing and oversight of this essential tool.

#### **Recommendation #7: Appeals Process**

*The Department of Health Services should 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.*

The Department identified three streamlining alternatives within the constraints of the Federal Social Security Act and implementing regulations. These options, as well as the current process, are detailed in *Attachment 8: Options for Streamlining Appeals in Managed Long-Term Care*.

The Department asked the Member Rights Workgroup which consists of representatives from the MCOs, the external quality review organization (EQRO) and the ombudsman programs to consider the advantages and disadvantages to the alternatives. The Department also solicited feedback from its Council on Long Term Care in July and issued a survey in August to gather further input from various stakeholders. This includes soliciting feedback from the Aging and Disability Resource Centers (ADRCs) and posting information on the web to seek public input about the various options as well as the current appeal and grievance processes. The choices are described as follows:

1. Continue to use the current system with no change.
2. Eliminate direct DHS review. The member may choose MCO appeal or fair hearing at any time, including pursuing both processes at the same time.
3. Eliminate direct DHS review. The member may choose MCO appeal or fair hearing at any time, but not at the same time.
4. Eliminate direct DHS review. The member must use the MCO appeal process before accessing the fair hearing process.

The Department will review the comments that are received through this process to determine if the DHS review could be eliminated to create a more efficient appeal process, without compromising member rights. The benefits, as well as potential issues with the MCO appeal and fair hearing process, will also be analyzed.

### **Recommendation #8: Plans to Use Personal Outcome Data**

*The Department of Health Services should 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.*

The Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) has been validated, as noted in the LAB report. The Family Care/Partnership External Quality Review Organization (MetaStar) conducted 25 interviews in each MCO service area during 2010-11. Interviews were conducted by trained and reliability-tested interviewers. The training and reliability testing was conducted by the University of Wisconsin Center for Health Systems Research and Analysis (CHSRA) which had developed the PEONIES tool and process.

**Attachment 9: Personal Experience Outcomes for Long Term Care**, provides more in-depth information on personal experience outcomes.

DHS and MCO managers need reliable information about the achievement of member outcomes to understand Family Care quality and to provide care managers with constructive feedback about successful efforts to identify and support each member's outcomes; and to plan and coordinate cost-effective care. Services that do not support a member's outcomes are wasteful and ineffective. DHS considered how to implement the use of the PEONIES tool in Family Care. Four options were identified, with variations on whether the EQRO or MCO staff would administer the reliable interviews. After seeking input from external stakeholders and MCOs, DHS determined that for 2011-12 DHS will contract with the EQRO to administer the interviews. Non-MCO stakeholders were, in general, more confident in the results of interviews administered by an agency external to the MCO and MCOs were concerned about investing the staff and fiscal resources necessary to have reliable interviewers. The MCOs are most interested in developing staff expertise related to using the PEONIES results to improve quality. The PEONIES tools, include: a manual for care managers; training materials for care managers and quality reviewers; and data collection tools that are available to MCOs in order to complete comprehensive assessments and to develop member-centered care plans.

DHS also evaluated options regarding the numbers of interviews to conduct in order to achieve a reasonable level of statistical significance of the results. Therefore, the EQRO will conduct approximately 550 personal experience outcome interviews in 2011-12. This number includes interviews of Family Care, Partnership and IRIS participants. This number of interviews will provide results that are statistically significant across these long term care programs as a whole. However, the sample size to achieve statistical significance by MCO, program areas, or target group were time and cost prohibitive.

Completing enough interviews to be statistically significant for each MCO would have allowed for comparison of performance of one MCO against other MCOs. However, information obtained from the PEONIES interviews will be used to improve performance at the individual MCO level. This is based on the understanding that even if a sample is too small to produce statistically significant results, the results can be useful for purposes other than reaching conclusions about performance. For example, a sample size of 30 care plan reviews has been shown to be effective for identifying MCO issues that should be the focus of MCO improvement efforts.

DHS is developing plans for sharing the PEONIES interview results with MCOs as providing results has the following benefits:

- The opportunity for care managers to receive prompt, objective, and collegial interaction to improve their work with members;
- The opportunity to reinforce the mission of the program; and
- Providing data related to member outcomes is persuasive and convincing evidence for stakeholders, such as legislators, CMS, and advocacy groups, of the DHS commitment to program goals.
- MCOs will use the results to improve their own performance in supporting members' outcomes.

DHS, MetaStar and CHSRA have worked with MCO Quality Managers to develop and improve the process for reporting results of the interviews back to the MCOs. The Department is working to achieve a balance between member confidentiality interests and reporting results that are specific enough for the MCOs to use effectively in improvement activities. This will be an area of focus for collaborative work between DHS, its contractors, and the MCOs, during the next year.

### **Recommendation #9: Performance Measures and Outcome Data**

*The Department of Health Services should 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.*

DHS measures specific service utilization related to key measures of quality care including: preventable hospitalizations and emergency room visits; influenza vaccination rates; and changes in participants' ability to carry out activities of daily living. These results are contained in the annual report titled *Long Term Care in Motion*. The report for 2010 will be available in the near future (goal is by end of September) and posted on the website.

Other performance measure data, as noted by LAB are collected by DHS as follows:

### Medication Management Outcomes

- The DHS contracts with MCOs include language for performance measures related to medication management. Contractual requirements include a nursing assessment and reassessments to include member's ability to set-up, administer and monitor his or her medications, and ongoing medication review and intervention to correct any errors in medications taken. Technical assistance information about medication management best practices has been provided in the resource document found at: <http://www.dhs.wisconsin.gov/LTCare/Partners/infoseries/rs11-02.pdf>.
- Outcomes of medication management are measured through the clinical outcomes of individual members and the incidence of medication errors having adverse effects on members. These medication errors are reported to DHS as critical incidents and investigated by MCOs, so that root cause of errors can be remediated.
- During Annual Quality Reviews of each MCO, the EQRO contracted by DHS reviews a sample of member care plans and case notes, and verifies whether the medication reconciliation required during assessments and re-assessments were done. MCO compliance with this particular requirement has not previously been separately reported by the EQRO. DHS will direct the EQRO to include information on MCO compliance with this element as a discrete finding in its Annual Quality Review reports beginning in the next contract year.

### Incidence of Pressure Sores

- Data about the incidence of pressure sores is collected on the functional screen. This is performed at least annually for all enrolled members.
- DHS has completed analysis on this performance measure and the data has shown that pressure sores occur infrequently. Therefore, DHS did not deem this as an effective quality indicator for Family Care.
- Prior to January 1, 2012, DHS will conduct an analysis of the incidence of pressure sores among members, both those living at home and those in substitute care facilities and nursing homes. DHS will use these updated results to determine efficacy of this as an ongoing performance indicator of the quality of care provided by MCOs.

DHS is developing a performance indicator scorecard that will be used to identify areas of focus for program oversight activities. The scorecard will contain performance indicators for each of the major program functions of the MCO, including assessment, care planning and care coordination. In addition to these process indicators, clinical and functional outcome data will be included in the scorecard. Potential indicators of members' clinical status include results of care management and coordination such as unstable health or mental health, shown by hospital and emergency room usage for chronic conditions treatable outside of those settings and utilization of inpatient psychiatric care. Changes in members' functional status, as measured in their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are tracked on each individual member's functional screen, performed at least annually; this information can be compared to data across the program.

The Department will continue to identify national standards for changes in functional status across the life span. Several MCOs are participating in a longitudinal study of changes in functional status of individuals in the developmental disability target group that may provide national standards for expectations of people with developmental disabilities and long term support programs in this regard. Specific trends or spikes in data related to these indicators, either alone or in comparison with program wide data, would identify areas for DHS intervention and potential corrective action.

### **Recommendation #10: Regional Long-Term Care Committees**

*The Department of Health Services should 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.*

Since 2007, the Department has worked extensively with the Wisconsin Council on Long Term Care, ADRCs, MCOs, and other interested parties on the use of Regional Long Term Care Advisory Committees to comment on the quality and adequacy of the State's long term care system. In reviewing plans for Regional Committees, significant concerns have been identified, including: a cumbersome structure; a broad scope of duties; the costs, which are not funded; and the duplication with other long term care quality efforts. In addition, the phase-in of managed long term care and the lack of ADRCs in some areas posed challenges with the implementation of a Regional Long Term Care Advisory Committee structure.

Throughout 2010, DHS had further discussions with the Wisconsin Council on Long Term Care. Consumer feedback related to the long term care system was identified as a critical need. Consequently, the Department developed a plan to obtain consumer input as a first priority.

