Wisconsin Association of Homes and Services for the Aging, Inc.

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October 27, 2009

To: Members, WAHSA Long-Term Care (LTC) Managed Care Committee Meeting
{Note: This meeting is open to all WAHSA members}

From: Todd Wilson, Chair
Mike Christensen, Vice-Chair

Subject: November 18, 2009 LTC Managed Care Committee Meeting --**10:00 a.m. to 2:00 p.m.**

The next meeting of the WAHSA LTC Managed Care Committee has been scheduled for Wednesday, November 18, 2009, from 10:00 a.m. to 2:00 p.m. at the Comfort Inn & Suites, 5025 County Highway V in DeForest. {***As with all WAHSA Committee meetings, the November 18h meeting is open to all members***.} A working lunch will be served.

Directions: From Interstate 90-94, take Exit 126, the Dane-DeForest exit, which is Highway V. The Comfort Inn & Suites is on the left hand side of County Highway V, ¼ mile west of I-90/94.

The meeting agenda and handouts for the LTC Managed Care Committee meeting are available directly from the WAHSA website at: www.wahsa.org/ltc1118.pdf. Please download and bring these documents with you to the meeting.

The purpose of the meeting is to share information on a number of important Family Care related developments, including: An assisted living rate-setting methodology currently being utilized by at least two Managed Care Organizations (featured presentation by Larry Lester, WIPFLI Senior Manager); Second quarter MCO financial performance; Results of 11-12-09 Assembly legislative hearing on Family Care; and emerging 2010 contractual issues. As always, the Committee has scheduled ample time for members to share and exchange information on Family Care operational issues impacting the provider community.

To enable us to make the appropriate meeting arrangements, **please RSVP by November 13th using the following link:**

https://www.surveymonkey.com/s.aspx?sm=CQG9Qmp_2fAqG7tLIhPre_2fqg_3d_3d

We look forward to seeing you at the November 18th LTC Managed Care Committee meeting in DeForest.

WAHSA LTC Managed Care Committee Meeting
Wednesday, November 18, 2009
Comfort Inn & Suites, DeForest
10:00 a.m. to 2:00 p.m.

I. Introductions/Purpose of the Meeting

II. Assisted Living Rate-Setting Methodology: Presentation by Larry Lester, WIPFLI Senior Manager and, tentatively via teleconference, Dr. Jennifer Johs-Artisensi, UW Eau Claire Health Care Administration. The presentation will discuss how the Family Care LTC functional screen is being used by MCOs to establish residents' acuity levels and payments to residential care providers.

III. MCO 2009 Second Quarter Financial Data: Operational losses & reserve/solvency requirements, and impact on providers.

IV. LTC Council Meeting on 11-4-09: MCO comments on "the Issues in Family Care from the MCO perspective."

V. Assembly Aging and Long-Term Care Committee Family Care Informational Hearing, 11-12-09 and LTC Council Meeting on 11-4-09: Summary of key points presented to the Committee. Is Family Care achieving the savings projected by the 2003 evaluation? Are MCOs being asked to deliver unreasonable cost reductions?

VI. *Focus 2009*-- Summary of 10-22-09 Family Care Presentations by DHS Deb Rathermel and WAHSA Legal Counsel Linda Dawson: Guidance on MCO subcontractor provisions and critical incident reporting requirements. 307-1, 307-2, 307-3, 307-4

VII. 2010 Contract Provisions, Rates and Negotiations: Roundtable discussion on MCO-Provider contracts effective 1-1-10. Updates on local negotiations on rates, hospice participation, civil rights compliance, and other contract provisions.

VIII. Working with MCOs to Address Issues of Mutual Concern

IX. Other Issues and Updates

X. Next Meeting

Explanation of AFH Interim Rate-Setting Methodology Process

In an effort to provide a fair and consistent interim rate for care of clients in AFHs, MCO has established a rate-setting methodology that results in a points-based model, based on acuity needs.

The model was designed with the assistance of consultants from WIPFLI and the University of Wisconsin-Eau Claire, who conducted a thorough review of the literature and accepted best practices, and conversations with various stakeholders from the MCO and the provider community.

The process used to establish the rate setting model was as follows:

1) The state imposes limits on reimbursement for Room and Board, which are currently set at $???/month. The rate to providers will combine the Room and Board rate with the ancillary rate, based on acuity and behavioral needs to calculate the total rate.

2) An empirically-based study was published in The Gerontologist in 2006, which evaluated a variety of approaches to establishing a rate methodology based on residential care needs of Medicaid supported clients. A statistical analysis identified a "best fit" model for using comprehensive assessment information to predict care needs of frail elderly assisted living clients. Using this model, data collected from the WI LTCFS is used to establish an acuity score for each AFH client that ranges from 0-75.

3) One limitation of the acuity tool was that the need for resources to accommodate certain behavioral needs was under assessed. To fill this need, a behavioral score (0-26), also utilizing WI-LTCFS data for each client is established. This algorithm was developed based on research including an analysis of former county rate setting methods for AFHs, models being used by various states, and other widely validated and frequently used standardized tools to assess medical, functional, and behavioral needs that impact resource use. This research also supported establishment of a fair "weight" to give to the role of behaviors on resource allocation within the broader algorithm.

4) The behavioral score is multiplied by the established "weight" given to behaviors toward total resource allocation and added to the acuity score for a total ancillary score of 0-101 points.

