



Wisconsin Department of Health Services

# Family Care Financial Evaluation

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Submitted by

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# Executive Summary

## Family Care Financial Evaluation

### Project Scope

On May 14, 2010 the Wisconsin Department of Health Services (DHS) Division of Long Term Care, Bureau of Financial Management, issued a Request for Services to evaluate:

- 1) Whether current methods for determining capitation payments to managed care organizations under contract to provide Family Care benefits are consistent with Department goals, requirements, and the needs of program enrollees; and
- 2) When the Family Care Managed Care Organizations (MCOs) are likely to come into full compliance with the Department's capital requirements, given the current MCOs' financial positions assumptions and funding availability.

APS Healthcare, a specialty health care services provider and registered vendor of consulting and accounting services, was selected to perform the evaluation and produce this final report of findings and recommendations (WI DHS Request for Services, DOA Contract 15-01985-601).

### Overall Evaluation Plan

The evaluation was conducted by reviewing existing documents and interviewing key informants. Interviews were conducted with DHS personnel, the Chief Financial Officers of each MCO, and program actuaries at Pricewaterhouse Coopers (PwC). A list of supporting documents and person interviewed is provided in the appendices.

Following the two major directives in the scope of the request for services, this report is presented in two parts. In the first part, we evaluate whether current payment methods meet DHS goals, MCO requirements, and member needs. The DHS goals are

- Choice: Give people better choices about the services and supports available to meet their needs
  - Capitation methods should provide sufficient funding for services and supports to meet people's assessed outcomes.
  - The data that is used in the methods should reflect a LTC system where needs have been fully assessed and met.
  - Methods should not be budget-based (i.e., set with the purpose of fitting within a predetermined budget).

- Access: Improve people's access to services
  - Capitation methods should provide sufficient funding to give members access to services.
  - MCOs must remain solvent if they are to provide access to services.
  - Capitation methods should support MCO development of providers in specific service areas where insufficient capacity currently exists.
  
- Quality: Improve the overall quality of the long-term care (LTC) system by focusing on achieving people's health and social outcomes.
  - Capitation methods should fund the outcome-based Family Care program design.
  - Data used in those capitation methods should reflect experience in delivering this program design, as opposed to, for example, the design of the fee-for-service system.
  - Initiatives in support of enhanced quality should be actively pursued.
  
- Cost-Effectiveness: Create a cost-effective long-term care system for the future.
  - Capitation methods should result in cost-effective capitation rates.
  - These costs should be lower than equivalent fee for service costs.
  - Any additional expansion funding should take account of historical costs structures but also be phased out as expansion areas become more cost-effective (as in the pilot program).

In the first part of this report, we examine the MCO requirements in order to evaluate whether the MCO capitation rates are 1) adequate to cover short-term and long-term member service costs, care management costs, administrative costs, 2) meet and maintain financial capitalization requirements, 3) have reasonably predictable revenue and cost streams, 4) minimize risk from uncontrollable events, and 5) achieve satisfactory member outcomes consistent with long-term care (LTC) needs and activity of daily living (ADL) functional status.

In the second part of the report, we assess 1) the current and projected future financial status of the MCOs based on current financial statements of each MCO received from DHS, and 2) make projections for the six-year period CY 2010 to CY 2015. Multiple scenario projections are performed to evaluate the need for, and potential results of, policy actions consistent with DHS goals, with a focus on meeting capital reserve requirements for long-term solvency of the MCOs.

## Recommendations

The recommendations for Family Care capitation payment formula adjustment or modification are:

- 1) Consider modification to better account for very high-cost outlier cases by investigating:
  - Use of an exponential cost regression model, rather than linear model;
  - Collection and use of additional measures pertinent to the care of persons with the most severe behavioral health limitations, including behavioral diagnosis groups or staffing needs.
  
- 2) Consider the use of Medicare prospective payment provider cost reports (for Nursing Homes and Home Health Providers) as quantitative benchmarks that may account for a significant portion of regional cost variation not already accounted for by the Bureau of Labor Statistics (BLS) wage indexes.

### Recommended Next Steps / Fiscal Implications:

Proceed with an investigative report by DHS, PwC, or other qualified body to collect and analyze primary data to test the hypotheses that

- Cost model may be exponential rather than linear;
- Additional measures have statistically significant association with costs; and
- Provider costs from cost reports have statistically significant association with regional cost variation, over and above wage index.

If results of the study support policy changes in the capitation payment formula, we anticipate the changes would be budget-neutral, having the effect of redistributing revenues between MCOs rather than increasing total revenues paid to MCOs.

The recommendations for Family Care MCO solvency and sustainability are:

- 1) In light of a longer than expected time-line for service cost transition from initial fee-for-service (FFS) level to target capitation payment level (due to higher-than-expected initial costs and utilization patterns, high-cost provider networks, more counties to integrate into an MCO, greater share of high-cost cases relative to the pilot counties, or the MCO's inability to quickly implement the Family Care model), consider extending capitation-rate phase-in adjustments or risk-sharing arrangements for up to 2 more years beyond the initial 3 years for MCOs that have a disproportionate share of very complex, or high acuity, developmentally



- disabled members, provided that these MCOs show progress toward implementing the Family Care operating procedures for clinical and business management that are necessary to achieve a lower service cost structure with satisfactory member outcomes as demonstrated by the Family Care Pilot;
- 2) Consider mandating reductions in administrative expenses for MCOs with excessive administrative expenses (e.g. above an established program benchmark);
  - 3) Maintain or increase oversight of MCO progress toward Family Care long-term care system transformation to ensure that opportunities for cost savings are realized:
    - Provide technical assistance, particularly with respect to training and monitoring of Family Care service delivery model by which financial efficiencies are realized through the resource allocation decisions by inter-disciplinary teams (IDTs) to meet member outcomes with lower-cost informal or community supports rather than utilization of purchased services;
    - Facilitate opportunities to share best practices among MCOs;
  - 4) Provide further opportunities for program cost savings with State-wide initiatives:
    - Deploy residential care fee schedules and develop standard fee schedules for other “waiver services;”
    - Provide a more centralized or standardized infrastructure for data processing and other services that may be shared among MCOs.
  - 5) Develop a contingency plan in the event that technical assistance or temporary financial support fail to prevent the insolvency of an MCO:
    - Develop criteria to define unacceptable financial performance or insolvency;
    - Consider a solvency standard that requires year-over-year improvement in capital reserves rather than achieving a fixed amount within a certain time-frame;
    - Develop an action plan to cope with insolvency.

Budget implications:

- It is impossible to foresee every circumstance that would influence the need for such policy action. Among the scenarios projected, if DHS adopted the risk sharing options described in this report, DHS could incur an additional payout to MCOs of \$3 million (0.1% of total capitation payments) under the intermediate, or most likely, scenarios;

- Recommendation 3 may increase the program budget by 1 full-time employee (FTE) or more if additional training and oversight activity cannot be accomplished at present staffing levels;
- The initial investment costs for the second part of Recommendation 4 may be substantial but the initial costs may be offset by lowering administrative costs for MCOs in future years. A cost/ benefit analysis of the implementation of this recommendation is beyond the scope of this report;
- The remaining recommendations would most likely have little if any budget impact if they can be accommodated by present staff within a reasonable roll-out schedule.

# I. Evaluation of Capitation Payment Methodology

## Description

Annual financial summary reports for calendar year 2009 showed that several of the Family Care MCOs had substantial financial losses, provoking concern for their long-term viability. To gain a better understanding of the reasons behind the financial distress, we considered both the revenue provided to the MCOs by the State primarily through the functional screen-based capitation formula, as well as the cost structure of the MCO as it coordinates member services.

Evaluation of the early Family Care pilots in five counties found that the funding formula was adequate to ensure that member outcomes were met by the Family Care service model while achieving substantial cost savings relative to the prevailing fee-for-service cost structure and care model. It is important to recognize that the Family Care service model is a transformation of the Wisconsin long-term care delivery system: new operating procedures and management structures were developed and implemented by the pilot MCOs in order to deliver high-quality, person-centered services in a managed care environment.

In brief, the Family Care service model achieves cost savings by first assessing member's functional status and identifying desired member outcomes, then working with an interdisciplinary team (IDT) to develop new care plans (for members enrolling off wait-lists), or to review legacy Community Integration Program (CIP)/Community Options Program (COP) Waiver care plans, re-align them with the Family Care benefit package and make resource allocation decisions that find cost-effective ways to achieve desired outcomes, including the use of informal family and community support as well as purchased professional services. MCOs must implement the new operating procedures and efficient management practices in order to benefit financially from the lower cost structure demonstrated by the Family Care pilots.

Apart from the cost savings to be expected under a fully deployed Family Care service model, the other side of the financial equation for successful MCOs is the revenue stream provided primarily through capitation payments. To address the first major question in the Request for Services, we provide a thorough examination of the funding formula in the analyses that follow.

## Analyses and Findings

In this section we evaluate whether current methods for determining capitation payments to managed care organizations under contract to provide Family Care benefits are consistent with Department goals, requirements, and the needs of program enrollees.

The primary goal for DHS is to ensure that the capitation payment rates to the MCOs are actuarially sound for a plan providing LTC services under the Family Care model. In addition, the rates should reflect the department goal of eliminating arbitrary regional cost variations, moving towards an eventual uniform fee structure and cost-effective service utilization patterns for the entire program. The system of payments to the MCOs must also avoid introducing any perverse incentives to compromise quality of care for the members.

To be considered actuarially sound, the payment rates for a Medicaid MCO must be adequate to cover all reasonable and appropriate costs.\* The underlying assumptions of the calculation must also be reasonable and appropriate. Some of the questions regarding the appropriateness of the assumptions implicit in the calculation of rates include:

- Is the functional status model appropriate for calculating Family Care capitation rates?
- Is the proper set of cost data used?
- Are the costs properly adjusted for the regional cost variation?
- Do the rates provide for a reasonable transition period to the new managed care cost structure?

### Description of PwC Functional Status Model

The consulting firm of PricewaterhouseCoopers (PwC) has been preparing the capitation payment calculation for DHS since 2006. PwC uses a risk assessment model based on the data from a Functional Status (FS) screening questionnaire to determine individual capitation rates based on such variables as nursing home level of care, number of Instrumental Activities of Daily Living (IADLs), specific ADLs, communication, behavior, mental illness, and medication

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\* For a more detailed definition and discussion of Actuarial Soundness, see the American Academy of Actuaries' Health Practice Council Practice Note "Actuarial Certification of Rates for Medicaid Managed Care Programs", August, 2005.

management indicators. These rating factors are determined by means of a multivariate linear regression of costs on the FS screen response items, using data for counties which have been involved in the Family Care program for long enough to have successfully implemented the operating procedures that comprise the Family Care program design. Starting in 2010, separate models were developed for the target categories of Developmentally Disabled (DD), Physically Disabled (PD), and Frail Elderly (FE) members (an improvement over prior years, when the target group categories were included as factors in a single model). The factors are additive so that each FS factor that has a statistically significant association with cost adds a specific dollar amount to a base starting amount for the respective target group categories.

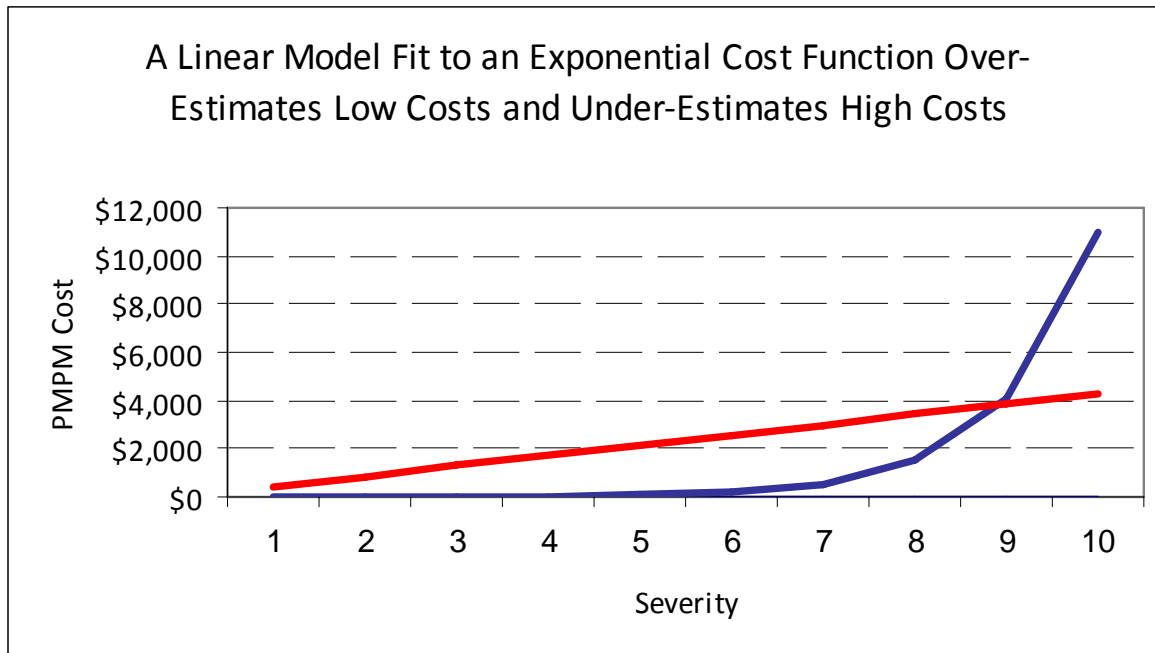
In application, capitation rates are built in several stages. Beginning with the FS screen, the rating factors are applied to each individual covered in the MCO, then the resulting amounts for the individuals are averaged together based on the projected case mix of the target populations to get the raw per member per month (PMPM) capitation amount. The raw PMPM amount is adjusted for long-term care cost trend and regional variation in long-term care wages. The adjusted PMPM amount is further modified with an administrative funding model to account for overhead, which yields a final PMPM capitation payment. For new or expansion MCOs, a phase-in adjustment may also be added to cover additional expected costs while the MCOs transition from an unmanaged fee-for-service (FFS) model to the Family Care model of care management. These phase-in payments are intended to allow time for the MCOs to hire and/or train staff in Family Care service model operating procedures, implement changes in service utilization, restructure provider networks, and adjust business administration to the managed care environment.

### **Appropriateness of Linear Functional Status Model**

Currently the rate model assumes that costs rise linearly with increasingly severe functional status limitations. We are concerned that this linear assumption may not adequately represent the true relationship between costs and functional status severity. PwC has conducted analyses of actual and expected costs during Family Care expansion and has found that generally actual costs are lower than expected for low-acuity cases and higher than expected for high-acuity cases. A DHS summary of these analyses notes that “PwC has begun developing rate models that would account for the possibility that some costs may vary exponentially with increased severity of functional screen characteristics.” Below we present some fictitious data and hypothetical cases to illustrate the mathematical problem of “misspecification” when a linear model is fit to exponential data. It is important to realize that while this is one possible explanation for the pattern observed in the actual-to-expected analysis, it is not the only one.

Figure 1 illustrates that if costs rise exponentially as severity increases, a linear model will over-estimate the low severity cases (levels 1-8) and under-estimate costs for the high severity cases (levels 9 & 10). In Figure 1, the curved line represents the (hypothetical) cost function, which rises exponentially with increasing levels of functional status impairment severity. The straight line is a linear regression model that is fit to the data points generated by the exponential cost function.

Figure 1.



The hypothetical data points for both the exponential cost function and the linear model are given in Table 1. The difference between the exponential cost function and the linear payment model is greatest at the highest level of severity (\$6,751), where the payment of \$4,262 is less than half of the cost of \$11,013.

Table 1. Exponential costs and linear payments over-pay low severity and under-pay high severity levels

Severity	Cost	Payment	Difference
1	\$ 1	\$ 426	\$ (425)
2	\$ 4	\$ 852	\$ (849)
3	\$ 10	\$ 1,279	\$ (1,269)
4	\$ 27	\$ 1,705	\$ (1,678)
5	\$ 74	\$ 2,131	\$ (2,057)
6	\$ 202	\$ 2,557	\$ (2,355)
7	\$ 548	\$ 2,983	\$ (2,435)
8	\$ 1,490	\$ 3,410	\$ (1,919)
9	\$ 4,052	\$ 3,836	\$ 216
10	\$ 11,013	\$ 4,262	\$ 6,751

The highest severity cases are greatly underestimated when a linear model is fit to an exponential cost distribution. Since the lower severity cases are overestimated, the under-payments and over-payments would tend to balance each other out if there were an even distribution of cases at all severity levels. However, when the distribution of cases is not even, MCOs with a high concentration of high severity cases would tend to be underpaid. Consider two hypothetical MCOs with different concentrations in the highest-severity group as in Table 2

below. MCO-1 has 10% of enrollees in the top group and MCO-2 has 91% of enrollees in the top group.

Table 2. Distribution of members enrolled in two hypothetical MCOs, by severity level

Severity Level	MCO-1	MCO-2	Total Population
1	100	10	110
2	100	10	110
3	100	10	110
4	100	10	110
5	100	10	110
6	100	10	110
7	100	10	110
8	100	10	110
9	100	10	110
10	100	910	1,010
Total Enrollment	1,000	1,000	2,000
Percent High Severity	10%	91%	51%

Multiplying the number of enrollees in each severity group (Table 2) by the payment and cost for each severity group (Table 1) and summing shows that MCO-1 receives total payments slightly higher than cost, while MCO-2 receives payments far below costs (Table 3)

Table 3. Total cost and payments to two hypothetical MCOs

	MCO-1	MCO-2
Cost	\$ 1,742,189	\$ 10,086,128
Payment	\$ 2,344,109	\$ 4,070,226

Case-mix adjustment should be used whenever there is variation in the distribution of enrollment among the different risk groups in each plan. A case-mix adjustment factor can be computed as the ratio of average severity in a specific plan, relative to the over-all average level of severity in the population. Plans with below-average severity would have payments reduced by the adjustment factor, while plans with above-average severity would have payments increased by the adjustment factor, as shown in Table 4.

Table 4. Average severity and risk-adjustment factor (= MCO average severity / total population average severity), with risk-adjusted payments (= Table 3 payment times adjustment factor)

	MCO-1	MCO-2	Total Population
Average Severity	5.5	9.55	7.53
Adjustment Factor	0.73	1.27	1.00
Adjusted Payment	\$ 1,713,302	\$ 5,165,536	

As a result of the case-mix adjustment, payments for MCO-1 are brought down much closer to costs, while payments for MCO-2 are increased due to higher average severity. However, even after case-mix adjustment, the payments to MCO-2 are still only about half the costs.

This analysis uses hypothetical numbers to illustrate the problem of underpayment if a linear model is fit to an exponential cost function. Exaggerated examples were used to make the point that MCOs with high concentrations of more severe cases would be more vulnerable to underpayment, even after risk adjustment. With that said, we must be cautious to avoid jumping to a conclusion: because underpayment due to mathematical misspecification is **possible** under certain conditions does not mean that it is the **only** possible explanation for differences between observed and expected costs.

Another possible explanation for the observed pattern of actual costs exceeding expected costs for high severity cases is that the MCO has not fully implemented the Family Care service model to realize cost efficiencies. The “expected” costs are expected when the long-term care service delivery system has been successfully transformed to the new managed care program design and operating procedures that produce satisfactory member outcomes at lower cost as demonstrated by the Family Care pilot. If observed costs are incurred by utilizing the old fee-

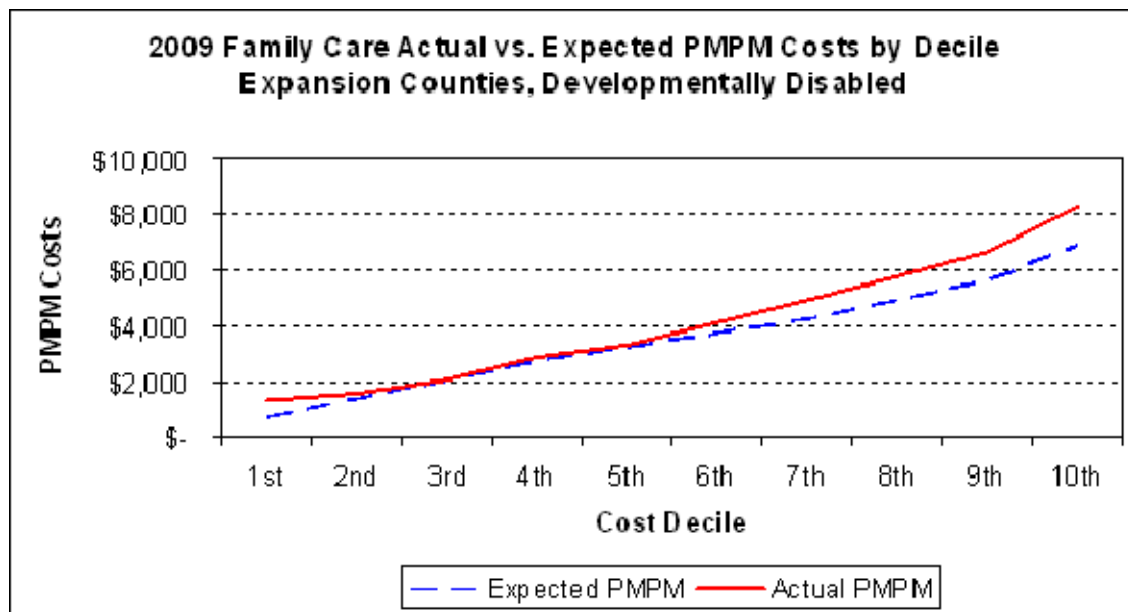


for-service cost structure, then they would be higher than expected under the new Family Care cost structure.

