

COUNTY OF MILWAUKEE
Inter-Office Communication

Date: March 16, 2007
To: Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors
From: Jerome J. Heer, Director of Audits
Subject: Follow-up Review of the Family Care Program Eligibility and Enrollment Process.

We have completed a limited review of the Family Care eligibility determination and enrollment process. County Board supervisors initiated the review over concerns that there may have been an increase in the number of ineligible individuals being served by the program.

Responses from the Department on Aging (Exhibit 1) and the Department of Health and Human Services (Exhibit 2) are attached.

Background

Family Care Program

The Department on Aging operates a Care Management Organization (CMO) responsible for administering Milwaukee County's Family Care Program. The Family Care Program is a long-term care pilot program operating in selected Wisconsin counties under four federal Medicaid waivers. The program is a re-design of the State's long-term support systems, targeting eligible adults age 60 or older and also eligible adults with physical and developmental disabilities. While other counties involved with the pilot program serve both population groups, Milwaukee County serves only eligible adults who are at least age 60. The program is intended to provide eligible individuals with better choices about their living arrangements and services they receive, improve access to services, improve quality of care including an emphasis on both health and social outcomes, and establish a system that will be cost-effective into the future.

In May 2006, the State passed Senate Bill 653, legislation to expand the Family Care program statewide over the next five years. The Department of Health and Family Services has awarded \$1.4 million in planning grants to counties across the state to prepare for the program's expansion, including \$150,000 for Milwaukee County. The funding awarded to Milwaukee County will be used to develop a plan for a new managed care approach to providing long-term care for individuals with disabilities under the age of 60 in the County.

Care Management Organization

The budgeted number of clients served has grown from 850 in 2000 to 6,048 for 2007. The Department on Aging operates the CMO under the premise that no County property tax levy will be required to fund the operation. Budgeted expenditures for the CMO in 2007 are approximately \$162 million. In addition to the 64 positions budgeted for 2006, the CMO is also staffed with contracted professionals in some of its key positions.

In early 2004, the County Board was informed that there were significant operational and financial problems associated with the Family Care Program, some of which stemmed back to its implementation in 2000. Due to these problems, the CMO recognized a cumulative deficit of \$6.2 million occurring during 2000-2003 with the close of its 2003 financial statements and also incurred a \$3.4 million deficit in 2004. As a result of the deficits, the CMO depleted its State mandated reserves and found itself insolvent. To enable the CMO to continue in operation, the County Board ultimately approved contributions totaling \$12.2 million from the County's General Fund.

With the disclosures of the 2003 deficit level, the County Board authorized and directed the Director of Audits to initiate a formal audit of the Department on Aging [File No. 04-12(a)(a)], including but not limited to the Family Care Program, to determine what factors led to the deficit and to recommend what steps should be taken to improve operation of the department.

The Department of Audit responded to this directive with the issuance of an audit report in December 2004. It was noted in the report that the problems leading to the deficit were numerous, complex, and interrelated, but could generally be associated with issues in two major areas: member eligibility/enrollment and financial reporting/fiscal accountability. Among the problems in the area of eligibility and enrollment was the provision of services to individuals who were determined to be ineligible for the Family Care program and for which no State payments could be collected.

Since our previous audit, management has made considerable strides in addressing these problems, which has led to a substantial increase in State reimbursements and the fiscal turnaround of the CMO. The CMO achieved an operating surplus of \$10.9 million in 2005 and reported that it is on track to meet its budgeted surplus of \$3.1 million for 2006. Due to its improved fiscal performance, the CMO has been able to meet the State's reserve requirements, create a \$5 million surplus fund and return a similar amount to the County General Fund to reimburse a portion of the \$12.2 million contributed by the County.

Family Care Program Eligibility and Enrollment

Client eligibility for Family Care program benefits is based on both functional and Medicaid financial requirements. Eligibility is a prerequisite for the initial and continued enrollment (membership) in the Care Management Organization and is the premise for the State's capitation payments to the CMO.