5) For each provider type, total number of current dollars spent are calculated, as are total ancillary score points for all clients being served. The total number of dollars is divided by the total number of points, to determine the total rate per ancillary point for that provider type.

6) To calculate an ancillary rate for an individual, their Ancillary score is multiplied by the per point value for that provider type and added to the standard Room and Board rate.

7) This methodology provides a framework by which to allocate existing dollars in a method more in accordance with acuity and behavioral needs. This method will allocate rates based on a points method as opposed to a tier method. There are advantages to individualized rates, particularly where

providers may only serve 1 or 2 of the MCOs clients, thus minimizing the potential to mitigate variability in those who fall on the low or high ends of a given tier. The downside is that a single change of any of the variables used in the algorithm will have an impact on the rate.

8) Additional Suggestions:

There will need to be a reliable system in place to capture LTCFS changes on algorithm variables. Providers will probably request a review if they believe acuity has increased, but it is incumbent on the care teams and an established operational procedure to ensure that accurate rates are being paid based on the most current LTCFS data.

Before piloting this methodology, to establish face validity of this method, care teams should be asked to look at what the new rates will be, to see if they make sense in terms of ranked acuity based on clients' perceived needs.

In evaluation of this model as it goes under further use, the easiest ways to alter it, without jeopardizing its integrity involve adjusting the % weight that behavior is allowed to contribute to the total ancillary score, and/or to adjust at what percentile the MCO chooses to pay per point. It is also possible to establish a new set of sample data on which to calculate the per point amount, if you continue to enroll new clients who are rolling into your program with a previously established rate.

Managed LTC Programs

Surplus / (Deficits)

Historical Results

Family Care							
Total Revenues, FC	**2004**	**2005**	**2006**	**2007**	**2008**	**Q1 2009**	**Q2 2009**
SFCA/Richland	$ 6,807,396	$ 7,887,973	$ 8,802,687	$ 9,684,041	$ 14,082,113	$ 7,159,161	$ 14,798,115
CCCW/Portage	$ 19,040,524	$ 22,069,742	$ 24,984,035	$ 27,440,857	$ 32,239,300	$ 19,334,158	$ 40,286,940
CCO/Fond du Lac	$ 20,654,814	$ 24,379,601	$ 25,435,208	$ 27,047,647	$ 27,979,165	$ 7,277,902	$ 14,573,423
WWC/La Crosse	$ 32,231,886	$ 35,837,353	$ 40,300,193	$ 45,171,481	$ 47,449,159	$ 19,427,681	$ 45,171,459
MCDA	$ 109,979,122	$ 135,738,127	$ 145,311,868	$ 157,200,481	$ 175,120,366	$ 47,787,823	$ 95,838,826
Total Revenues, Original FC Pilots	$ 188,713,742	$ 225,912,796	$ 244,833,992	$ 266,544,507	$ 296,870,103	$ 100,986,725	$ 210,668,763
CCI				$ 28,187,083	$ 95,460,003	$ 34,408,603	$ 70,653,166
CW					$ 29,801,797	$ 27,038,156	$ 54,611,766
CHP-LTS					$ 8,818,658	$ 8,922,003	$ 21,196,689
Northern Bridges (NB)							$ 4,253,752
Total Revenues, All FC MCOs	$ 188,713,742	$ 225,912,796	$ 244,833,992	$ 294,731,590	$ 430,950,561	$ 171,355,487	$ 361,384,136
Net Income, FC	**2004**	**2005**	**2006**	**2007**	**2008**	**Q1 2009**	**Q2 2009**
SFCA/Richland	$ 158,001	$ 483,209	$ 42,065	$ (54,273)	$ 79,249	$ 232,214	$ 215,115
CCCW/Portage	$ (1,689,871)	$ (908,966)	$ 1,783,026	$ 2,129,361	$ (2,328,852)	$ (388,647)	$ 65,843
CCO/Fond du Lac	$ (746,538)	$ 3,125,176	$ 2,112,758	$ 1,429,173	$ 54,057	$ 244,177	$ (191,570)
WWC/La Crosse	$ (2,799,577)	$ (765,239)	$ 2,196,670	$ 3,078,798	$ (3,360,286)	$ (1,987,867)	$ (1,348,457)
MCDA	$ (3,223,031)	$ 10,645,192	$ 4,651,429	$ 3,915,925	$ (509,681)	$ 929,213	$ 1,706,497
Total Net Income,Original FC Pilots	$ (8,301,016)	$ 12,579,371	$ 10,785,948	$ 10,498,984	$ (6,065,514)	$ (970,909)	$ 447,428
CCI				$ (1,332,424)	$ (4,170,701)	$ (1,418,354)	$ (1,781,965)
CW					$ (7,335,121)	$ (213,386)	$ (1,328,097)
CHP					$ (2,570,088)	$ (1,482,759)	$ (2,097,490)
Northern Bridges							$ (1,151,401)
Total Net Income, All FC MCOs	$ (8,301,016)	$ 12,579,371	$ 10,785,948	$ 9,166,560	$ (20,141,424)	$ (4,085,408)	$ (5,911,525)
Net Income, All FC MCOs (% terms)	-4.4%	5.6%	4.4%	3.1%	-4.7%	-2.4%	-1.64%
FCP/ PACE							
Total Revenues, FCP/PACE	**2004**	**2005**	**2006**	**2007**	**2008**	**Q1 2009**	**Q2 2009**
Care WI	$ 23,628,716	$ 27,116,336	$ 34,470,237	$ 43,610,575	$ 57,707,033	$ 16,899,813	$ 33,890,287
CLA	$ 19,460,839	$ 21,459,363	$ 23,763,898	$ 27,159,359	$ -	$ -	$ -
CHP	$ 29,603,325	$ 39,200,782	$ 55,162,473	$ 71,473,998	$ 100,719,300	$ 28,621,798	$ 59,583,165
CCI-CCHP	$ 45,895,360	$ 52,164,851	$ 60,636,601	$ 69,557,623	$ 74,610,355	$ 17,942,759	$ 37,148,658
Total Rev, FCP/PACE MCOs	$ 118,588,240	$ 139,941,332	$ 174,033,209	$ 211,801,555	$ 233,036,688	$ 63,464,370	$ 130,622,110
Net Income, FCP/PACE (1)	**2004**	**2005**	**2006**	**2007**	**2008**	**Q1 2009**	**Q2 2009**
Care WI	$ 93,107	$ 297,629	$ 3,304,211	$ 5,402,540	$ (408,262)	$ (79,987)	$ 532,726
CLA	$ 205,372	$ 971,193	$ 3,437,851	$ (3,157,859)	$ -	$ -	
CHP	$ 1,585,349	$ 3,178,537	$ 4,269,117	$ 2,255,621	$ 2,922,296	$ 242,872	$ (1,105,538)
CCI-CCHP	$ 674,922	$ (856,247)	$ 4,363,510	$ 5,847,301	$ 5,645,285	$ (835,061)	$ (20,912)
Net Income, All FCP/PACE MCOs	$ 2,558,750	$ 3,591,112	$ 15,374,689	$ 10,347,603	$ 8,159,319	$ (672,177)	$ (593,724)
Net Income, All FCP/PACE MCOs (% terms)	2.2%	2.6%	8.8%	4.9%	3.5%	-1.1%	-0.45%
Revenue, All MLTC Programs	$ 307,301,982	$ 365,854,128	$ 418,867,201	$ 506,533,145	$ 663,987,249	$ 234,819,856	$ 492,006,246
Net Income, All MLTC Programs	$ (5,742,266)	$ 16,170,483	$ 26,160,637	$ 19,514,163	$ (11,982,105)	$ (4,757,585)	$ (6,505,250)
Net Income, All MLTC Programs (% Terms)	-1.9%	4.4%	6.2%	3.9%	-1.8%	-2.0%	-1.32%

