



**Assembly Committee on Aging and Long-Term Care
Information Hearing – November 12, 2009**

History

Community Health Partnership, Inc. (CHP) is a private, non-profit, community-based managed care organization that began operations in 1999 providing integrated managed care services under the Wisconsin Partnership Program to frail elders and physically disabled adults in Chippewa, Dunn, and Eau Claire counties. CHP's Partnership program had its beginnings in an independent living center with members first being served in 1997. The Wisconsin Partnership Program integrates Medicare and Medicaid and also integrates acute and primary healthcare services with long-term care services. In 2008, CHP expanded member choice by offering the Family Care Program in addition to the Partnership Program. The addition of the Family Care Program also coincided with a geographic expansion into Pierce and St. Croix counties and the addition of new target population – adults with developmental disabilities. CHP has the largest Partnership Program in the State serving approximately 2,000 members. CHP's Family Care Program serves approximately 1,000 members. Both programs are regulated by the Office of the Commissioner of Insurance and DHS. The Partnership Program is also contracted with CMS to provide Medicare acute and primary benefits including pharmacy benefits.

Values

CHP is a mission- and values-based organization that has grown out of an independent living center. CHP's mission statement says:

Community Health Partnership, Inc., through creative teamwork, facilitates quality choices that empower people to live as independently as possible.

And the vision states CHP will be:

Leading the revolution for excellence in managed care, serving people with complex needs one unique life at a time.

The organization's values are very much aligned with the Family Care values of: *Access, Choice, Quality and Cost-effectiveness.*

The following sections describe CHP's individual circumstances in relationship to the major issues defined in the Family Care Association handout.

Financial Issues

CHP's 2009 capitation rates, as well as anticipated 2010 capitation rates, significantly underfund CHP's Family Care Program. In 2010, our estimated member service costs combined with our care management costs exceed revenue by nearly \$12 Million.

Several factors unique to CHP magnify the losses that are also being experienced by other MCOs. These include:

- A disproportionately high percentage of members with developmental disabilities compared to other MCOs [69% for CHP – Family Care].
- Disproportionately high-cost service plans inherited from counties in our service area compared to other MCOs (especially in this same DD population). This was difficult to anticipate because of the challenges related to analyzing disparate data from the waiver program prior to expansion.
- An Adult Family Home provider network that has a greater percentage of more expensive corporate providers rather than owner-occupied providers.

An estimated 22% across-the-board reduction in all member services, care management, and A&G costs would be required to align revenues and expenses. This still would not address CHP's regulatory reserve requirements that would remain unmet.

The following table shows our financial results since our expansion began in 2008.

	2008	2009 Estimate	2010 Estimate
Family Care	(\$2.6M)	(\$5.2M)	(\$11.5M)
Partnership	\$2.9M	(\$4.1M)	\$1.5M
Consolidated	\$290K	(\$9.4M)	(\$10.0M)
CHP Contribution to Expansion	\$8.5M start-up costs	\$3.5M loan and owed Admin fees from FC entity to CHP parent	No ability to assist due to limits on available cash and OCI risk reserve requirements.

Provider Issues

CHP clearly recognizes that there is opportunity to better manage these costs as long-term care moves from our old county waiver approach to a managed care approach. CHP has needed to focus on residential services first since that is the major driver of our negative financial status. CHP has creatively used resources at UW-Eau Claire and the Wipfli accounting firm to develop a rate methodology that more clearly considers individual member's residential needs and yet brings down the overall costs of residential services. Other MCOs are starting to use this methodology. Specific provider issues for us include the following:

- CHP's current and projected losses have caused us to take a very aggressive approach with residential providers in lowering our costs/their rates.
- Unlike the experience of the five Family County pilot counties to gradually implement care management strategies over a 3–5 year period, CHP's need to implement an immediate aggressive approach is creating more of an adversarial atmosphere with providers, particularly residential. It

should be noted some of CHP's corporate providers have had to make some significant staffing reductions because of this, adding to the unemployment challenges in our area.

- An adversarial situation puts at risk CHP's quality premise that developing collaborative relationships with our providers better facilitates the alignment of meeting member outcomes and enhancing quality while practicing good stewardship.
- CHP will be moving to an almost unilateral Medicaid fee structure for our Medicaid providers, and we expect this will negatively affect service access for our members. Home health care providers are one particular area of concern, and another is dental care, a benefit for members of the Partnership Program. We have used an enhanced rate for dentists in order to create better access in our area and now anticipate a significant reduction in dental providers.

Member and Care Team Issues

The major issue is the conflict between the pressure to quickly reduce member costs inherited from the old waiver system and helping members achieve their outcomes.

For teams this means:

- Quickly mastering approaches to providing care management, learning that took place over several years in the Family Care pilot counties.
- Rapid learning of member-centered planning and service development using the RAD (Resource Allocation Decision) approach required in our contract with DHS, especially for new staff hired during expansion.
- Developing and maintaining positive, trusting relationships with members.
- Anticipating increases in grievances and appeals by members as cost savings initiatives are carried out, such as the Adult Family Home rate methodology.

For members this means:

- Reduced access to services because of providers unwilling to accept Medicaid rates
- Larger team caseloads
- Reduced ancillary team supports such as behavioral health specialists, therapists, financial eligibility assistance, etc.
- Increasing their fears of Family Care looking more like the stereotype of managed care that concerned consumers in the first place, a stereotype of being primarily financially focused and using denials to manage the costs.

A Profile of a Member

This member is a younger adult with both physical and developmental disabilities who enrolled in the Family Care program at CHP in 2008. She is functionally able to communicate well and be involved in work and social activities in the community. Nine years ago she moved from her home into an adult family home. This first placement was not a good fit with other clients in the home so she moved into another facility that this corporate provider owned. This second placement has lasted for 8 years. The member is engaged in community work and other activities and has a good level of communication skills. She has been very comfortable in this second setting but has relied on staff to meet her social needs since her peers were at a different functional level. The new rate/acuity methodology developed to reduce our residential costs suggested that this member could be better served in another adult family home that was more of a match

between her functional abilities with services and supports she needed. This transition took 6-7 weeks. The process included many conversations with the member and her family/guardian about the pros and cons of moving, a tour of the prospective new facility, conversations between the CHP Team and the provider, and finally a major care conference with everyone to ensure a smooth transition after the member/family made the decision to move. The move has been successful. This story illustrates the uniqueness of each member's life, the need to be deliberate in making this decision, the importance of having a collaborative relationship with the provider, and the potential negative impact of rushing this process because of financial pressure.

In Summary

Community Health Partnership has a strong interest in continuing to offer Family Care Partnership and Family Care to consumers and to be quality partners with DHS in ensuring the statewide viability of the Family Care system. There is much support for the laudable goal of statewide family care and the elimination of waiting lists. However, the current capitation rate structure puts many MCOs at great financial and organizational risk. We are concerned that we are at "a crossroads of promise versus financial sustainability" for the Family Care program.

Thank you for the opportunity to provide this information to committee members.

Paul Cook
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