

**An Audit of
Milwaukee County
Department on Aging
Care Management Organization
Oversight of Provider Payments**

December 2006

Committee on Finance and Audit

Richard D. Nyklewicz, Jr., Chairman
Ryan P. McCue, Vice-Chairman
Elizabeth M. Coggs-Jones
Michael Mayo, Sr.
Willie Johnson, Jr.
Gerry P. Broderick
Peggy West

Milwaukee County Department of Audit

Jerome J. Heer, Director of Audits
Douglas C. Jenkins, Deputy Director of Audits

Audit Team

Paul Grant, CPA
Joe Williams, CIA
Narcisia Bland

Review Team

Amos Owens
James Felde, CPA, CFE

Administrative Support Team

Catherine Remiszewski
Cheryl A. Hosp
Karen J. Martinson



Department of Audit

Milwaukee County

Jerome J. Heer

• Director of Audits

Douglas C. Jenkins

• Deputy Director of Audits

December 8, 2006

To the Honorable Chairman
of the Board of Supervisors
of the County of Milwaukee

We have completed an audit of the Department on Aging Care Management Organization (CMO) Oversight of Provider Payments. This report focuses on the oversight of CMO provider payments, budgeted at \$148.8 million for 2006. It also addresses questions raised in a County Board Resolution [File No. 06-83] regarding CMO practices with respect to write-offs of outstanding debt and/or overpayment to contracted providers.

A response from the Department on Aging is included as **Exhibit 4**. We appreciate the cooperation extended by the department and its staff during the audit.

Please refer this report to the Committee on Finance and Audit.

Jerome J. Heer
Director of Audits

JJH/cah

Attachment

cc: Milwaukee County Board of Supervisors
Scott Walker, Milwaukee County Executive
Linda Seemeyer, Director, Department of Administrative Services
Stephanie Sue Stein, Director, Department on Aging
Terrence Cooley, Chief of Staff, County Board Staff
Steve Cady, Fiscal & Budget Analyst, County Board Staff
Delores Hervey, Chief Committee Clerk, County Board Staff

An Audit of Milwaukee County Department on Aging Care Management Organization—Oversight of Provider Payments

Table of Contents

Summary..... 1

Background..... 6

Audit Sections:

 Section 1: Provider Oversight 11

 Section 2: Oversight of TPA Claims and Payments..... 26

 Section 3: Identification and Recovery of Overpayments..... 28

Exhibit 1 Audit Scope 39

Exhibit 2 Glossary of Family Care Program Related Terms 41

Exhibit 3 Milwaukee County CMO Organization Chart 43

Exhibit 4 Management Response from the Department on Aging 44

Summary

The Department on Aging operates a Care Management Organization (CMO) that is 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. Milwaukee County serves 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 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. To enable the CMO to continue in operation, the County Board ultimately approved contributions totaling \$12.2 million from the County's General Fund. Since that time, 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.

This report focuses on the oversight of CMO provider payments, budgeted at \$148.8 million for 2006. The objectives of this audit were to:

- determine whether internal controls related to the CMO vendor payment system are in place and functioning as intended;
- assess the adequacy of supporting documentation for vendor claim payments;
- evaluate the effectiveness of the CMO contract administration function; and
- address County Board concerns regarding the potential dismissal of amounts owed by providers as a result of overpayments by the CMO.

Provider and Service Level Oversight

In reviewing a sample of provider records, we noted there is no procedure for verifying the validity of signatures attesting to the accuracy of timesheets. The timesheets are the only supporting documentation that services authorized by the CMO are, in fact, provided.

Further, we noted that, in response to multiple operational issues including computer glitches, the former CMO Director directed the former Third Party Administrator (TPA) to pay claims lacking authorization and those in excess of authorized levels for supportive home care services. While the CMO placed a general restriction on the TPA, directing that it pay only those claims involving eligible members, it overrode internal controls at the individual service level for an extended period of time. Ultimately, the care management staff was required to telephone the providers with the level of service to be provided to members in order for services to be delivered, according to the former CMO Director. We sampled a total of 20 payments made to the two principle supportive home care service providers by the current TPA, WPS, during 2005 and reviewed the contract with WPS to determine whether there was evidence that the directive to override service authorizations had continued. Based on this work, we found that service authorizations were present and the level of service paid was within authorized limits.