(1) Net income for the P/P programs for 2004-07 period are off the OCI Statutory Reports, 2008 forward are off the DHS GAAP statements

Family Care
MCO Financial Statement Summaries
YTD for Period Ending June 30, 2009

	SFCA	CCCW	CCO	WWC	MCDA	CCI	CWF	CHP	NB	Total
Revenue										
Capitation	14,781,169	40,214,520	14,537,750	42,056,977	95,692,285	65,989,814	50,004,682	19,096,689	4,165,546	346,539,432
Pvt Pay & other Operating Revenue										0
Interest Income- Operating Acct		41,125	31,805		1,763	6			2,751	77,450
Risk Sharing Accrual				2,572,343		381,245	4,607,084	2,100,000		9,660,672
Other Income	16,946	31,295	3,867	542,139	144,778	4,282,102			85,455	5,106,582
Total Revenue	14,798,115	40,286,940	14,573,423	45,171,459	95,838,826	70,653,166	54,611,766	21,196,689	4,253,752	361,384,136
Expenses										
Member Services	12,229,224	36,473,803	13,389,025	42,647,043	88,017,847	68,196,931	51,757,631	21,564,443	4,126,486	338,402,433
Cost Share	(328,589)	(677,155)	(445,460)	(971,583)	(5,472,035)	(892,473)	(523,398)	(145,012)	(27,688)	(9,483,393)
Room & Board	(977,570)	(3,409,348)	(1,213,613)	(3,098,933)	(6,470,512)	(6,165,695)	(5,165,028)	(1,847,757)	(328,819)	(28,677,275)
Spend Down/ Third Party/ Refunds	(50,402)	(191,351)	(90,326)	(140,505)	(257,723)	(291,683)	(193,296)		(5,829)	(1,221,116)
Net Member Services Costs	10,872,661	32,195,949	11,639,625	38,436,022	75,817,577	60,847,080	45,875,909	19,571,675	3,764,150	299,020,649
Care Management (External)	2,479,696		30,789		10,742,603	2,620,473	1,958,723			17,832,284
Care Management (Internal)		5,868,953	2,090,835	6,336,840	741,544	5,086,977	3,666,852	2,512,608	978,159	27,282,768
Care Management-Admin Allocation					1,386,103	232,924		68,333	203,592	1,890,952
Net Care Management Costs	2,479,696	5,868,953	2,121,624	6,336,840	12,870,249	7,940,374	5,625,575	2,580,941	1,181,751	47,006,004
Administrative Expenses	1,230,643	2,285,761	933,552	1,864,453	4,428,072	3,122,619	4,438,379	1,144,029	459,252	19,906,761
Total Operating Expenses	14,583,001	40,350,663	14,694,801	46,637,315	93,115,898	71,910,073	55,939,863	23,296,645	5,405,153	365,933,413
Income (Loss) from Operations	**215,115**	**(63,723)**	**(121,379)**	**(1,465,856)**	**2,722,927**	**(1,256,907)**	**(1,328,097)**	**(2,099,957)**	**(1,151,401)**	**(4,549,277)**
Other (Revenue)/Expense										
Prior Year Adjustment		(113,504)	(31,238)	(100,000)		(85,499)				(330,242)
Other Funding										0
Investment Income		(17,657)	(5,198)	(17,399)		(31,646)		(2,467)		(74,367)
Start-up Expenses										0
Other Non-Operating		1,595	106,627		1,016,431	642,204				1,766,857
Total Non-Operating (Revenue)/Expense	0	(129,566)	70,191	(117,399)	1,016,431	525,058	0	(2,467)	0	1,362,248
Net Surplus (Deficit)	**215,115**	**65,843**	**(191,570)**	**(1,348,457)**	**1,706,497**	**(1,781,965)**	**(1,328,097)**	**(2,097,490)**	**(1,151,401)**	**(5,911,525)**
Member Months	**5,490**	**14,118**	**6,190**	**17,162**	**40,410**	**21,734**	**16,275**	**5,234**	**1,408**	**128,022**
Key Ratios										
Member Service Cost	73.47%	79.92%	79.87%	85.09%	79.11%	86.12%	84.00%	92.33%	88.49%	82.74%
Care Management Service Cost	16.76%	14.57%	14.56%	14.03%	13.43%	11.24%	10.30%	12.18%	27.78%	13.01%
Total Member Service Cost (Loss Ratio)	90.23%	94.48%	94.43%	99.12%	92.54%	97.36%	94.30%	104.51%	116.27%	95.75%
Administrative Expense	8.32%	5.67%	6.41%	4.13%	4.62%	4.42%	8.13%	5.40%	10.80%	5.51%
Total Operating Expenses	98.55%	100.16%	100.83%	103.25%	97.16%	101.78%	102.43%	109.91%	127.07%	101.26%
Net Surplus (Deficit)	1.45%	-0.16%	-0.83%	-3.25%	2.84%	-1.78%	-2.43%	-9.91%	-27.07%	-1.26%