Initial Eligibility Determination and Enrollment

Using data obtained from the MIDAS system (the CMO's internal computer system), we determined that 1,333 (67.8%) of the 1,965 individuals who applied for Family Care in 2006 had enrolled in the CMO. The remaining individuals were not enrolled due to ineligibility or by personal choice. In varying degrees, the following four key entities are involved in the process for determining initial eligibility for Family Care benefits and for enrollment in the CMO:

- **Resource Center** - Department on Aging agency that serves as the point of entry for Family Care services, provides information and assistance regarding the program and other services, determines functional eligibility (level of care needed), and through its access plan, facilitates enrollment in the CMO.
- **Independent Enrollment Consultant** - Entity contracted by the State to provide integrity to the overall eligibility and enrollment process by ensuring objective and comprehensive information regarding Family Care, including an explanation of fair hearing and grievance rights.
- **Economic Support Division (ESD)** - Milwaukee County Department of Health and Human Services division responsible for determining whether functional and Medicaid financial eligibility requirements have been met for participation in Family Care.
- **Care Management Organization (CMO)** - Milwaukee County Department on Aging division under contract with the State to coordinate enrollment, develop comprehensive assessments and care plans for Family Care members, and coordinate delivery of program services through an extensive network of contracted providers with the use of external Care Management Units.

Close coordination between these entities is required to perform the steps necessary to determine whether or not the applicant meets program financial and functional requirements within 30-days (excluding any permitted extensions) of the submission of a completed application to the Economic Support Division as prescribed by Medicaid rules.

One of the problems leading to CMO deficits in its early years of operation was the provision of services to individuals who were enrolled in the CMO but were later determined to be ineligible and for which no State payments could be collected. Because the State does not provide capitation payments for ineligible individuals, the CMO is responsible for the cost of services that are provided in these instances.

As discussed in our previous audit, the underlying problems leading to the enrollment of ineligible individuals in the CMO were both complex and interrelated. However, they have since been successfully addressed with the following measures:

- Improved coordination among the key entities involved in the process, including a better understanding of each other's roles and responsibilities and intensified efforts to resolve problems through regular meetings.
- Better tracking of eligibility and enrollment processing.
- Creation and increased staffing of a unit within the Economic Support Division dedicated to processing Family Care eligibility. This group also processes the annual Medicaid eligibility recertification required for continued enrollment in the CMO.
- The addition of controls to the MIDAS computer system that prevent enrollment and block the entry of services to individuals who are not eligible.
- Implementation of a screening procedure whereby the eligibility of all individuals slated for enrollment is verified in the State CARES computer system prior to enrollment the CMO.
- Improvement in the review process performed to identify any ineligible individuals that may have been enrolled in error.

While these measures have effectively mitigated the enrollment of ineligible individuals in the CMO, a breakdown in any aspect of the process could have an adverse fiscal effect on the CMO, due to its responsibility to pay the service costs of ineligible members at a time it is also forfeiting capitation payments. Consequently, vigilance on the part of the entities involved is required for the CMO's continued success.

In our discussions with CMO management, we noted that the screening function that is performed to prevent enrollment of ineligible individuals through verification of eligibility in the CARES system is complex and requires a level of expertise currently possessed only by the eligibility coordinator within the CMO. We were informed that efforts have begun to train another CMO employee to eventually serve as the backup to this person. Additionally, procedures used in performing this function are not documented. Given the critical nature of this function it is important to maintain continuity in this area.

To ensure the continuity in preventing the enrollment of ineligible individuals in the CMO afforded by verification of eligibility status in the State Cares system, we recommend that Department on Aging management:

1. *Arrange for the creation of adequate documentation of the procedures followed to verify eligibility in the State CARES system and assign high priority to the training of a backup employee.*

Timeliness of Initial Eligibility and Enrollment Processing

In past years, there was significant concern with the long delays in the processing of initial eligibility, enrollment backlogs, and the financial impact associated with the enrollment of ineligible individuals. However, as previously discussed, enrollment does not occur under current procedures until eligibility has been established and verified, thus avoiding the provision of services in instances where the State does not provide capitation payment.