The CMO currently employs various methods, such as contracting with a private agency to monitor and mentor Case Management Units (CMUs), to achieve program oversight. However, the CMO lacks a cohesive plan to guide it toward achieving a reasonable level of assurance that all provider billings are legitimate, service quality is satisfactory, and providers are in compliance with critical contract requirements.

Monitoring CMO Provider Service Costs

The CMO has undertaken a number of member service cost savings initiatives. For instance, a flat-rate payment arrangement was implemented for nursing homes effective January 1, 2006, a residential facilities placement team, which matches members with facilities appropriate for their needs was recently created, and the use of Medicare funding as the payer of first resource whenever possible, such as to cover the first 35 hours of post hospitalization services, is now emphasized.

Beyond these initiatives, it appears that CMO management and the State Department of Health and Family Services differ in perspective regarding the requirement to provide services that are outside the Family Care benefit package. CMO management has the perception that services outside the Family Care benefit package that are authorized by an interdisciplinary team must be provided in all

instances. However, the State indicated that services authorized outside the Family Care package should be paid, but only if the service is the most cost effective alternative to achieve the desired member outcome. Particularly since the CMO operates under a capitated rate structure, control of member service costs is paramount to avoid budgetary shortfalls, as occurred in previous years.

Self-Referral--Conflict of Interest

During the course of our review we noted that a number of CMU's have affiliations with CMO service providers, some of which share common ownership. Consequently, the care managers, who are involved with determining the type and level of services required by members, may also refer them to providers affiliated with the CMU. Since the financial viability of many service providers and accordingly, the common owner, hinges on its volume of business under the Family Care Program, a conflict of interest exists between care manager responsibilities to the CMO and clients, and loyalty to organizations affiliated with its employer.

Therefore, the existence of common ownership serves as an incentive for care managers to engage in 'steering' or self-referral, the referral of members to affiliated provider agencies, and creates an environment that could diminish care manager objectivity toward service quality issues of an affiliate.

Provider Contract Administration

The State contract with the CMO requires that "All subcontracts shall be in writing" and that they include the array of provisions specified by the State. Among the provisions specified are those related to insurance, indemnification, certification, and licensure requirements and others that provide for access to provider premises and records and a delineation of the services being provided.

However, due to a multitude of vacancies in the Contract Administration Section of the CMO, including the unfilled positions of manager of the group and contract specialist, the CMO was unable to execute contracts with all of the network providers in 2005. Contracts were not executed with providers of Title 19 services (e.g. therapy, home health, and nursing home services), where the federal government establishes rates. However, the CMO did execute contracts with those providers with whom it had to establish service rates.

Data Back-up and Retrieval

While we recognize that the CMO maintains an internal computerized back-up system, we were not given adequate assurance that there is a sound, tested disaster recovery plan in place to ensure

that historic payment and member data can be functionally restored in the event of any catastrophic disaster.

Identification and Collection of Overpayments

Programs for individuals over age 60 are administered through the CMO, Resource Center, and Area Aging Services Division of the Milwaukee County Department on Aging (MCDA). Although some services are provided directly by MCDA staff, the bulk of services are delivered using contracted providers. While the CMO manages contractual relationships with its providers independently, the Area Aging Services Division (AASD) is generally involved with the administration of the provider contracts for the remainder of the department.

We noted that both MCDA Fiscal Services and AASD Contract Administration staffs are involved, to varying degrees, with the review of certified audit reports associated with contracts administered by the Area Aging Services Division. However, according to management, the in-depth financial analysis necessary to identify and develop findings that could lead to the recovery of overpayments has not been conducted in the past few years for AASD providers due to a shortage of technical resources and a level of ambiguity regarding the responsibilities between the two staffs.

Due to the documentation issues with overpayments from earlier years and because the 2005 certified audit report reviews were in the early stages of completion, we focused our examination on completed 2003 and 2004 certified audit report reviews. We examined a sample of 21 completed reviews from these years and found that established receivable amounts equaled the calculations resulting from the reviews in all instances, an indication that overpayments had not been dismissed/waived in determining amounts owed by providers.