Although we do not have sufficient data to conduct a definitive analysis to sort out which of these competing explanations fits best in practice, we can compare actual results with some plausible assumptions about exponential costs to see if the mathematical misspecification problem may underlie some of the observed 2009 financial shortfalls for several MCOs that have a disproportionate share of high-cost cases.

For example, Figure 2 shows the 2009 observed costs by decile for the DD population in expansion counties. The PD population in expansion counties also has a pattern similar to Figure 2, but not the FE population.

Figure 2



Comparing the actual data in Figure 2 with the fictitious data in Figure 1, there are some similarities and differences to note. The main similarity of interest is the widening gap between actual and expected costs on the right-hand end of the graph. A major difference is that Figure 1 uses “severity” as the X-Axis, while Figure 2 shows “cost decile”. It is plausible that costs rise as severity increases and therefore cost decile may be a reasonable proxy for severity holding “all other things equal.” However, it is likely that other factors contributing to observed costs are not equal (e.g. regional variation in utilization, practice patterns & service costs, failure to fully implement the FC program design, etc.) To the extent that these various factors contribute to variation in costs, the comparison between the observed actual-to-expected costs (Figure 2) and the purely mathematical misspecification problem (Figure 1) has questionable

validity. We present the comparison here only to raise the possibility of misspecification, which cannot be ruled out by the available evidence and thus calls for further careful investigation. Due to the limitations of this analysis, any corrective policy action should be driven by the results of further investigation, not by the analysis presented here.

**Conclusion:** The problem of extreme high-cost outliers in higher severity groups can cause a systematic underpayment if not properly accounted for, especially when high-cost cases make up a disproportionate share of the member population. We recommend that correction be considered over and above case-mix adjustment by investigating an exponential payment model. Such investigation must take care to draw observed cost data exclusively from MCOs that have demonstrated successful implementation of the Family Care operating procedures and care management model. If the investigation finds no evidence for the exponential model, then other factors must account for the difference between observed and expected costs.

### **Appropriateness of Input Data for Functional Status Model**

The functional screen parameters for the FS model appear to be thorough. However, several CMO Chief Financial Officers (CFOs) expressed concern that the formula does not accurately reflect the true costs of caring for the most severe “high-cost outlier” cases, particularly those with developmental disabilities who may also have severe behavioral health issues that require extensive supervision from multiple attendants. One example given by a CFO was “an individual who may require multiple attendants around the clock for their own protection or public safety.” The staffing needs required by an individual might more accurately account for cost variation than would a simple “yes/no” indicator of whether or not an attendant is required. The model may be enhanced by a count such as this or testing other new measures to quantify severe behavioral health issues, such as behavioral health diagnosis groups. The assessment process might do a better job of matching payments to risk by applying data such as:

- Diagnoses, including behavioral health (ICD-9, DSM III);
- Information related to progression of condition (e.g. early stage vs. advanced Alzheimer’s);
- Additional cost indicators, such as intensity of behavioral interventions, for example, the number and type of staff required.

These items are not currently captured on the functional screen but perhaps could be drawn from other sources, such as Medicaid claim history, the Human Services Reporting System (HSRS) Long-Term Care or Mental Health databases, or professional review of care plans.

In the absence of adequate data to improve the capitation formula’s ability to account for high-cost outliers, an alternative approach to addressing the anecdotal concerns about extreme high-cost outliers would be to calculate payments for outliers outside of the FS model, similar

to what Medicare uses for outlier additions to Diagnosis-Related Group (DRG) payments to hospitals. For hospital payments, hospitals receive reimbursement for a percentage of costs that exceed an “outlier threshold” well above the average DRG payment per discharge. By analogy, a mechanism for measuring an individual’s service costs that exceed the capitation PMPM by a wide margin would protect MCOs from large losses in unusually severe cases. Such payments should be rare and subject to DHS review for appropriateness to ensure that costs are not avoidable via an alternate care plan. This mechanism may add considerable administrative complexity and should only be considered if adequate evidence for a problem exists, and alternate means cannot be found to address it through the capitation formula with an exponential functional form or the addition of new markers for high-cost cases.

### **Appropriateness of Regional Cost Adjustments**

One of the goals of DHS is to establish uniform standards for care management across the state (the “Family Care Model”). With uniform standards, differences in members’ severity and functional status would be the major drivers of variation in utilization rates, removing geographic differences in practice patterns as a factor in total service costs. This standardization would leave geographic variation in cost per unit of service as the only significant factor in adjusting payment rates by region.

DHS estimates that approximately 70% of service costs are due to personal care from a nursing aide, home health aide or other personal care provider. As a result, the current FC rate calculation allows for a county-by-county wage index to be applied to 70% of unit service costs as a regional adjustment. The regional wage index used by DHS has a very narrow range of values, varying by just 3.6% from the lowest-wage region to the highest. The regional cost adjustment applied to MCO capitation rates assumes that the cost of providing any particular service is the same in all areas. It also does not include variation for cost of doing business other than wages, such as overhead or occupancy rates.

Prior to 2010 the Family Care pricing model included county as a rating variable in the regression analysis, thereby incorporating actual regional cost differences into the calculation. The cost estimates varied considerably. With Milwaukee County as the standard, the 2009 adjustments to the capitation ranged from -\$321.74 for Fond du Lac County to +\$139.21 in Richland County. In the 2010 rating process, regional variation was dropped from the calculation on the grounds that it reflected artificial differences based on differing utilization and provider cost patterns which ran contrary to the Family Care model.

Outside of Family Care there is considerable variation in the average costs of Medicaid LTC services across Wisconsin. For example, the average 2007 FFS PMPM costs (including Medicaid

FFS claims and Legacy waiver services) for Medicaid members with developmental disabilities varied from \$3,286 in northwest Wisconsin (NorthernBridges service area) to \$4,824 in Manitowoc and Winnebago counties, a 47% difference. The composited (DD, PD and FE) rates differed by 29%. However, using the wage factors applied in the 2010 capitation rate calculation the difference is only 1.4%. The PWC pricing model attributes the difference to variations in average care needs, provider costs and utilization patterns. These developed historically under the management and administration practices of 72 different county agencies. Inheriting different practices from different county agencies poses operational challenges for MCOs.

APS did not have the data available to perform a more in-depth analysis of regional differences, but the contrast is noteworthy. The potential exists for DHS to investigate Medicare long-term care prospective payment system cost reports by Nursing Home and Home Health providers as a source of data for regional variation in capital and operating costs that are not covered by the

BLS long-term care wage index. Those cost reports may be downloaded from the Centers for Medicare and Medicaid Services (CMS) website.

### **Appropriateness of Phase-In Period for New or Expansion MCOs**

APS Healthcare was asked as a part of this report to evaluate whether the “phase-in” payments and the duration of the phase-in period were adequate for new and expanding MCOs. The phase-in payments are intended to be a sort of bridge payment for MCOs to account for the fact that it may take several years for a plan to bring costs from the unmanaged Medicaid fee-for-service level down to the expected level once the plans have reached full managed care efficiencies.

Capitation payments during the phase-in period reflect the initial difference in costs between the FFS and Family Care models and the duration of the phase-in period. For example, if the unmanaged FFS costs for long-term care services are expected to be 15% higher than what the costs under a fully-implemented managed care plan, and it is expected to take three years to achieve full managed care efficiencies, then the phase-in adjustment for year 1 would be an additional 10% of expected costs from the functional status model (since 1/3, or 5% of the extra 15% would be eliminated from costs in the first year). In year 2 of operations, the phase-in adjustment would be 5% of expected costs, and in the third year the MCO would be expected to have achieved full efficiency so there would be no adjustment made.

Based on information provided by DHS, it is thought that the original pilot MCOs took approximately 5 years to achieve full managed care efficiencies. Based on the premise that the knowledge acquired by the pilot plans would help future expansion plans achieve full efficiency more quickly, DHS set the duration for the initial phase-in period for new and expanding MCOs at 3 years.

This decision for a 3-year phase-in period was based on several assumptions:

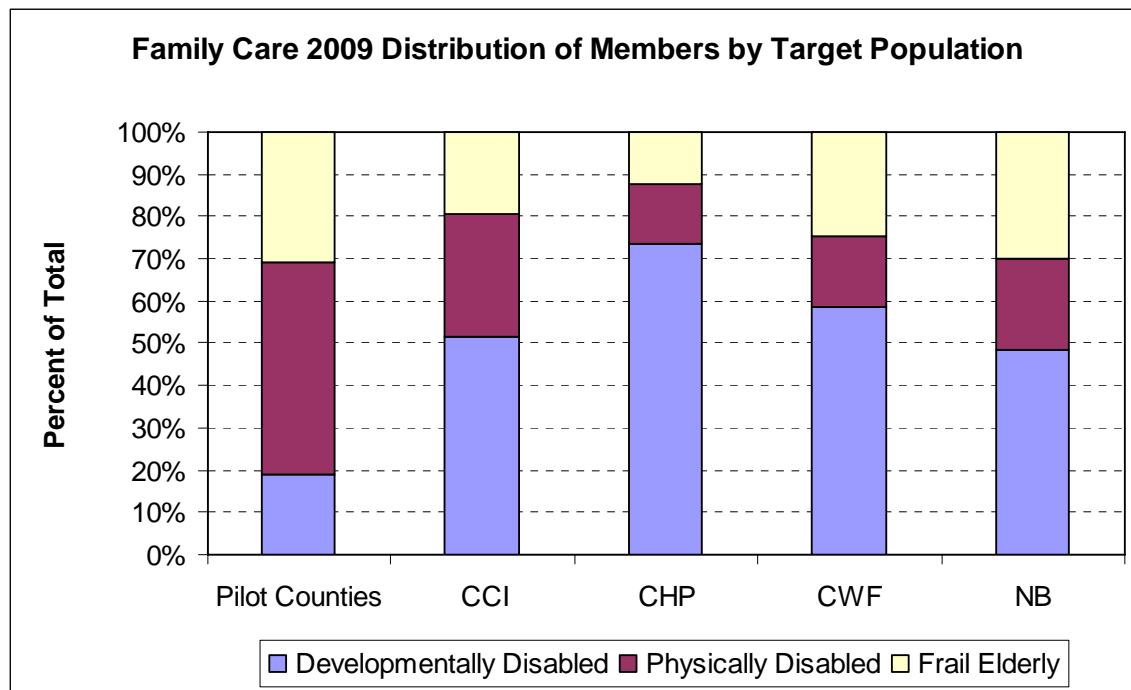
1. Knowledge affecting how to achieve full managed care efficiencies would be readily transferred from pilot MCOs to new start-ups, shortening the “learning curve”,
2. The Family Care populations in the new expansion counties would be substantially similar to those in the pilot counties in terms of receptiveness to change in practice patterns,
3. The functional status pricing model for Family Care would be adequate for predicting costs for all members regardless of their characteristics.

While the first assumption regarding learning the Family Care service model is quite reasonable for an existing MCO expanding into new counties, it is questionable for a new start-up Family Care MCO without senior staff with experience in the Family Care program. It is not a given that information sharing will exist between new MCOs and existing MCOs. Anecdotally, DHS staff have expressed that some of the newer MCOs do not appear to fully understand the Family Care model for providing long-term care services. DHS may consider maintaining or improving monitoring and training activities to facilitate the sharing of best practices among the MCOs.

Additional barriers to rapid implementation arise from added administrative complexity. The pilot MCOs were all in single counties, while the expansion and new MCOs must integrate and coordinate among agencies (e.g. Aging and Disability Resource Centers (ADRCs), Income Maintenance units, other county agencies, as well as service providers) in multiple counties.

It is not certain whether the second assumption regarding receptiveness of populations to change was met. Expansion MCOs have a much higher proportion of DD members than do the pilot plans, as can be seen in Figure 3.

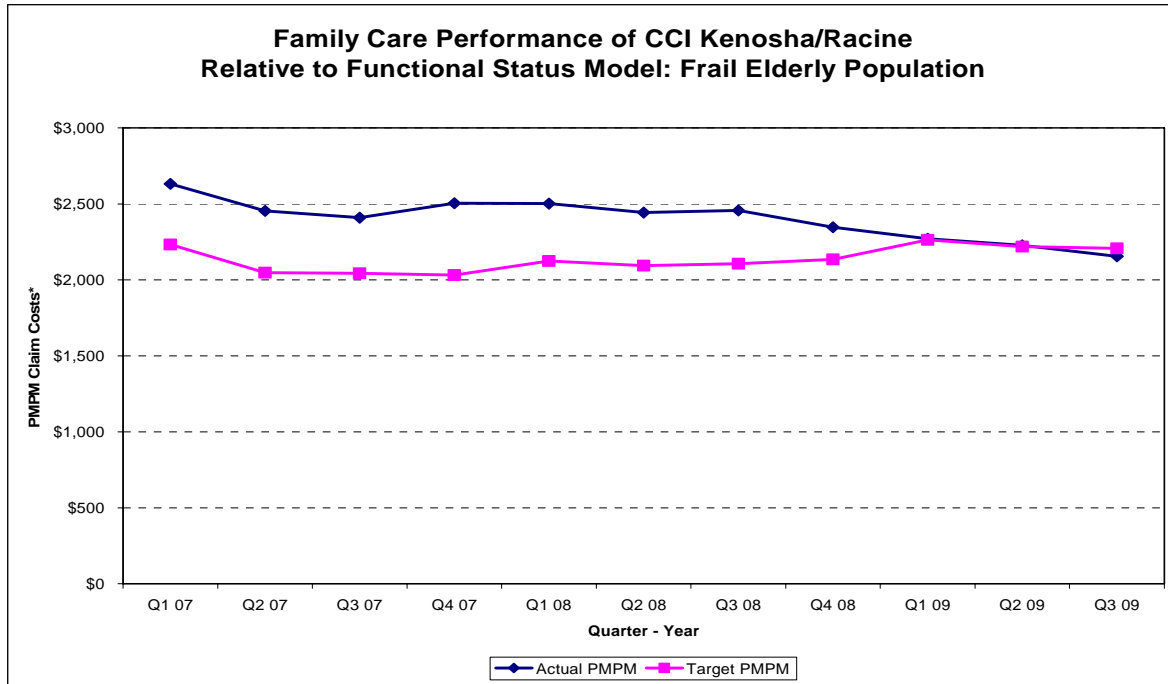
Figure 3.



As shown in Figure 3, the number of DD members in the pilot counties is only about 19% of the total in 2009, whereas the expansion plans encountered over 50% of their enrollees falling into the DD target group. It is therefore risky to compare pilot to expansion counties without first determining whether or not there are significant differences between the target populations in terms of receptiveness to changes in the care management model. (It should be noted, however, that the Milwaukee County Family Care plan, then Milwaukee County Department of Aging (MFCDA), primarily served the frail elderly through 2006. If MFCDA data is excluded from Figure 3 then the proportion of developmentally disabled served by pilot plans in 2009 increases to 37%).

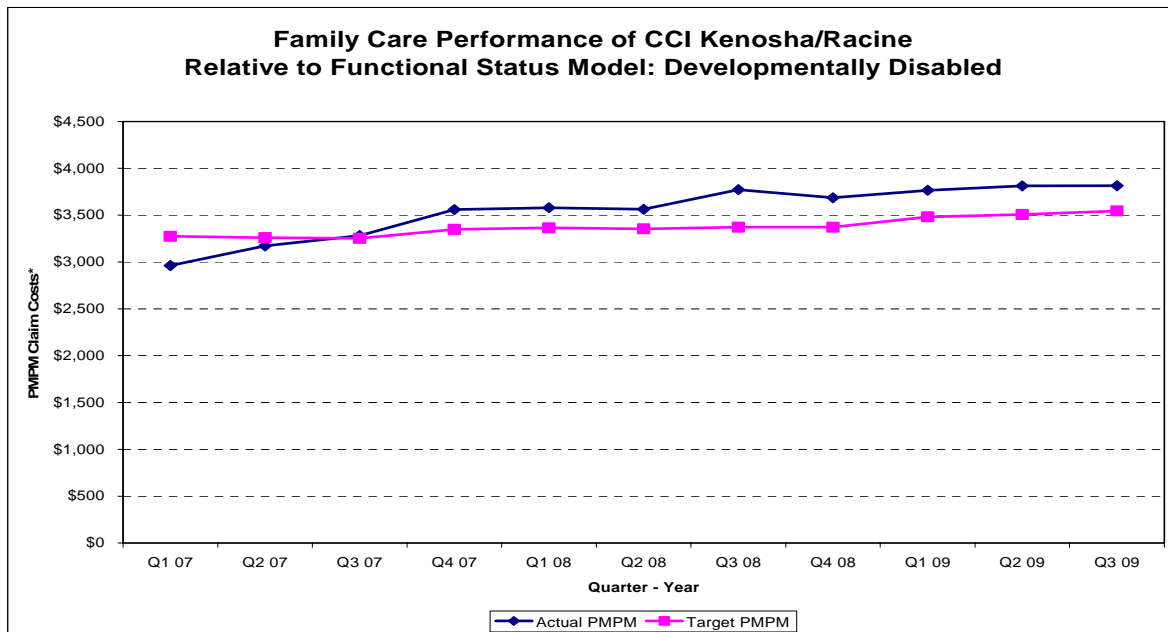
Experience from Community Care Incorporated (CCI) after their start-up may also shed light on the question of variable phase-in periods for different target groups. For CCI, the actual costs for the Frail Elderly (FE) population started out in 2007 about 20% higher than what was projected under the functional status model, which was based on the experience of the established pilot MCOs. However, as shown in Figure 4, by 2009 the actual and expected “target” cost lines had converged, consistent with a three-year phase-in model.

Figure 4



However, the DD population did not follow this pattern. Instead, while the actual and target costs started out very similar, the actual costs grew faster than the target costs, resulting in an approximate 10% difference which did not show any convergence through the end of 2009 as shown in Figure 5.

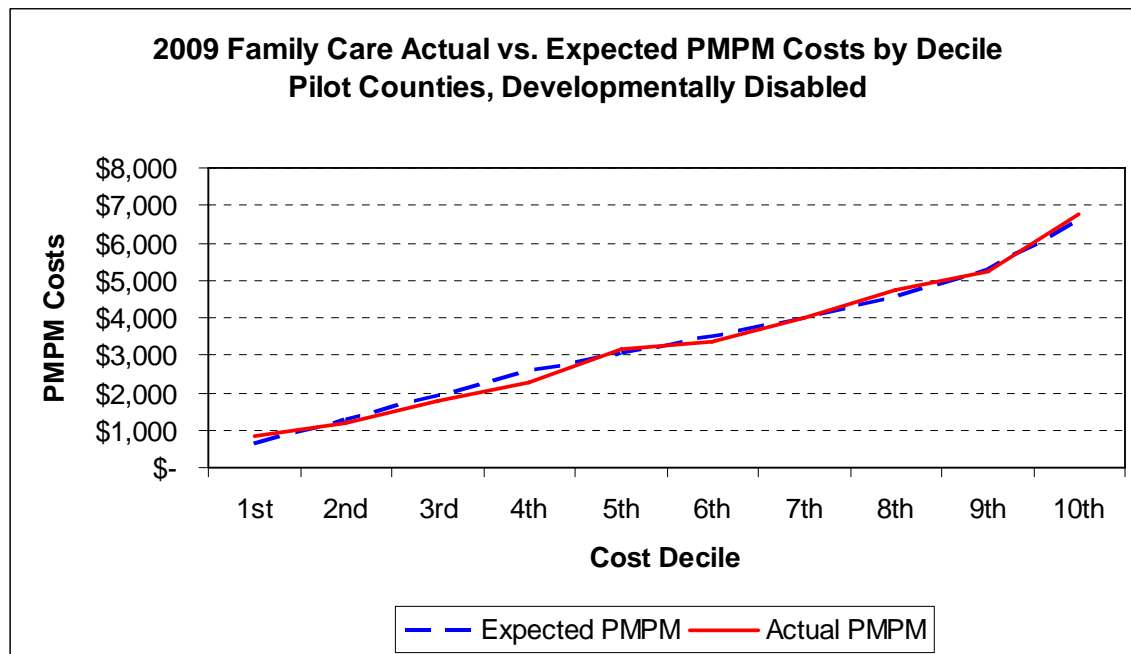
Figure 5



Based on this experience, it appears that a three-year phase-in period for a new Family Care MCO with a large DD population is probably too short.

In regards to the third assumption regarding the adequacy of the functional status model, there is the potential for error if an MCO's population has a disproportionate share of high-cost enrollees and the functional status model does not assign risk evenly. In the pilot counties, the model's predicted costs for the DD population fit very well to the actual PMPM values across all cost deciles, as shown in Figure 6.

