Written Testimony to Joint Legislative Audit Committee

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"Family Care: A Program in Trouble"

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I have personally been involved with the Family Care and Family Care – Partnership Programs since 1998, both as an outside consultant/auditor and as a former administrator of Community Health Partnership, Inc. My personal background and education are in healthcare finance with 17 years of experience in the field.

Even though the Department of Health Services is reporting positive financial performance for most of the Family Care managed care organizations in 2012, I come here today to testify because Wisconsin's system of long-term services and supports for individuals with the highest degree of needs has many problems that need to be addressed.

I am sure that many of you have heard from beneficiaries and providers alike complaining about the difficulties accessing quality services, being denied an appropriate benefit, receiving an unsustainable provider rate, dealing with an underpaid workforce and the ongoing increases in costs that providers must deal with. Many of these problems are not caused by the Program's design but rather by Wisconsin Department of Health Services' implementation of the Program. The areas I intend to talk about today are: the Family Care capitation model flaw, the provider challenges with Family Care, the impact to beneficiaries and finally DHS's administration of the Program.

Family Care Capitation Model is Flawed

The premise of DHS's managed long term care model is that managed care organizations are capitated for enrolled beneficiary needs. Given the nature of these beneficiaries' needs and the wide variability of costs for services to appropriately serve them, the capitation model that DHS uses must be both accurate and fair. The current model that is used by DHS is neither.

Long-Term Care Functional Screen

The foundational tool that DHS uses to determine the actual capitation level for each MCO is the long term care functional screens of the members enrolled in that MCO. The tool was not designed for this purpose and as such is inadequate and inappropriate for this use.

Originally, the long-term care functional screen was developed to determine functional need for eligibility in the Medicaid program. It was originally not intended as a tool for capitation for MCOs. When the screen is used for the calculation of the capitation, the problem with the tool is not what is there, but what is not there. While the long-term care functional screen appears to capture functional needs and diagnoses fairly completely, many areas fail to fully differentiate the degree of deficiency. This is most evident for beneficiaries with behavioral health issues. Behavioral health issues are a significant cost driver in the long-term care system. For the MCO, what ends up happening is the long-term care functional screen misses important factors that drive actual service costs and over emphasizes factors that are not as important.

To mitigate the risk from the inadequacies of the long-term care functional screen, most MCOs have or are starting to use the long-term care functional screen to determine their payments to providers. This methodology passes the long-term care functional screens' deficiencies down to the provider level, reducing the financial risk to the MCO. This is a significant departure from the old system that primarily paid providers based on what services actually provided.

Many of you in your districts have probably heard complaints from providers complaining about lack of connection between beneficiary's needs and the rate the MCO is offering. A significant part of the problem is the long-term care functional screen does not fully capture the full needs of the individual being served. This must be addressed in the future.

Regional Variations

The DHS capitation model does not fully account for regional variations. Through June 30, 2012, the MCOs financial performance ranges from a positive 8.5% margin to a negative margin of approximately 3%. I believe this substantial variation in performance, is due to the improper accounting of regional variations. Long-term care provider systems have evolved at different points of time and have been influenced by different factors throughout this state. Unfortunately, the state capitation model assumes that the provider system in each MCO region will mirror the provider system of the original Family Care pilot counties. It does not.

In Community Health Partnership's region, individuals with developmental disabilities were served largely by a more costly corporate adult family home system. This came about because of the Northern Center closure. The state and counties needed providers that could expand quickly to serve the members discharging from the Center. It also came about because the counties in the region could afford the costs associated with the corporate adult family homes. In other parts of the state, MCOs have had a greater percentage of persons with disabilities served by low cost owner occupied adult family

homes. These regions tended to develop the provider network over a longer period of time and in counties with limited resources.

Corporate Adult Family homes typically cost two to three times as much as an owner occupied home for the same level of care. While I will not make the argument that one provider type is necessarily better than another, it does impact the costs incurred by the MCO and it is not a change that can made quickly. Many of the individuals in CHP's region had been in their home for 10-15 years or longer. As one would expect, few were willing to move.

Another example of regional provider variability is transportation. Transportation options for beneficiaries vary widely across this state, particularly urban versus rural. Some regions have low cost bus systems or ride share programs available, others do not. The type of system that a MCO region has available is not accounted for in the capitation model. By not accounting for the regional variation, MCOs are forced to live within a dollar amount that may not be realistic for its region. The MCOs only choice to living within the capitation would be to either lower transportation utilization or find another service area from which to reduce costs.