It could prove to be in the best interest of the County to negotiate concessions with providers when it is likely to maximize recoveries. However, beyond County Ordinance 46.09(4)(h), which mandates the charging of interest on overpayments to providers, there is no formal policy to ensure consistency and reasonableness is exercised in the recovery of overpayments. Guidelines should be developed, for County Board consideration, in establishing repayment terms with providers. If departmental management believes it to be in the County's best interest to accept repayment terms that fall outside of established guidelines, a recommendation should be presented to the County Board for review and approval.

Recommendations are presented to address issues identified in this audit report. We wish to acknowledge the cooperation of MCDA management and staff during the audit. A management response to audit recommendations from MCDA is presented as **Exhibit 4**.

Background

Family Care Program

The Department on Aging operates a Care Management Organization (CMO) that is 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 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.

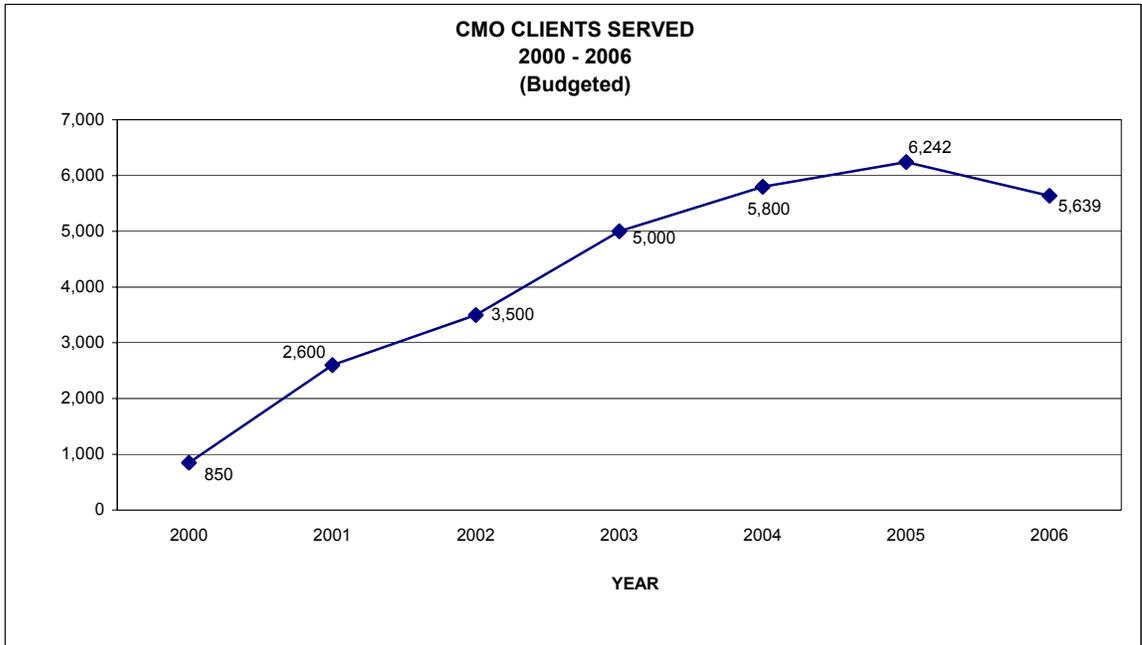
In May 2006, the State passed Senate Bill 653, legislation to expand the Family Care program statewide over the next five years. The Department of Health and Family Services has awarded \$1.4 million in planning grants to counties across the state to prepare for the program's expansion, including \$150,000 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 following **Figures 1** through **3** show the growth in the number of CMO clients served and expenditures incurred, as well as its staffing levels since its inception in 2000 through 2006.

As shown in **Figure 1**, the budgeted number of clients served has grown from 850 in 2000 to a peak of 6,242 in 2005. The budgeted number of clients served dropped to 5,639 in 2006, a decrease of 603 from 2005.