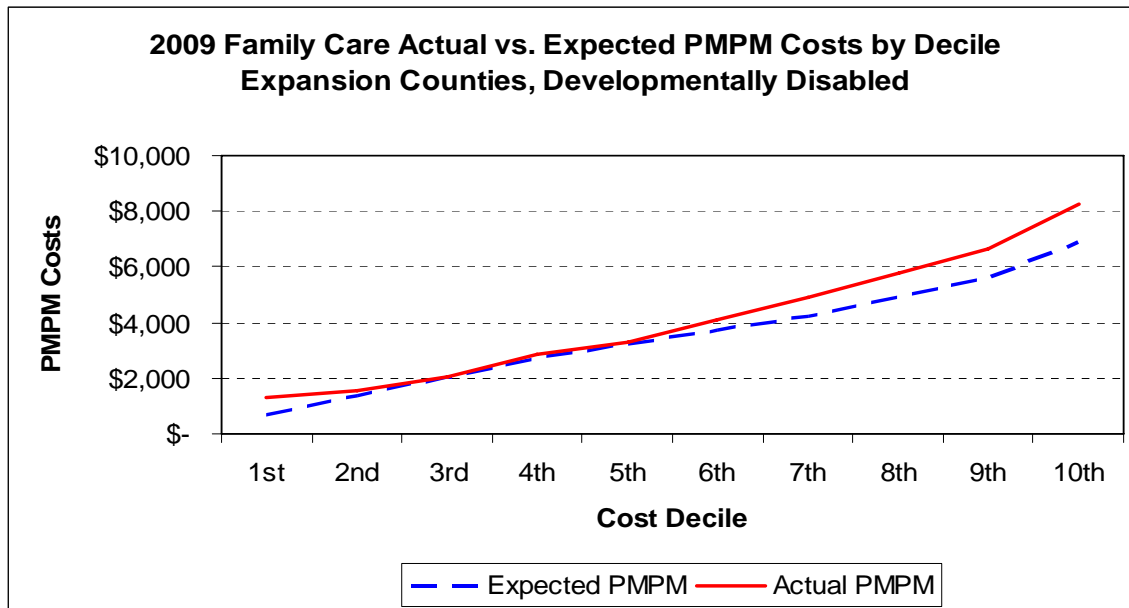
Figure 6



However, in the expansion counties the model's projected costs for higher deciles in the DD population have fallen below what the actual experience was, as shown in Figure 7.



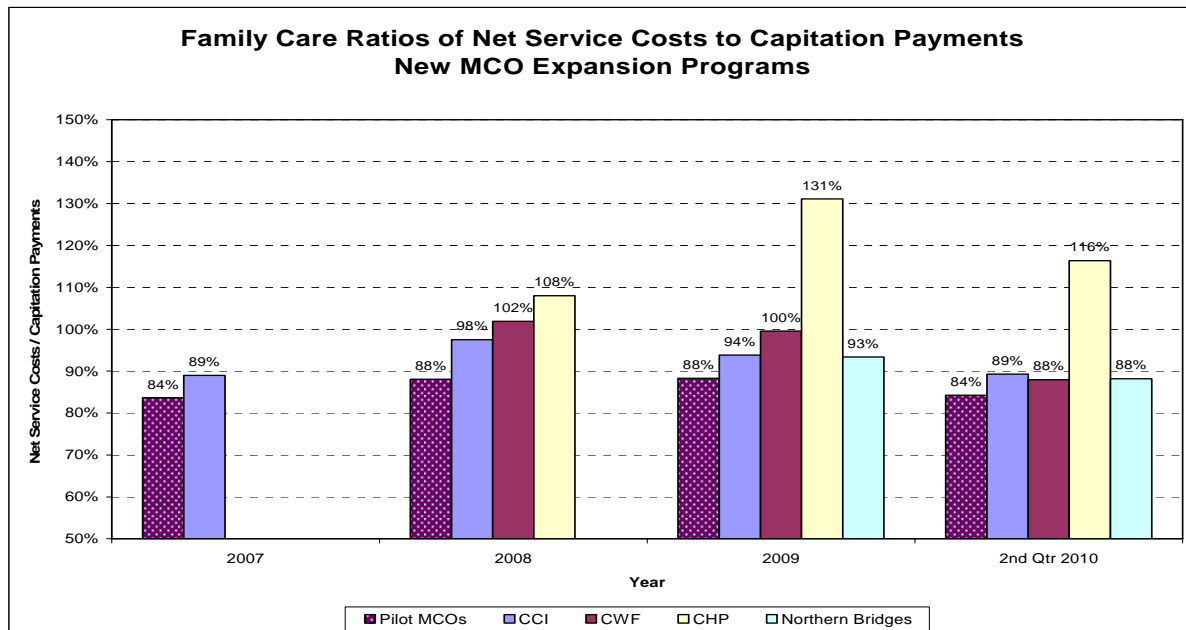
Figure 7



A similar pattern is observed for the PD population while the fit for the Frail Elderly population is very good for both pilot and expansion counties. To the extent that a plan’s enrollment is skewed towards higher-risk enrollees, the capitation payments may be inadequate, or progress toward a lower cost structure by implementing the Family Care program design may be inadequate

There is also evidence concerning the adequacy of phase-in payments from the claims data of the new MCO’s themselves. Figure 8 shows how actual claim costs compare to capitation rates for new plans from 2007 to 2009. Claim costs are shown as total service costs net of room and board from the DHS annual year-end financial summaries and total capitation payments are taken from the same documents.

Figure 8



While there is a definite trend towards convergence with the average pilot MCO ratio, claim costs compared to capitation payments for new expansion plans were higher than for the pilot MCOs in all cases. Since the capitation payments included adjustments for the phase-in costs, this would indicate that overall the phase-in adjustments may have been too small because the plans are not as fast in implementing the Family Care service model as was anticipated.

## Discussion

The rate formula is certified actuarially sound by PWC, and our review finds little room for improvement with one important exception: several CFOs expressed concern that the formula does not accurately reflect the true costs of caring for the most severe “high-cost outlier” cases, particularly those with who may have severe behavioral health issues that require extensive supervision from multiple attendants. A case can be made that the linear regression model would systematically underfund high-cost cases if the underlying cost distribution increases exponentially for higher levels of severity. Apart from the functional form of the model, another potential problem is omission of important risk factors. One example given by a CFO was “an individual who may require multiple attendants around the clock for their own protection or public safety” – the staffing needs required might more accurately account for cost variation than would a simple “yes/no” indicator of whether or not an attendant is required. Two potential modifications to the capitation rate model might remedy the situation: (1) using an exponential regression model, rather than a linear regression model, and (2) adding new measures to the model to quantify the severe behavioral health issues, such as behavioral

health diagnosis groups, or the staffing needs required for adequate care in extreme cases. Any further analysis or modification of the payment model would definitely require the examination of cost data that derives from a properly implemented Family Care managed care delivery model that incorporates the major clinical and fiscal management features of the Family Care program design. This would include the original Pilot MCOs, and any new MCOs or expansion counties that have fully implemented the Family Care plan.

Another relatively minor question arose over the accounting for regional cost variation in the capitation rate model. Our examination of regional cost variation showed there is much more variation between regions than is accounted for by the inclusion of Bureau of Labor Statistics county wage indexes in the model. No comprehensive medical or long-term care cost index is available at the county level that could be used to better account for this variance. However, it may be possible to use cost reports submitted by Nursing Home and Home Health providers to the Center for Medicare and Medicaid Services (CMS) for the Medicare prospective payment system as benchmarks of regional costs. DHS might ask its actuaries to investigate this possibility. It should be noted that simply including a geographic indicator for each county was used in earlier versions of the payment model. This approach was abandoned on the grounds that not all of the variance in “customary and prevailing” rates may reflect actual differences in the cost of services, but rather arbitrary differences in willingness or ability to pay the going price offered by local providers or unexplained geographic variation in practice patterns. One aim of the Family Care program is to reduce this kind of arbitrary variation by implementing a more uniform practice model across the state.

Finally, there remains the question of what the appropriate phase-in adjustment for any particular MCO in any given year should be. There are several potential factors in play.

First, there are certainly differences between counties of legacy benefits beyond basic Medicaid, which the Family Care model eliminates. It stands to reason that those areas with richer benefits would take longer to fully implement the Family Care model as it is more difficult to pare down a richer benefit package to the new standard than it would for a lean one. Although the Family Care benefit package offers as much or more flexibility in the range of services offered, the focus on member outcomes in Family Care may result in a leaner, more cost-effective mix of service utilization. Evaluating and effecting these changes in utilization patterns takes time.

Second, as evidenced by CCI’s experience, there may be differences between the three target populations in how long it takes to achieve the full implementation of the Family Care model. It may be that issues surrounding the provision of LTC services to the DD population make it less conducive to rapid adoption of the Family Care service model than for the other target

populations. Since the DD population is on the order of 50% higher cost than the PD and FE populations, MCOs with a higher proportion of DD members would be more affected by this lag, which may also vary with differences in MCO experience or expertise with this population.

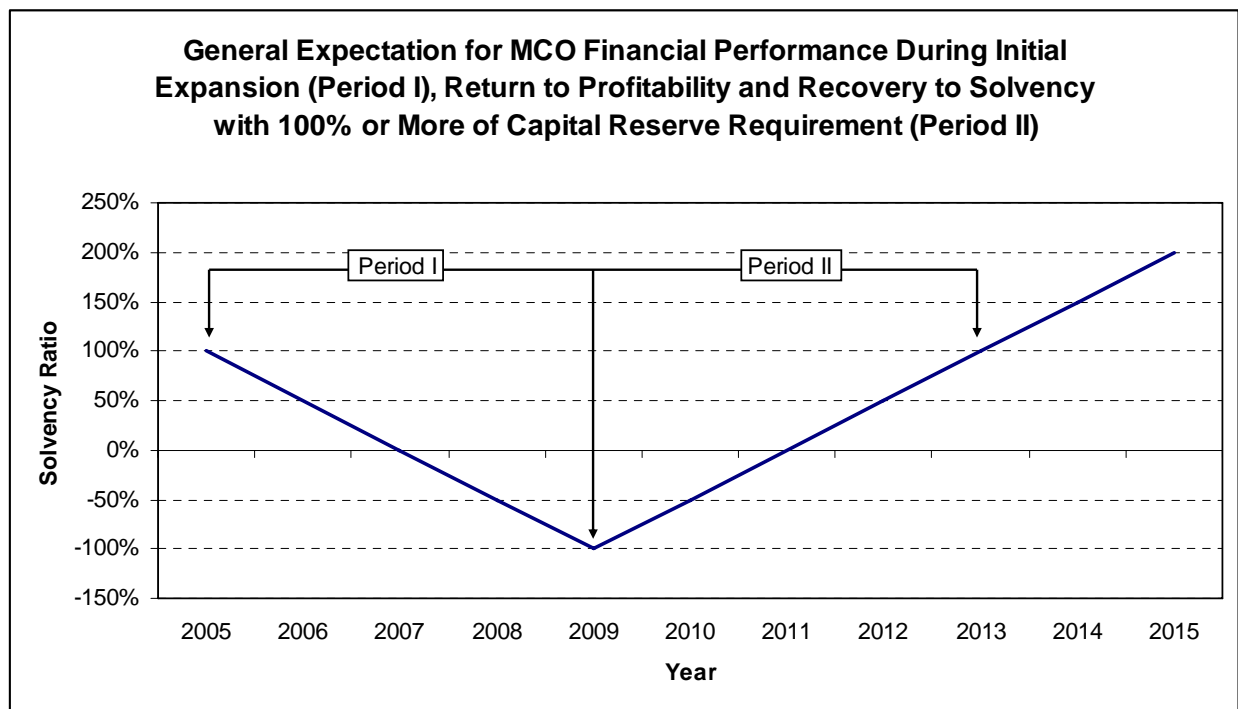
We recommend that the length of the phase-in period for the calculation of capitation rates be tied to the initial costs as determined by the historical fee-for-service costs in the area or some other measure. For example, in areas where the initial cost differential is less than 15%, then the phase-in adjustment would be calculated based on it taking 3 years to achieve full implementation of the Family Care service model. For MCOs in areas where the difference is between 15% and 25% that period would be 4 years, and for MCOs for which the difference is 25% or more, the phase-in period would be set at 5 years. The administrative complexities of expanding into multiple counties may also be taken into consideration when determining appropriate target phase-in periods.

## II. Evaluation of Financial Solvency and Sustainability

### Description

Figure 9 shows a conceptual schematic diagram for a typical MCO start up. The start-up is distinguished by two distinct periods. During Period I an MCO consumes capital by investing for growth, including investing in new infrastructure and human resources, where capital reserves are depleted from an initial level of 100% of solvency requirement, declining annually as operations generate net losses in the initial years, until an operational break-even point is reached when enrollment stabilizes and efficiencies realized under the Family Care service plan begin to fully offset operating costs. At that point, Period 2 begins, when operating margins are positive and net surpluses accumulate annually until capital reserves are eventually restored to 100% of designated solvency requirements. This pattern is typical of a “business cycle” as reserves are used to fund expansion, followed by a recovery period where reserves are restored for accumulating surplus. It is not unique to Family Care. It should be pointed out that in Figure 9 the solvency ratio values for the starting point of Period I and the minimum value of -100% are arbitrary. In actual practice the starting and minimum values will be different from these values. In some cases the starting point is in the negative range.

Figure 9



DHS has asked APS to evaluate aspects of each period of MCO development: the initial period required to achieve operational break-even results, and the duration of time expected to achieve capital surplus sufficient to satisfy the risk reserve requirement for MCOs in Period II. In the previous section we assessed the reasonableness of a three-year duration for phase-in adjustments during the first period, and in this section we evaluate the time required to achieve solvency during the second period. References in this section to duration of the phase-in period can be interpreted as either incorrect assumptions about the amount or duration of the adjustments by DHS or a failure on the part of the particular MCO to achieve implementation of the Family Care service model, or both.

It is the position of DHS that, as far as possible, each MCO should finance their expansion costs from their own reserves built up from Family Care operations, as would any other business.

In the analysis below we focus on the measure of “Solvency Ratio”, which we define as the ratio of the total end-of-year solvency funds (including working capital, restricted reserve and solvency fund) divided by the sum of required solvency funds as provided by DHS regulations. The 100% solvency ratio represents when all solvency requirements for the MCO have been met, and is represented in the figures by a horizontal line at the 100% mark of the vertical axis. Usually, but not always, an upward slope to the solvency ratio line indicates that the MCO is achieving a positive surplus in that year, and a downward slope indicates that it is losing money. Period I can be taken as the time from start-up (or expansion) to when the solvency ratio line “bottoms out” at a minimum value. Period II is the time from that point until the solvency ratio line recovers to the 100% value.

The projections in the following section are developed from the APS Healthcare Family Care Financial Projection Model (“the APS projection model”) which was developed specifically for the analysis. A detailed description of the model is presented in Appendix B. The basic assumptions for input into the model are contained in Appendix C. It should be noted that some of the assumptions, such as rate of increase of administrative and care management expenses and duration of the phase-in period, are controllable at least to some extent by the MCOs themselves. Other assumptions, such as errors in projection of trend rates and relative mix of new enrollees by target population, are outside of the control of the MCOs (although in new expansion counties deviations in the population mix are largely adjusted for by retroactive rate adjustments). As such, the various scenarios should be viewed as a mix of what the MCOs can achieve on their own and what may be imposed on them by the variability of the

exogenous assumptions. A sensitivity analysis of the variable assumptions was performed to determine which assumptions were the most critical to financial performance. It found that the model was most sensitive to error in trend rate estimation and variation in duration of the phase-in period. The mix of new members was of intermediate importance, while the rates of increase of administrative expenses and care management expenses had the least effect on financial trajectories.

### **Analysis and Findings**

In this section, individual MCOs are examined and their future financial status is projected through the end of calendar year 2015 using the APS Family Care Financial Projection Model (see Appendix B). They are presented in their order of entry into the Family Care program, so that pilot programs are shown first, followed by expansion plans. While there are five scenarios posited in the base analysis of each MCO, the number of actual scenarios is virtually infinite and those presented here should be viewed as merely a reasonable range of possibilities. In most cases the “Intermediate” scenario may be viewed as the most likely since it represents pricing assumptions being met. The “Best case” and “Worst case” scenarios are intended to represent outliers with assumptions which differ significantly from the Intermediate scenario but which might still be considered reasonably likely to occur individually and in the aggregate. A listing of the assumptions used in the various scenarios is given in Appendix C. While the scenarios assume fairly constant operating environments, it is expected that year-to-year experience will vary as the different assumptions are met in some years and missed in others.

A summary is given below of the projected results for the various MCOs under the intermediate set of assumptions. The MCOs are listed in order of their entry into Family Care.

Table 5. Benchmark dates for financial projections of Family Care MCOs

MCO	Operational Break-Even Date	Solvency Ratio as of December 31		
		2010	2012	2015
Community Care of Central Wisconsin	2012	90%	114%	252%
Lakeland Care District	2012	158%	126%	263%
Milwaukee County Department of Family Care	2010	145%	291%	560%
Southwestern Family Care Association	2010	104%	190%	291%
Western Wisconsin Cares	2010	96%	176%	328%
Community Care Incorporated	2011	12%	101%	191%
Care Wisconsin First	2011 <sup>1</sup>	-142%	-72%	-76%
Community Health Partnership <sup>2</sup>	2011	-202%	-77%	39%
NorthernBridges	2011	-80%	-27%	48%

1) While Care Wisconsin First is expected to have a positive contribution to surplus in 2011, it is expected to lose money from 2012 through 2015.

2) Although the intermediate scenario is shown here for Community Health Partnership, given its recent experience it is deemed that the moderately adverse scenario is probably a better estimate of future experience.

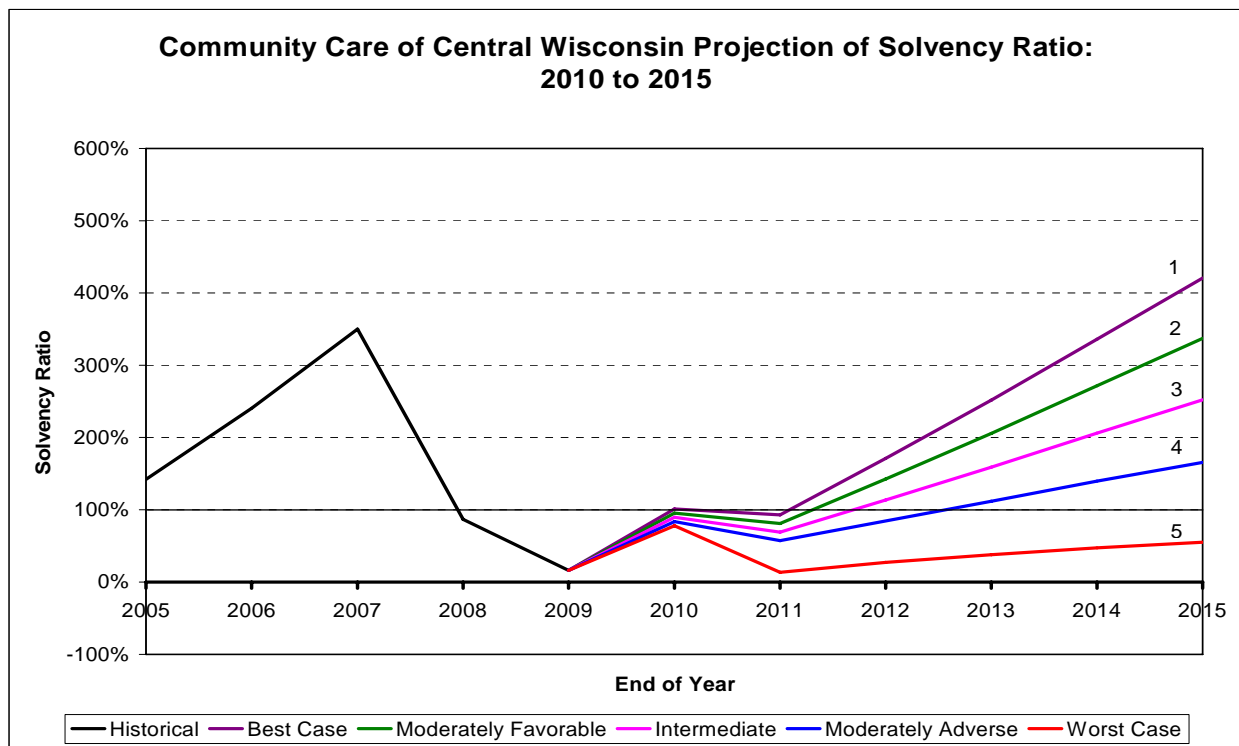


## Community Care of Central Wisconsin (CCCW)

Operating in Portage County, CCCW participated in Family Care as one of the original five pilot counties. In November of 2008, CCCW expanded its operations to include Marathon County and expanded into Wood County in January, 2009. Coincident with this expansion, CCCW lost \$2.3 million (7.6% of revenue) in 2008 and its combined reserve funds fell below 100% of the total required solvency fund level. In 2009, CCCW also lost money (\$2.4 million, or 2.9% of revenues based on the audited financial statement without acuity adjustment), driving the total combined solvency reserve fund level to just 16% of the required level.

The solvency for CCCW was projected from 2010 through 2015 using the APS projection model based on the current service area. The results are shown in Figure 10. The date when the solvency requirement is met is indicated by the point at which the projection line crosses the 100% solvency ratio line (vertical axis).

Figure 10



The intermediate scenario (projection line 3), which uses assumptions stated in the 2010-2012 business plan and capitation model and is deemed the most likely to occur, indicates that CCCW will achieve a positive contribution to surplus of approximately 4% of total revenue in CY 2010.

Under this scenario, it is expected that CCCW will reach a solvency ratio of 100%, meeting all solvency requirements, in the second quarter of 2012. Under the intermediate scenario, CCCW will experience a surplus margin of approximately 3.9% of total revenue in CY 2010, 0.0% in 2011, and 2.8% in 2012.