While the long-term care functional screen tries to measure the needs of the beneficiaries, DHS's capitation model does not fully account for how those needs are met by providers and who is available to meet those needs. This is a very important point. As we move forward with the continued Family Care expansion, better understanding and accounting for the unique profile of a region's enrollees and how members are actually served by each region is critical to the program's success.

Capitation Model Not Tied to Achieving Outcomes

Currently, MCOs are financially rewarded if their total expenditures are below the capitation model. From an MCO perspective, the more services and rates are cut, the better the financial picture will be. MCOs are not tied financially to the quality of services that they deliver or the achievement of member specific outcomes. I strongly believe this is a major fault of the Program and something that needs to be addressed. The rest of the healthcare system is quickly moving to outcome based reimbursement to drive quality, innovation, efficiency and cost effectiveness. Family Care should as well.

Financial Incentive to Expand in High Cost Regions of the State

MCOs that started or expanded in high cost areas of the State have been financially challenged, while MCOs that started or expanded in low cost areas have been financially rewarded. I believe this is the exact opposite of what should happen. The current capitation model weakens MCOs that are trying to achieve the greatest level of utilization change and provider system change. Had Community Health Partnership been aware of

this, we would have never chosen to expand into St. Croix County, one of the highest cost counties in the state.

IRIS Compounds the Capitation Model Flaw

Many of you are already aware that IRIS costs more per beneficiary than a similar person in the Family Care program, what most do not know are the negative effects IRIS is having on the Family Care Program.

When a beneficiary decides to enroll in IRIS, their budget is determined from their long-term care function screen. If that budget is more than the person's current expenditures, the beneficiary is likely to stay with the IRIS Program. If the budget is less than the current expenditures, he or she is likely to enroll in Family Care instead. IRIS is naturally selecting lower cost beneficiaries for each acuity level, because of its person specific budget model. Family Care loses the opportunity to have a lower cost enrollee to offset the higher cost members. This problem will grow as more individuals enroll in IRIS.

As an example, Community Health Partnership saw a significant number of lower cost enrollees disenroll from the Family Care program and enroll into the IRIS program because the budget they received from IRIS was substantially more than the cost of the services they were receiving from Family Care. The financial impact to CHP was in excess of a million dollars a year to the bottom line.

A number of us have heard DHS argue that competition between IRIS and Family Care is good. Based on the existing funding formulas for both Family Care and IRIS, the opposite is true particularly in high utilization and high cost regions of the State.

Provider Challenges with Family Care

The expansion of Family Care in this State has had a significant impact to providers. Much of the savings claimed by the Family Care program has been a result of provider rate reductions. Providers that provide services that do not have a corresponding Medicaid fee schedule have been the most impacted.

Beneficiary utilization of a service, times the rate the provider is paid, determines the cost of any particular service. When there is a Medicaid fee schedule for the service, the only variable within the control of the MCO is the beneficiary utilization. When there is not a Medicaid fee schedule, the MCO has the ability to manage both utilization and provider rates. In higher cost regions of the state over the last several years, MCOs have favored dramatic rate reductions because it is much easier to accomplish than actual changes to beneficiary utilization in a short period of time. Beneficiaries have appeals and grievance protection that slows changes in

utilization. Provider services that do not have Medicaid fee schedule enjoy no such protection from rate reductions.

At CHP, DHS monitored both beneficiary utilization and provider rates and expected CHP to match the pilot Family Care pilot counties' experience. Quickly attaining these benchmarks to meet DHS expectations meant dramatic reductions for provider rates because utilization changes could not happen fast enough. Between 2009 and 2012, many providers in CHP's region received substantial rate reductions. Some reductions were in excess of 30%.

Even MCOs that are financially positive are motivated to continue to trim provider rates. Because of the variability of the Family Care capitation rate from one year to the next and the nature of the regression model that the state uses to set the capitation, MCOs are motivated to continue rate reductions even though many in 2012 should be considering rate increases. This race to bottom will continue until the provider system starts collapsing or until the state uses a more static regression model for capitation.

Additionally, providers of services that do not have a Medicaid fee schedule are given terms in the Family Care contracts that I believe are very difficult for providers to accept. MCOs have an unfair advantage in the negotiation process. This is particularly true for Providers who exclusively serve Family Care beneficiaries as they do have the ability to cover losses with other payor sources. Providers' only real recourse is to complain to their legislators or go out of business or both. Individual providers have very little chance to negotiate a fair and balanced contract.