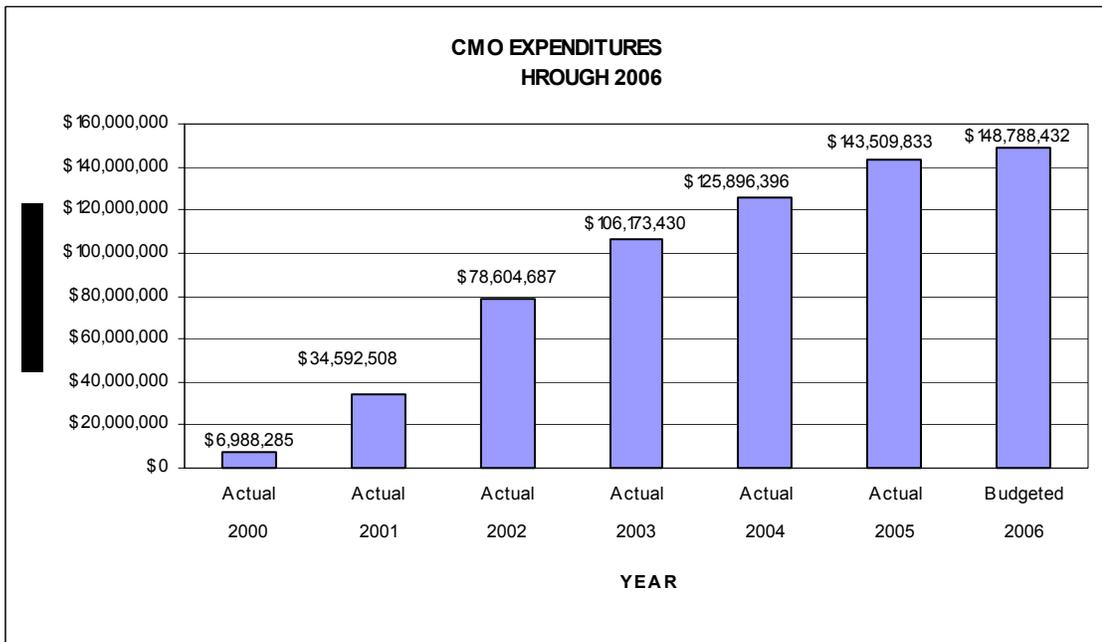
Figure 1



Source: Milwaukee County Adopted Budgets 2002-2006.

Figure 2 shows that CMO expenditures have grown from \$6,988,285 in 2000 to the budgeted amount of \$148,788,432 for 2006.