1. Initial calulation for Risk Sharing for NBs was $950K in June, began accruing as income in July
2. We believe only one MCO (CCI) was accruing an acuity adjustment as of the second quarter.

Family Care
MCO Financial Statement Summaries
YTD for Period Ending June 30, 2009
PMPM

	SFCA	CCCW	CCO	WWC	MCDA	CCI	CW	CHP	NB	Total
Revenue										
Capitation	2,692.46	2,848.46	2,348.41	2,450.59	2,368.03	3,036.25	3,072.50	3,648.30	2,958.48	2,706.88
Pvt Pay & other Operating Revenue	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Interest Income- Operating Acct	0.00	2.91	5.14	0.00	0.04	0.00	0.00	0.00	1.95	0.60
Risk Sharing Accrual	0.00	0.00	0.00	149.89	0.00	17.54	283.08	401.19	0.00	75.46
Other Income	3.09	2.22	0.62	31.59	3.58	197.02	0.00	0.00	60.69	39.89
Total Revenue	2,695.54	2,853.59	2,354.17	2,632.06	2,371.66	3,250.81	3,355.58	4,049.49	3,021.13	2,822.84
Expenses										
Member Services	2,227.61	2,583.50	2,162.85	2,484.97	2,178.12	3,137.80	3,180.21	4,119.75	2,930.74	2,643.32
Cost Share	(59.85)	(47.96)	(71.96)	(56.61)	(135.41)	(41.06)	(32.16)	(27.70)	(19.66)	(74.08)
Room & Board	(178.07)	(241.49)	(196.05)	(180.57)	(160.12)	(283.69)	(317.36)	(353.00)	(233.54)	(224.00)
Spend Down/ Third Party/ Refunds	(9.18)	(13.55)	(14.59)	(8.19)	(6.38)	(13.42)	(11.88)	0.00	(4.14)	(9.54)
Net Member Services Costs	1,980.50	2,280.49	1,880.25	2,239.60	1,876.21	2,799.63	2,818.81	3,739.05	2,673.40	2,335.70
Care Management (External)	451.69	0.00	4.97	0.00	265.84	120.57	120.35	0.00	0.00	139.29
Care Management (Internal)	0.00	415.71	337.75	369.24	18.35	234.06	225.31	480.02	694.72	213.11
Care Management - Admin Allocation	0.00	0.00	0.00	0.00	34.30	10.72	0.00	13.05	144.60	14.77
Net Care Management Costs	451.69	415.71	342.72	369.24	318.49	365.34	345.66	493.07	839.31	367.17
Administrative Expenses	224.17	161.90	150.81	108.64	109.58	143.67	272.71	218.56	326.17	155.50
Total Operating Expenses	2,656.36	2,858.10	2,373.78	2,717.48	2,304.28	3,308.64	3,437.18	4,450.68	3,838.89	2,858.37
Income (Loss) from Operations	**39.18**	**(4.51)**	**(19.61)**	**(85.41)**	**67.38**	**(57.83)**	**(81.60)**	**(401.18)**	**(817.76)**	**(35.54)**
Other (Revenue)/Expense										
Prior Year Adjustment	0.00	(8.04)	(5.05)	(5.83)	0.00	0.00	0.00	0.00	0.00	(2.58)
County Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Investment Income	0.00	(1.25)	(0.84)	(1.01)	0.00	(3.93)	0.00	0.00	0.00	(2.58)
Other Non-Operating	0.00	0.11	17.22	0.00	25.15	29.55	0.00	0.00	0.00	13.80
Total Non-Operating (Revenue)/Expense	0.00	(9.18)	11.34	(6.84)	25.15	25.61	0.00	0.00	0.00	8.64
Net Surplus/(Deficit)	**39.18**	**4.66**	**(30.95)**	**(78.57)**	**42.23**	**(83.45)**	**(81.60)**	**(401.18)**	**(817.76)**	**(44.18)**
Member Months	**5,490**	**14,118**	**6,190**	**17,162**	**40,410**	**21,734**	**16,275**	**5,234**	**1,408**	**128,022**