In December 2010, DHS invited organizations comprised of citizen and consumer advocates to host public meetings to discuss DHS defined questions related to quality and cost-effectiveness of ADRCs and MCOs; and to report results to DHS. The invitation was sent to "Leaders in Aging and Disability" and included numerous consumers, stakeholders and other entities, including:

- Federally-authorized Area Agencies on Aging;
- County and Tribal Aging Offices;
- Aging and Disability Resource Centers;
- The Wisconsin Council on Long Term Care;
- The State Independent Living Council;
- The IRIS Advisory Committee;
- The Children's Long Term Support Council;
- The Board on Aging and Long Term Care; and
- The Board for People with Developmental Disabilities.

More public meetings will be scheduled, however, at this time fifteen public meetings have been convened or scheduled by these organizations. Discussions are held in different geographic areas

of the State, including: Appleton, Ashland, Barron, Dodgeville, Eau Claire, Manitowoc, Menasha, Milwaukee, Oshkosh, Portage, Watertown, and Wisconsin Dells. Written reports are sent to the Department by the sponsoring agency reflecting the comments and attendance of consumers at the meetings. The Department will present those reports to the Council on Long Term Care, as required in the statutory provisions. In addition, in 2012 the Department intends to convene regional meetings of ADRC governing board members to discuss the findings of these public meetings.

Given this initiative, which is extensive and geographically diverse, DHS has determined that to oversee performance of ADRCs and MCOs these efforts represent a better approach to gaining input from a cross-section of Wisconsin citizens, rather than adding another administrative layer which would be created by regional committees. Although DHS will continue to explore the use of regional long term care committees in the future, for 2011 these public meetings are in lieu of establishing seven permanent regional committees. The Department will continue to monitor and evaluate the effectiveness of this alternative approach to gathering consumer input, which has the potential to encourage input from more consumers and individuals than a regional long term care committee structure and will determine whether to request modifications to the regional structure in the future.

**Attachment 1****Care Management Caseload Staffing in Family Care****Care Management Interviews**

In response to the recommendation from the Legislative Audit Bureau (LAB) report, the Department examined the staffing of the care management function in Family Care MCOs. Managers in all nine Family Care MCOs were interviewed for this report. The interviews included discussion regarding care management caseloads and the MCOs' techniques for managing this function. Additional information was evaluated from fiscal and program data collected by the Department.

**Effective and Cost- Efficient Long Term Care**

Family Care MCOs must provide effective and cost-efficient services within the capitated rate provided by the Department in order to be fiscally sound. Therefore, the MCO assumes responsibility and financial risk for each new member. The MCOs use a process called the Resource Allocation Decision (RAD) method to create the most effective and cost-efficient services based upon each member's needs and strengths.

The RAD requires the MCO to:

- Understand the member's needs, resources, and desired results;
- Assist the member in identifying various options to address his or her needs, including actions that the member can take independently, or with the assistance of informal supports such as family or friends;
- Support the member to access non-Medicaid services such as energy assistance, housing programs, food stamps and food pantries, Medicare, veteran's benefits, pensions, insurances, workers compensation and any other community resources, that may help the person live independently while limiting Medicaid costs;
- Create a service plan for publicly funded long term supports and services which includes locating a qualified provider and negotiating the best price with that provider;
- Coordinate the purchasing and scheduling of supports and services for the member, or support the member who wants to self-direct aspects of his or her services; and
- Oversee the supports and services to assure quality, as well as health and safety.

**Staffing the Care Management Function**

The costs of providing members with care management accounted for 11.8% of the MCOs' service expenditures in 2010. Therefore, controlling the cost and effectiveness of this service is vital to the MCOs' success. The quality of care management is also critical to meet the support needs of the MCO members. Each Family Care member works with a social services coordinator (SSC) and a registered nurse care manager (RN). The SSC, RN and member work as a team, with the SSC and RN coordinating their efforts, each taking responsibility for tasks suited to their expertise.



Staffing is often discussed in terms of either staffing ratios or caseloads. A *staffing ratio* is determined by comparing full-time equivalent (FTE) employees to enrolled members, and a *caseload* is the number of members for whom an individual MCO staff person has direct responsibility. Although the two concepts are related, an MCO's staffing ratio will never be the same as its average caseload size, for several reasons, including:

***New staff:*** In most MCOs, new care management personnel do not carry a caseload for their first few weeks in order to ensure adequate orientation and training unique to this position. This increases the MCO's staffing ratio without having an effect on the average caseload size.

***Specialized staff:*** Most MCOs assign specialized responsibilities to care management staff to promote quality and efficiency. These specialized care managers provide consultation and specialized service authorizations, as well as specialized assessments or long term care functional screen updates. Typically, these specialists do not carry a specific caseload.

***Caseloads handled by other staff:*** Some MCOs provide for supervisors to carry small caseloads as needed to help manage caseload size for the staff they supervise.

Average caseloads and staffing ratios observed at a single point in time can fluctuate fairly significantly making a point-in-time comparison challenging. The LAB report shares observations of staffing ratios during June 2010. One unique factor at that time was Lakeland Care District hiring care managers in preparation for the July 2010 enrollment of more than 1,000 new members from the Winnebago County legacy waiver programs. As a result, the staffing ratios were abnormally high for this MCO during the LAB observation period.

MCOs' annual business plans, submitted to the Department each fall, provide a clearer staffing ratio comparison. The ratio can be calculated based on the full-time equivalent employees who will be billing their time as care management services in comparison to each MCO's anticipated enrollment. A comparison of staffing ratios with each MCO's year-to-date operational cost-and-revenue ratios as of May 31, 2011 reveals that a large workforce does not necessarily create excess costs, nor does a small workforce necessarily enable an MCO to operate more economically.

The MCO with the largest operating deficit maintained the second smallest care management workforce, while the MCO with the largest care management ratio had a positive year-to-date operating surplus of 2.88%. The MCO with the largest care management ratio found a correlation between care management activities and reduced costs related to members self-directing some of their supports. The MCO studied its self-directed supports program, in which the MCO assists members to hire and supervise their own caregivers rather than purchasing services from service agencies, and found that the program reduced service costs by more than \$750,000 each quarter, or more than \$3 million annually.

### **Travel Distance Affects Staffing Ratios**

The size of an MCO's workforce also varies depending upon the size of the service area. The average round-trip driving time between a Northern Bridges care manager's office and a member's home is 49.6 minutes, almost four times the average round-trip time for a care

manager in the Milwaukee County MCO, which is 12.9 minutes. MCOs with smaller staffing ratios tend to be those with shorter average travel times.

### **Attrition of Care Managers Affects Caseload**

High attrition rates of care managers increase staffing ratios because average caseload sizes are smaller for recently hired staff. In 2010, care manager attrition was strongly affected by two MCOs which hired a large number of former county waiver care managers. These MCOs also reported a higher first-year turnover rate among these care managers.

### **Care Manager Training on Managed Care**

All MCOs reported a need to train staff who had previously worked in the Medicaid legacy waiver system. Some county waiver care managers tended to make decisions on a service basis, rather than based on member outcomes. Additionally, Medicaid card services, rather than Medicaid waiver services, were prioritized in the legacy system to conserve costs within the waiver. The Family Care model and benefit package encourages coordination of these services and cost management of overall Medicaid expenditures. MCO staff are required to assess the cost effectiveness of each service decision using the RAD method, and in many situations are able to streamline the service plan with the member to reduce or eliminate costs.

MCOs negotiate competitive reimbursement rates with service providers to secure a market driven and cost effective rate. This includes value-based purchasing, as well as the benefit of establishing rates that are based upon volume purchasing in some areas. This leverages cost savings for all MCO members.

### **Caseload Size Policies**

Every MCO specifies larger caseloads for RNs when compared to the SSCs. Also several MCOs specify smaller sizes for specialized caseloads, such as those composed of members with developmental disabilities or mental health issues. The MCOs that have studied cost effectiveness of various caseload sizes have arrived at varying conclusions about optimal caseload size. This is likely because of factors that vary by MCO such as geography and use of ancillary staff.

Lakeland Care District managers reported that cost effectiveness improved when they reduced caseload sizes to a guideline of 41 members for each SSC and 55 members for each RN. Community Care of Central Wisconsin has an average caseload target of 34 members for each SSC and 50 for each RN. As of May 31, 2011, both MCOs have positive year-to-date operating surpluses, indicating they are operating efficiently.