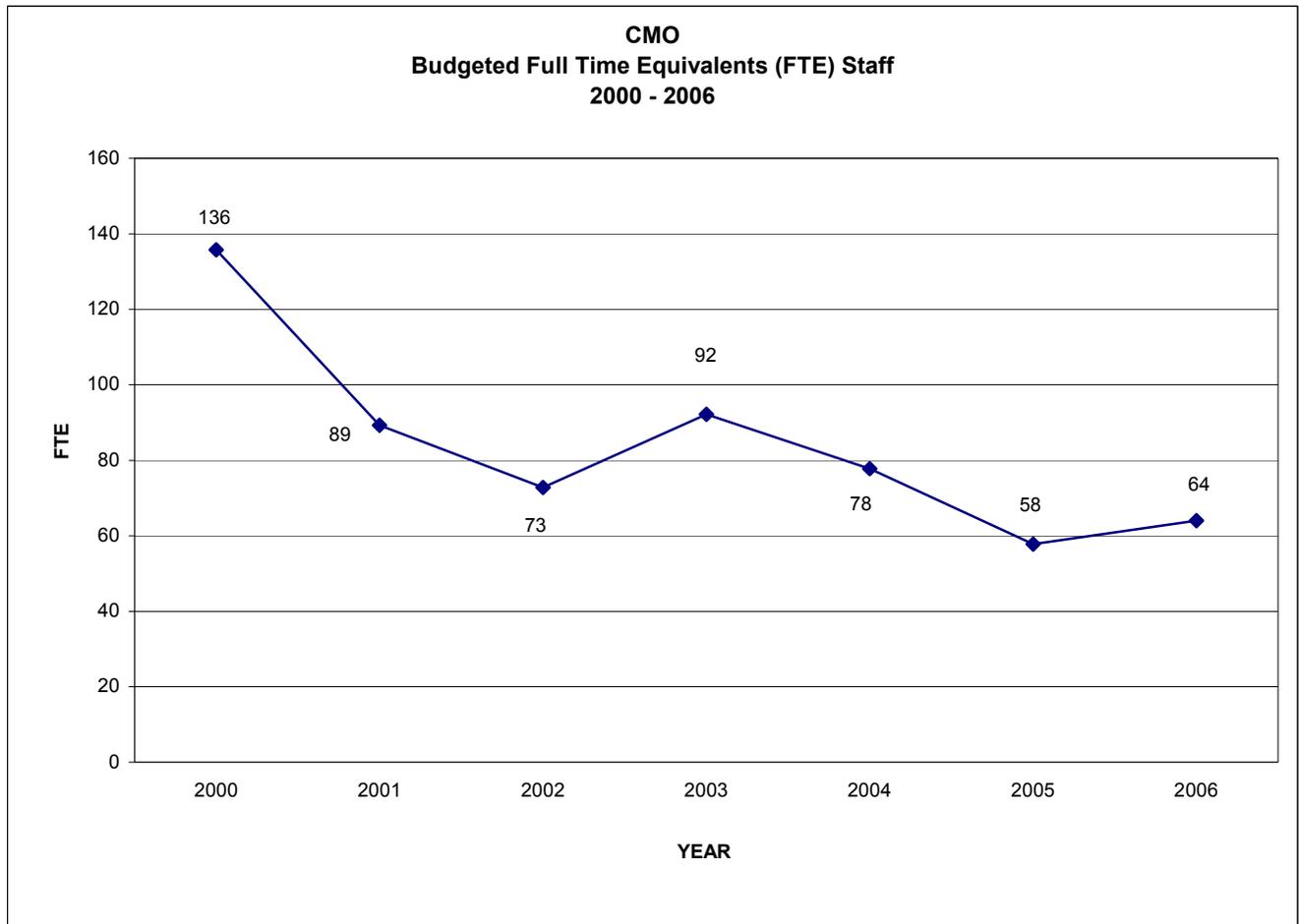
Figure 2



Source: Milwaukee County Adopted Budgets 2002-2006 and Single Audit Report for 2005.

Figure 3 shows that budgeted staffing associated with CMO activities have decreased from approximately 136 employees in 2000 to 64 in 2006. The downward trend reflects the impact of the conversion from the traditional long-term care delivery framework to the Family Care initiative during the early years of the CMO's existence and the increased use of contracted staff, particularly in the area of case management.

Figure 3



Source: MCDA BRASS Reports 2000-2006. Applicable Long-Term Care Unit FTE figures are combined with those of the CMO during conversion years to enhance the portrayal of staffing associated with CMO activities.

In contrast to this overall downward staffing trend, the department has increased the number of CMO positions devoted to program administration and fiscal oversight. Added staff positions include a Privacy Manager, a Lead Screen Specialist, and a Quality Improvement Coordinator. In addition, the positions of Chief Financial Officer, Chief Information Officer, Chief Operating/Clinical Officer and Operations Consultant are staffed with contracted professionals.

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 results of its 2003 operations 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.

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.

However, as a result of the work performed in our previous audit, we had concerns regarding controls over vendor payments. Consequently, this report focuses on the oversight of CMO provider payments, budgeted at \$148.8 million for 2006.

Furthermore, during the course of our review, the County Board adopted a resolution [File No. 06-83] which expressed concerns that the CMO may have dismissed payments owed by providers, specifically involving instances of overpayments related to residential facility and transportation services. The resolution authorized and directed a formal audit of the CMO, including but not limited to write-offs of outstanding debt and/or overpayments to contracted providers and to

recommend steps that should be taken to ensure all receivables are acquired. These concerns are also addressed in the report.

Section 1: Provider Oversight

On-Site Provider Reviews

The Department on Aging operates the CMO, which authorizes and delivers services to its members through a network of contracted providers. Additionally, the CMO contracts with a Third Party Administrator (TPA) to administer and pay provider claims. The TPA in turn, invoices the CMO for reimbursement. KeyLink Solutions, Inc. was the TPA during the first four years of the program and Wisconsin Physicians Service Insurance Corporation (WPS) has been the TPA since 2004.

In this part of the audit, we reviewed provider records, tested controls over service authorization, and identified potential conflict of interest issues associated with affiliated provider agencies.