Family Care
MCO Financial Statement Summaries
Solvency Protection

YTD for Period Ending June 30, 2009

	SFCA	CCCW	CCO	WWC	MCDA	CCI	CW	CHP	NB
Solvency Protection									
Working Capital									
Current Assets	4,913,018	15,175,462	10,459,525	11,170,195	30,672,676	25,379,146	16,197,576	6,603,522	3,053,639
Current Liabilities	3,888,353	15,572,994	3,497,515	12,640,768	21,096,798	24,883,013	24,915,500	7,880,774	4,053,701
Working Capital	1,024,665	(397,532)	6,962,010	(1,470,573)	9,575,878	496,132	(8,717,924)	(1,277,252)	(1,000,062)
Requirement	732,373	1,641,148	593,798	1,769,790	3,891,661	2,841,942	2,091,261	899,280	677,749
Excess (Shortage)	292,292	(2,038,680)	6,368,212	(3,240,363)	5,684,217	(2,345,810)	(10,809,184)	(2,176,532)	(1,677,811)
Restricted Reserve									
Current Restricted Reserve	361,659	1,870,574	1,212,128	1,546,204	2,000,000	2,230,641	1,718,967	250,285	0
Required	1,282,373	1,870,574	1,143,798	1,934,895	2,000,000	2,000,000	2,000,000	1,449,280	1,227,749
Excess (Shortage)	(920,714)	0	68,330	(388,691)	0	230,641	(281,033)	(1,198,995)	(1,227,749)
Solvency Fund									
Current Solvency Fund	0	1,524,798	305,320	252,676	250,000	2,018,542	0	0	0
Required	1,166,187	1,620,574	250,000	1,684,895	250,000	1,772,034	1,845,630	1,249,640	1,138,874
Excess (Shortage)	(1,166,187)	(95,776)	55,320	(1,432,219)	0	246,508	(1,845,630)	(1,249,640)	(1,138,874)
Total Equity	1,386,324	4,728,355	8,610,146	1,330,705	11,825,878	4,903,483	(2,113,046)	(3,467,578)	(769,911)

MCO Financial Statement Summaries
Family Care Partnership
YTD for Period Ending June 30, 2009

	CHP-PHP	Care WI- CWHP	CCI-CCHP	Total
Revenue				
Capitation-MA	39,463,880	21,391,640	20,038,689	80,894,209
Capitation- MC	20,119,284	11,438,481	17,098,078	48,655,843
Interest Income-Operating Account		266,003	11,891	277,894
Other Income		794,163		794,163
Total Service Revenue	59,583,165	33,890,287	37,148,658	130,622,110
Expenses				
Member Services-LTC	33,881,791	15,557,609	23,897,057	73,336,457
Member Services-Other	16,914,067	10,321,774	8,343,650	35,579,492
Cost Share, Net	(1,081,328)	(584,853)	(435,359)	(2,101,540)
Room & Board, Net	(1,906,626)	(745,183)	(552,446)	(3,204,255)
Spend Down & Third Party	(211,451)	(6,575)	(15,597)	(233,623)
Net Member Services Costs	47,596,454	24,542,772	31,237,305	103,376,531
Care Management (External)		6,278		6,278
Care Management (Internal)	10,419,384	5,605,106	3,393,111	19,417,601
Care Management-Admin Alloc	113,847			113,847
Net Care Management Costs	10,533,230	5,611,384	3,393,111	19,537,725
Administrative Expenses	2,890,054	3,360,200	2,442,361	8,692,615
Total Operating Expenses	61,019,737	33,514,356	37,072,777	131,606,870
Income (Loss) from Operations	**(1,436,573)**	**375,931**	**75,881**	**(984,761)**
Other (Revenue)/Expense				
Prior Year Adjustment			68,599	68,599
Other Funding				0
Investment Income	(331,034)	(156,795)	(89,202)	(577,031)
Other Non-Operating			117,396	117,396
Total Other (Revenue)/Expense	(331,034)	(156,795)	96,793	(391,036)
Net Surplus/(Deficit)	**(1,105,538)**	**532,726**	**(20,912)**	**(593,724)**
Member Months	**11,377**	**6,612**	**6,858**	**24,847**
Key Ratios (as % of Revenue)				
Member Service Expense, Net	79.88%	72.42%	84.09%	79.14%
Care Management Service Expense	17.68%	16.56%	9.13%	14.96%
Total Member Service Expense	97.56%	88.98%	93.22%	94.10%
Administrative Expense	4.85%	9.91%	6.57%	6.65%
Total Operating Expense	102.41%	98.89%	99.80%	100.75%
Net Suplus(Deficit)	-1.86%	1.57%	-0.06%	-0.45%

MCO Financial Statement Summaries
Family Care Partnership
YTD for Period Ending June 30, 2009