Every MCO implements its caseload-size policy with flexibility, balancing workload across novice and experienced teams. MCO managers match new members with care management teams by managing several factors, including: preferences the member has expressed; staff expertise related to the member's characteristics; staff and member location; and the member's residential status. If a care management team is already working with other members within a residential setting, then it is efficient to assign the new member to that team. MCOs also try to balance the number of new members assigned to a team, as well as considering the complexity of the other members managed by a specific care management team. Several MCOs also provide

care management staff who speak a foreign language and have the capacity to assign a team based on this factor as well.

### **Nurse Care Manager Caseloads**

All MCO managers interviewed for this study value the health assessments completed by an RN from the MCO care management team. This assures that the RN is not influenced by a paid provider's financial interests. This neutrality is critical to cost-effective management of the member's care, as well as the assessments of health risks by a highly qualified professional.

Members with unstable conditions have the need for routine nursing assessments. Members with significant intellectual disabilities or physical impairments may find it difficult to identify risks or to communicate emerging health problems on their own. Primary healthcare providers, without disability-specific expertise, are limited in their ability to serve these individuals without the assistance of a disability-specialized medical professional such as the RN.

RNs also support members' health and independence, depending on each member's needs, by:

- Assessing the need for medical or health services related to the members' needs;
- Assisting members in selecting the most cost-effective option to meet assessed needs;
- Authorizing those services that will be provided or purchased by the MCO;
- Ensuring members and caregivers understand medical orders and medication instructions, and have the ability to follow through on instructions;
- Ensuring that members and caregivers understand health-related behaviors and risks, and supporting their ability to make good choices;
- Communicating with physicians and clinics to ensure accurate and sufficient information about the member's medical needs and other information such as use of over-the-counter drugs and risks or limitations in the members' home;
- Communicating with discharge planners to ensure accurate and sufficient information for the member's return to the community; and
- Assuring that the MCO has sufficient information to plan effective and economical support immediately after discharge.

The need for the RN services depends on the member's health and resources within the residential setting. If the member lives in a facility with nurses on staff, the need for RN depends on the facility. Many facilities cooperate in sharing information about the member's medical needs and coordinate efforts to support the member's needs to avoid duplication of services. This is cost-effective for both the MCO and the facility, and supports the best results for the member. MCO RNs can carry larger caseloads when working with members who live in such facilities.

In other facilities, MCO managers report a greater need for the RN's involvement. Some of these facilities may rely on off-site medical staff, or have quality issues which require careful monitoring. Managers of all the MCOs interviewed for this study reported having experiences where the involvement of the MCO RN was critical in maintaining the member's health, including detecting and correcting medication errors, as well as identifying previously unnoticed health issues.

The Department promotes cost-effective use of nurse care managers. However, budgeted staffing ratios for RNs vary more widely among MCOs than do those for SSCs. The budgeted staffing ratio of the SSC's for the MCO with the most staff per thousand members is 48% greater than that of the MCO with the least staff. In contrast, the MCO with the most RNs budgeted a staffing ratio is 91% larger than the MCO with the fewest nurses.

The DHS-MCO collaborative workgroup has recently focused attention the role of the nurse in Family Care. DHS has published a technical assistance document on the role of the RN. The Department and MCOs will continue to refine these guidelines to ensure the most effective use of nurse care managers in the program.

### **Designing Care Management Efficiencies**

Family Care MCOs are adopting different strategies for organizing and managing their work. Several lessons about the care management function have been learned.

#### ***Employing Care Management Staff is More Effective***

Five of the nine current Family Care MCOs staffed their care management entirely with employees as the MCO began Family Care program operation. Four others relied entirely, or partially, on contracted care management services. All MCOs, except one, have subsequently decided to rely entirely on their own employees to create care plans and authorize services. One MCO's internal review found that contracted care managers created more costly care plans, had lower productivity, and did not score as well as MCO employees on other quality measures such as the Department-administered tests of functional screen knowledge.

The Milwaukee County Department of Family Care continues to rely on contracted care management services. The MCO is a department within Milwaukee County government, and is bound by rules and regulations adopted by a much larger organization. Therefore, even if the MCO employed its own care management staff rather than purchasing the service from private-sector human services agencies, it may not gain the workforce-management flexibility the other MCOs achieve by employing care management staff.

Advantages of direct employment of care managers include:

***Ability to select staff:*** The MCO has full discretion in employment decisions and in determinations regarding care manager performance.

***Clear roles and responsibilities:*** Care management staff who have responsibility for authorizing MCO expenditures for services are most responsible for expenditures when part of the MCO that is at risk for providing those services. There is responsibility to a single agency, rather than to both an employing and contracting agency which may create conflicting expectations and requirements.

***Flexibility to Transfer Staff Among Service Areas:*** An MCO has the ability to transfer staff between the various regions of a service area, either temporarily to cover situations such as parental leaves, or permanently, for example to handle unequal enrollment growth among the regions within an MCO's service area.

***Specialized Caseloads may Improve Efficiency:*** Some MCOs maintain specialized caseloads that include members of only one or two target groups or members who have mental health issues in addition to long term care needs. Other MCOs maintain caseloads that are a mix of all types of members. The Milwaukee County Department of Family Care (MCDFC) MCO maintains the greatest level of specialization among the MCOs. The MCDFC has care management units specializing by target group, language, ethnicity, age group, behavioral needs, and other factors. This level of specialization is feasible in a large, diverse, and urban service area. Three other MCOs noted that, to the extent possible, specialized caseloads are established, but travel time often prevents specialized caseloads in rural areas.

***MCOs Utilize Specialized Staff for Some Care Management Tasks:*** All MCOs employ some staff who specialize in particular care management functions. Typically, these staff do not carry an assigned caseload. These specialized care management staff consult with lead care managers regarding specific issues such as: completing assessments related to assistive technology needs and procuring equipment; supporting self-directed services; creating employment opportunities; completing mental health and behavioral assessments and related care planning; and coordinating benefits.

Several MCOs have also had staff that fostered good organizational working relationships with local agencies such as ADRCs, county human service agencies, and healthcare providers. This assures strong collaboration with these organizations as necessary to meet a member's care needs.

Community Care of Central Wisconsin, for example, reports that Care Managers access to members' electronic healthcare records at local clinics, as needed, has saved time and money. Other MCO managers noted good organizational relationships with clinics and hospitals, which enable care management staff to plan for members' preventive care and for smooth discharge planning, as well as partnerships with county agencies, when addressing competency and guardianship issues.

***Care Management Assistants:*** Many MCOs have defined responsibilities that can be handled by staff who are not human service professionals. Several MCOs have also implemented practices that make the professional's day-to-day work more efficient by assigning some responsibilities to lower-paid staff. Another MCO assigns a paraprofessional assistant to each regional office to support the care management teams.

The assistants perform less complex tasks such as helping members in making and remembering appointments for primary healthcare or other services; providing daily living skill training; gathering information needed by the care management staff; and assisting members when they need help with tasks as varied as finding a source for donated furniture for an apartment or helping a member manage options to get a wheelchair past temporary sidewalk construction.

***Clerical and Business Office Support:*** Community Care of Central Wisconsin describes its business office staff as “an extension of the care management teams”. These staff handle mailing and documentation tasks, provide support in the correct coding of services for authorization, and work with members and county Income Maintenance units on issues related to documenting members’ continued financial eligibility for Medicaid.

All MCOs provide the care management staff with some level of clerical support. However, many regional MCO offices are small, and do not have clerical support on site. In these circumstances, some clerical tasks still fall to the care management staff.

***Automation Helps Efficiency:*** Reducing paperwork for human service professionals saves money, improves productivity, and reduces turnover. Some MCOs are exploring the use of automated applications to reduce errors, improve timeliness of healthcare records, enable efficient quality assurance, and decrease the amount of time staff spend to create and retrieve information.

The MCOs have a number of information technology systems, some of which are used by two or more MCOs, to automate key processes. The information about effective design of these systems is being used in the development of a Department endorsed automated management system for long-term care. This effort is known as ‘the infrastructure project.’ The Department is in the process of procuring a vendor in this area with an intent to award a contract by the close of 2011. The Department has relied on the experience and expertise of MCO care management staff in developing and evaluating the proposals for this system, and will keep MCO care management staff involved in the final design stages as well.

### **Department Oversight of Care Management**

The Department provides oversight and improvement efforts to the care management function in the following ways:

#### ***Monitoring the MCO’s Capacity to Provide Care Management***

The appropriate resources needed to provide quality care management include staffing levels and staff qualifications. The Department does not require a specific staffing ratio. However, DHS reviews each MCO business plan with regard to the structure and capacity to provide care management services. The Department review assures that the MCO has adequate care management capacity to fulfill its mission to provide high quality and cost effective care to members, and looks for data-driven decision making about appropriate care management staffing from each MCOs.