Widespread delays in initial eligibility processing can lead to the creation of enrollment backlogs. This, in turn, can cause snowballing inefficiencies due to increased tracking and rework and a growing number of cases requiring problem resolution. Consequently, since the same ESD staff members involved with initial eligibility determination also perform annual Medicaid eligibility recertification, process breakdowns that occur in either function can pull ESD resources away from the other. However, in the event that insufficient ESD resources contribute to the failure to meet recertification deadlines, the CMO can be financially impacted with the loss of capitation revenue in instances where individuals continue enrollment in the CMO beyond the due date.

Based on reports showing the result of samples of processing completion times contained in our previous audit report, we noted that there was significant difficulty in meeting the 30-day deadline, particularly in respect to individuals with no existing Medicaid eligibility (Type 2 applicants). For instance, during the period December 2003 – August 2004, a monthly high of only 44% of applicants were completed within the 30-day deadline. In our examination of comparable reports for 2006, we noted that the 30-day deadline was also exceeded in a number of instances. However, in the majority of these cases the deadline was extended by the Economic Support Unit, avoiding the necessity for closing and reopening of cases.

While the increased level of coordination between the entities involved in the initial eligibility and enrollment process has brought about overall improvement in the process, a number of other factors, many outside the control of any of the entities, will continue to cause delays in the process. As examples, slowdowns attributable to the submission of applications with missing or incorrect information, the provision of outdated or insufficient material for asset or income verification, and lack of applicant responsiveness, can all lead to delays in process completion according to ESU management.

The Milwaukee County Commission on Aging – Resource Center Oversight Committee has long served as a forum for the resolution of issues affecting the initial eligibility and enrollment process, and it has played an integral role in bringing about improvements in this area.

Annual Medicaid Recertification of Member Eligibility

In contrast to the initial eligibility and enrollment process, only two of the four key entities, the Economic Support Division and the Care Management Organization, are principally involved with annual recertification of member eligibility. Core procedures followed to establish initial eligibility are also followed for eligibility recertification. Therefore, many of the same factors that impede completion of initial enrollment processing can also delay completion of eligibility recertification. However, the eligibility recertification process differs in that there are greater consequences associated with the failure to meet required timeframes for completion. This is discussed in following paragraphs.

Recertification Process

Beyond the initial program eligibility determination for Family Care, Medicaid rules also require an annual review of the eligibility status of each member to determine whether they continue to meet requirements for participation in the program, and to modify the required member cost share when necessary. Members that are determined to be eligible following the annual review are recertified for continued enrollment in the CMO, and those who no longer qualify for Family Care are disenrolled.

The annual recertification process starts with the mailing of the Medicaid application 45 days in advance of the member recertification due date and it involves activities comparable to those carried out for initial eligibility determination, such as application review, verification of asset and income levels, and confirmation that functional requirements have been met. Likewise, various issues are encountered that can delay processing, periodically resulting in the failure to complete the recertification when due. However, since recertification involves individuals who are enrolled in the CMO and receiving services, the failure to meet deadlines can have fiscal consequences.

The State has set forth the following criteria to address situations where eligibility recertification has not been completed when due.

- No capitation payments will be made beyond the recertification due date if the eventual outcome of the eligibility review is that the member has lost eligibility.
- The State may provide retroactive enrollment (and capitation payment) provided that the recertification is completed within three months of the due date, the member met both functional and financial eligibility requirements, and the CMO provided uninterrupted services during the period following the due date.