Summary PMPM Presentation	CHP-PHP	Care WI- CWHP	CCI-CCHP	Total
Revenue				
Capitation-MA	3,468.65	3,235.38	2,921.94	3,255.68
Capitation- MC	1,768.37	1,730.01	2,493.16	1,958.21
Interest Income-Operating Account		40.23	1.73	
Other Income	0.00	120.11	0.00	31.96
Total Service Revenue	5,237.02	5,125.74	5,416.84	5,245.85
Expenses				
Member Services-LTC	2,978.02	2,353.01	3,484.55	2,951.51
Member Services-Other	1,486.65	1,561.12	1,216.63	1,431.94
Cost Share	(95.04)	(88.46)	(63.48)	(84.58)
Room & Board	(167.58)	(112.71)	(80.55)	(128.96)
Spend Down & Third Party	(18.59)	(0.99)	(2.27)	(9.40)
Net Member Services Costs	4,183.46	3,711.97	4,554.87	4,160.51
Care Management (External)	0.00	0.95	0.00	0.25
Care Management (Internal)	915.80	847.74	494.77	781.48
Care Management-Admin Alloc (Internal)	10.01			4.58
Net Care Management Costs	925.81	848.69	494.77	786.32
Administrative Expenses	254.02	508.21	356.13	349.84
Total Operating Expenses	5,363.29	5,068.88	5,405.77	5,296.67
Income (Loss) from Operations	**(126.27)**	**56.86**	**11.06**	**(50.82)**
Other (Revenue)/Expense				
Prior Year Adjustment	0.00	0.00	10.00	2.76
Other Funding	0.00	0.00	0.00	0.00
Investment Income	(29.10)	(23.71)	(13.01)	(23.22)
Other Non-Operating	0.00	0.00	17.12	4.72
Total Other (Revenue)/Expense	(29.10)	(23.71)	14.11	(15.74)
Net Surplus/(Deficit)	**(97.17)**	**80.57**	**(3.05)**	**(35.08)**
Member Months	**11,377**	**6,612**	**6,858**	**24,847**

Solvency Protection	CHP-PHP	Care WI- CWHP	CCI-CCHP
Working Capital			
Current Assets	12,620,366	21,545,196	12,987,903
Current Liabilities	15,266,662	10,165,944	9,551,049
Working Capital	(2,646,296)	11,379,252	3,436,854
Total Equity	10,099,722	11,577,806	11,574,459

DHS Requirements for Subcontracting: *All subcontracts for member services shall be in writing, include the provisions of this subsection, and any general requirements of this contract that are appropriate to the service. The subcontractor must agree to abide by all applicable provisions of this contract.*

- ✓ *Parties of the Subcontract*
- ✓ *Program Purpose*
- ✓ *Services*
- ✓ *Compensation*
- ✓ *Term and Termination*
- ✓ *Legal Liability*
- ✓ *QM Programs*
- ✓ *Restrictive Measures*
- ✓ *Critical Incidents*
- ✓ *Utilization Data*
- ✓ *Non-Discrimination*
- ✓ *Insurance and Indemnification*
- ✓ *Notices*
- ✓ *Access to Premises*
- ✓ *Culturally Competent*
- ✓ *Certification and Licensure*
- ✓ *Or meet MCO State approved standards.*
- ✓ Records
- ✓ *Member Records*
- ✓ *Confidentiality*
- ✓ *Access to Services*
- ✓ *Authorization for Providing Services*
- ✓ *Billing Members/ Hold Harmless*
- ✓ *Provider Appeals*
- ✓ *Member Appeals and Grievances*
- ✓ *Prohibited Practice*
- ✓ *Criminal Background Check*

In Establishing and Maintaining Subcontracts, the MCO Must:

- ✓ Establish mechanisms to ensure compliance by providers.
- ✓ Monitor providers regularly to determine compliance.
- ✓ Take corrective action if there is a failure to comply.

Prohibited Providers

The MCO may not knowingly subcontract with barred or ineligible providers

Additional Factors which affect MCO Subcontracting Language

DHS requires MCOs to assure the quality and coordination of member support services, subsequently MCO subcontracts will incorporate many of these requirements into their subcontracts. Some of the most universally applicable standards MCOs incorporate into subcontracting language for this purpose include:

- ✓ Individual Service Plan and Member-Centered Plan Development & Review
- ✓ Comprehensive Assessment
- ✓ Providing, Arranging and Coordinating Services
- ✓ Re-Assessment Conditions
- ✓ Member Safety and Risk
- ✓ Prevention and Wellness Plan
- ✓ Protection of Member Rights
- ✓ Quality Management Program
  - o Monitoring the Quality of Purchased Services
  - o Identifying and Responding to Unintended Events
- ✓ Data Integrity Audits
- ✓ Program Integrity Plan, Program and Coordination
- ✓ Reporting and Data

Name of MCO	
Reviewer(s)	
Date Reviewed	
Title of Document(s) Reviewed	

Subcontracting

1. *Ability to Subcontract*

   The MCO may subcontract for any or all functions covered by this contract, subject to the requirements of this contract.