#### ***Monitoring Care Management Activities and the Products of Activities***

Measures of care management activities include the reliability and timeliness with which those activities are performed; the products of care management include care plans, service

authorizations and the utilization of those authorized services. The quality of care in Family Care MCOs is reviewed annually by an External Quality Review Organization (EQRO).

The methods, focus, and scope of the EQRO reviews are largely dictated by federal regulations which focus on processes and outputs of the care management function. This information is provided to DHS and the MCO in a written report. If issues are identified by the EQRO, then the Department requires the MCO to correct deficiencies.

The results of the care management activity are measured by the long term care outcomes achieved for members, as well as member health and well-being. Additionally, the economy of cost effective, value-based purchasing for the MCO and the State's Medicaid program are expected outcomes of the Family Care program.

Information about services authorized through the care management process and then delivered to members is provided by the MCOs in the form of encounter reporting. Encounter reporting is used as one of the MCO performance indicators. DHS also reviews the utilization of specific services to monitor effective care outcomes for members. For example, the effectiveness of the care management function can be observed in the members' lives through measures such as preventable emergency room visits, loss or gain of functional abilities, and achievement of desired employment or living-situation goals.

The Department monitors and addresses issues related to these indicators and includes the results in the annual report titled *Long-term Care in Motion*. The Department also has a project to develop a set of performance measures related to care management results that are calculated with relevant data. DHS intends to use these measures to study and identify successful strategies, and to focus investigation, oversight, and remediation activities if the measures indicate that care management is being less effective than expected.

The Department's capitated rate can be understood as the Department's standard for economic, cost-effective operation of an MCO. If an MCO has an operating surplus—that is, has revenue in excess of expenses and is meeting its working capital and solvency requirements—it is operating at least as economically as the Department expects. If it has an operating deficit of expenses in excess of revenue, then the MCO is not meeting the economic, cost-effective goals of the Family Care program.

The Department currently monitors the fiscal condition of each MCO. The Department implements corrective action for those MCOs that are not successfully managing care within the established cost structure. The Department is also increasing efforts to arrange for successful MCOs to share management strategies and techniques with MCOs that are struggling in this area.

## **Conclusion**

The MCOs and the Department each have roles in oversight of effective and efficient care management. The MCOs are contracted by DHS to deliver the Family Care program benefit and must do so efficiently to meet members' needs and to maintain fiscal solvency. The Department

gives MCOs reasonable flexibility to adjust personnel and caseloads to meet current and emerging needs of the MCO. MCOs continue to refine staffing models and administrative infrastructures to ensure efficient and effective practices.

The MCO managers interviewed for this study exhibited strong leadership and the awareness of the necessity to ensure high quality care management functions. The incentives created for the MCOs to demonstrate positive outcomes for members and to manage within the capitated rate advance these goals. Many MCOs have implemented innovative and high quality practices in this critical area.

The Department has responsibility for statewide administration of the Family Care program and must ensure that it continues to monitor the efficiency and effectiveness of care management. The Department's oversight role is essential to monitor these results and to improve the care management functions within MCOs. DHS oversees the quality and economy of the long term care provided to Family Care members.

The Department will, therefore, support the MCOs in discovering and sharing reliable lessons from high quality management strategies. This will continue to improve the DHS and MCOs' understanding of the best methods for improving cost-effectiveness of care management. Specifically, the Department will:

- Complete the performance measures related to care management as calculated with available data;
- Assign responsibility to designated staff to calculate and evaluate these performance measures on a regular basis; and
- Assign responsibility to staff to address the improvement efforts necessary for any MCO with results that are below expected performance.

The results of these studies will be shared, in writing, with the MCOs and Department leadership, to promote shared organizational understanding of the factors that contribute to effective care management.



## Attachment 2

### Family Care Financial Oversight and Sanctions Procedure

#### Purpose

The purpose of the “Financial Oversight and Sanctions Procedure” is to clarify the circumstances under which a Family Care MCO may be subject to a fiscal corrective action, to outline the process for monitoring a MCO’s progress, and to identify the benchmarks for improvement needed to release an organization from fiscal corrective action status.

The goal of an effective fiscal corrective action policy is to proactively identify and monitor financially at-risk or distressed organizations to avoid insolvency (i.e., the inability to meet day-to-day obligations, operating from a negative equity position, and lacking a source for additional capital). A balanced approach is required for effective oversight. For example, an organization can operate from a negative equity position for an extended period in the HMO industry without interruption of operations if there are sufficient inflows of cash in advance of cash requirements. Thus, a negative equity position alone would not necessarily define insolvency. Since capitation is paid out at the beginning of a month and an MCO pays claims for that month in subsequent months, the MCO has the ability to use funds in advance and sustain ongoing operations with a negative equity position.

#### Background

The Family Care Long Term Care Contract, Article XVII, section A, requires the MCOs to demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under the contract and ensure continuity of care for enrolled members. The MCO must demonstrate its financial management capacity to both the Wisconsin Department of Health Services and the Wisconsin Office of the Commissioner of Insurance, as outlined under Chapter 648 of Wisconsin Statutes.

#### Financial Oversight and Sanctions Procedure

A joint DHS/OCI team oversees the organizations’ compliance with Family Care and Partnership contract requirements using a variety of resources, including review of financial submissions and the investigation of issues with fiscal implications identified by an oversight team. Although a failure to meet capital funding requirements is the most common “trigger” for an MCO to be placed under fiscal corrective action, additional factors are considered, including the identification of potentially problematic policies or financial procedures at the organization, or the review of due diligence findings that result in a corrective action recommendation and action decision.

1. **Identification of a Trigger** can include issues discovered by the OCI/DHS team through regular monitoring of financial submissions or issues brought to the attention of the team

by others. Examples include failure to meet solvency requirements, unexpected financial performance fluctuations, unbudgeted purchases, adverse trends in financial results, internal control findings, or a breakdown in a required operational process.

2. **Due Diligence**, or the investigation of identified issues by the DHS and/or OCI fiscal oversight team, is based on the potential severity of the issue and may include a range of responses from written and/or verbal communications, a review of required supporting documentation, up to a site visit including an audit.
3. Recommendation - the due diligence work results in a **no corrective action recommendation** or a **recommended action for State agency review**.  
*See Attachment 3: Family Care Financial Monitoring and Corrective Action Tiers*
4. **State agency decision** and communication of action decision and requirements to the MCO.

The policy and procedure further defines:

1. **Monitoring of a MCO while in a state of ongoing corrective action** includes ongoing reviews of required MCO submissions based on the terms of the corrective action to ensure compliance with the requirements and to determine when the MCO meets the defined criteria for release from corrective action. Failure to meet the terms of corrective action results in recommendation of escalation to a higher level of corrective action.
2. **Release of an MCO from corrective action** includes the meeting the requirements and defined timelines to demonstrate ongoing stability and full compliance over time to include:
  - Satisfaction of the corrective action terms for six consecutive months,
  - Compliance with terms of the corrective action, performance expectations, and procedural requirements to eliminate documented system risks, and
  - Validation of financial projections and financial reporting to support ongoing stability.
3. **Contract termination due to an MCO's insolvency and bankruptcy** includes the required steps for an MCO that meets the definition of insolvency in accordance with a pending bankruptcy and no long-term plan for recovery and addresses the timeline and member transition plan, written MCO notification, MCO hearing, and responsibilities to meet the MCO's obligations and the distribution of pooled solvency funds, as needed.