In this environment of service rates tied to MCO funding and not tied to the reasonable cost to provide the service, much has been lost at the provider level. Many providers have reduced employee compensation, eliminated or reduced dramatically the availability of employee benefits, increased employee workload, closed or consolidated facilities, reduced coverage of rural areas, and been more selective about which beneficiaries they are willing to serve. At this point in time, few providers if any have additional opportunities to reduce costs short of cutting quality or going out of business.

The current system is not working. We need to move away from the current provider reimbursement system and introduce a system that fairly compensates providers for quality service that efficiently achieves member outcomes.

Family Care's Impact to Beneficiaries

For MCOs in high cost regions of the state, the interdisciplinary teams that develop the care plan with the beneficiary are under increasing pressure to make service decisions based on the capitation funding model as opposed to supporting beneficiary outcomes.

The original premise of the model was that teams would work with the member to find cost effective solutions to support member outcomes. The real problem for the teams is determining what "cost effective" means in actuality. Teams feel real pressure when members on their team exceed the total capitation revenue coming in.

This pressure on the teams can and does translate into service denials or reductions for beneficiaries. For an individual in the pre-vocational workshop, this may translate into only four days of service instead of five. For an individual living in the middle of rural Wisconsin, this might mean only receiving four transportation vouchers per month for social transportation as opposed to the eight they had before. It may mean that a family taking care of an elderly loved one is only offered adult day care two days a week rather than the five that is needed so that the family can still work outside the home. I fear the situation, if hasn't happened already, where the team delays a service or reduces a service that the beneficiary truly needs, and the person has a serious negative outcome because of that reduction or denial.

Even under the same budgetary constraints, a much better approach would be to base the capitation on the achievement of beneficiary outcomes as I have mentioned before.

DHS Administration of Family Care

This administration's and the previous administration's implementation and management of the Family Care and Family Care Partnership programs has been a major disappointment to enrollees, providers, and myself and others at Community Health Partnership.

When the program was rolled out in CHP's region, DHS appeased concerned potential enrollees by telling them that their services would not change. DHS was not honest to these enrollees especially about the sustainability of some of their residential placements. Even to this day, DHS will not admit that in CHP's service areas. there are more individuals currently placed in a corporate adult family home than the capitation model will support. DHS will also not admit that the capitation model they have developed will require those individuals to move to a lower cost setting. They have chosen to blame the challenge on the MCO rather than support the MCO with the appropriate system change message. This administration has repeatedly chosen to blame the MCO rather than admit an inconvenient or politically challenging truth. DHS will not admit it, but a significant number of corporate adult family homes need to go out of business for the current capitation model to work in CHP's service area.

Even more disappointing is the fact that DHS in Madison either ignores or discounts regional staff when informed about what is happening at the local level. Requests for support from local DHS staff were repeatedly ignored. Many of the requests were ignored because they were politically challenging for DHS. I have examples that I would be willing to share in only in private because of confidentiality concerns.

Another source of frustration at the MCO level has been the intensive, non-value added oversight that simply does not make sense. DHS has continually expanded its reporting requirements, adding unnecessary administrative costs to the MCO. Its review process for Member and Provider information has led to CHP not sending timely written communication to these groups as it could take weeks for letters to go through the official DHS review process. Ultimately, I believe that DHS oversight could more effectively and efficiently be managed through release of Madison control and trust of the local DHS representatives.

And finally, the termination Family Care – Partnership in CHP's region at the end of 2012 is in my opinion inexcusable. Even if one accepts the premise that a MCO change was needed, DHS should have planned the transition so that enrollees were not negatively impacted. They did not. DHS has placed the blame on Center for Medicare and Medicaid Services. However, it was DHS' lack of planning and the lack of understanding of the transfer process that caused the loss of Partnership in our region. As a result of this failure, 1500 enrollees will lose their Medicare Advantage Special Needs Plans benefits at the end of the year and be forced to return to Medicare fee for service. They will lose access to providers that limit the number of people they serve under fee-for-service Medicare and Medicaid. They will lose access to a dedicated nurse practitioner who can visit them in the home. And they will lose care coordination between the medical system and the long-term care system that has proven so effective.

Family Care – Partnership is truly a better more complete program. Many of the other parts of the country believe that to be true as well and are moving to fully integrated care. It is unfortunate for our enrollees that this Administration chose to go backwards.