This set of criteria places the CMO in the position of having to choose between the following two options in those instances where eligibility recertification has not been completed by the due date:

- a. Arrange for member disenrollment coincident with the recertification due date, effectively terminating services to the member, or
- b. Continue to provide services to the member and risk the loss of capitation revenue in the event it is determined that the member has lost eligibility or completion of recertification extends beyond three months.

Selection of the first option, disenrollment and service termination, can have a far greater impact than the loss of capitation revenue if affects health or safety of an individual. For instance, the termination of services may result in the loss of member housing or other critical service. In some cases, only to find out within the three months that the outcome of the review is that the individual was eligible and could have continued in the CMO without loss of capitation.

On the other hand, choosing the second option can have a significant fiscal impact on the CMO, depending on the number of individuals with pending eligibility reviews past the deadline and the timing and eventual outcome of the eligibility review, given the State criteria in these circumstances. Ultimately, if the outcome of a pending recertification shows that the member has lost eligibility or the recertification extends beyond three months, the CMO will not receive capitation payments, thus forcing the CMO to absorb the full cost of services provided beyond the due date.

Prior to November 2005, the State provided a 30-day grace period for eligibility recertification. Capitation payments were made for this period whether or not the member was found eligible. The State's provision for retroactive enrollment and capitation payment for up to the three months for members deemed to be eligible was also in place at that time. Elimination of the grace period changed the dynamics for recertification processing, in essence shortening the timeline for completion, and placing the CMO in the position of having to decide 30 days sooner whether to arrange for member disenrollment or face a greater level of financial exposure by continuing to provide services.

This emphasizes the importance of meeting Medicaid recertification deadlines, which requires continued vigilance toward the timely completion of all phases of this process and efforts to bring about additional improvements. Since the Economic Support Division is the key entity for processing both initial eligibility determinations and eligibility recertification, management of ESD staffing resources is integral to the success of Family Care.

Realistically, in spite of the efforts of all entities involved with eligibility processing, it is recognized that there will be a number of instances where eligibility recertification processing will not be completed when due. In order to minimize the potential consequences associated with this, the CMO must closely monitor the status of past due recertifications and undertake timely efforts to resolve issues to expedite completion of recertification reviews.

CMO staff uses reports generated from its MIDAS system to monitor individual recertifications that are past due. The reports indicate the number of days beyond the recertification deadline by member and include notes regarding the actions taken to complete the review. In addition to the usefulness of these reports in the tracking and completion of individual recertification reviews, information from the reports could be summarized and regularly provided to CMO management to identify and manage trends relating to past due recertifications.

To assist CMO management in the identification and management of trends relating to past due recertifications, we recommend that Department on Aging management:

2. *Develop periodic recertification summary reports using information contained in MIDAS.*

Economic Support Division Resources

A common thread woven throughout implementation of Family Care is the key role that the Economic Support Unit plays in both the initial eligibility enrollment determination and the member eligibility recertification processes. To stem earlier problems associated with a shortage of ESD staffing, the CMO provided funding and entered into a memorandum of understanding (MOU) with the Department of Health and Human Services (DHHS) for the provision of a fixed level of staff dedicated to Family Care eligibility processing.

The MOU called for a staffing level of 22 individuals comprised of 18 Economic Support Specialists (ESS workers), two supervisors and two assistants. However, according to CMO and DHHS management, it has been difficult to consistently achieve the desired staffing level. According to management of both areas, a total of five of the 18 ESS worker positions were vacant for an extended period of time in 2006. However, we were informed that staffing is currently at full force.

According to DHHS management, the filling of vacancies in the Economic Support Division unit dedicated to Family Care processing has received its highest staffing priority, in recognition of the fiscal impact to the CMO. We also learned DHHS management faces numerous challenges to keeping these positions filled, including the following:

- The need to fill vacancies with experienced ESS workers due to the specialized training and extended learning curve associated with Family Care.
- The impracticality of providing ESS training to groups of less than four individuals.
- High turnover and vacancy levels in other economic support units within the division, making it difficult to find candidates in general.
- Union seniority considerations that can slow the hiring process and the filling of vacant positions with individuals who may join the group only a short time before retirement.
- The reduction of Economic Support Division resources as a result of the elimination of pool ESS workers due to budgetary considerations.