Attachment 3

Family Care Financial Monitoring and Corrective Action Tiers

Level	Criteria	Action
<p><b>FISCAL MONITORING:</b> This state is the routine operating state of a Family Care MCO. The MCO is fully in compliance with the program’s capital requirements and there are no major regulatory concerns. There may be some modest heightening within this state, if a relatively minor issue is discovered by oversight staff.</p>		
<p>Quarterly Financial Monitoring</p>	<p>Ongoing performance consistent with annual projections and trends that demonstrate the ongoing long term fiscal health of the MCO operations.</p>	<ul style="list-style-type: none"> <li>Ongoing quarterly monitoring</li> </ul>
<p>Heightened Financial Monitoring</p>	<p>This level is based on results and information provided in the MCO financial submission or from information provided by an external party. The specific criteria include but are not limited to IBNR volatility, unplanned declining positive trends in liquidity position, large variances to the projected current year financial plan, or other operational issues as evidenced through the financial reporting or other forms of communication.</p>	<ul style="list-style-type: none"> <li>Written and verbal communications with the MCO are carried out to identify the issues/concerns and to require specific responses with a plan, if warranted, to ensure stability and improvement in the area of concern. This may include assessment of the underlying cause of the identified issues/concerns, submission of projections, implementation of revised policies and procedures and/or monthly reporting and may result in escalation to corrective action.</li> </ul>
<p><b>CORRECTIVE ACTION:</b> This state is characterized by the fact that the MCO has encountered financial issues that warrant greater oversight and intervention by the dual state agency oversight team. These issues range from modest to severe, and the oversight model becomes progressively more involved as the risks to the MCO, its members and the State increase. Note that the increased levels of action are cumulative and include all actions in the lower levels of intervention.</p>		
<p>Corrective Action: Initial Level</p> <p>Initial Level (cont’d.)</p>	<p>Specific requirements imposed by the OCI and DHS fiscal oversight bodies with criteria including the following:</p> <ul style="list-style-type: none"> <li>MCOs inability to achieve stability and/or provide a satisfactory plan or other requested documentation to support a plan for stability.</li> <li>Failure to meet any of the three distinct capital requirements that is not due to a previously approved shortfall to accommodate a mandatory capitation payment delay.</li> <li>Identification of an operational weakness in critical processes/procedures or internal controls.</li> <li>Sudden unexplained change in trend and/or volatility or explained change highlighting a systemic problem in the required MCO operations.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly reporting</li> <li>Additional analysis of the MCO business and operations is required and may lead to a targeted or full examination.</li> <li>Monthly fiscal reporting requirement.</li> <li>Performance Expectations to address specific areas of required improvement.</li> <li>MCO is required to update financial projections to demonstrate required results.</li> <li>Technical support is provided.</li> <li>Submission of additional supporting documentation may be required.</li> <li>Possible accelerated release of RFP.</li> </ul>

Level	Criteria	Action
<p>Corrective Action: Intervention Level</p>	<p>This level requires all of the actions included in the Corrective Action Initial Level with the addition of specific requirements imposed by the OCI and DHS fiscal oversight bodies, with criteria including the following:</p> <ul style="list-style-type: none"> <li>• The percent of total FC capital requirements is zero / negative, and declining and without an approved plan to recover within the required timeframe.</li> <li>• Failure to demonstrate correction of an identified weakness in operational procedures or internal controls within the communicated required period.</li> <li>• Deteriorating trends and/or volatility over a three month period that does not have a satisfactory plan for correction.</li> <li>• Sudden failure of critical systems or organizational structure such as IT system failure, loss of critical financial systems/staff, other major organizational change that is identified as causing extreme risk to the ongoing day-to-day operations and management of the risk-based MCO.</li> </ul>	<ul style="list-style-type: none"> <li>• Corrective action requirements defined in contract with identified contingencies.</li> <li>• Business plan development and submission</li> <li>• Required insertion of on-site program expert(s) to facilitate achievement of required correction.</li> <li>• Site visit</li> <li>• Weekly updates with MCO management.</li> <li>• DHS/OCI meeting with the MCO Board.</li> <li>• Additional fiscal reporting requirements.</li> <li>• Provisional contract/permit, with possible accelerated release of RFP.</li> <li>• OCI examination</li> </ul>
<p>Mandatory Control Level</p>	<p>This level is based on the determination that the MCO has the potential to conduct day-to-day operations and effect required change under different leadership.</p>	<ul style="list-style-type: none"> <li>• DHS identifies temporary or permanent replacement management for an existing organization.</li> <li>• Actions in lesser levels are ongoing.</li> </ul>
<p>Termination Level</p>	<p>This level is based on the determination that the MCO is insolvent and unable to manage the day-to-day financial obligations and/or risk of ongoing managed care operations and the MCO is unable to identify and secure a source of capital infusion to support the MCO operations and infrastructure. The MCO meets the definition of insolvency in accordance with pending bankruptcy and there is no long-term plan for recovery.</p>	<p>DHS termination options include:</p> <ul style="list-style-type: none"> <li>• DHS takes over management of the MCO.</li> <li>• DHS identifies temporary replacement management for existing organization to achieve member transition.</li> <li>• The enrollment membership is transitioned to a certified and permitted MCO.</li> <li>• The enrollment region is divided and transitioned to existing MCO(s) in neighboring regions.</li> <li>• The membership is transitioned into another identified program.</li> </ul>

**Attachment 4****Family Care Summary of Improper Payments in 2010**

In 2010, Family Care MCOs reported four instances of alleged fraud and abuse.

1. In the 1st quarter, Community Care of Central Wisconsin (CCCW) was notified by a provider that they discovered potentially fraudulent billing activity had occurred within their company. CCCW was billed and paid for services not provided. As a result of the investigation, it was determined that the billing person for the provider was billing CCCW for services not rendered. The individual could not explain, nor provide documentation to support the billing activity. It was agreed that all billing records would be reviewed and CCCW would be reimbursed for any overpayments that occurred. The provider also agreed to develop a corrective action plan to tighten billing practices in the future. The provider removed the employee responsible for the billing issue and established internal controls to prevent future fraudulent billing activity. A process of checks and balances was implemented which includes multiple employees reviewing the billing for accuracy. The provider is also requesting that billing records and the billing process be reviewed during their annual audit and will share the results with CCCW. Following the investigation, CCCW recovered \$40,162.45, the full amount owed.
2. Also in the 1st quarter, Lakeland Care District (LCD) reported that a care manager recognized inconsistencies within the self-directed support (SDS) option being utilized by a member's guardian/mother. Additional investigation by the care manager uncovered that the guardian/mother was inappropriately signing off on SDS timesheets for an SDS worker. The care manager noted a discrepancy in the hours submitted (total dollar amount was \$11.32). The potential for inappropriate billing could have been up to \$22,945, as that was the allotted SDS budget for the year. The care manager verified that the time sheets submitted were false because they spoke with the business owner who indicated the guardian was not an employee. After law enforcement review, it was determined that the budget which consisted of supportive home care (SHC) hours and respite hours could not be pinpointed to be fraudulent (i.e., guardian quickly indicated that the hours were for Respite vs. SHC) and the officer assigned to the case could not verify the actual SDS worker's signature (the officer was never able to make contact with the SDS worker). The District Attorney did not pursue the case.
3. In the 4th quarter, Community Care, Inc. (CCI) reported an instance of a provider double-billing for services. The individual provided services in Sheboygan to two siblings in the same household. Because the two individuals were in different programs, the provider submitted claims for eight hours of care to each program for eight hours worked. CCI became aware of the concern once the younger sibling aged into the program, at which time the provider was informed that the MCO would only pay once for eight hours of work. The incident was investigated with the assistance of the Wisconsin Department of Justice, but the MCO was not able to obtain records from the county (the second payer). Without the

evidence of a second payer, the investigation was not completed and a dollar amount could not be determined.

4. In the same quarter, CCI reported an incident involving staff at an Adult Family Home stealing a member's personal funds. The staff member diverted \$850 that had been sent to a Family Care member to purchase clothes and other personal items. This was reported to the local police. The owner of the facility advised CCI that he severed his business relationship with the staff person, reimbursed the member for the misappropriated funds, and worked closely with Community Care to resolve other concerns. The facility remains on an admission hold list due to ongoing concerns.

**Attachment 5****Enhancement of MCO Program Integrity Plans****Purpose**

Building on the program integrity provisions originally enacted in the Deficit Reduction Act, and additional provisions in Title VI of the Patient Protection and Affordable Care Act, the Department will be enhancing the Program Integrity efforts to align the MCO objectives and oversight with those required in federal legislation.

**History**

The Family Care Long Term Care Contract, Article XIII section I, defines the MCO's responsibility for establishing a Program Integrity Plan designed to guard against fraud and abuse. General contract requirements mirror current CMS requirements and include:

1. Designation of a compliance officer and compliance committee
2. Written policies and procedures that guard against fraud and abuse
3. Reporting of suspected fraud and abuse as situations arise and also reported within the MCO Quarterly Report
4. Investigation of potential fraud and abuse

State oversight activities have historically included:

1. Annual review of the MCO Program Integrity Plan
2. Investigation and monitoring of potential fraud and abuse
3. Communication to/from MCOs regarding reported provider fraud and abuse
4. Review of all operational policies and procedures

**Current Status**

The Patient Protection and Affordable Care Act, Title VI, creates new requirements to provide information to the public on the health system and promotes a newly enhanced set of requirements to combat fraud and abuse in public and private programs. The Patient Protection and Affordable Care Act, Title VI creates three key components in addition to existing program integrity practices:

1. Improving Transparency of Information.
  - a. Ownership disclosure
  - b. Reporting
  - c. Staff accountability
2. Targeting Enforcement.
  - a. Civil money penalties
  - b. Notification of facility foreclosures
  - c. National demonstration projects on culture change
3. Improving Staff Training. Includes several provisions but most notable is Subtitle F – Additional Medicaid Program Integrity Provisions:

- a. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.
- b. Medicaid exclusion related to certain ownership, control and management affiliations.
- c. Billing agents, clearinghouses, or other alternative payees required to register under Medicaid

To support the implementation of these new requirements, the Department is enhancing its oversight of MCO business practices as well as providing guidance to the MCOs on improving their own Program Integrity Plans and efforts.