To determine whether CMO claims are supported with appropriate documentation, we examined a random sample of records associated with the two largest recipients of CMO payments, Supportive Home Care Options, Inc. (SHO) and New Health Services, Inc. (NHS). Both agencies are contracted to provide supportive home care services and collectively accounted for approximately 19% of CMO claims paid in 2005.

We observed a high degree of professionalism and responsiveness from the two largest recipients of CMO payments during the course of the audit.

We observed a high degree of professionalism and responsiveness from these agencies during the course of the audit. The two agencies also expressed that WPS maintains a more stringent system of internal control over provider claims processing than the previous TPA.

In reviewing our sample of provider records, we identified a few incidents of deficiencies in record keeping such as missing documents and the inability to verify worker/member signatures on some worker timesheets. However, we noted a few more

Neither agency maintained a signature card file to spot check worker/member signatures on timesheets.

pervasive issues. For example, neither agency maintained a signature card file to facilitate the random spot check verification of worker/member signatures on timesheets. According to both agencies, the CMO does not require them to maintain signature cards on file.

Absent a procedure for verifying the validity of signatures, it is difficult to determine if the worker authorized to provide the service is the same individual who signed the timesheet or that it was the member who signed the timesheet attesting to the information reported.

In another case, we noted that the former CMO Director granted authorization to the TPA to pay claims lacking an authorization and those in excess of authorized levels for supportive home care services (discussed in a subsequent subsection).

To strengthen internal controls over the delivery of supportive home care services to CMO members and ensure proper record keeping and documentation, we recommend that MCDA management:

- 1. Develop written policies and procedures for the verification and validation of worker and member signatures to ensure that workers provide service and members attest to service delivery.*

Provider Oversight Process

As noted earlier, the CMO has contracted with a TPA to adjudicate and pay provider claims for direct member services since its start-up. To ensure that only valid claims are paid, the CMO requires the TPA to follow a set of business rules in processing claims. Among the business rules is a protocol for claims screening. The protocol requires the TPA to verify that claims relate to or are consistent with, authorized members, providers, service types, rates, and quantities and meet other billing criteria established by the CMO.

Although use of this screening protocol is effective for determining whether claims contain valid data in general, it is not designed to provide assurance regarding the legitimacy of the quantity of units billed or the level of quality of services provided. Based on our interviews we learned that while the CMO does not have a formal plan for provider oversight, it has supplemented the claims screening process with the assignment of two members of its fiscal staff to conduct a detailed review of claims involving residential and care management services to identify instances of provider over-billing.

Service delivery quality is monitored through contracted Care Management Unit oversight and the Contract Administration Group.

Further, CMO management indicated that service delivery quality is monitored through a combination of contracted Care Management Unit oversight and the Contract Administration Group. Among other functions, this latter group deploys a team of four nurses, on a part-time basis, to conduct service quality reviews of residential services.

We were informed that residential services were chosen for the detailed claims review due to the high dollar unit cost of these services. Similarly, these services were targeted for quality review since they have a significant impact on the safety and well-being of CMO members. These efforts demonstrate that CMO management has employed a general level of strategy in respect to its oversight of residential services.

Additionally, we learned that CMO fiscal staff had performed a handful of on-site provider reviews at management's request, although none has been performed since 2003. The on-site reviews included verification of claims and provider compliance with key contract requirements such as insurance coverage, supervisory oversight, service quality, and complaint resolution. In addition to the findings that can be uncovered as the result of on-site reviews, the visible nature of this type of oversight can serve as a strong deterrent to provider fraud.

A comprehensive provider oversight plan should be developed.

While it is essential that the CMO continue with the provider oversight that it currently employs, it lacks a cohesive plan to guide it toward achieving a reasonable level of assurance that all provider billings are legitimate, service quality is satisfactory, and providers are in compliance with critical contract requirements.

To arrive at a provider oversight plan that is both effective and efficient, it should be developed based on a risk assessment of the estimated nearly \$149 million of services purchased annually by the CMO. This approach would provide management with the guidance necessary to design and implement a strategic oversight process that is comprised of a blend of claims and quality review and contract compliance. This process should be ongoing and to maximize efficiency, it should involve a combination of both desk and on-site reviews that are performed and modified according to changes in related risk factors.