Due to these challenges and with the understanding that a fixed dollar amount is budgeted by the CMO for ESD staffing, ESS worker vacancies are generally not filled until multiple vacancies have taken place. However, if experience shows that a pattern of multiple vacancies occurs each year in the unit dedicated to Family Care, it may prove advantageous to begin the hiring process in advance of anticipated vacancies (essentially hedging against vacancies) and still remain within budget. In any event, before this type of strategy is considered DHHS management should first explore opportunities to enhance workflow and develop caseload standards as discussed in the following paragraphs.

Furthermore, due to these staffing challenges and the time sensitivity of eligibility processing, it is important for management to explore alternative ways to enhance its productivity and the timeliness of completion of eligibility review. In this regard, ESD management have already undertaken efforts at leveling caseloads within the Family Care unit. Productivity and the timeliness of processing could also be enhanced if the volume of recertification processing was consistent from month to month. However, to achieve this would require State approval to modify member recertification due dates.

Additionally, the State has not provided workload standards for ESS workers who perform Family Care eligibility, according to DHHS management. Therefore, it may also prove helpful to develop these standards for the unit to determine whether it is adequately staffed. Development of workload standards could also be useful in determining required staffing levels in the event an initiative was successfully undertaken to equalize the monthly recertification volume.

To maximize the productivity and timeliness of eligibility processing performed by the Economic Support Division unit dedicated to Family Care eligibility processing, we recommend that DHHS management:

3. *Develop workload standards for Economic Support staff for use in determining the adequacy of current staffing and the appropriate staffing levels in the event potential initiatives to adjust workflow are accomplished in recommendation 4., below.*
4. *Explore the feasibility of instituting initiatives to adjust the workflow of associated with member eligibility recertification.*
5. *Determine the feasibility of incorporating a strategy to use a "hedge" against anticipated vacancies.*

6. *Work with the Department of Human Services to create a separate classification of ESS worker through the execution of a "collateral" agreement with the union to help stabilize staffing the Economic Support Division unit dedicated to Family Care eligibility processing.*

Fiscal Impact of Providing Services to Ineligible Individuals

As part of ongoing improvement efforts, the CMO fiscal unit implemented a process to estimate and report the amount of lost capitation revenue attributable to the failure to complete eligibility recertification when due. The process, implemented in January 2006, involves the identification of instances where the collection of capitation payments appears doubtful, as well as the compilation of the estimated amount lost, on a monthly basis. The monthly estimates of lost capitation are reported as an allowance (reduction) of capitation revenue in the CMO's internal operating statements. Since this process was not in place prior to 2006, the fiscal impact of lost capitation was instead absorbed in the net revenue figure shown in CMO operating statements for previous years.

We examined the process followed to estimate and report lost capitation revenue and made the following observations:

- Setting forth an allowance for lost capitation revenue in the financial statements presents an enhanced picture of CMO operations, improving management's ability to monitor the degree of success attained in minimizing the level of lost capitation.
- Information regarding lost capitation may also be useful to CMO management in the development of disenrollment policy and decision-making.
- Given the State's policy regarding payment of capitation involving past due recertifications, the methodology employed for developing the estimated amount of lost capitation appears to be reasonable and yields timely results.

According to CMO fiscal records, the total amount of lost capitation revenue estimated for 2006 was \$554,346 and of this amount, \$253,150 (45.7%) has been collected to date. Consequently, the maximum amount of lost revenue associated with the estimate for 2006 is the current uncollected balance of \$301,196. While this amount is expected to decrease with additional collections in 2007, for the purpose of context, the uncollected balance represents the equivalent of losing capitation for 12.2 ineligible members for an entire year (based on the monthly capitation rate of \$2,055.01 for the comprehensive level of care). The 12.2 member equivalent constitutes about 0.2% of the 5,639 budgeted CMO members for 2006.