DHS efforts over the next six months will include the following:

1. Create a summary/briefing paper to inform MCOs, LAB and other State stakeholders of the initiative.
2. Respond to the LAB recommendation to report on potentially fraudulent payments in 2010 that were identified by MCOs.
3. Collaborate with the State Audit/Program Integrity unit to facilitate sharing of information, policies and procedures and establish on-going communications.
4. Understand the role of State Department of Justice in identification and resolution of fraud and abuse to facilitate on-going communications related to fraud and abuse issues.
5. Review existing MCO Program Integrity Plans against the Affordable Care Act provisions.
6. Develop a work plan to address gaps between current Program Integrity Plans and the provisions of the Affordable Care Act.
7. Support MCO efforts through communications, collaboration and sharing of information.
8. Review 2013 Long-Term Care contract language to ensure compliance with the Act's provisions and requirements.

The Department's goal for this initiative is to create a heightened awareness and collaborative effort with the MCOs regarding the Patient Protection and Affordable Care Act provisions for program integrity initiatives. It is important for the MCOs to become familiar with the provisions in Title VI – Transparency and Program Integrity and continue to align their efforts with those of the Act.

MCOs have been directed to continue to develop their plans and operations using the Long Term Care Contract and the Patient Protection and Affordable Care Act provisions as guidance. DHS will provide further guidance and assist in organizing MCO collaboration as a proactive response to the new provisions.

Below are some resources that might be helpful to MCOs in preparing their Program Integrity Plans for 2012:

<http://dpc.senate.gov/healthreformbill/healthbill04.pdf>

<http://www.dol.gov/ebsa/healthreform/>



**Attachment 6****Continuing Skills Testing (CST) for the Adult Long Term Care Functional Screen  
(LTC FS)  
Policy and Procedure****Purpose**

- To ensure the Adult LTC FS is applied appropriately and that it determines the individual's correct level of care.
- To ensure all Adult LTC FS screeners have the knowledge and skills to submit complete and accurate Adult LTC FSs.
- To ensure all Adult LTC FS screeners retain screening access by completing the on-going training requirements.

**Persons/Programs Affected**

Staff who complete the LTC FS including: ADRC, APS, Family Care, Family Care Partnership, IRIS, PACE, CIP and COP Waivers, and COP.

**Policy**

An Adult LTC FS screener needs to successfully complete the Continuing Skills Testing every twenty-four months, to maintain their screening access, and if applicable, a screener specific plan of correction. Every twenty-four months, the DLTC Adult LTC FS Quality Team will administer a Continuing Skills Testing to all certified Adult LTC FS screeners in Wisconsin. LTC FS staff will need to comply with this requirement and demonstrate sufficient knowledge and accuracy in completion of the LTC FS in order to maintain access to the LTC FS application.

**Abbreviations**

ADRC: Aging and Disability Resource Center  
APS: Adult Protective Services  
BLTS: Bureau of Long Term Support  
COP: Community Options Program  
CST: Continuing Skills Testing  
DLTC: Division of Long Term Care  
IRIS: Include, Respect, I Self-Direct  
LTC FS: Long Term Care Functional Screen  
MCO: Managed Care Organization  
OFCE: Office of Family Care Expansion  
ORCD: Office of Resource Center Development  
POC: Plan of Correction

**Responsibilities**

The Functional Screen Supervisor will oversee planning and implementation of the Continuing Skills Testing project. The Functional Screen Quality Team, plus a subgroup of Functional Screen Instructions Workgroup members will also support the Continuing Skills Testing process.

**Procedure**

1. LTC FS Continuing Skills Testing team will develop an effective and valid skills evaluation process to ensure that adult LTC FS staff are accurate in content and clinical aspects of the LTC FS.
2. LTC FS Continuing Skills Testing team will develop all aspects of the testing including the use of distance technology and different test formats (written, video, etc.) for the Continuing Skills Testing.
3. After determining most effective and efficient format, the LTC FS CST team will consult with other internal DHS staff to see if test needs can be met with internal DHS resources or if external resources will be needed.
4. LTC FS Continuing Skills Testing Team will meet with DLTC Managers to determine the project's budget.
5. If external resources are required to complete the Continuing Skills Testing, the LTC FS Continuing Skills Testing team will follow applicable DHS procurement procedures to obtain a contractor for needed services.
6. LTC FS Continuing Skills Testing Team will develop a project timeline.
7. LTC FS Continuing Skills Testing Team will develop test content and correct responses and complete any additional materials needed to accompany the Continuing Skills Testing. Functional Screen Team members will write the rationales for correct answers that will be sent to each screen liaison for use as a teaching tool when the Continuing Skills Testing results are shared.
8. Continuing Skills Testing team notifies the LTC FS screeners of the upcoming Continuing Skills Testing via listserv communication and will include general timeframes for the completion of the Continuing Skills Testing process.
9. LTC FS Continuing Skills Testing team will work with selected vendors to get Continuing Skills Testing ready for distribution to LTC FS screeners.
10. Functional Screen Team will write up and send out a listserv to LTC FS screeners further explaining the Continuing Skills Testing process and how to complete it at each agency.
11. The Continuing Skills Testing will be administered statewide to all Adult LTC FS screeners within a time period specified by the Department.
12. After the Continuing Skills Testing time period has elapsed, the Continuing Skills Testing results will be scored on an individual and agency basis.
13. Continuing Skills Testing test scores will be disseminated to each screening agency's screen liaison and appropriate DHS staff.
14. Individuals who fall below the designated score will be required to complete a screener specific Plan of Correction.

**Attachment 7****LTC FS Continuing Skills Testing Score Results in Plan of Correction  
Policy & Procedure****Purpose**

- To ensure the Adult LTC FS is applied correctly, in order to provide individuals with accurate level of care determinations.
- To ensure all Adult LTC FS screeners have the knowledge and skills to administer and submit complete and accurate Adult LTC FSs.
- To ensure all Adult LTC FS screeners retain screening access by completing the on-going training requirements.

**Persons/Programs Affected**

ADRCs, Family Care, Family Care Partnership, IRIS, PACE, ADRC, Medicaid legacy home and community based services waiver programs including the Community Integration Program (CIP) and Community Options Program (COP), and county Adult Protective Services staff who complete the LTC FS.

**Policy**

Adult LTC FS screeners must successfully complete the Continuing Skills Testing every twenty-four months, and if applicable, complete a screener specific plan of correction (POC) to maintain their screening access. Every twenty-four months, the Adult LTC FS Unit will administer a Continuing Skills Testing to all certified Adult LTC FS screeners to maintain their screening access to complete a LTC FS.

After Continuing Skills Testing is completed and test scores have been disseminated, individuals who fall below a total composite score of 80% will be required to complete a screener specific Plan of Correction. Each Plan of Correction is mutually agreed upon by the DHS Functional Screen Team with the applicable Division LTC FS Screen Lead and the screen liaison at the local screening agency. If applicable, an agency-wide Plan of Correction can be implemented to address agency-wide issues needing remediation.

Individuals with read-only access to the LTC FS data are not required to complete the Continuing Skills Testing.

**Abbreviations**

ADRC: Aging and Disability Resource Center  
BLTS: Bureau of Long Term Support  
COP: Community Options Program  
CST: Continuing Skills Testing

DLTC: Division of Long Term Care  
IRIS: Include, Respect, I Self-Direct  
LTC FS: Long Term Care Functional Screen  
MCO: Managed Care Organization  
OFCE: Office of Family Care Expansion  
ORCD: Office of Resource Center Development  
POC: Plan of Correction

### **Responsibilities**

The Functional Screen Supervisor Manager will oversee the planning and implementation of the Plan of Correction project, and document the completion status of all Plan of Corrections. The LTC FS staff associated with each programmatic area will have responsibility for developing and overseeing the Plan of Correction at the counterpart local agency. The OFCE Functional Screen staff will work with MCOs; the ORCD LTC FS Screen Lead will work with ADRCs, and the BLTS LTC FS Screen Lead will work with IRIS and legacy waiver programs to ensure compliance and quality improvement.