Under the best case scenario (projection line 1) CCCW will meet 100% of solvency requirements in the third quarter of 2010. The moderately favorable scenario (line 2) shows that CCCW will be close to 100% of solvency requirements by the end of 2010, but will not actually reach the 100% mark until the first quarter of 2012.

Under the moderately adverse scenario (projection line 4), the solvency ratio is not projected to reach 100% until the second quarter of 2013. This delay in reaching full solvency is due largely to the actual phase-in period for the expansion counties lasting 4 years rather than 3. The longer phase-in period results in claim costs significantly higher than expected in 2010 and 2011.

In the worst case scenario (projection line 5), the actual phase-in period for claim costs lasts for 5 years, resulting in a suppression of surplus so that the solvency ratio remains below 100% through the end of the projection period, although it does stay positive.

The intermediate and favorable scenarios show CCCW meeting 100% of solvency fund requirements by the end of 2012. The moderately unfavorable scenario indicates a delay until the second quarter of 2013. While the worst case scenario shows a loss for CCCW in 2011, it shows a positive surplus to the end of the projection period, so the MCO is not in any real financial danger.

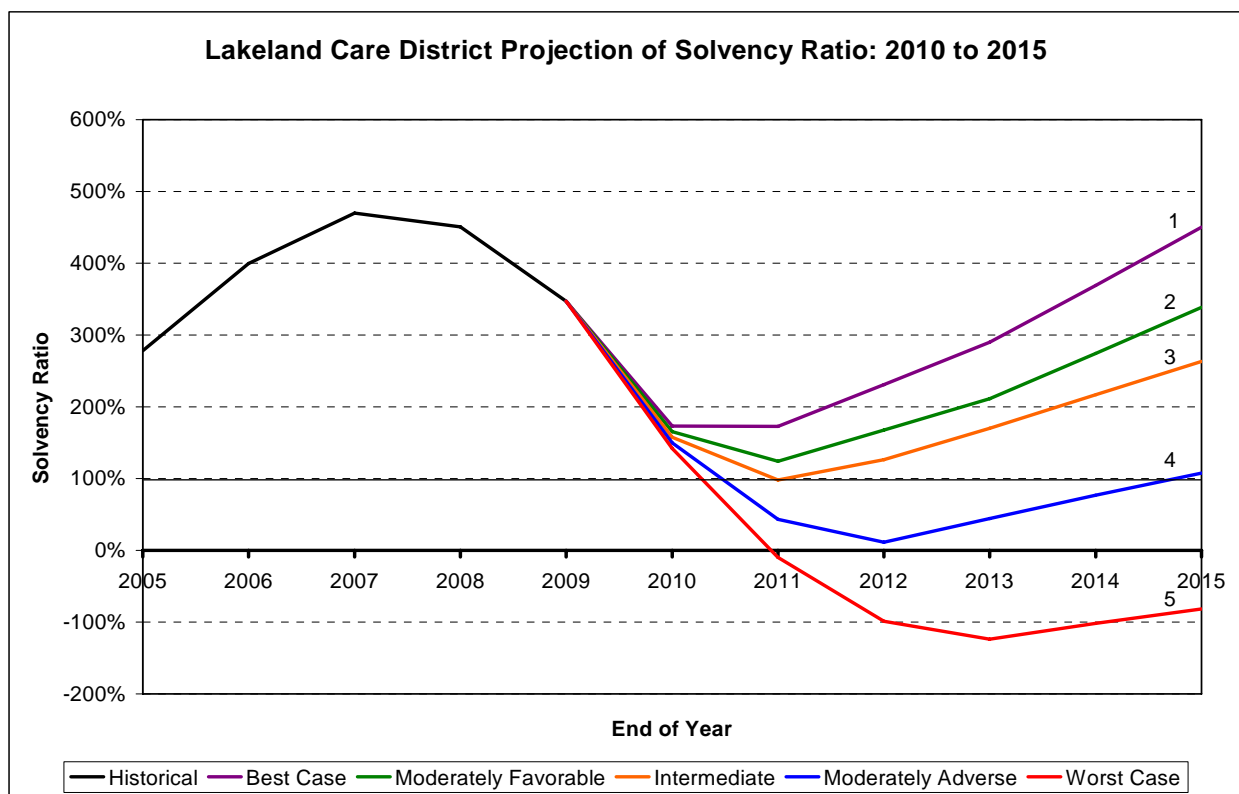
It should be noted that CCCW is planning on expanding into Langlade and Lincoln counties in 2011. The effects of that expansion on the financial projections are not taken into account here. Based on the financial performance of CCW concurrent with the 2008 expansion, however, it is expected that there will be a short-term negative impact on the solvency ratio.

## Lakeland Care District (LCD)

Lakeland Care District was one of the original five pilot Family Care programs, offering LTC services to Medicaid enrollees in Fond du Lac County. In April 2010 Lakeland expanded its service area to include Manitowoc County and to Winnebago County in July 2010. In years prior to the expansion Lakeland had possessed liquid assets well in excess of what was required. The solvency ratio reached 470% at the end of 2007, after which two successive losing years dropped it to a still-healthy 347%. In 2009 Lakeland experienced operating losses of \$1.27 million, or 4.3% of total revenue. Combined administrative and care management expenses equal to 21.2% of revenue were a factor in these losses.

The solvency ratio for Lakeland was projected through 2015 using the APS projection model. The results are shown in Figure 11.

Figure 11



Based on the intermediate scenario (line 3) set of assumptions, Lakeland is projected to lose approximately \$1.7 million in 2010, or 3.6% of total revenue. In 2011 the losses are projected to be less. These losses are attributable to a combination of high administrative expenses and high service costs associated with the phase-in period for the expansion counties. From 2012

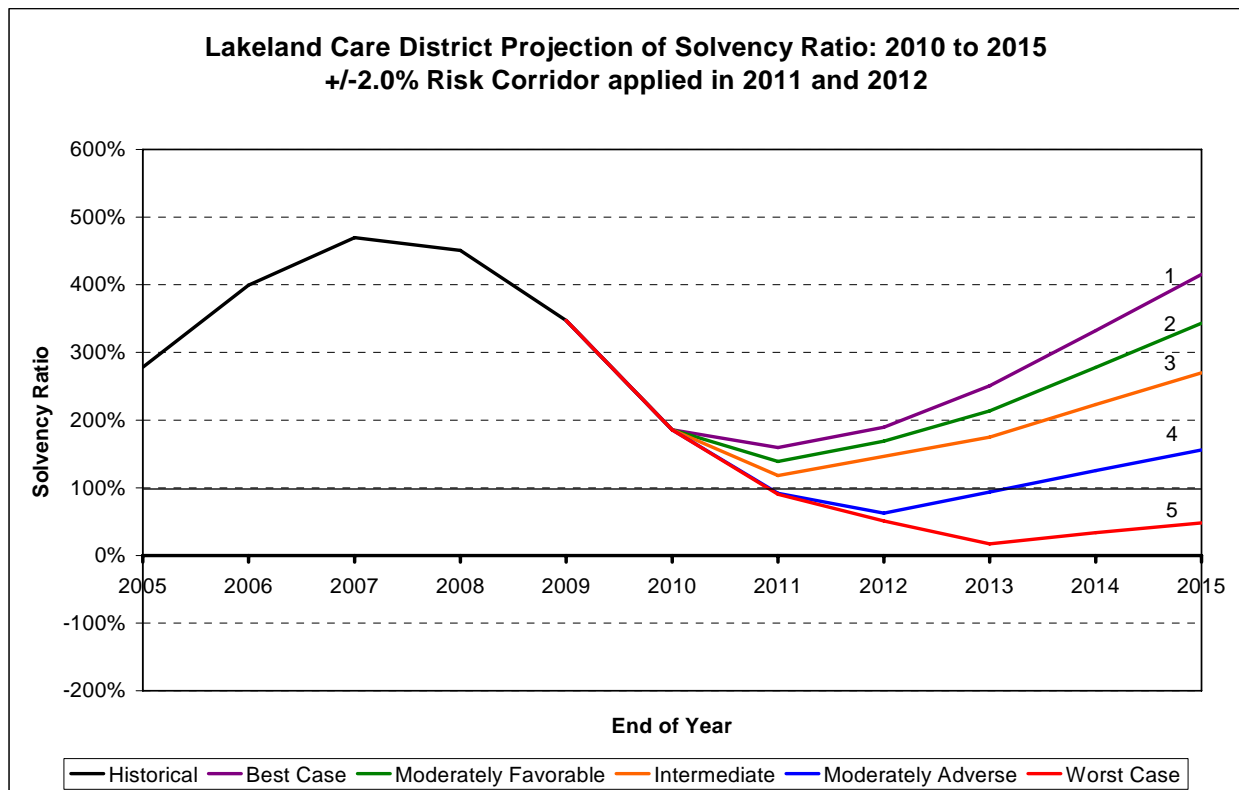
on, Lakeland is projected to achieve a positive surplus as the phase-in period wears off and enrollment growth causes fixed expenses to become a smaller portion of revenue.

In the best case scenario (line 1), losses in 2011 are lessened due to a faster wearing-off of the phase-in costs in the expansion counties. The moderately favorable scenario (line 2) is very similar the intermediate scenario with more modest losses in 2010 and a slightly better return in successive years as the administrative expenses increase at a slower rate.

In the moderately adverse scenario (line 4), the solvency ratio dips below 100% in 2011 following greater than expected service costs associated with a longer-than-expected phase-in period. After small losses in 2012, the MCO turns positive again, reaching the 100% solvency ratio in the third quarter of 2015. In the worst case (line 5) the plan loses money through 2013 due to higher than expected claim costs and a mix of members more heavily weighted towards the high-cost developmentally disabled than anticipated by the capitation calculations. The solvency ratio dips below -100% in 2013, recovering only slightly to -82% by the end of 2015.

The main concern with Lakeland is the risk of volatile financial performance due to the uncertainties of expansion, especially in regards to the length of the phase-in period. This volatility can be leveled out significantly by implementation of a risk-sharing arrangement with DHS. Figure 12 illustrates what the scenario projections would look like if there was a +/- 2% risk-share corridor applied to the Lakeland MCO through the end of 2012.

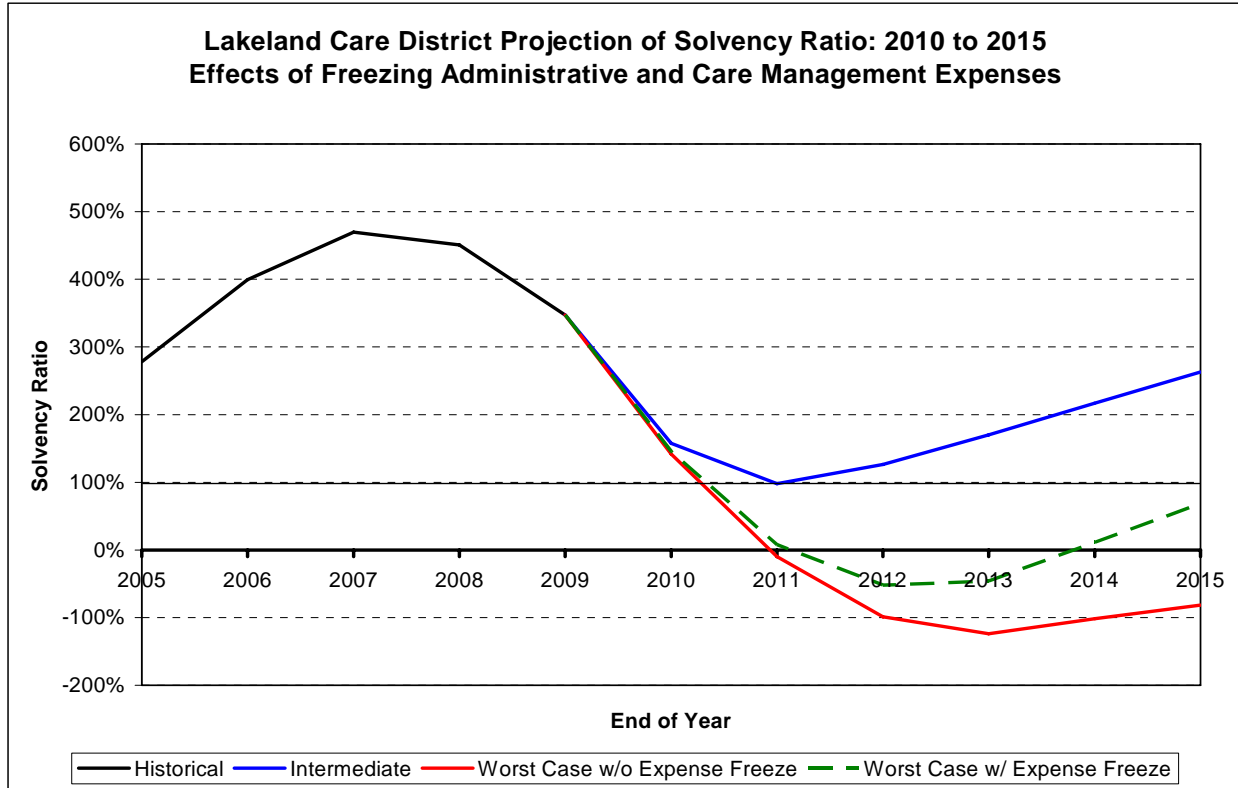
Figure 12



In the worst case under this risk-sharing arrangement DHS would pay out \$6.5 million in 2011 and 2012. However, in the best case scenario DHS would recover \$2.7 million from Lakeland. The intermediate scenario would be completely unaffected.

A second option is to impose some cost control on the Lakeland MCO. This MCO has the highest care management expense ratio in the Family Care program (14.0% of revenue in the first 6 months of 2010) and the second-highest administrative expense (7.7%). A part of these high expenses is attributable to the ramping up for the 2010 expansion. Freezing care management and administrative expenses at current levels would improve the financial performance under the worst case scenario such that a return to a solvency ratio of 69% would be likely by the end of 2015. This is shown in Figure 13.

Figure 13



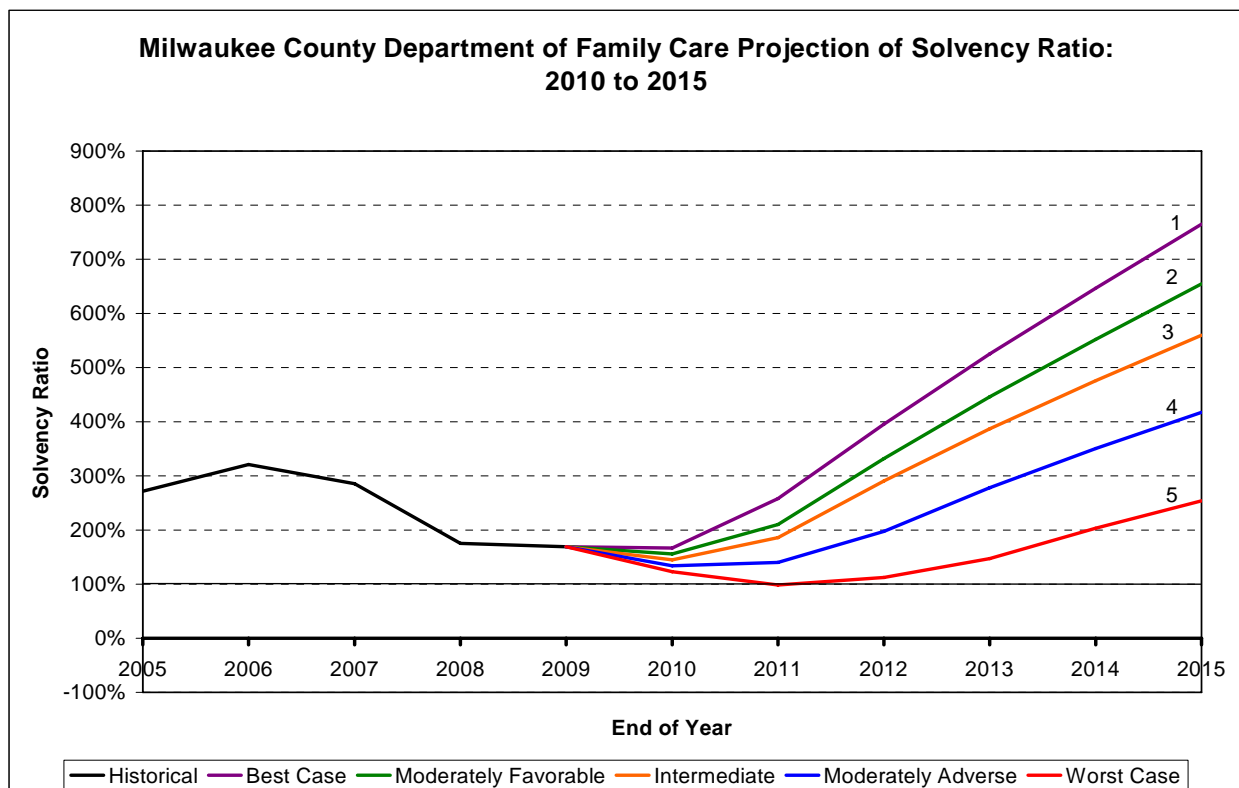
## Milwaukee County Department of Family Care (MCDFC)

Milwaukee County was one of the 5 pilot Family Care programs which began operations in 1999. Through October 2009 MCDFC served almost exclusively the elderly population, expanding its operations in November 2009 to include the younger physically and developmentally disabled as well. By 2011 the disabled population is expected to reach 76% of the total population.

In recent years, MCDFC has been among the most financially stable of the Family Care MCOs. Losses in CY 2008 resulted in the solvency ratio dropping to 175%, and the solvency ratio dropped further to 168% in 2009 despite the fact that the plan essentially broke even in that year.

Future year-end solvency ratios were projected for MCDFC through 2015 using the APS projection model. The results are shown in Figure 14.

Figure 14



Under the intermediate scenario (line 3) the solvency ratio drops slightly to 145% at the end of 2010 despite a projected surplus margin of 1.6% of total revenue. This apparent contradiction is due to the fact that the solvency requirements are expected to increase by 37%, due

primarily to increased requirements for working capital and increases in enrollment. Projected surpluses in subsequent years increase the solvency ratio every year. Financial performances under the best case (line 1) and moderately favorable (line 2) scenarios follow a similar pattern but with more positive results.

Under the moderately adverse scenario (line 4) the solvency ratio drops to 134% at year-end 2010 despite a small surplus being posted. Only under the worst case scenario (line 5) does the solvency ratio get near to being below 100%, reaching a low level of 104% in 2011 before recovering.

MCDFC appears to not be in real danger of reaching a seriously underfunded financial position during the projection period.

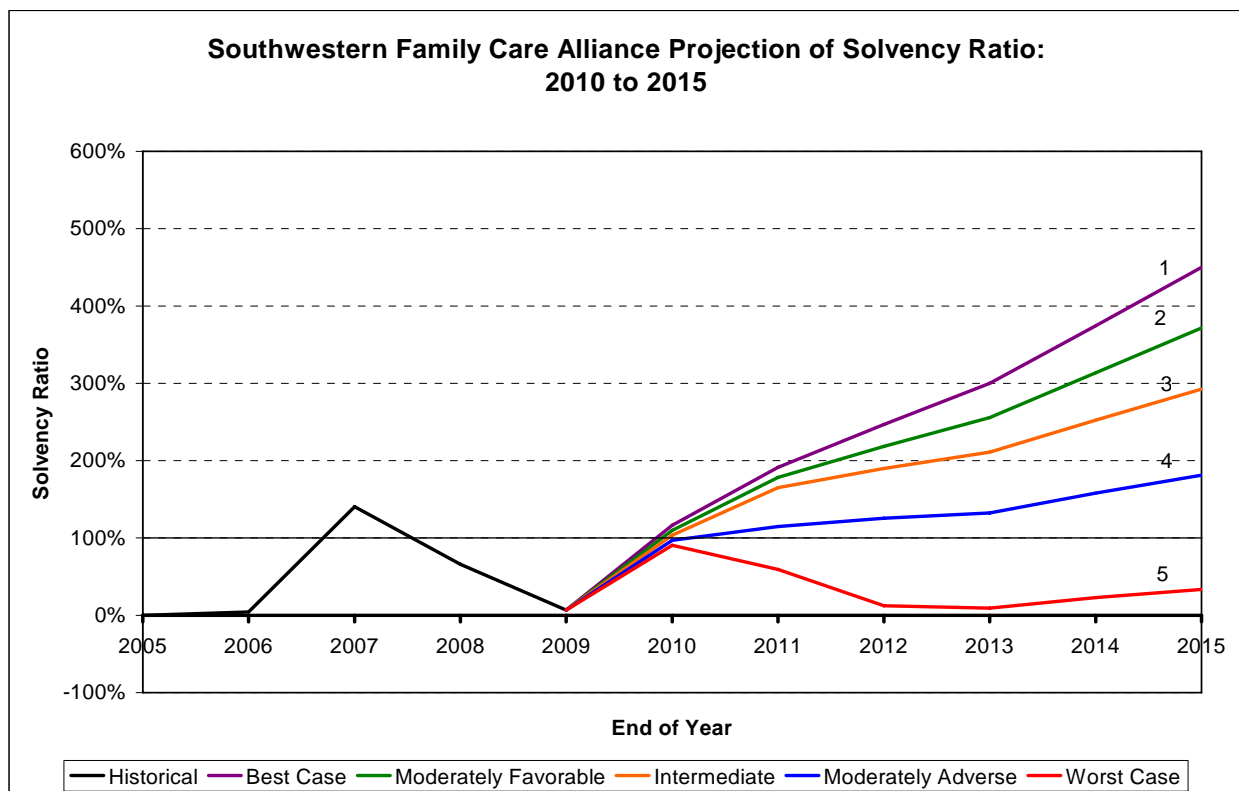


## Southwestern Family Care Association (SFCA)

SFCA operated one of the Family Care pilot programs in Richland County since 2001. In September 2008, SFCA expanded its Family Care coverage area to include Sauk County, adding Green County in January 2009 and Crawford Juneau, and Lafayette counties in July 2009. SFCA last saw a positive surplus year in 2005, followed by a small loss of \$12,000 in 2006 and a larger operating loss of \$111,000 in 2007. However, a loan from Richland County helped SFCA to meet its solvency requirements in 2007. In the ramp-up to the expansion in 2008, SFCA lost a further \$412,000 primarily due to high administrative expenses (10.8% of revenue). Following the expansion, SFCA lost \$602,000 in 2009 which dropped its year-end solvency ratio from 133% of required reserves to 7% on December 31, 2009.