Since data regarding lost capitation was not tracked in previous years, there are no comparative figures to assess the reasonableness of the number for 2006. While eligibility and enrollment problems significantly contributed to the \$5.6 million deficit experienced by the CMO in 2003, the lost capitation associated with 2006 has already been absorbed in the CMO's bottom line and will not affect the \$3.1 surplus budgeted for 2006, according to CMO fiscal management. However, using the final 2006 figure for lost capitation can serve as baseline to gauge the level of lost capitation in future years.

It is understood that in the first year of use of this process, a conservative approach would be taken in developing estimates of lost capitation and, that this would potentially result in the overstatement of the allowance. According to fiscal management, the overstatement was also attributable to an increased level of collections that followed a change in the personnel integrally involved with the resolution of recertification issues late in 2006. In this respect, a CMO fiscal report indicates that nearly 30% (\$72,829) of \$253,150 collected thus far occurred in 2007.

Until recently, the accounting for estimated allowance for lost capitation has been confined to CMO internal operating statements. This information is now entered in the County's Advantage accounting system to achieve consistency between the two.

Sufficient time has passed where fiscal management could refine its estimates of lost capitation revenue in future periods using the results of collection experience associated with at least the first six months of 2006. This refinement would lead to improved accuracy in the reporting of the fiscal impact of associated with the failure to meet recertification deadlines.

Consequently, to improve the accuracy of estimates of lost capitation revenue reported on its monthly operating statements and in the Advantage system, we recommend that Department on Aging management:

- 7. Periodically refine future estimates using its growing base collection experience data.*

We also noted during our review that the process used to develop these estimates is labor intensive and spreadsheet driven, relying largely on manual entry and frequent spreadsheet interaction to carry out the function. The nature of this environment subjects the process to a greater potential for error and the inefficient use of accounting staff.

In order to reduce the potential for human error and achieve greater efficiency in the use of staff involved with the process for estimating lost capitation revenue, we recommend that Department on Aging management:

- 8. Evaluate the feasibility of incorporating further use of information technology and integrated system controls in this process.*

Management of Risks Associated with the Recertification Process

Based on our current review of the Family Care eligibility and enrollment process, we determined that procedures implemented to prevent the enrollment of ineligible individuals appear to be adequate for this purpose. We also determined that as a result of the State's elimination of the 30-day grace period for completion of eligibility recertifications and criteria it has set forth regarding the payment of capitation when recertification reviews become past due, the CMO is exposed to an increased level of financial risk.

The options available to CMO management in these situations are to arrange for the disenrollment of a member or to continue to provide services with the hope that the individual is subsequently found to be eligible. As noted earlier in the report, there are consequences associated with either option. As a result, CMO management is placed in the position where it must make a decision as to whether or not the disenrollment of a member in a given set of circumstances should be pursued to prevent the loss of capitation revenue.

These decisions should be based on established policy which sets forth the general criteria developed by management to guide the decision making process. To provide a firm basis for making good decisions about disenrollment, all relevant information should be considered. This should include information such as the following:

- Fiscal information, including the cost of services being provided and the capitation rate applicable to the member.

- The status of the recertification review, such as the information needed and steps remaining for completion, in the context of how long the review is past due.
- The potential impact of disenrollment on the member.
- The likelihood of the member's eligibility

Ultimately, use of this information provides the ability to assess circumstances of each case and to understand the risks associated with disenrollment decisions.

To adequately manage risks associated with the recertification process, we recommend that Department on Aging management:

9. *Develop a formal disenrollment policy that calls for the assessment of member circumstances in arriving at decisions regarding disenrollment of individuals with past due recertifications.*

We wish to extend our appreciation to Department on Aging and Department of Health and Human Services staff for their assistance and cooperation.