2. *Accountability for Subcontracts*

   The MCO oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor. In order to meet these requirements the MCO must assure that:

   - *All subcontracts fulfill the Medicaid managed care requirements in 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;*
   - *The MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated; and*
   - *The MCO and the subcontractor have a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.*

3. *Certification of Subcontracts*

   - *The Department shall review MCO subcontracts. The Department's subcontract review will assure that the MCO has the standard language in this article in subcontracts, except for specific provisions that are inapplicable in a specific MCO management subcontract.*
   - *By the effective date of this contract, the MCO shall have submitted to the Department its subcontracts, or revisions to previously approved subcontracts, for approval. This can occur by one of two means:*

     i. *The MCO submits each subcontract; or*

     ii. *The MCO submits template language planned for use in the MCO's subcontracts.*

   - *The MCO shall attest annually that all subcontracts include the required provisions for subcontracts in this article.*

Department's Discretion Regarding Subcontracts

- *At any time, the Department may review, approve, approve with modification, impose conditions or limitations or deny any and all subcontracts under this contract at its sole discretion and without the need to demonstrate cause. The Department may consider factors to protect the interests of the State and members, including but not limited to, the subcontractor's past performance.*

- *If as the result of a Department action under paragraph a, the Department requires the MCO to find a new subcontractor, the MCO shall secure a new subcontractor in one hundred-twenty (120) calendar days, and allow sixty (60) calendar days to implement any other change required by the Department:*

  iii. *The MCO may request a waiver of this deadline for subcontracting and for any other change, justifying the reasons the extension is needed.*

  iv. *The Department, at its own discretion, may extend the deadline if the MCO shows to the satisfaction of the Department that additional time is needed.*

- *Any disapproval of subcontracts or failure of the MCO to comply with conditions or limitations imposed under paragraph 4.a.may result in the application by the Department of remedies pursuant to Article XVI.D., Sanctions for Violation, Breach, or Non-Performance, page 184.*

Instructions: *Standard Language for Subcontracts*

All subcontracts for member services shall be in writing, shall include the provisions of this subsection, and shall include and comply with any general requirements of this contract that are appropriate to the service.

The subcontractor must agree to abide by all applicable provisions of this contract. Subcontractor compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific subcontract):