To provide a reasonable level of assurance that provider claims are legitimate, service quality is acceptable and that providers are in compliance with key contractual requirements, we recommend that MCDA management:

- 2. Develop and implement a formal and cohesive risk-based provider oversight process.*

Internal Controls--Service Authorizations

Use of service authorizations are required of care managers to notify providers of the types of service and the maximum number of units that will be compensated by the CMO for individual members. Service authorizations also specify the time period within which services are to be delivered and are the primary control over providers since they set-forth the rules and limits that the CMO's contracted third-party administrator (TPA) is required to follow in its payment of provider claims.

During the period in which KeyLink Solutions, Inc. served as the TPA, the previous CMO Director authorized the payment of

According to the former CMO Director, a number of factors caused a breakdown in the issuance of service authorizations.

claims submitted by the two principal supportive home care providers, New Health Services, Inc. and Supportive Homecare Options, Inc., that were in excess of service authorizations and also in instances where there were no service authorization. According to the former CMO Director, this action was taken in response to a number of factors that caused a breakdown in the issuance of service authorizations.

Among the factors cited were that many of the care managers recently came from the County's Child Welfare Division following the State takeover of the program and were unfamiliar with the elderly population, there was no 'road map' for the CMO to follow since the Family Care program was new, and there were computer system and other operational problems, all during a time that large numbers of individuals, most of whom required supportive home care services, were enrolling in the program. Ultimately, the care management staff was required to telephone the providers with the level of service to be provided to members in order for services to be delivered, according to the former CMO Director.

We noted that while the CMO placed a general restriction on the TPA, directing that it pay only those claims involving eligible members, it overrode internal controls at the individual service level.

Furthermore, there was no indication that the CMO implemented any measures to monitor individual payments, such as specifying a dollar threshold to flag excessive claims, or that the CMO revoked its directive to the TPA to discontinue the override of service authorization requirements.

In addition, once the issues leading to the interruptions in service authorization generation were resolved, there was no evidence of any efforts, such as reconciling units paid to those determined

through member assessment, to identify and correct instances where excessive amounts had been paid.

Based on our work, we found that service authorizations were present and the level of service paid was within authorized limits.

Ultimately, we sampled a total of 20 payments made to the two principle supportive home care service providers by WPS during 2005 and reviewed the WPS contract to determine whether there was evidence that the directive to override service authorizations had continued. Based on this work, we found that service authorizations were present and the level of service paid was within authorized limits. In addition, we did not find any contract provision allowing the override of service authorizations, an additional indication that the directive is no longer effective.

Many of the problems that led to the directive to pay claims outside of authorizations, such the deluge of new enrollments in the CMO, have long been corrected and are unlikely to be encountered again in this magnitude. However, a significant interruption of the CMO information technology infrastructure could create widespread operational disruption that requires an override of controls associated with the authorization and payment processes.

To minimize the potential for payment of excessive or fraudulent provider claims in the event of significant interruption of the CMO information technology infrastructure, we recommend that MCDA management:

- 3. Invoke the mass override of service authorization and payment controls only as a last resort and if necessary, implement alternative controls, such as payment thresholds, an expiration date for the override, and other strategic actions to mitigate the impact of the override and facilitate recovery.*

Monitoring CMO Provider Service Costs

The delivery of services to the approximately 5,600 CMO members is coordinated through its 30 Care Management Units (CMU). All but one of the CMU's are contracted by the CMO

from outside agencies. CMU agencies are comprised of interdisciplinary teams, each of which consists of, at a minimum, the member, a human services worker, and a registered nurse.

Interdisciplinary teams prepare the initial individual service plans (ISP) based on member needs that are identified through functional screening and comprehensive assessment. The teams also conduct periodic reviews and updates of the plans to determine the appropriateness and adequacy of the services and to ensure that services furnished are consistent with the nature and severity of the member's condition.

The ISP is a document that lists the type of service or support to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service. The ISP is a supplement to the Member-Centered Plan document, which is the central document that reflects how the member's strengths, skills, and resources, informal, community and those available through the Family Care benefit, will be used to achieve defined member outcomes.