Please refer this report to the Finance and Audit Committee.

Jerome J. Heer

JJH/cah

Attachment

cc: Milwaukee County Board of Supervisors
Scott Walker, Milwaukee County Executive
Stephanie Sue Stein, Director, Department on Aging
Corey Hoze, Director, Department of Health and Human Services
Rob Henken, Director, Department of Administrative Services
Cynthia Archer, Fiscal & Budget Administrator, Department of Administrative Services
Scott Manske, Controller, Department of Administrative Services
Terrence Cooley, Chief of Staff, County Board Staff
Steve Cady, Fiscal & Budget Analyst, County Board Staff
Delores (Dee) Hervey, Chief Committee Clerk, County Board Staff



DEPARTMENT ON AGING

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Milwaukee County
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Peggy Montez
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Date: March 15, 2007

To: Jerry Heer, Director of Audits
Paul Grant, Audit Supervisor

From: Stephanie Sue Stein, Director,
Department on Aging

Re: MCDA Management Audit Response

The Milwaukee County Department on Aging wishes to commend the Milwaukee County Department of Audit for its professional demeanor and deportment while carrying out this audit.

Eligibility and enrollment in the Family Care CMO have provided numerous and complicated challenges. As you know, the State's funding of Income Maintenance/Economic Support Workers is woefully inadequate. Nonetheless, the daily efforts of the Department of Health and Human Services and Department on Aging staff has led to a remarkable turnaround in the Medicaid interface.

We welcome your recommendations and our response is attached.

Cc: Maria Ledger, Assistant Director, CMO

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The mission of the Milwaukee County Department on Aging is to affirm the dignity and value of older adults of this county by supporting their choices for living in and giving to our community.



MILWAUKEE COUNTY
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1. Arrange for the creation of adequate documentation of the procedures followed to verify eligibility status in the State CARES system and assign high priority to the training of a backup employee.
 - a. CMO management agrees with the audit recommendation and has begun formally documenting policies and procedures in this area. In addition, a cascading algorithm with accompanying checklist will be developed to guide in the process. There is currently staff trained as back up in this area.
 - b. Responsible Party: Maria Ledger, Jack Melton
 - c. Time Frame: June 2007

2. Develop periodic recertification summary reports using information contained in MIDAS.
 - a. CMO management agrees with the audit recommendation and will aggregate the individual findings on a quarterly basis to identify trends and develop policies and procedures to preclude future occurrences.
 - b. Responsible Party: Maria Ledger, Jack Melton, Bill Bethia
 - c. Time Frame: July 2007

Items 3, 4, 5 and 6 will be answered separately by DHHS

3. Develop workload standards for Economic Support staff for use in determining the adequacy of current staffing and the appropriate staffing levels in the event potential initiatives to adjust workflow are accomplished in recommendation 4., below.
 - a.
 - b. Responsible Party:
 - c. Time Frame:

4. Explore the feasibility of instituting initiatives to adjust the workflow of associated with member eligibility recertification.
 - a.
 - b. Responsible Party:
 - c. Time Frame:

5. Determine the feasibility of incorporating a strategy to use a “hedge” against anticipated vacancies.
 - a.
 - b. Responsible Party:
 - c. Time Frame:



MILWAUKEE COUNTY
DEPARTMENT ON AGING

6. Work with the Department of Human Services to create a separate classification of ESS worker through the execution of a “collateral” agreement with the union to help stabilize staffing the Economic Support Division unit dedicated to Family Care eligibility processing.
 - a.
 - b. Responsible Party:
 - c. Time Frame:

7. Periodically refine future estimates using its growing base collection experience data.
 - a. Management concurs with the recommendation and has refined its estimate beginning in 2007. Recent historical information used has resulted in a lowering of the estimate.
 - b. Responsible Party: Jim Hodson
 - c. Time Frame: Completed

8. Evaluate the feasibility of incorporating further use of information technology and integrated system controls in this process.
 - a. Prior to 2007 the necessary hardware and software was not available to further automate the process. As of February 26, 2007 a fiscal IT workgroup meets weekly to further advance the automation for estimating loss capitation revenue as well as other accounting processes and procedures within the department.
 - b. Responsible Party: Jim Hodson, CFO, MCDA CMO and Bill Bethia, CIO, CMO
 - c. Time Frame: Completed.