A projection of future solvency ratios was performed for SFCA using the APS projection model. The results for 5 scenarios ranging from “worst case” to “best case” are shown in Figure 15.

Figure 15



The future for SFCA appears to be good, with all scenarios except the worst case showing the 100% solvency ratio level being met in 2010 or early 2011. In the intermediate scenario (line 3) SFCA makes a surplus in 2010 of 6.6% of total revenues (\$3.5 million), and achieves 100% of

solvency requirements in the fourth quarter. In the best case (line 1) and moderately favorable (line 2) scenarios, the results are even more positive.

In the moderately adverse case (line 4), 100% of solvency requirements are met in the first quarter of 2011 and that amount approaches 200% by the end of 2015. Under the worst case scenario, the MCO loses money in 2011 and 2012 but still maintains a positive solvency ratio.

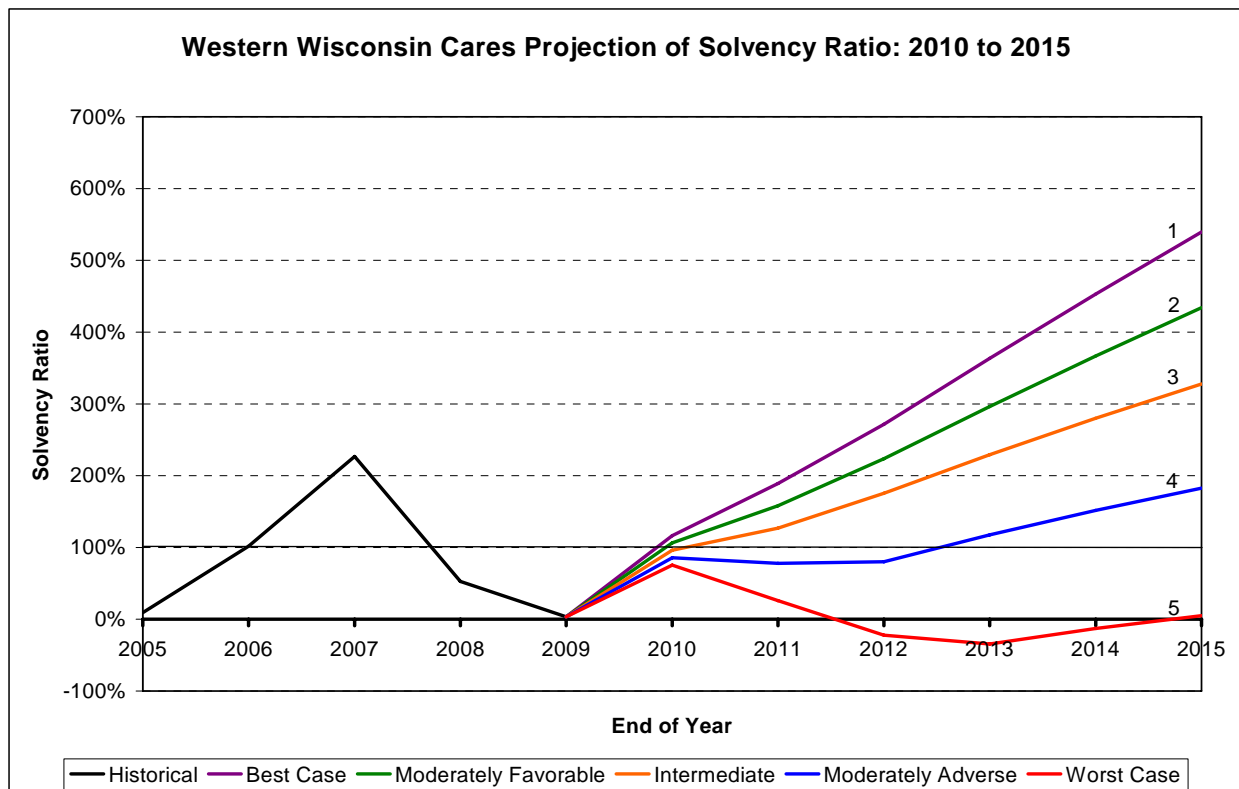
Part of the reason for SFCA's relatively stable projections results from the fact that initial claims in expansion counties are expected to be only about 10% higher than what has been achieved in Richland county after several years of experience. As a result, the plan is at much less risk from difficulties resulting from the possibility of the amount of time it would take for SFCA to attain full efficiencies in the expansion counties being somewhat longer than the expected period of 3 years. Furthermore, while administrative expenses were at a high level of 7.3% of revenue in 2009, they have dropped to around 6% in 2010 as fixed costs were spread over a greater enrollment, and are expected to get even smaller as a percentage of revenue as the plan grows.

## Western Wisconsin Cares (WWC)

WWC operated one of the 5 pilot Family Care programs in La Crosse County. In late 2008 and early 2009 WWC expanded its Family Care operations to include Buffalo, Clark, Jackson, Monroe, Pepin, Trempealeau and Vernon counties. Prior to the expansion, WWC had positive surplus years in 2006 and 2007, followed by losses in the expansion years of 2008 and 2009 which were associated with significantly higher service claim costs. On December 31, 2009 WWC's solvency ratio stood at 3% of required reserves.

The solvency ratio for WWC was projected forward from January 2010 using the APS projection model. The results are shown in Figure 16. The date when 100% of solvency requirements is met is indicated by when the projection line crosses the 100% solvency ratio line (vertical axis).

Figure 16



Under the intermediate projection (line 3), WWC is expected to make a surplus of approximately 4.7% of total revenue (\$5.1 million) in 2010 and to achieve the 100% level of solvency reserves in the first quarter of 2011. In the best case (line 1) and moderately favorable (line 2) scenarios, WWC is expected to reach the 100% solvency ratio level in the fourth quarter of 2010.

In the moderately adverse scenario (line 4), following a 4.1% surplus in 2010 WWC will show modest positive results in the next few years, but will not achieve 100% of financial solvency requirements until the second quarter of 2013. In the worst case (line 5), WWC will lose money through 2013 and show a surplus in 2014. The solvency ratio will fall to the -34% level before climbing into positive territory by the end of 2015.

Because the FFS level of costs prior to expansion in the WWC region was not a great deal more than what is expected under a fully-implemented care management plan, there is less risk and volatility associated with variations in the length of the phase-in period, relative to some other Family Care MCOs. Much of the observed variance in the various projections is due to the effects of error in trend projections and, to a lesser extent, shifts in enrollee mix between the target categories of frail elderly, physically disabled and developmentally disabled.

The generally positive nature of the various projections for WWC is attributable in part to a continuation of the relatively low administrative expense ratio for the plan. In the first six months of 2010, administrative expenses were 4.5% of total revenue, and this ratio is expected to drop to 4% or below for subsequent years as the plan continues to grow and achieves efficiencies of scale.

WWC care management expenses are running above average for Family Care by about 1.3% in 2010 so there is a potential for improving financial performance by better controlling costs there. Under the worst case scenario except with care management costs frozen, the solvency ratio drops to only 13% at year-end 2012 before recovering and passing the 100% level in the third quarter of 2015.

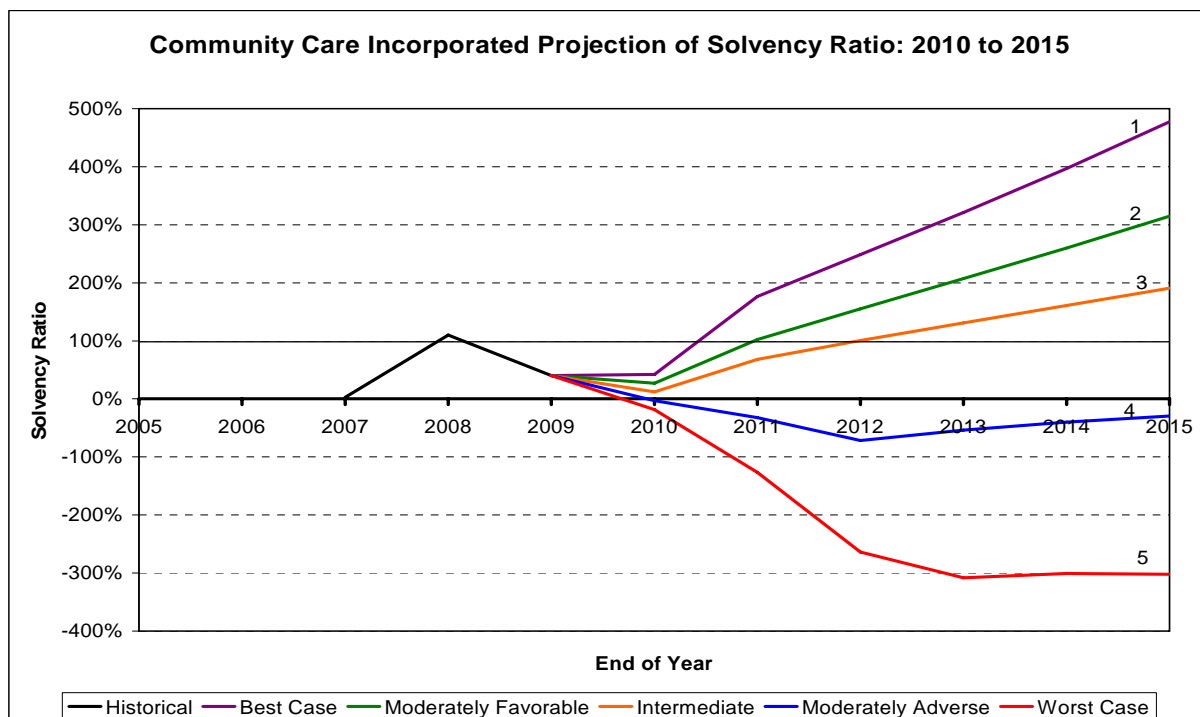
## Community Care Incorporated (CCI)

Community Care Incorporated (CCI) entered into the Family Care program in early 2007 when it began operations in Racine (January 1, 2007) and Kenosha (February 1, 2007) counties. CCI expanded into Ozaukee, Sheboygan, Washington and Waukesha counties (the “Teal” region in the Family Care Map, Appendix A) in 2008. It then added another Teal region county (Walworth) in October 2009, followed by Milwaukee County in November 2009 and three “Pink” region counties (Calumet, Outagamie, and Waupaca) in 2010. This series of consecutive expansions makes CCI unique in the Family Care program and complicates the general model.

In the initial year of 2007, CCI lost \$1.3 million, ending the year with a solvency ratio of 3%. In 2008 CCI again did poorly financially, having approximately \$5.0 million in operational losses (4.4% of revenue). Due to a cash infusion from its Partnership program, however, they finished 2008 with a year-end solvency ratio of 110% of required reserves. It experienced further losses of \$3.9 million (2.9% of revenue) in 2009, driving the solvency ratio down to 40%.

Using the APS projection model, end-of-year solvency status was forecast through 2015. The results are shown in Figure 17.

Figure 17



There is a considerable variance in the range of potential results due to uncertainty of experience resulting from a major expansion effort. Under the intermediate scenario

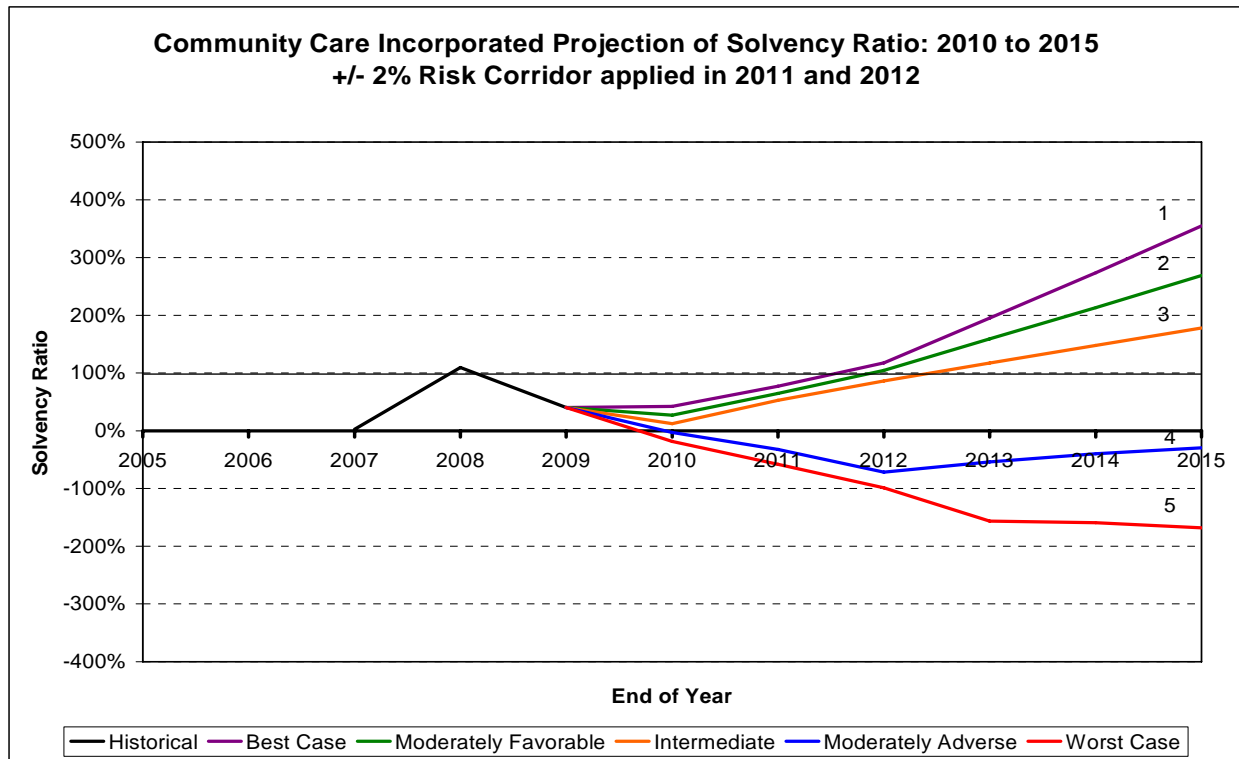
(projection line 3), which is considered to be the most likely, CCI will experience a loss of approximately \$1.7 million (0.8% of revenues) in 2010 after which it will experience a moderate surplus (approximately 2.8% of revenues in 2011 and 1.8% for the following years). The solvency ratio is expected to reach 100% by the end of 2012.

Under the best case scenario (line 1), CCI will experience an operating surplus of approximately 0.5% of revenues in 2010, followed by a solid surplus of 6.8% in 2011, which will cause the 100% solvency ratio to be reached in the second quarter of 2011. The moderately favorable scenario (line 2) indicates that the 100% solvency ratio will be achieved in December of 2011.

The unfavorable scenarios anticipate high claim costs, particularly in Milwaukee County, where FFS costs were estimated at 135% of what is anticipated under a fully functional managed care program. Driven mostly by a prolonged (5 year) phase-in period to achieve full efficiencies and compounded by an under-estimation of trend (that is, service costs grow at a greater rate than what is projected in the rate development), the worst case scenario (line 5) shows CCI experiencing significant losses in the first few years following the most recent expansion, possibly jeopardizing its financial solvency. In the moderately adverse case (line 4), CCI loses money through the end of 2012, and then stabilizes with modest surplus levels through 2015.

Due to the risk assumed by CCI from their expansion, it may be desirable to offer the plan a risk-sharing option. Figure 18 shows the range of results if a risk corridor of +/-2% is applied in 2011 and 2012. While a +/-2% corridor is used for illustrative simplicity, the implemented arrangement would have a different design, such as the current FC model of a +/-1% corridor where the MCO is at 100% risk, while risk is shared 50%/50% with DHS outside of that range.

Figure 18



Although the intermediate scenario is affected to a small degree (\$1.8 M recouped by DHS in 2011), the variation in the outlier cases is considerably reduced. Under the worst case scenario DHS would have to pay out an extra \$21.3 million to CCI in 2011 and 2012. However, despite this influx of extra money, the solvency ratio would stay well below 0% through 2015. On the other hand, in the best case scenario DHS would recoup \$15.9 million over those two years.

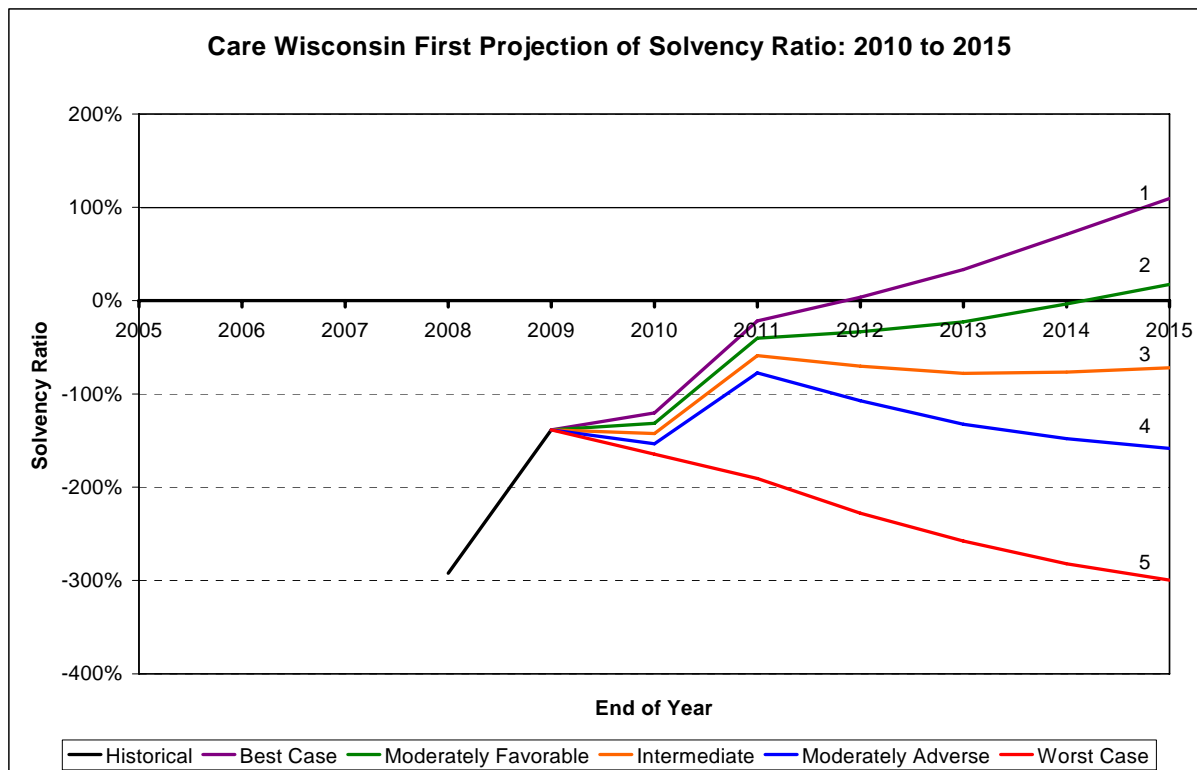
### Care Wisconsin First (CWF)

CWF started operations as a Family Care MCO in 2008 covering 8 counties; Columbia, Dodge, Green Lake, Jefferson, Marquette, Washington, Waukesha and Waushara. CWF got off to a difficult start, losing \$7.3 million in 2008 and losing another \$2.7 million in 2009 to finish the year with a total solvency ratio of -138%. This poor performance was largely driven by a combination of higher than expected claim costs among the PD and DD populations. However, the ratio of actual to expected claim costs decreased every quarter through the end of 2009.

There also appears to be an issue with administrative expenses for CWF. Administrative expenses totaled 7.3% of total revenue in 2009 and 7.9% in the first 6 months of 2010, the highest for any MCO in the Family Care program. It should be noted, however, that problems at CWF with the proper allocation of expenses between administrative and care management may confound a direct comparison with other MCOs. DHS has been working with CWF to properly allocate expenses, but the problem has not yet been fully corrected.

The solvency ratio for CWF was projected forward through 2015 using the APS projection model. The results are shown in Figure 19.