### **Procedure**

1. After Continuing Skills Testing is complete, each individual with composite score below 80% will be identified as needing a Plan of Correction.
2. Identified individuals will be listed by agency and will be securely emailed to the screen liaison at the local agency.
3. The Functional Screen Quality Supervisor in conjunction with the OFCE, ORCD and BLTS Screen Leads will have a conference call with each agency's screen liaison that has screeners requiring remediation to develop a Plan of Correction for those screeners.
4. Each screening agency will need to develop and submit a timeline and learning plan describing steps the agency will undertake to ensure the screener(s) fully understands the LTC Functional Screen Instructions and in turn are completing the LTC FS accurately.
5. Each screening agency will determine the most appropriate training and technical assistance for local screeners needing a Plan of Correction and additional training.
6. The developed and agreed upon Plan of Correction could include, but is not limited to, the following types of corrective activity:
  - Screener is to reread the LTC Functional Screen Instructions;
  - Screener is to watch applicable DHS webcasts;
  - Screener is to review applicable technical assistance documents (e.g. Question/Answer material, target group decision tree material);
  - Screener is to attend regional or statewide trainings (as offered);
  - Screener is to shadow a certified screener(s);
  - On completed LTC FSs, the screener is required to write in the notes sections, justification for selected need for assistance with the Activities of Daily Living, Instrumental Activities of Daily Living, and Health Related Services tasks;
  - Initially, a 100% review of the screener's work by the screen liaison (and possibly by state staff). These desk reviews will be written up and submitted to the

Functional Screen Quality Team. Any areas needing further clarification or correction to what was recorded on the LTC FS will be resolved.

- Over time, the screen liaison will spot-check the screener's work; or over time, DHS Functional Screen Quality Team staff will spot-check the screener's work.
7. Each Plan of Correction will be submitted to DHS Functional Screen Quality Team for written approval.
  8. While a screener is working through their Plan of Correction, he/she will retain full access to complete an online LTC FS. At 6 and 12 months after the Plan of Correction process is completed, state staff may spot-check the screener's work.
  9. Failure to complete the Plan of Correction will result in the screener's access being limited to read-only access or the screener will be removed as an active screener for the agency. Read-only access will not allow the screener to complete and submit a LTC FS, until the screener can demonstrate acceptable knowledge of the Functional Screen Instructions, as determined by DHS Functional Screen Quality Team.

**Attachment 8****Options for Streamlining Appeals in Managed Long-Term Care**

The Federal Social Security Act that authorizes Medicaid and managed care requires that for an appeal related to denial of a request for new service, reduction or termination of a service or dissatisfaction with member centered plan, members have access to all of the following actions concurrently:

- An MCO appeal process
- A DHS Review
- A State Fair Hearing process

The Department has identified streamlining alternatives within those constraints and is seeking public input from stakeholders about the available options. The Department has already solicited feedback from its Council on Long Term Care and is now looking for input from other stakeholders.

Following is a description of and considerations related to the current appeals process as well as three options to streamline this process:

**Continue to use the current system with no change**

- Advantages:
  - Provides the most choice for consumers
  - Consumers who prefer a decision by a third party decision-maker may bypass the MCO appeal process and request fair hearing with DHA
- Disadvantages:
  - Too much choice may create unnecessary confusion rather than meaningfully increasing the likelihood that members will be comfortable accessing the appeals system
  - Complexity of the current system may inadvertently serve as barrier to appeals system
  - Allowing concurrent filing of three different types of review inherently allows for the waste of already limited resources

**Streamline Option 1**

Member may choose MCO appeal or fair hearing at any time, including both processes at the same time. Direct DHS review process.

- Advantages:
  - Consumers who prefer a decision by a third party decision-maker may bypass the MCO appeal process and request fair hearing with DHA
  - Eliminating *direct* DHS review provides some simplification, but DHS maintains authority to conduct *concurrent* reviews during a fair hearing and maintains authority to correct clear contract violations
- Disadvantages:
  - Undertaking MCO appeal and fair hearing at the same time may be confusing
  - Limited DHA resources may be unnecessarily expended if the matter is resolved at the MCO level

**Streamline Option 2**

Member may choose MCO appeal or fair hearing at any time, but not at the same time. Direct DHS review process eliminated.

- Advantages:
  - Consumers who prefer a decision by a third party decision-maker may bypass the MCO appeal process and request a fair hearing with DHA
  - Eliminating *direct* DHS review provides some simplification, but DHS maintains authority to conduct *concurrent* reviews during a fair hearing and maintains authority to correct clear contract violations
  - Not allowing concurrent processes may be less confusing and less prone to wasted effort if the matter is resolved at the MCO level
- Disadvantages:
  - Once there is a fair hearing decision on an issue, there is no opportunity for an MCO appeal
  - As a result, some members may bypass the MCO appeal even though the MCO appeal process might have resolved the matter

**Streamline Option 3**

Member must first use the MCO appeal process before accessing the fair hearing process. Direct DHS review process eliminated.

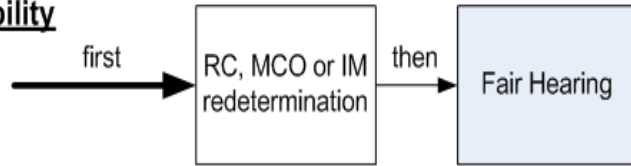
- Advantages:
  - Eliminating *direct* DHS review provides some simplification, but DHS maintains authority to conduct *concurrent* reviews during a fair hearing and maintains authority to correct clear contract violations
  - Requiring MCO appeal first assures that there is an opportunity for the issues to be resolved at the MCO level
  - Makes the process standard for all appeals
- Disadvantages:
  - Requires members who are uncomfortable with the MCO appeal process or who believe the MCO appeal process is not objective to nevertheless use the MCO appeal process
  - Members who are interested in obtaining a final administrative decision as expeditiously as possible by requesting a fair hearing with DHA immediately will be denied that opportunity

Of the other five states within the same CMS region as Wisconsin, two require that a member appeal at the MCO level before accessing a fair hearing.

Options for Streamlining Appeals in Managed Care

**Current Process - Eligibility**

- Member may:
- request redetermination
  - request fair hearing

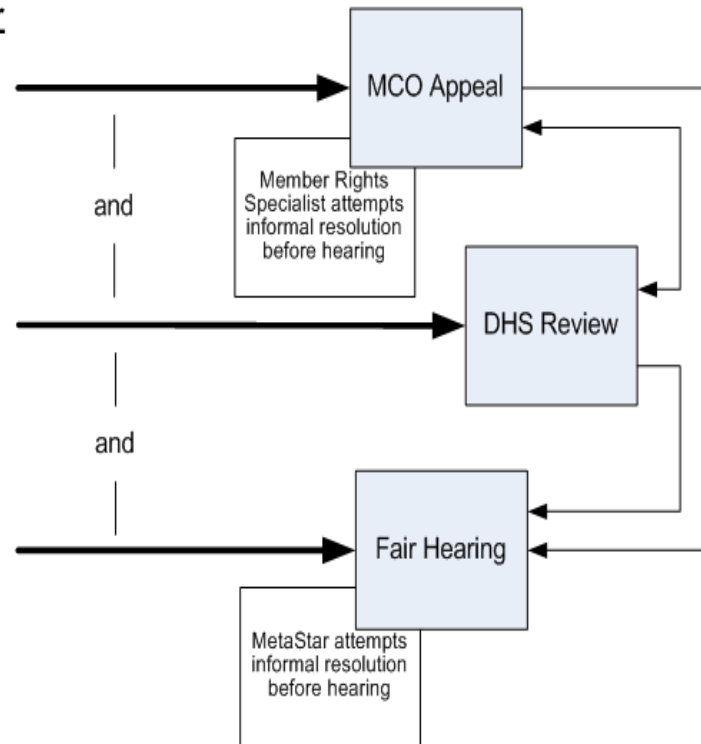


Fair hearing is the final level of administrative review

-- This process cannot be changed --

**Current Process - Other**

- Member may:
- choose any of three processes at any time
  - or at the same time