9. Develop a formal disenrollment policy that calls for the assessment of member circumstances in arriving at decisions regarding disenrollment of individuals with past due recertifications.
 - a. CMO management agrees with the audit recommendation and has begun formally documenting policies and procedures in this area. In addition, a cascading algorithm with accompanying checklist will be developed to guide in the process.
 - b. Responsible Party: Maria Ledger, Jack Melton
 - c. Time Frame: June 2007



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Milwaukee County

Corey Hoze, Director

Date: 03/15/07

To: Jerome Heer, Director of Audits

From: Felice Riley, Division Administrator

Subject: Family Care Program Eligibility and Enrollment Process Review.

Dear Mr. Heer:

I have attached the Economic Support Division's (ESD) response to the recommendations as related to your recent review of the Family Care Program Eligibility and Enrollment Process.

We are delighted that the audit identifies a host of improvements that both ESD, and the Department of Aging have worked together to implement, with a goal of improving our service delivery.

Please do not hesitate to contact me if you require any additional information relative to our response, or the Family Care Program.

Sincerely,

Felice Riley

Cc. C. Hoze

**Milwaukee County Department of Health & Human Services
Economic Support Division**

**Family Care Program Eligibility and Enrollment Process
Follow-Up Audit
Response**

Recommendation 3- Develop workload standards for Economic Support staff for use in determining the adequacy of current staffing and the appropriate staffing levels in the event potential initiatives to adjust workflow are accomplished in recommendation 4.

The Division will utilize in-house resources to analyze the overall caseload to worker ratio in comparison to other ESD program areas, and discern whether the current Family Care caseload warrants the need for a staffing pattern adjustment.

The analysis will be conducted by the Division' budget analyst, Clare O'brien by 06/30/07.

Recommendation #4- Explore the feasibility of instituting initiatives to adjust the workflow associated with member eligibility recertification.

Rather than implementing a process that would modify review dates, a more workable solution to adjust workflow effectively could be exploring a pooling approach that would allow the total number of re-certifications received to be evenly disbursed among the total staff as the recertification documents filter into the agency.

The Division will assign the current section manager, Diana Jenkins, to analyze, and prepare a write-up of the process by 04/30/07 for review of possible implementation by 06/01/07.

Recommendation #5- Determine the feasibility of incorporating a strategy to use a “hedge” against anticipated vacancies.

The Division believes the best strategy to maintain full staffing in the Family Care area is to continually monitor the vacancies within the Family Care area, and to move trained ESS staff from other ESD program areas to fill Family Care vacancies as they occur. ESD would backfill vacancies within other ESD areas after the conclusion of a training class.

The Division Administrator, Felice Riley, will begin implementing this procedure immediately.

Recommendation # 6- Work with the Department of Human Services to create a separate classification of ESS worker through the execution of a “collateral” agreement with the union to help stabilize staffing the Economic Support Division unit dedicated to Family Care eligibility processing.

The Division believes the process described in recommendation # 5 can resolve any vacancy issues.

We will, however, meet with the Department of Human Resources to discuss the process involved in creating a separate ESS classification. ESD does have a concern that a separate classification for this area may result in a reduced opportunity to fill positions at the time of vacancy, due to the smaller pool of staff that would exist within the newly created classification.

The Division Administrator, Felice Riley and Deputy Administrators, Paula Roberts, and Susan Moeser, will arrange a meeting with Human Resources by April 16, 2007.