Figure 19





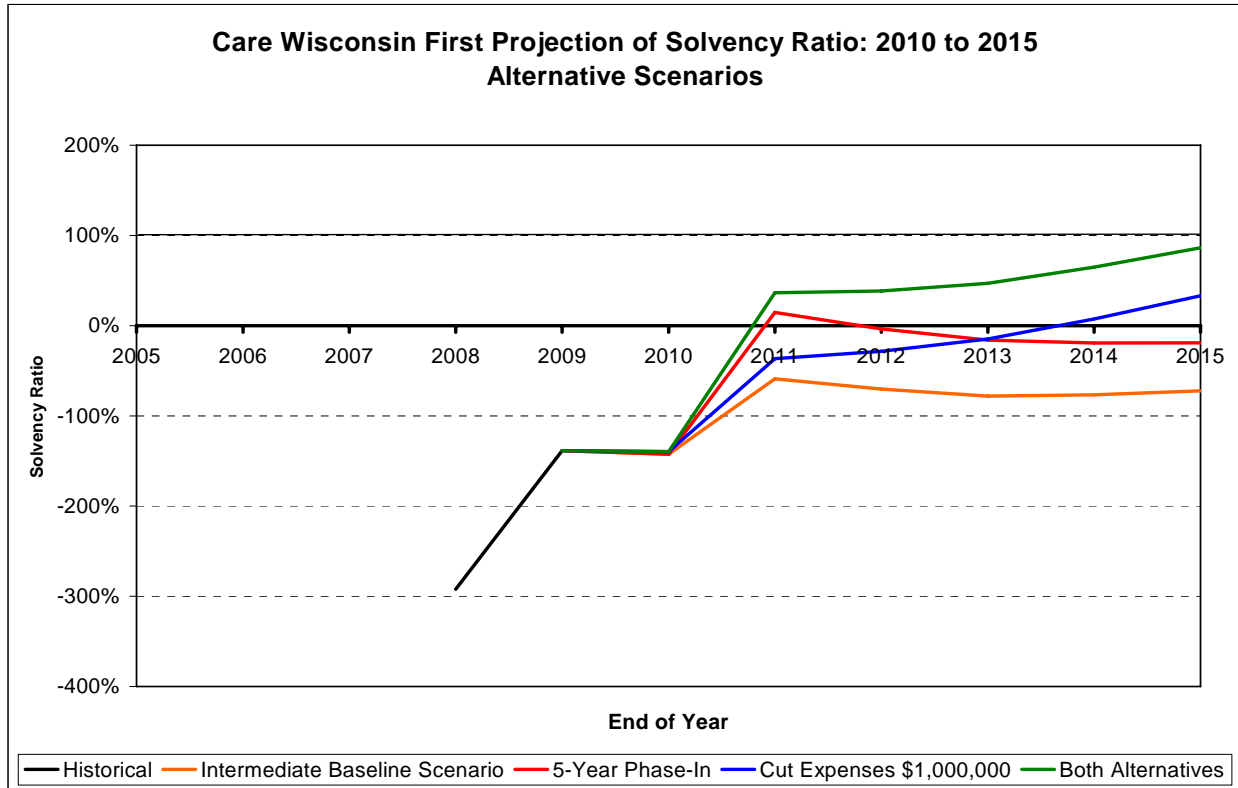
Under the intermediate scenario (line 3), CWF will break even in 2010 and show a surplus in 2011, but then lose money in the following years. In this instance the solvency ratio stays below the 0% level through 2015. Only in the best case scenario (line 1) do the solvency funds reach the 100% of the required amount before the end of 2015. In the moderately favorable scenario (line 2), the solvency ratio stays relatively flat in 2010, increases to -40% in 2011 reflecting a 3.3% surplus, then slowly increases through 2015 as modest contributions to surplus are realized. In both the moderately adverse (line 4) and worst case (line 5) scenarios the solvency ratio remains well below the 0% level throughout the projection period.

Much of the poor experience in the first two years of operations for CWF was due to higher-than-expected claim costs. The ratio of service costs net of room and board to capitation payments was 101.9% in 2008 and 99.6% in 2009. For unknown reasons, actual costs in those years were higher than indicated by FFS payments for LTC services in the CWF service area prior to the plan start-up. In that case, the phase-in period may also need to be lengthened. Lengthening the phase-in period for the calculation of capitation amounts to 5 years would add approximately 4% to CWF revenue in 2011. This alternative does not include any retroactive adjustments for potential understatement of the capitation rates in previous years.

The issue of high administrative costs may also be a point for improving performance. If administrative expenses were decreased by \$1,000,000 in 2011 (approximately 9.5% of total projected administrative expenses) then the surplus margin in 2011 would improve by 0.7%. Freezing expenses at that level through 2015 would increase the long-term savings, resulting in an end of year 2015 solvency ratio of 33%.

Finally, if both of these changes are implemented, then CWF would likely reach 86% of financial solvency requirements by the end of 2015. The projections under these alternatives are shown in Figure 20.

Figure 20



## Community Health Partnership (CHP)

CHP began operations in May 2008 in Chippewa County, followed later in the year by Dunn, Pierce, St. Croix and Eau Claire counties. CHP lost \$2.6 million in its start-up year of 2008. Despite an extra \$9.2 million in risk-sharing recoveries from DHS in 2009, CHP lost an additional \$4.6 million (9.9% of total revenue) in 2009. Starting 2010 with a solvency ratio of -119%, CHP lost \$1.2 million in the first six months of 2010, including \$5,150,000 in risk-sharing accruals. On a before-risk-sharing PMPM basis, CHP lost \$1,076.25 PMPM in 2008, \$1,241.24 PMPM in 2009, and \$1,011.12 PMPM in the first half of 2010.

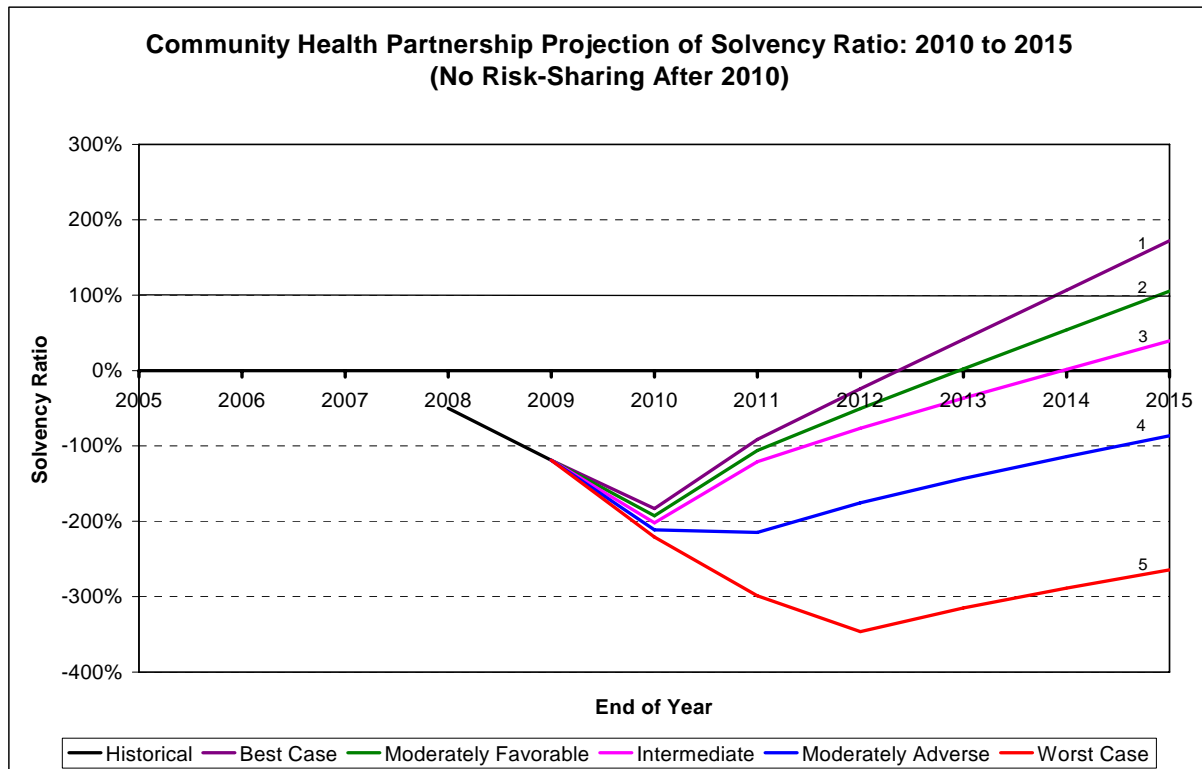
The main reason for these losses is much higher than expected claim costs, as evidenced by the fact that in 2009 member service costs accounted for 131.1% of capitation payments as compared with an average 91.3% for the rest of Family Care MCOs. Through the first 6 months of 2010, the service cost to capitation ratio had improved to 90.5%, but still well above the average of 82.3%. Both care management and administrative expense ratios for CHP are running below the Family Care averages.

There are several potential contributing factors for this shortfall in capitation payments relative to service costs. First, it appears that historically LTC patients in this area have received richer benefit packages than was typical of the state-wide fee-for-service LTC population. This disparity would naturally drive up initial costs to the MCO and complicate efforts to implement the Family Care management model. Second, anecdotally there may have been a number of very high-cost outlier cases compared to what was predicted by the functional status model used in calculating capitation rates, especially among the developmentally disabled population. The functional status model, like other risk-adjustment models, tends to understate the cost of high-cost outliers and overstate the cost of low-cost outliers. Finally, the 3-year phase-in period set by DHS for CHP to achieve those efficiencies may be too short, due to the personnel at CHP not fully implementing the Family Care service model within the expected time period. Based on the relative cost of services under the FFS model and the FC model, and the experience to date, it appears that CHP's time to fully phase in the Family Care service model may be 4 or 5 years rather than 3.

Future solvency ratios were estimated for CHP using the APS projection model. The results are presented in Figure 21. This chart should be interpreted keeping in mind that the Intermediate scenario is based on the premise that the functional status model is accurate for this MCO's mix of members and that the initial costs and phase-in period achieved by CHP are in line with DHS

expectations. To the extent that these assumptions may be wrong, the most likely scenario may not be the intermediate, but rather one of the adverse scenarios.

Figure 21



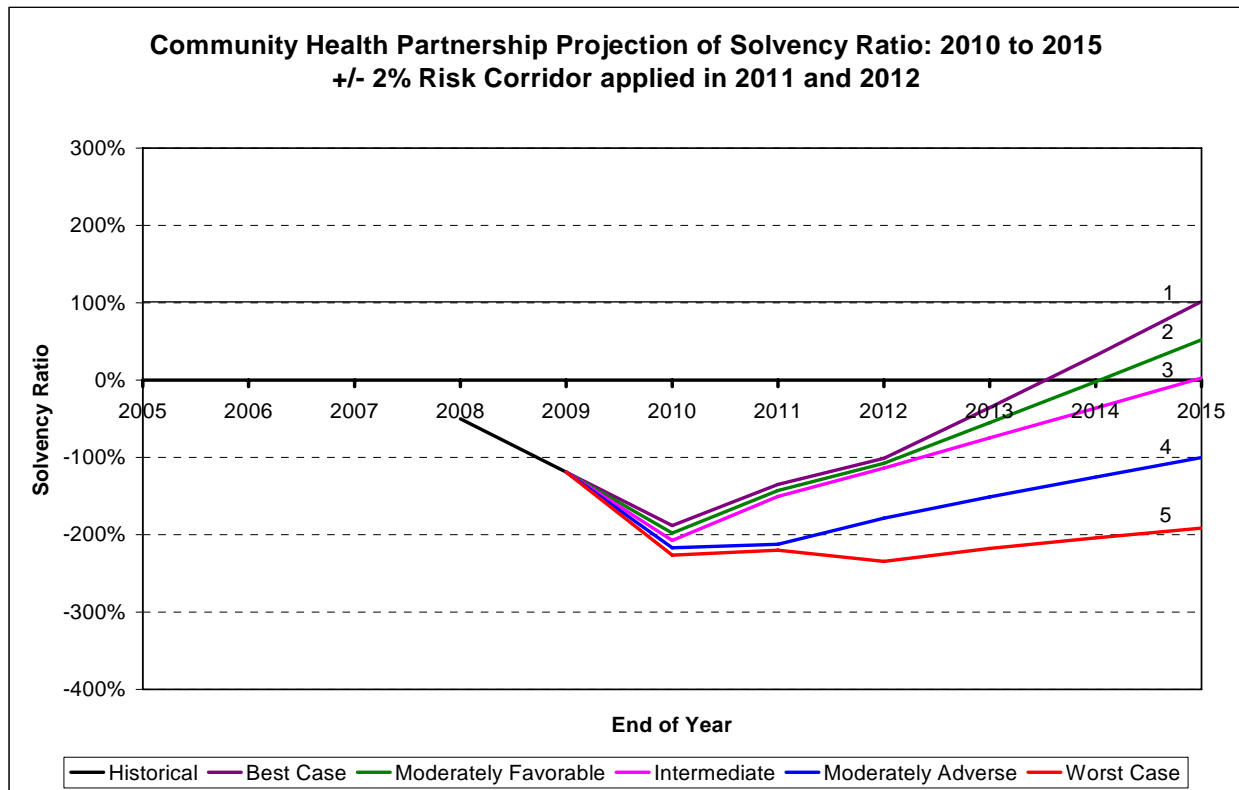
Under the intermediate scenario (line 3), the phase-in period has worn off and CHP shows a positive surplus from 2011 onward, reaching the 0% solvency ratio in December 2014. Under the favorable scenarios a similar pattern develops, with the 100% solvency ratio reached in the fourth quarter of 2014 in the best case scenario (line 1), and in the fourth quarter of 2015 in the moderately favorable scenario.

Under the moderately adverse scenario (line 4), CHP loses a small amount of money in 2011, but then shows a positive surplus in succeeding years. The worst case scenario (line 5) shows significant losses in 2011 and 2012 followed by positive years. However, CHP still would remain with a -264% solvency ratio at the end of the year 2015.

Extending the risk sharing arrangement between DHS and CHP past 2010 to 2012 would help dampen the negative results for CHP, as shown in Figure 22. Under the intermediate scenario (line 3) surplus would be held to 2% of revenue in 2011 and 2012 (with DHS recoveries of \$1.0 million), and CHP would reach a positive solvency position before the end of 2015. However, under the worst case scenario DHS would pay out an extra \$4.5 million in 2011 and 2012 and

the solvency ratio would stay in the -200% to -220% range through the end of 2014 before increasing slightly to -191% by the end of the projection period.

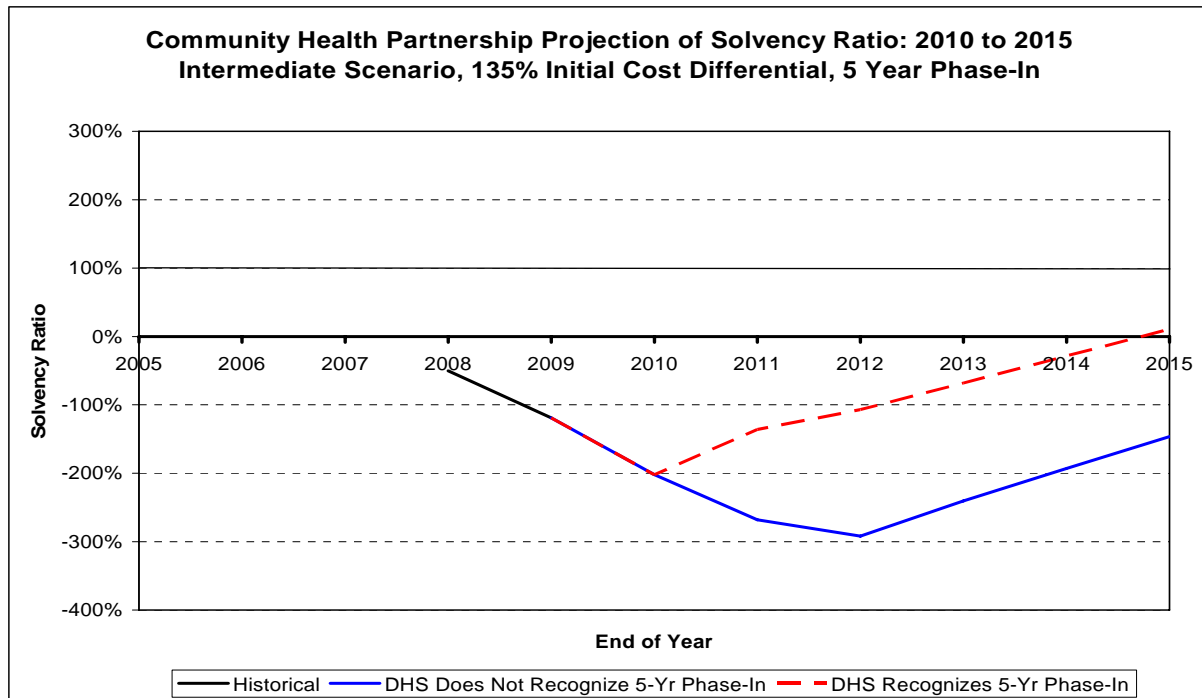
Figure 22



It is problematic, however, that extending the risk-sharing arrangement past 2010 may have the undesired effect of rewarding failure on the part of CHP to properly implement the Family Care service model for its members. Extending supplemental financial support to CHP from DHS should probably be linked to some sort of mechanism for ensuring proper implementation of the Family Care model, such as a pay-for-performance approach.

As mentioned above, CHP’s poor financial performance may be due in part to an under-estimation of the length of time it would take CHP to achieve full managed care efficiencies and an unexplained adverse deviation from initial service cost estimates. In Figure 23 all assumptions are set to the intermediate scenario except for the magnitude of the difference in costs between FFS and managed LTC in the CHP service area and the duration of the phase-in period.

Figure 23



The bottom solid line in Figure 23 represents the projection if the initial cost differential is 135% and the actual phase-in period is 5 years, but the DHS funding formula only recognizes a 125% differential and a 3-year phase-in period, as is currently the case. The top dashed line represents the case where, beginning in 2011, the DHS capitation formula recognizes a 5-year phase-in period. All other assumptions are equal between the two projections. In the latter case, however, the composite capitation rate paid by DHS in 2011 is 10% greater than without the phase-in adjustment, and in 2012 the difference is 5%. These percentages translate to approximately \$10.2 million in payments in 2011 and 2012 combined. From 2013 onwards the capitation rates are the same.

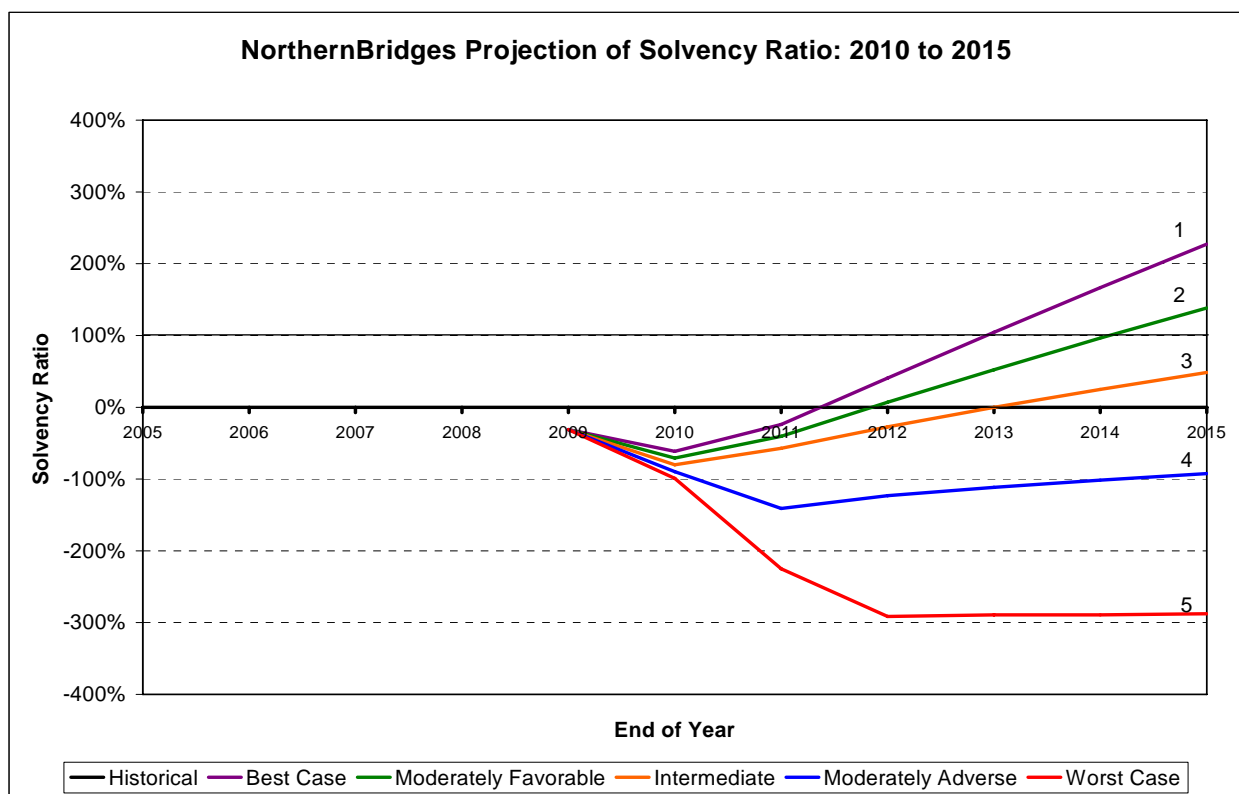
The difference between the two projections is marked. CHP shows a positive surplus rather than losses in 2011 and 2012, and the 0% solvency ratio level is met in the third quarter of 2015. At the end of 2015 the solvency ratio reaches +10% with the extra payments rather than -146% without. Once again, however, such an action by DHS may simply be rewarding a failure to perform on the part of CHP. Further exploration of a way to distinguish between poor performance by the MCO and actual uncontrollable service costs may be warranted but such a detailed study is beyond the scope of this analysis.