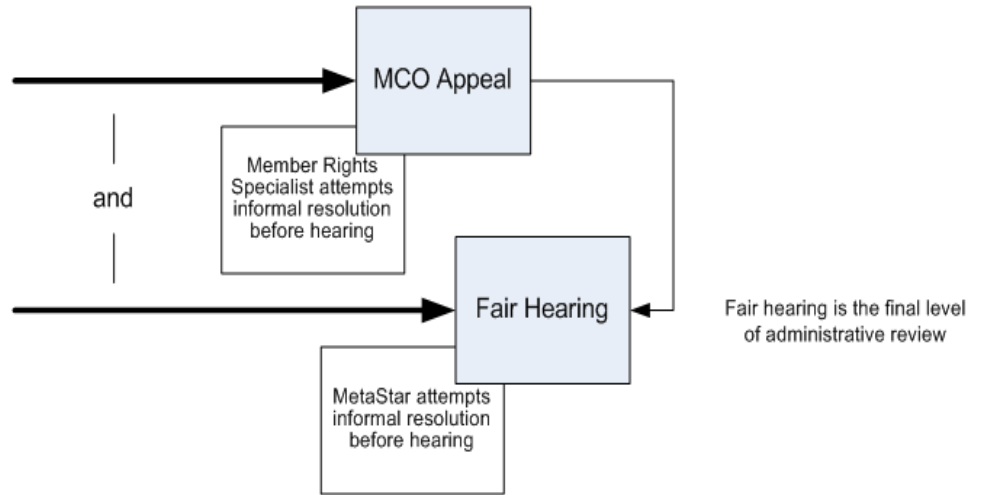
Fair hearing is the final level of administrative review

**Continuing the current process with no streamlining is one option. Possible streamlining options are described on the next page.**



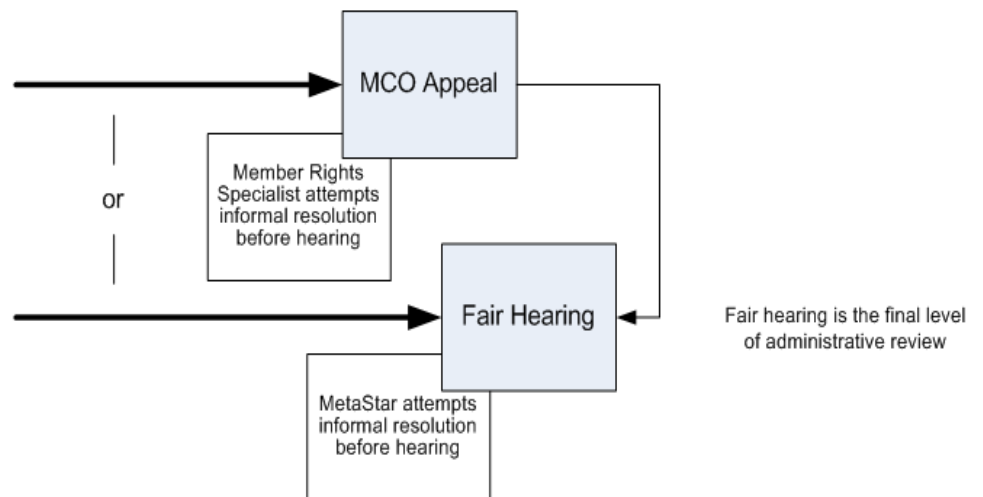
**Streamline Option 1**

- Member may:
- choose either of two processes at any time
  - or at the same time



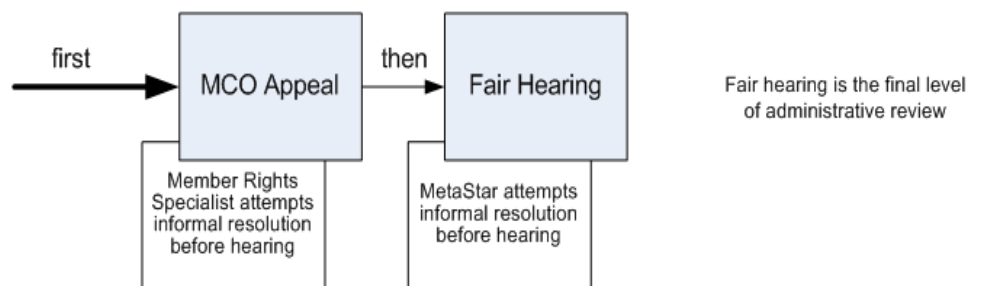
**Streamline Option 2**

- Member may:
- choose either of two processes at any time
  - but not at the same time



**Streamline Option 3**

- Member must:
- use MCO appeal processes first, then
  - may proceed to fair hearing if not satisfied



**Attachment 9****Personal Experience Outcomes for Long Term Care**

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of Wisconsin's long term care system. The following statements and definitions demonstrate the areas of life that people in long-term care programs have identified as being important to their quality of life. They are stated in the first person to emphasize the importance of the personal voice and experience of the individual. These statements provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning and in monitoring the quality of long term care supports and services.

**Choice**

People participating in human service systems may feel a loss of control over their lives as professionals or others in authority get involved. Wisconsin's long term care programs strive to empower individuals who receive services (participants, members, or consumers) to have choices—to have a "voice" or say about things that affect their quality of life and to make decisions as they are able. People with intellectual disabilities are supported to actively participate in the ways they are able, and their decision-makers such as guardians, are also engaged to keep the person's perspectives in mind for making decisions. In working extensively with consumers the following statements were developed to reflect some of the ways in which the system can help support people to maintain control over their lives.

**I decide where and with whom I live.**

One of the most important and personally meaningful choices I can make is deciding where and with whom to live. This decision must acknowledge and support my individual needs and preferred lifestyle. My home environment has a significant effect on how I feel about myself and my sense of comfort and security.

**I make decisions regarding my supports and services.**

Services and supports are provided to assist me in my daily life. Addressing my needs and preferences in regard to who is providing the services or supports and how and when they are delivered allows me to maintain dignity and control. To the extent that I desire and am able, I am informed and involved in the decision-making process about the services and supports I receive. I am aware that I have options and can make informed choices.

**I decide how I spend my day.**

Making choices about activities of daily life, such as sleeping, eating, bathing, and recreation enhances my sense of personal control, regardless of where I live. Within the boundaries of the other choices I have made (such as employment or living with other people), I am able to decide when and how to do these daily activities. It gives me a sense of comfort and stability knowing what to expect in my daily routine. It is important to me that my preferences for when certain activities occur are respected and honored to the extent possible.

**Personal Experience**

A person's day-to-day experience should meet his or her expectations for quality of life. People who participate in a long term care programs are recognized as citizens rather than just a part of a program and they are treated with respect. The focus of supports and services is to assist people in their daily lives, not to take over the person's life or get in the way of the person's life experiences.

**I have relationships with family and friends I care about.**

People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and affirms my identity. To the extent that I desire, people who care about me and my well-being provide on-going support and watch out for my best interests.

**I do things that are important to me.**

My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose.

**I am involved in my community.**

Engaging in the community in ways that I enjoy provides me with a sense of belonging and connection to others. Having a presence in my community enhances my reputation as a contributing member. Being able to participate in community activities gives me opportunities for socialization and recreation.

**My life is stable.**

My life is not disrupted by unexpected changes for which I am not prepared. The amount of turnover among the people who help me, paid and unpaid, is not too much for me. My home life is stable, and I am able to live within my means. I do not worry about changes that may occur in the future because I am reasonably well prepared.

**I am respected and treated fairly.**

I feel that those who play a continuing role in my life respect me. I am treated fairly as a person, program participant, and citizen. This is important to me because it can affect how I view myself in relation to others and my sense of self-worth.

**I have privacy.**

Privacy means that I have time and space to be by myself or with others I choose. I am able to communicate with others in private as needed. Personal information about me is shared to the extent that I am comfortable. Privacy allows me to be free from intrusion by others and gives me dignity.

**Health and Safety**

Health and safety is an essential and critical part of life that can affect many other areas of a person's life. The following outcome statements represent the person's right to determine what is important to him or her in these areas, and the risks he or she is willing to take. It is about the steps a person feels he or she needs to meet his or her personal priorities. It is not an assessment of whether or not the person's circumstances meet others' standards for good health, risk, or safety.

**I have the best possible health.**

I am comfortable with, or accepting of, my current physical, mental, and emotional health situation. My health concerns are addressed to the extent I desire. I feel I have enough information available to make informed decisions about my health.

**I feel safe.**

I feel comfortable with the level of safety and security that I experience where I live and work, and in my community. I am informed and have the opportunity to judge for myself what is safe. People understand what I consider to be an acceptable level of risk and respect my decisions. If I am unable to judge risk for myself due to my level of functioning, then I have access to those that can support me in making those determinations.

**I am free from abuse and neglect.**

I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences of abuse or neglect have been adequately dealt with or are being addressed.