Subcontract Review Tool

	Review Criteria	***Yes***	***Partial***	***No***	***Reviewer Comments:***
	Parties of the Subcontract ***The MCO and subcontractor entering into the agreement are clearly defined.***				
	Purpose of the Program ***The subcontract clearly defines the purpose of the program.***				
	Services ***The subcontract clearly delineates the services being provided, arranged, or coordinated by the subcontractor***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	Compensation ***The subcontract specifies rates for purchasing services from the provider. The subcontract specifies payment arrangements in accordance with Section M.6., Thirty-Day Payment Requirement, page 108 of this article..***				
	Term and Termination ***The subcontract specifies the start date of the subcontract and the means to renew, terminate and renegotiate. The subcontract specifies the MCO's ability to terminate and suspend the subcontract based on quality deficiencies and a process for the provider appealing the termination or suspension decision.*** ***The MCO will ensure that subcontracts reflect all current MCO Contract and subcontract requirements.***				
	Legal Liability ***The subcontract must not terminate legal liability of the MCO.*** ***If the MCO delegates selection of providers to another entity, the MCO retains the right to approve, suspend, or terminate any provider selected by that entity.***				
	Quality Management (QM) Programs ***The subcontractor agrees to participate in and contribute required data to the MCO's QM programs as required in Article XII, Quality Management (QM), page 148.***				
	Utilization Data				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	The subcontractor agrees to submit MCO utilization data in the format specified by the MCO, so the MCO can meet the Department's specifications required by Article XIV, Reports and Data, page 169.				
	Restrictive Measures ***The MCO must require its subcontractors to adhere to regulatory requirements and standards set by the MCO relative to restrictive measures including any type of restraint, isolation, seclusion, protective equipment, or medical restraint as required in Article V, Care Management, page 44. The MCO must require its subcontractors to adhere to regulatory.***				
	Critical Incidents ***The MCO shall require its subcontractors to identify, respond to and document and report critical incidents including unexpected deaths, as required in Article XII, Quality Management (QM), page 148***				
	Non-Discrimination ***The subcontractor agrees to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations as described in Article XIII.B., page 159 (also reference http://dhs.wisconsin.gov/civilrights/Index.htm).***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	Insurance and Indemnification ***The subcontractor attests to carrying the appropriate insurance and indemnification***				
	Notices ***The subcontract specifies a means and a contact person for each party for purposes related to the subcontract (e.g., interpretations, subcontract termination).***				
	Access to Premises ***The subcontractor agrees to provide representatives of the MCO, as well as duly authorized agents or representatives of the Department and the Federal Department of Health and Human Services, access to its premises, and/or medical records in accordance with Article XIII.F., Access to Premises and Information, page 165.***				
	Certification and Licensure ***The subcontractor agrees to provide applicable licensure, certification and accreditation status upon request of the MCO and to comply with all applicable regulations. Health professions which are certified by Medicaid agree to provide information about their education, board certification and recertification upon request of the MCO. The subcontractor agrees to notify the MCO of changes in licensure.***				
	Records ***The subcontractor agrees to comply with all applicable Federal and State record retention requirements in Article XIV.F., Records Retention, page 173.***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	Member Records ***The subcontractor agrees to the requirements for maintenance and transfer of member records stipulated in Article XIII.A., Member Records, page 157.*** ***The subcontractor agrees to make records available to members and his/her authorized representatives within ten (10) business days of the record request if the records are maintained on site and sixty (60) calendar days if maintained off site in accordance with the standards in 45 CFR 164.524 (b)(2).*** ***The subcontractor agrees to forward records to the MCO pursuant to grievances and appeals within fifteen (15) business days of the MCO's request or, immediately, if the appeal is expedited. If the subcontractor does not meet the fifteen (15) business day requirement, the subcontractor must explain why and indicate when the records will be provided.***				
	Confidentiality ***The subcontractor agrees otherwise to preserve the full confidentiality of records, in accordance with Article XIII.A., Member Records, page 157, and protect from unauthorized disclosure all information, records, and data collected under the subcontract. Access to this information shall be limited to persons who, or agencies such as the Department and CMS which, require information in order to perform their duties related to this contract.***				
	Access to Services ***The subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services in the benefit package that are necessary to achieve outcomes.***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	Authorization for Providing Services ***The subcontract directs the subcontractor on how to obtain information that delineates the process the subcontractor follows to receive authorization for providing services in the benefit package to members. The subcontractor agrees to clearly specify***				
	Billing Members /Hold Harmless ***The payments by the MCO and/or any third party payer will be the sole compensation for services rendered under the Contract. The subcontractor agrees not to bill members and to hold harmless individual members, the Department and CMS in the event the MCO cannot pay for services that are the legal obligation of the MCO to pay, including, but not limited to, the MCO's insolvency, breach of contract, and provider billing.*** ***The MCO and the subcontractor may not bill a member for covered and non-covered services, except in accordance with provisions in Article VII, Sections I. Billing Members, and J. Department Policy for Member Use of Personal Resources, page 79.***				
	Provider Appeals ***The subcontractor agrees to abide by the terms of Section N, Appeals to the MCO and Department for Payment/Denial of Providers Claims, page 109 of this article.***				
	Member Appeals and Grievances ***The subcontractor must recognize that members have the right to file appeals or grievances and assure that such action will not adversely affect the way that the subcontractor treats the member.*** ***The subcontractor agrees to cooperate and not interfere with the members' appeals, grievances and fair hearings procedures and investigations and timeframes in accordance with Article XI, Grievances and Appeals, page 132.***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	The MCO must furnish the following grievance, appeal and fair hearing procedures and timeframes to all providers and subcontractors at the time that they enter into a contract: ***The member's right to a fair hearing, how to obtain a hearing, and representation rules at a hearing;*** ***The member's right to file grievances and appeals and their requirements and timeframes for filing;*** ***The availability of assistance in filing;*** ***The toll-free numbers to file oral grievances and appeals;*** ***The member's right to request continuation of benefits during an appeal or fair hearing filing and, if the MCO's action is upheld in a hearing, the member may be liable for the cost of any continued benefits; and*** ***The member's appeal rights to challenge the failure of the MCO to cover a service.***				
	Prohibited Practice ***The MCO and the subcontractor agree to prohibit communication, activities or written materials that make any assertion or statement, that the MCO or provider is endorsed by CMS, the Federal or State government, or any other entity.*** ***Marketing/outreach activities or materials distributed by a residential services subcontractor, which claim in marketing its services to the general public, that the Family Care, Partnership or PACE programs will pay for an individual to continue to receive services from the subcontractor after the individual's private financial resources have been exhausted are prohibited.***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	Establishing and Maintaining Subcontracts ***The MCO must:*** ***Establish mechanisms to monitor the performance of subcontractors to ensure compliance with provisions of the subcontract on an ongoing basis, including formal review according to a periodic schedule, consistent with industry standards or state laws and regulations.*** ***Identify deficiencies or areas for improvement.*** ***Take corrective action if there is a failure to comply.***				
	Cultural Competency and Values ***The MCO shall encourage and foster cultural competency among MCO staff and providers.*** ***The MCO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds.***				
	Access to Providers ***Access Standards*** ***The MCO shall ensure all services and all service providers comply with access standards provided in Article VII, Services, page 70 and the access standards in this article.***				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	Assuring Access				
	The MCO must do the following to assure access:				
	Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.				
	Ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service members, if the provider serves only Medicaid members.				
	Caregiver Background Checks				
	The MCO shall comply with DHS 12 and DHS 13 Wis. Adm. Code, related to caregiver background and other checks				
	All requirements of DHS 12 and DHS 13 Wisconsin Administrative Code pertain to any providers or MCO staff who comes into direct contact with a member, including:				
	The MCO shall establish and implement a policy consistent with DHS 12 and DHS 13 Wisconsin Administrative Code, to appropriately respond to an MCO employee who is paid to provide services to a member when the employee has a caregiver conviction that is substantially related to the care of a member;				
	The MCO shall perform, or require providers to perform, caregiver background checks on people paid to provide services to a member in accordance with DHS 12 Wisconsin Administrative Code;				
	For MCO subcontractors that have staff providing services that result in direct contact with MCO members, the MCO shall ensure caregiver background checks are completed in accordance with DHS 12 Wisconsin Administrative Code;				

	Review Criteria	*Yes*	*Partial*	*No*	*Reviewer Comments:*
	The MCO maintains the ability to not pay or contract with any provider if the MCO deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check; and, ***The caregiver background check shall be made available to the member or entity that is the employer.***				
	Additional Requirements for Management Subcontracts ***Management subcontracts for administrative services will be subject to additional review to assure that rates are reasonable:*** ***Services and Compensation*** ***Subcontracts for MCO administrative services must clearly describe the services to be provided and the compensation to be paid.*** ***Bonuses, Profit Sharing*** ***Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the MCO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.*** ***Any such bonus or profit sharing shall be reasonable compared to services performed. The MCO shall document reasonableness.*** ***A maximum dollar amount for such bonus or profit sharing shall be specified for the subcontract period.***				