## NorthernBridges

NorthernBridges began operations as a Family Care MCO on May 1 2009. By August 2009 it included 11 counties in northwest Wisconsin in its service area: Ashland, Barron, Bayfield, Burnett, Douglas, Iron, Polk, Price, Rusk, Sawyer, and Washburn. NorthernBridges lost \$617,000 in 2009 and ended the year with a solvency ratio of -31%.

The financial performance and solvency ratios for NorthernBridges were projected through the end of 2015 using the APS projection model. The results are shown in Figure 24.

Figure 24



The intermediate projection scenario (line 3) shows the plan with a loss (-4.2% of total revenue) in 2010, followed by a surplus of 3.9% in 2011 and modest contributions to surplus (~1.5%) thereafter. The plan reaches the 0% solvency ratio by the end of 2013, but only reaches a solvency ratio of 48% by the end of 2015.

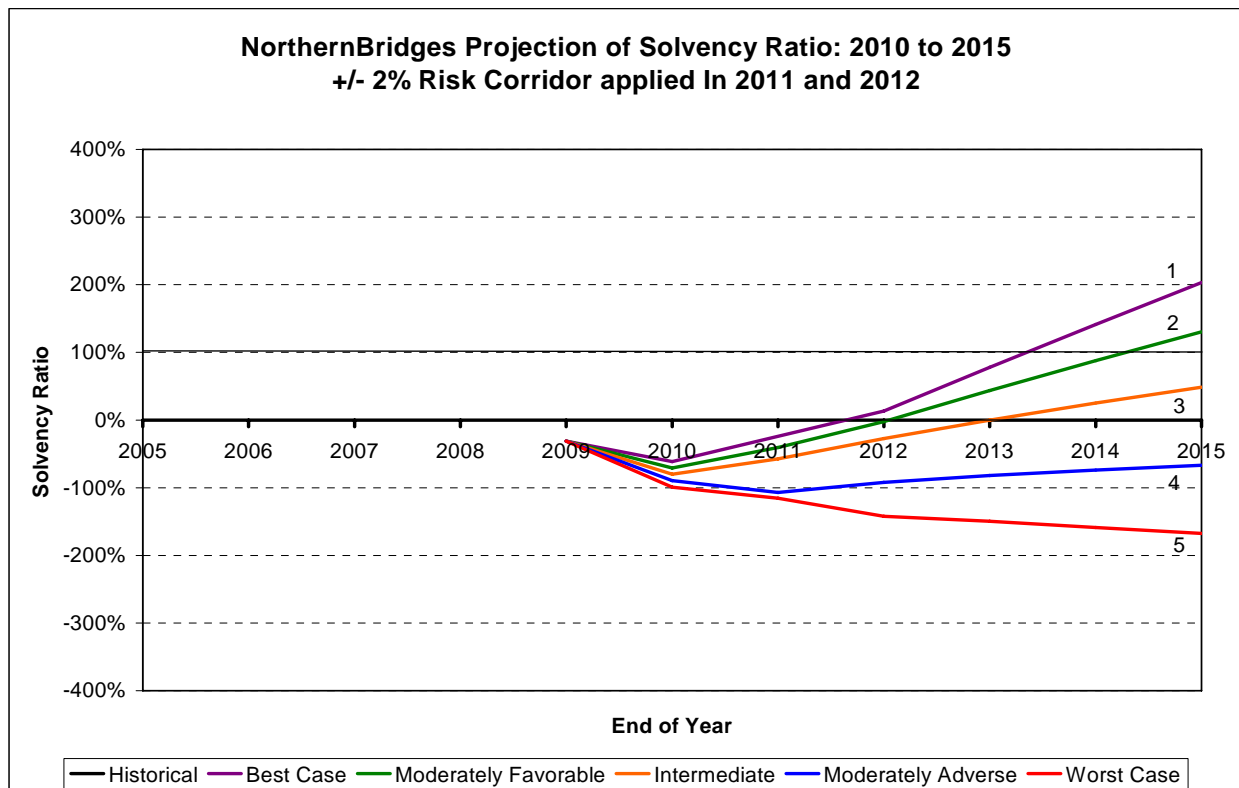
Under the best case (line 1) scenario the NorthernBridges plan loses 3.1% of revenue in 2010 but achieves solid positive results throughout the rest of the projection period, reaching the 100% solvency ratio level in the fourth quarter of 2013. The moderately favorable scenario

(line 2) yields more modest results with the 100% of solvency requirements being met in January of 2015.

In both the moderately adverse (line 4) and the worst case (line 5) scenarios, the MCO suffers losses in 2011 and (in the worst case) 2012 largely due to a prolonged phase-in period.

NorthernBridges is still in a very risky phase of its development due mainly to uncertainty regarding the actual time it takes to achieve full implementation of the Family Care management model. In Figure 24 above, the intermediate and both favorable scenarios assume that NorthernBridges is able to achieve full LTC efficiencies within three years, while the moderately adverse scenario reflects a four-year phase-in period and the worst case scenario envisions five years to reach full efficiency. This risk may be partly offset by applying a risk-share agreement between the MCO and DHS. Figure 25 describes the results of the various scenarios when a risk corridor of +/-2% of revenue is applied.

Figure 25



The intermediate scenario remains unchanged because the MCO never realizes surplus or losses outside of the +/-2% band. Under the best case scenario NorthernBridges would pay back \$1.6 million to DHS in 2012, lowering the curve but only delaying the achievement of the

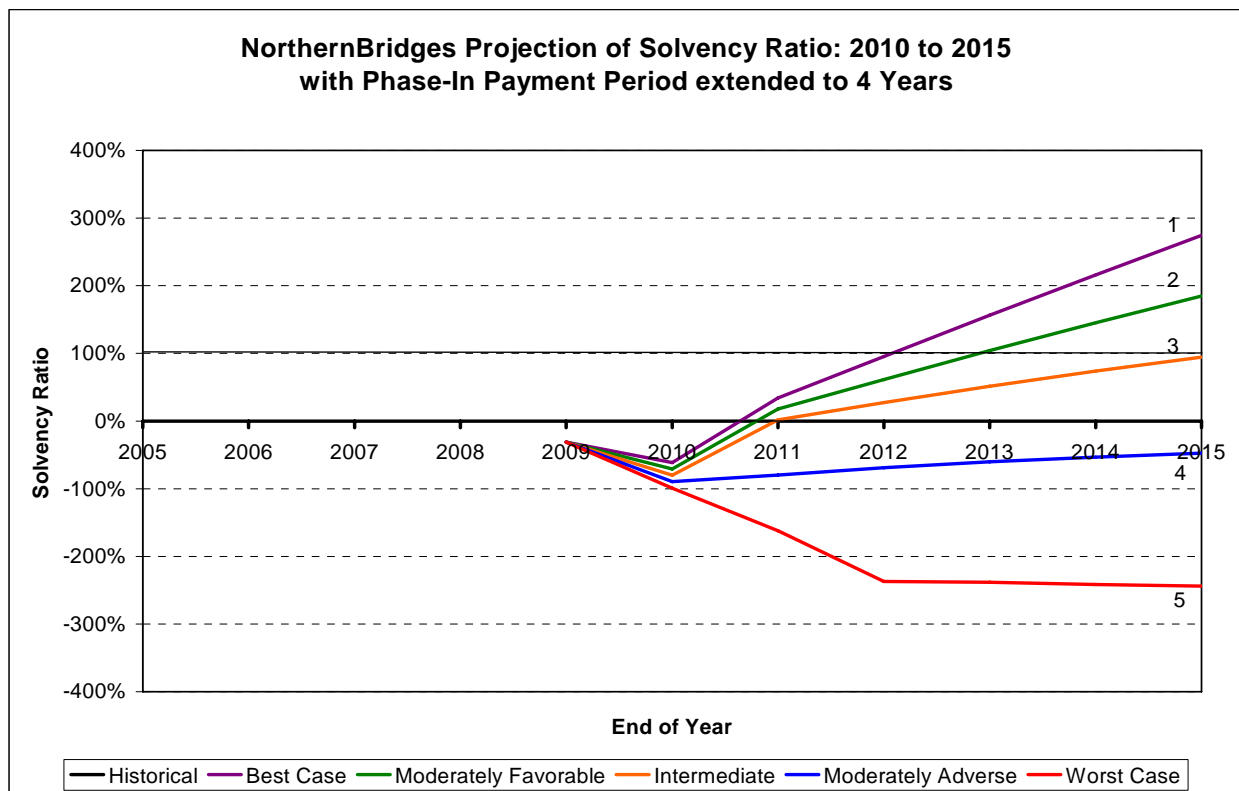


100% solvency ratio by a few months. Similarly, the solvency reserve requirements are met a few months later under the moderately favorable scenario, in the first quarter of 2014.

The main effects of the risk-share are felt most strongly in 2011 under the adverse scenarios. This period is when the MCO is at the greatest risk of losing money due to the phase-in period (the period of time it takes for the MCO to achieve full efficiency of care management) lasting longer than anticipated. Under the moderately adverse scenario NorthernBridges would receive an extra \$1.7 million in 2011, while under the worst case scenario the risk-sharing payout would be \$8.3 million between 2011 and 2012. In neither case does NorthernBridges recover enough to cover its solvency requirements, but the losses are not as deep as they would be without the risk-sharing agreement.

A second alternative is to recognize that the cost phase-in period may last more than 3 years. Considering that the difference between the FFS and managed care costs in 2009 was 16% in the NorthernBridges service area and given the administrative complexity of functioning in 11 counties in the first year of operations, a 4-year target phase-in period might be more realistic than 3 years. If payments for 2011 are adjusted such that a phase-in period of 4 years is included (an increase of approximately \$3 million, or 3.6% of total capitation payments), then the results are as shown in Figure 26.

Figure 26



In the best case (line 1) and moderately favorable (line 2) scenarios the effect is largely to move up the timeline for reaching 100% of solvency requirements by about a year. The best case scenario reaches the 100% solvency ratio in the first quarter of 2013 while under the moderately favorable scenario that point is reached in the fourth quarter of 2013.

The intermediate scenario (line 3) reaches the 0% solvency ratio level two years earlier, at the end of 2011, and the 100% requirement is almost met by the end of 2015.

Although the unfavorable scenarios (lines 4 and 5) both remain in negative solvency ratio territory through 2015, NorthernBridges is not as far below solvency requirements as they would be under the current funding arrangement.

## Discussion

The analyses presented above show that MCOs fall into two groups; those that appear poised to achieve financial solvency under current policy, which consists of the 5 pilot counties (CCCW, LCD, MCDFC, SFCA, WWC), and those that may require further policy action in order to more quickly achieve long-term solvency (CCI, CHP, CWF, NorthernBridges). Among the policy options that were modeled for this latter group were the expansion of risk-sharing corridors, extending the duration of phase-in adjustments, and controlling care management and administrative expenses.

During the 2008 & 2009 expansion of FC many MCOs encountered financial stress as their enrollments increased dramatically. Rapid growth is one source of financial stress that can be expected to subside over time as the initial phase-in is completed, but there may be other factors contributing to financial stress, such as: shortcomings in the capitation payment formula, administrative complexity associated with operating in multiple counties, and initial operating inefficiency as the MCO's personnel learn and implement the Family Care service model for long-term care. Each of these factors may require policy action to remedy and thus hasten the recovery of MCOs to full financial solvency.

Policy actions are of two basic types: they can be taken on the funding side (capitation or supplemental payments to MCOs) and on the cost side (utilization management, Family Care protocol for care plan development, fee schedules for services purchased from providers). An intermediate path could take the form of payments linked to performance by the MCOs through a pay-for-performance arrangement. Such an agreement could help struggling MCOs through the difficult phase-in period while still maintaining incentive to achieve efficiency under the Family Care service model.

DHS has responded to the financial challenges by requiring the MCOs to complete business plans for achieving positive financial results, and developing oversight teams to review the business plans and provide feedback to the MCOs in the form of performance expectations. These activities should be continued in the future.

On the funding side, it was suggested by several CFOs that the overall program funding is inadequate and greater program revenues are required to meet the net loss of 2.5% for all MCOs in aggregate in 2009. However, the program is not showing an aggregate loss through the second quarter of 2010, and even if total funding were increased, there would still be MCOs facing losses. It may be more productive to examine the reasons for losses at the MCOs, to find opportunities for savings and efficiencies within the current funding allocation. Introduction of

a pay-for-performance reimbursement arrangement might also alleviate some funding concerns.

Several CFOs commented that due to differences between pilot counties and expansion counties, the rate base should include the new expansion counties as soon as possible. Using expansion county data in the rate base is a viable idea only if there is evidence that the MCO has achieved optimal efficiencies by fully implementing the FC model: otherwise the inefficiencies of FFS will be perpetuated. The same rationale was applied to eliminate county variances in cost.

Another change in funding policy revolves around the three-year limitation on state risk sharing during phase-in. Among the reasons why three years may not be enough time for an MCO to realize the full operating efficiencies of the Family Care capitated funding formula and service delivery model during the initial phase-in period are: higher than expected initial service costs; administrative complexity when integrating multiple county agencies; difficulty gaining acceptance of Family Care model by members or interest groups; greater share of high-cost cases, and higher severity within high-cost groups relative to pilot counties. However, the speed of the individual MCOs in implementing the Family Care service model may also affect the timeline.

On the cost control side, DHS should hold MCOs accountable for adhering to the Family Care service delivery model, which consists of an evaluation of member's desired outcomes by an IDT, aligning services with those outcomes, and then applying the Resource Allocation Decision (RAD) method to find cost-effective means of achieving the outcomes. Adequate training and continuing support of MCO operations staff in applying the Family Care service model should be provided.

Current corrective actions are being taken to provide temporary funding and/or technical assistance. The business plans and performance expectations are one aspect of this. Our analysis suggests the following additional funding and technical assistance options should be considered:

- Extend initial phase-in adjustments beyond 3 years where warranted due to higher initial cost, multi-county administrative complexity, or disproportionate share of high-cost cases. MCOs in the highest FFS cost areas and with the greatest administrative complexity would be allowed 5 years to phase-in the Family Care service model, those with intermediate risk would be allowed 4 years, and those with the lowest risk would stay with the current 3 year period;

- Similar to the preceding bullet, risk-share arrangements would be extended for up to 2 years to cover the highest-risk period for the MCOs;
- Apply performance expectations to reduce administrative costs where those costs are higher than average;
- Provide additional training and monitoring of operational implementation of the Family Care service model (IDT review member target outcomes; RAD treatment plan development, rely on low-cost informal/community alternatives to purchased services where possible to achieve outcome at reduced cost);
- Facilitate the transfer of best practices from peer to peer MCOs.
- Provide centralized or standardized infrastructure (e.g. IT, billing & accounting, data portal & planning database) which would help to lower administrative expenses for all plans as well as facilitating financial and performance reviews across the program;
- Standardize provider rate schedules for residential and other purchased services, essentially eliminating variance in provider rates and rate changes as a factor in the cost of providing services.

Interviews with CFOs were conducted and written comments were solicited and reviewed to attempt to gain insight into the MCO financial difficulties from their perspectives, and to identify any issues that perhaps may have been overlooked by DHS. Themes that emerged from this discussion included:

- Recognition that expansion areas of multiple counties are larger and the plans are more complex to administer. It is a time-consuming process, and the expansion counties may be historically different from pilot counties;
- Also, expansion areas have a higher proportion of DD and there is a perception that there are a greater number of complex high-cost cases, especially behavioral health, than experienced by the pilot MCOs;
- Support for more funding and greater flexibility in program design, operations, and provider negotiations to harness entrepreneurial talent and market-driven efficiencies (Note that there is tension here between the MCOs desire for greater flexibility and DHS' goal of a more standardized payment structure.);
- Greater transparency of the rate capitation calculation.

These issues suggest additional opportunities for technical assistance to the most financially troubled MCOs. In cases where corrective action is clearly necessary, DHS should proceed with caution in collaboration with the MCO management.

Some thought needs to be given to the event that any MCO reaches or continues in a state of financial distress that is deemed unacceptable. The Office of the Commissioner of Insurance (OCI) has responsibility for examining the financial solvency of the MCOs and DHS has transitioned that responsibility to them. Currently DHS has several options in the event of persistent financial distress to the extent that an MCO is approaching failure:

“Four primary alternatives exist for DHS to address an MCO that is in financial distress:

- i) Provide temporary funding and/or technical assistance;
- ii) Allow the MCO to fail and transition membership into another MCO, assuming that one exists in the service region, or the Self-Directed Supports waiver;
- iii) Allow the MCO to fail and transition membership into the fee-for service system or the Self-Directed Supports waiver, recognizing that the scope of available services would be substantially smaller; or
- iv) Transition the operation of the MCO to the State.

The State should develop policy considerations around the acceptability of each of these options based on the underlying circumstances of the MCO that is in financial distress and the overall goals of the Family Care program, and develop specific plans that are supportive of that policy.” (March 26, 2009 PwC Phase 1 Report)

Currently, DHS is providing temporary funding and technical assistance (point i in the list above) to MCOs that are in financial distress. Our recommendations are to continue with those activities, and to develop a definite action plan in the event that corrective actions fail (see ii-iv above).

DHS should set defined limits for each MCO in regards to when to go beyond corrective action and declare that the financial status of a particular MCO is no longer acceptable. These limits should take into consideration the MCO’s history and prospects for future performance as well as the current financial state. DHS may also consider whether a standard based on year-over-year improvement, rather than a fixed time-table to achieve a pre-determined level of solvency may be appropriate. In evaluating future prospects, the evaluation should be based on assumptions that are reasonable both individually and in the aggregate.

### III. Conclusion

APS Healthcare has evaluated 1) whether current methods for determining capitation payments to managed care organizations under contract to provide Family Care benefits are consistent with Department goals, requirements, and the needs of program enrollees, and 2) when the Family Care MCOs are likely to come into full compliance with the Department's capital requirements, given the current MCOs' financial positions assumptions and funding availability.

We find that current methods for determining capitation payments to MCOs are actuarially sound, and provide an effective method for tailoring capitation rates to the risk profiles of each MCO. We also discovered several potential weaknesses that require further attention to address. In particular, the capitation model and the functional status screen on which it is based may under-estimate costs for members with the most severe functional status impairment and over-estimate costs for those with the least severe impairment. Further investigation of additional measures that may be made available through the assessment process or supplemental data sources may improve the ability to match payments to risk. Data to consider include:

- Diagnoses, including behavioral health (ICD-9, DSM III);
- Information related to progression of condition (e.g. advanced v. early stage Alzheimer's);
- Additional care-plan indicators, such as intensity of behavioral interventions, for example, the staffing needs required.

These items are not currently captured on the functional screen but could possibly be drawn from other sources, such as Medicaid claim history, HSRS Long-Term Care database, or professional review of care plans.

Second, it appears that the linear cost model based on functional status information may not efficiently account for cost-outliers. This is especially problematic for MCOs with a high concentration of members with high costs associated with high-acuity of functional status impairment. PwC should continue to investigate whether an exponential cost model is warranted. Data for the analysis should be taken from pilot counties or expansion counties with sufficient experience to ensure that the Family Care service model cost structure is in place.

Our evaluation of current financial positions and projections of future financial solvency led us to conclude that MCOs basically fall into two groups: those on track to achieve adequate reserves to maintain solvency within a three year time frame, and those that require further action to achieve solvency as soon as possible. Reasons for financial underperformance by the latter group include 1) higher initial fee-for-service costs, 2) higher administrative costs due to coordination of agencies across multiple counties, 3) higher proportions of developmentally

disabled members, and 4) failure to implement the Family Care service and financial management model.

Actions to support MCOs in the latter group fall into two categories: funding policies and cost control policies. On the funding side, risk sharing arrangements between DHS and the MCOs may need to be extended beyond the 3-year limit currently in effect. Using the risk-sharing arrangements mentioned here, these actions would increase the program budget by as much as \$40 million over two years (2.1% of total capitation payments) if all four of the MCOs suggested above encountered their worst case scenarios. However, DHS would have net positive recoveries of \$3 million under the intermediate scenarios, and would recoup \$23 million (1.2% of total capitation payments) if all MCOs with risk-sharing achieved their best case scenario results. Phase-in payments might also be extended for MCOs with higher initial cost structures, large multi-county service areas, or higher proportions of members with developmental disabilities relative to the pilot counties.

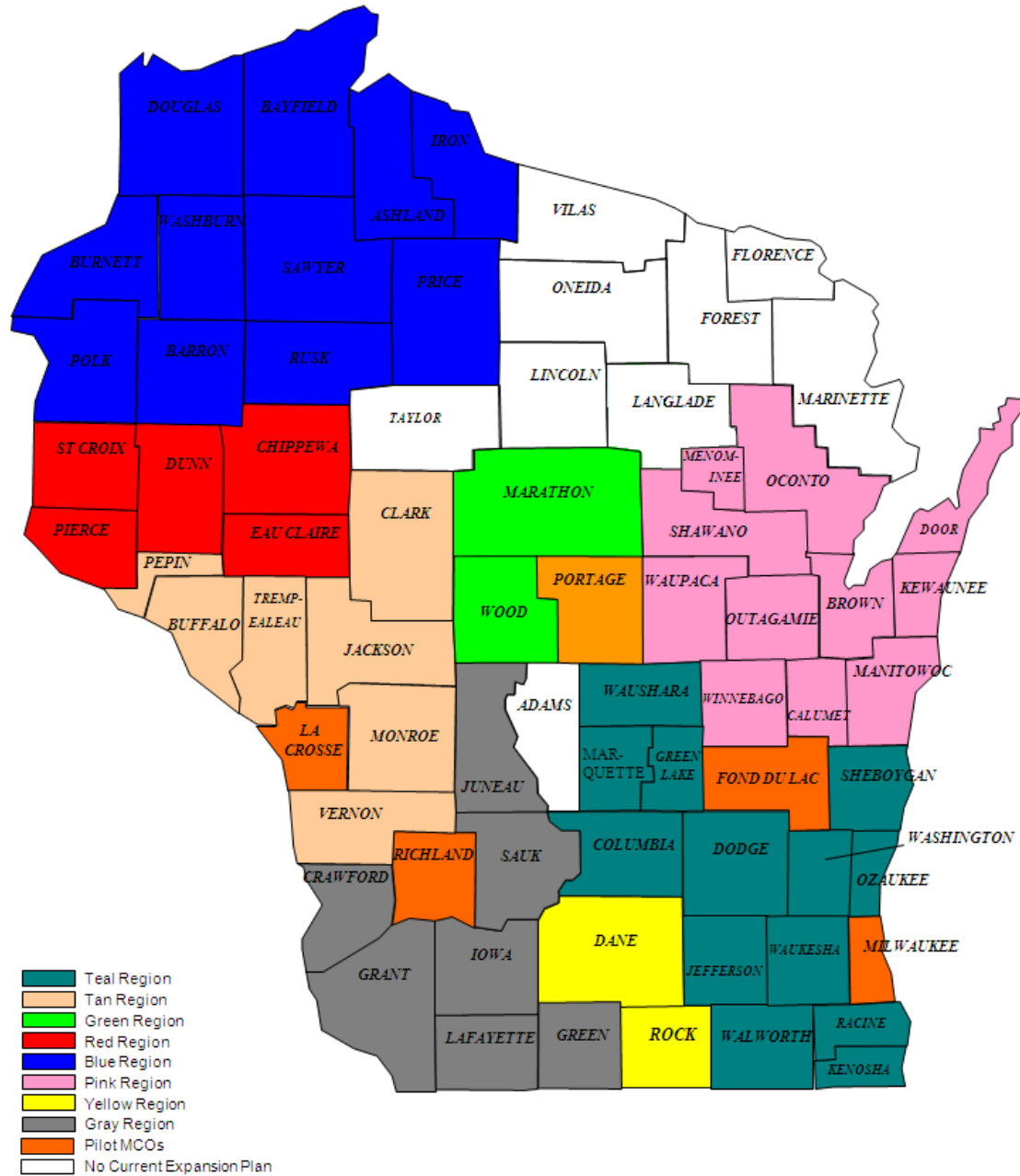
On the cost control side, some actions to achieve cost savings include:

- Reduce administrative costs where warranted;
- Provide technical training and monitoring to ensure that the Family Care service delivery model is deployed effectively;
- Share centralized or standardized infrastructure where feasible;
- Standardize provider fee schedules.



# Appendix A Family Care Map

Proposed regional configuration for the Family Care program (2010)



## Appendix B

# APS Healthcare Financial Projection Model

The APS Healthcare Family Care Financial Projection Model was created specifically for use in this report to predict the future solvency status of Family Care MCOs under a variety of assumptive scenarios. It is not intended for, and should not be used for, any other application.

The structure of the model is based on information in communications and documents to APS Healthcare from staff of DHS and their consulting actuaries at Pricewaterhouse Coopers (PwC). At its most basic level, the model projects costs and revenues side-by-side for the period from 2010 to 2015, using the difference between the two as an estimate of gains or losses for the particular MCOs, and then using those year-by-year results to project solvency reserve funds.

The projection uses the December 31, 2009 Family Care statement of financial summaries for the MCOs, as provided by DHS, as the starting point for financial status for the various MCOs. The results of the June 30, 2010 financial summaries were used to adjust the model for the 2010 period. However, due to the fact that those financial statements represent only 6 months of incurred dates with no payment runout, the completed claims have a great deal of uncertainty associated with them as far as being an accurate predictor of the final 2010 financial results. For the starting points of expected claim costs and capitation amounts, the model uses the results from the Calendar Year 2010 Family Care Capitation Rates report, submitted by PwC to DHS in January of 2010. That report provides initial estimates of claim costs based on PwC's functional status model for each region and target group within Family Care. Capitation rates are based on those expected claims costs with a two year lag for claim amounts and a 1-year lag for population projections. The model implicitly assumes that the functional status profile for each MCO's population does not change with time.

The model separately projects costs and rates for the three different target populations in Family Care: frail elderly (FE), physically disabled (PD), and developmentally disabled (DD). The model also projects data separately by the status of the population: pilot, expansion or waiver/waitlist. The values for the various segments of the total MCO population are then combined together to give total values for the entire MCO.

### Baseline Assumptions

The assumptions used in the model are taken from a number of different sources. Initial 2009 population composition for pilot counties and CCI Kenosha/Racine are taken from the Actual-to-Expected study provided by DHS, and adjusted to match totals in the 2009 financial summaries. 2010 population composition is based on values taken from the 2010 MCO business plans provided by DHS. 2011 population projections are based on data from the PwC development of 2011 capitation rates, provided to APS by DHS. Population projections beyond 2011 are based on APS' best estimate of future growth rates of the various MCOs.

Trend projections from the PwC 2010 capitation rate report were used as the baseline for 2009 and 2010, while baseline trend projections for 2011 and beyond were taken from information provided by PwC in connection with the development of 2011 capitation rates.

Variable administrative expenses were taken from a study provided by DHS and were equal to \$91.00 PMPM in 2010. Allowed fixed expenses were taken from the same study. Actual 2009 total administrative expenses were taken from the December 2009 MCO financial summaries and adjusted to conform with values provided in the June 2010 mid-year financial summaries, all provided by DHS. Baseline administrative expenses were projected forward in time at an annual inflation rate of 3.0%. Actual care management expenses were taken from the same documents and also projected forward at a baseline trend of 3.0%.

Allowed risk margins for calculation of capitation rates varied by MCO size and were provided by DHS. An additional risk adjustment for new plans of 0.50% in 2011 was taken from information provided by PwC.

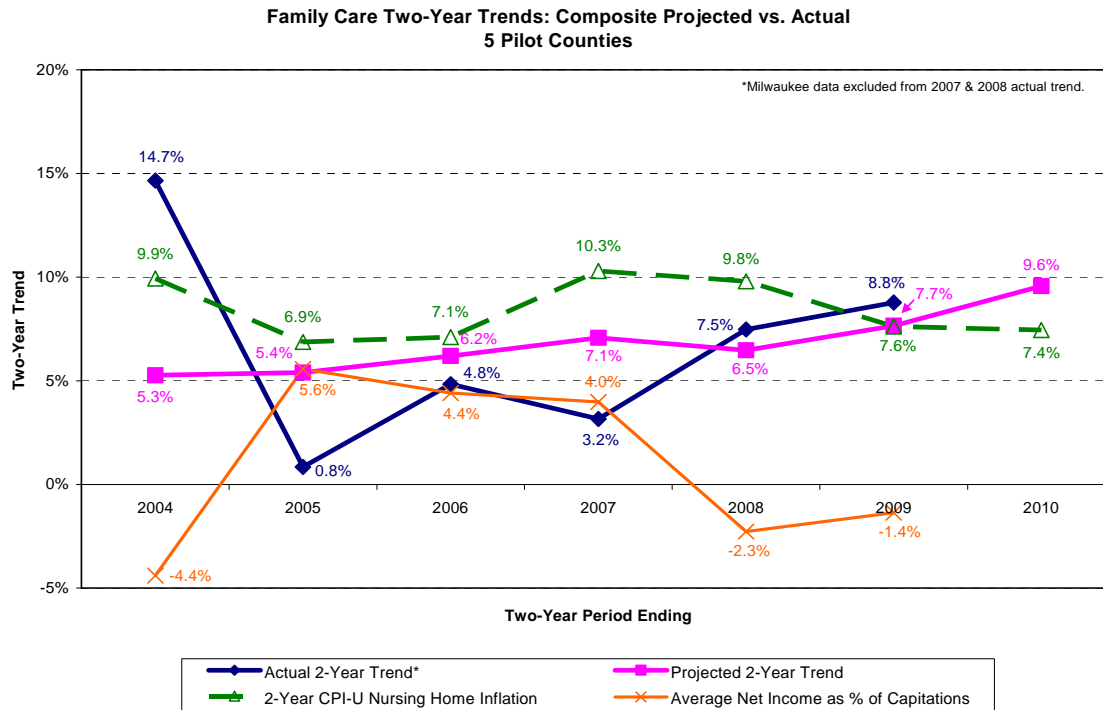
The relative values of claim costs for new expansion plans, reflecting unmanaged fee-for-service LTC costs compared with fully managed costs, were taken from an Excel spreadsheet provided by DHS. For use as baseline estimates, these adjustment factors were rounded to the nearest 5%. A minimum baseline assumption of 110% was used.

A baseline three-year period for claim cost phase-in was assumed, representing the amount of time it would take an MCO to reach full managed care efficiencies for an expansion population.

It needs to be stressed that there is expected to be considerable deviation from the individual projection lines under the various scenarios. The assumptions for each scenario are applied in the model to be constant from year to year. This will not be the case in reality. Rather the parameters will fluctuate from year to year, and so will the realized financial performances of the MCOs.

This expected variance is especially true for claim cost trend, which is very difficult to predict with great accuracy, but is an assumption to which the model is particularly sensitive. Historically, realized trend (as measured by year-to-year changes in the PMPM values given in the annual capitation rate reports) has sometimes deviated considerably from projected. These variances in trend rate have also been associated with considerable variation in the financial performance, as can be seen in Figure A1. (Two-year trend rates are shown because that is the effective time lag from FC claims data to applied capitation rates. For example, 2008 data was used to calculate 2010 capitation rates.)

Figure A1



The projected solvency ratios from the model should be interpreted as “best estimates” of the solvency ratio at a given time if the assumptions in the various scenarios are met *on average* during the preceding years.

## Appendix C

### Assumptions Used in Projection Scenarios

In order to assess the degree of risk associated with the various Family Care MCOs, a range of assumptions was applied. Five scenarios were applied: 1) a “Best Case” scenario in which the variables which affect the outcome were all set to better than expected values, 2) a “Moderately Favorable” scenario in which the set of variable were set to values between the Best Case and the Intermediate cases, 3) an “Intermediate” or best estimate scenario in which values were set at expected values for the duration of the projection period, 4) a “Moderately Adverse” scenario in which the variables were set at value between the Intermediate and Worst Case scenarios, and finally 5) the “Worst Case” scenario where variables were set to worse than expected, but still at a level which might be reasonably likely to occur in aggregate. Table B1 shows the typical values which were applied in the various scenarios.

Table B1 – Assumptions used in financial projection scenarios.

Assumption Description	Best Case	Moderately Favorable	Inter-mediate	Moderately Adverse	Worst Case
NH Cost Trend for Capitation Calculation					
Frail Elderly	5.50%	5.50%	5.50%	5.50%	5.50%
Physically Disabled	5.50%	5.50%	5.50%	5.50%	5.50%
Devel. Disabled	2.50%	2.50%	2.50%	2.50%	2.50%
NH Cost Trend for Actual Claim Costs					
Frail Elderly	5.00%	5.25%	5.50%	5.75%	6.00%
Physically Disabled	5.00%	5.25%	5.50%	5.75%	6.00%
Devel. Disabled	2.00%	2.25%	2.50%	2.75%	3.00%
Care Mgmt Cost Trend	1.00%	2.00%	3.00%	4.00%	5.00%
Allowed Administrative Expense Cost Inflation					
Fixed	3.00%	3.00%	3.00%	3.00%	3.00%
Variable	3.00%	3.00%	3.00%	3.00%	3.00%
Actual Administrative Expense Cost Inflation					
Fixed	1.00%	2.00%	3.00%	4.00%	5.00%
Variable	1.00%	2.00%	3.00%	4.00%	5.00%
Overall Allowed Risk Margin <sup>1</sup>	0.50%	0.50%	0.50%	0.50%	0.50%
Deviation from FFS LTC Costs in New Expansion Counties	-10%	-5%	0%	+5%	+10%
Years for Cost Phase-In Period	2	3	3	4	5
NH Enrollment Growth <sup>2</sup>					
Frail Elderly	15.0%	12.5%	10.0%	7.5%	5.0%
Physically Disabled	10.0%	10.0%	10.0%	10.0%	10.0%
Devel. Disabled	5.0%	7.5%	10.0%	12.5%	15.0%

1 Allowed risk margin varies by MCO size per DHS.

2 Base nursing home enrollment growth varies by MCO, but relative growth rates by enrollee category are the same.

A sensitivity analysis was also performed on the model to see which input assumptions had the greatest impact on results. It was found that the model was very sensitive to service cost trend and the mix of new members by target population (FE, PD or DD). Altering the duration of the actual phase-in period while holding the priced-for phase-in period constant had a significant impact in the short term, but once the phase-in period was through there was no further impact. Changing the rate of inflation for administrative expenses had a small impact longer-term, while changing the rate of enrollment growth had virtually no impact on the financial performance of the test MCO.

## Appendix D

# Actuarial Attestation for Family Care Financial Evaluation Report; State of Wisconsin Department of Health Services

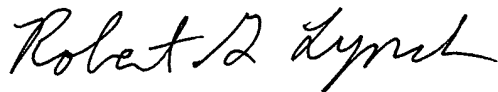
I, Robert G. Lynch, am an Associate Consultant with APS Healthcare, Inc. I am a member of the American Academy of Actuaries and an Associate of the Society of Actuaries. I meet the academy's Qualification Standards to perform the work encompassed in this report. APS Healthcare, Inc., was retained by the Wisconsin Department of Health Services (DHS) to (1) assess whether the current methods for calculating capitation rates for the Family Care long-term care program as consistent with DHS goals, managed care organization (MCO) requirements, and member needs, and (2) assess how far along the path towards financial solvency and sustainability the set of MCOs contracted under the Family Care program are.

To the best of my knowledge and belief the opinions, conclusions and recommendations set forth in this report are accurate and appropriate. I believe that the financial projections in this report have been developed in accordance with generally accepted actuarial principals and practices.

In the development of this report I have relied upon data and data summaries provided by DHS, the various MCOs contracted under the Family Care program, and DHS' retained actuarial consulting firm of Pricewaterhouse Coopers (PwC). I performed no independent audit or verification and take no responsibility for the accuracy of this data.

The financial projections made in this report are estimates of uncertain future events, and it is to be expected that actual results will vary from the values shown here. In order to give an understanding of the uncertainty and risk inherent in these projections I have provided a range of results based on sets of assumptions which may be reasonably expected to occur. I make no guarantee that actual results will fall within the ranges of results provided under the various scenarios.

This report assumes that the reader is familiar with Wisconsin's Family Care program. The report is intended for the State of Wisconsin and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of the financial projections presented in this report.



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Robert G. Lynch, A.S.A., M.A.A.A.

December 21, 2010

Date

## Appendix E Interviews

### APS Healthcare Interview with Family Care CMO CFOs, September 7, 2010

#### CMO Participants

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### APS Healthcare Interview with PricewaterhouseCoopers, October 12, 2010

#### PricewaterhouseCoopers Participants

Eric Meinkow

Jinn-Feng Lin

Benjamin Haworth



## Appendix F References

Documents received from Wisconsin Department of Health Services,  
Division of Long-Term Care (WI DHS-DLTC), by Date and Title

- 1) WI DHS-DLTC; 2007 Family Care MCO Review Summaries
- 2) WI DHS DLTC; Family Care Capitation Rate Development - Actual to Expected Costs by MCO 2007-2009
- 3) WI DHS DLTC; Summary of Start-Up, Phase-In, Risk-Sharing Funding, Post-Expansion (2008-2010)
- 4) WI DHS DLTC; Frye, Judith E., Memo to Managed Care Organizations; Expansion and Other Start-up Costs, July 1, 2008
- 5) WI DHS DLTC; Fee-For-Service vs. Managed Care per Capita Cost 121808
- 6) WI DHS DLTC; Family Care MCO Financial Summaries – YTD for Period ending December 31, 2008
- 7) WI DHS-DLTC; 2009 Family Care MCO Audit Reports
- 8) WI DHS-DLTC, 2009 Family Care MCO Financial Statement Summaries 01/01/09 – 09/30/09
- 9) WI DHS-DLTC; 2009 and 2010 Family Care MCO Performance Expectations
- 10) WI DHS-DLTC; 2009 and 2010 MCO Risk Sharing Contracts
- 11) WI DHS-DLTC, 2010 Family Care MCO Financial Statement Summaries; 01/01/10 – 06/30/10
- 12) WI DHS-DLTC; 2010 Pilot and Expansion MCO Managed Care Equivalent Rates
- 13) WI DHS-DLTC; Functional Screen Instructions, March 2010
- 14) WI DHS-DLTC; Responses to Family Care MCO Questions regarding Administrative Funding Levels; April 2, 2010
- 15) WI DHS DLTC; Family Care Capitation Rate Development – Actual vs Expected by Decile 042910

## Family Care Financial Evaluation

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- 16) WI DHS DLTC; 2011 Rate Setting, Base Data Options for 2011 Rate Setting, Draft 050610
- 17) WI DHS DLTC; Family Care Financial Narrative, Six Months ending June 30, 2010; October 1, 2010
- 18) WI DHS DLTC; Family Care Financial Summary, Six Months ending June 30, 2010; October 1, 2010
- 19) WI DHS DLTC; 2011 Business Plan Requirements 070610
- 20) WI DHS DLTC; Actual to Expected Cost Analysis, Summary for Financial Work Group; 070710
- 21) WI DHS; Family Care Residential Rate Setting Methodology Project, July 12, 2010; PowerPoint Presentation
- 22) WI DHS-DLTC; DHS/OCI Family Care Regulatory Workgroup; Potential Division of Roles & Responsibilities (For Discussion Purposes Only); 08/14/2010
- 23) WI DHS DLTC; CY 2010 Family Care Rate Development; 2010 Final Nursing Home Rates, Member Month Weights
- 24) WI DHS DLTC; Family Care Capitation Rate Development – CY 2011 Administrative Allowance per Member per Month
- 25) WI DHS DLTC; Family Care Capitation Rate Development – CY 2011 Projected Enrollment by Target Group by Member Month
- 26) WI DHS DLTC; Retro Payment Models by MCO, 092010

## PricewaterhouseCoopers, L.L.C. – Reports to WI DHS DLTC

- 27) PricewaterhouseCoopers, L.L.C.; WI DHS Family Care Capitation Rates for Expansion Regions, January 2008
- 28) PricewaterhouseCoopers, L.L.C.; WI DHS Family Care Capitation Rates, CY 2009; January 2009
- 29) PricewaterhouseCoopers, L.L.C.; Report to WI DHS; Regulatory Reform Project – Phase 1; March 2009
- 30) PricewaterhouseCoopers, L.L.C.; Report to WI DHS; Regulatory Reform Project – Phase II; July 2009

- 31) PricewaterhouseCoopers, L.L.C.; WI DHS-DLTC Family Care Administrative Allowance Analysis; October 13, 2009
- 32) PricewaterhouseCoopers, L.L.C.; WI DHS Family Care Capitation Rates, CY 2010; January 2010
- 33) PricewaterhouseCoopers, L.L.C.; CY 2011 Family Care Capitation Rate Development, September 14, 2010, Power Point Presentation

Other

- 34) American Academy of Actuaries; Health Practice Council Practice Note; Actuarial Certification of Rates for Medicaid Managed Care Programs; August 2005
- 35) Kronick, Richard, and Llanos, Karen, Center for Health Care Strategies; Rate setting for Medicaid Managed Long-Term Supports and Services, Best Practices and Recommendations for States, March 2008
- 36) WI Department of Health and Family Services (now WI Department of Health Services); APS Healthcare Family Care Independent Assessment - An Evaluation of Access, Quality, and Cost Effectiveness for Calendar Year 2003-2004; October 7, 2005.
- 37) WI Legislative Audit Bureau, Mueller, Janice, State Auditor; Memo to Joint Legislative Audit Committee; Proposed Audit of Family Care Program – Background Information, July 7, 2010
- 38) WI Long-Term Care Workforce Alliance; Concerns and Questions about the Family Care program, Attachment to Letter to Joint Legislative Audit Committee; Re: In support of a Family Care Audit; May 17, 2010
- 39) WI Long-Term Care Workforce Alliance; Letter to the Joint Legislative Audit Committee; Re: In support of a Family Care Audit; May 17, 2010
- 40) Wis. Stats. Chapter 648; Regulations of Care Management Organizations