Interdisciplinary teams determine the service options through use of the Resource Allocation Decision (RAD) method, a process sanctioned by the State and intended to assure, among other objectives, cost-efficiency in all resource expenditures. The cost-efficiency focus of the RAD method is key to achieving desired member outcomes at reasonable cost and effort.

Consequently, the appropriateness of the service options prescribed and as well as the fiscal impact on the CMO hinge on how well the interdisciplinary teams apply the RAD method. Due to the significant impact associated with service authorization, it is essential that interdisciplinary team performance be closely monitored by the CMO. In fact, the State contract requires that the CMO Quality Assurance/Quality Improvement (QA/QI) program include processes to monitor and detect underutilization

and over-utilization of services, and processes to monitor and assess the quality and appropriateness of care furnished to Family Care members.

The CMO has contracted with a private agency to monitor and mentor CMU's in the performance of their activities.

The CMO has contracted with a private agency to monitor and mentor CMU's in the performance of their activities. However, due to vacancies in key CMO positions and operational problems related to member assessment and re-certification, the bulk of contracted resources were redeployed. In spite of the redeployment, the private agency has provided training to 120 CMU staff on how to utilize the RAD method properly, according to a representative of the private agency.

Another impediment to the oversight of CMU activities, specifically those related to assessment of CMU performance in applying the RAD method, is that standard protocols had not been developed to conduct this type of review. However, according to documents submitted to the State to describe the level of technical oversight of the CMU teams, 58 random reviews will be conducted each month by the contracted agency in 2006. While the chief aim of the reviews is to monitor problematic areas previously cited by the State, primarily the timeliness and coordination of care, they will include some level of review of the use of the RAD method.

Beyond the randomized reviews of CMU's slated for 2006, the CMO lacks a comprehensive monitoring and utilization review process to help improve member outcomes and management of service costs through improved cost effectiveness. Operation of this process will require the procurement of adequate staffing to develop strategies, establish benchmarks, conduct analyses, and carry out other functions essential to effective service utilization review. For instance, the process can be used to identify successful practices followed to achieve high levels of cost effectiveness so that they can be instituted across all CMU's.

CMO management has undertaken a number of member service cost-saving initiatives.

To further control costs the CMO needs to ensure that the cost effectiveness aspect of the RAD method is also applied to the authorization of services that are outside the Family Care benefit.

Although CMO management may not have committed the desired level of resources to monitoring CMU activities thus far, it has undertaken a number of member service cost-saving initiatives. For instance, a flat-rate payment arrangement was implemented for nursing homes effective January 1, 2006, a residential facilities placement team, which matches members with facilities appropriate for their needs was recently created, and the use of Medicare funding as the payer of first resource whenever possible, such as to cover the first 35 hours of post hospitalization services, is now emphasized.

Beyond these initiatives, it appears that CMO management and the State DHFS differ in perspective regarding the requirement to provide services that are outside the Family Care benefit package. CMO management has the perception that services outside the Family Care benefit package that are authorized by the interdisciplinary team, must be provided in all instances. However, the State indicated that services authorized outside the Family Care package should be paid but only if the service is the most cost effective alternative to achieve the desired member outcome.

Particularly since the CMO operates under a capitated rate structure, control of member service costs (budgeted at \$148.8 million for 2006) is paramount to avoid budgetary shortfalls, including those that draw down risk reserve funds or the need for property tax levy dollars to fund a large deficit, as occurred in previous years.

Furthermore, costs associated with services authorized outside the Family Care benefit are not included in the State's calculation

of the capitated rate. Consequently, these costs are absorbed by the CMO, placing additional fiscal pressure on its operations.

To ensure the continued fiscal health of the CMO, we recommend that MCDA management:

4. *Implement a comprehensive monitoring and utilization review process to improve member outcomes and manage service costs through improved cost effectiveness.*

To enhance member cost oversight and minimize costs that are not factored into calculation of the capitated rate, we recommend that MCDA management:

5. *Establish a policy requiring that all instances of service authorized outside the Family Care benefit must first be reviewed and approved by the CMO. Ultimately, statistics and costs associated with these types of services should be tracked, summarized and reported to the State in an attempt to seek reimbursement.*

Self-Referral--Conflict of Interest

As described in earlier sections, the Family Care program is predicated on member choice, health and social outcomes, and cost-effectiveness. Care Management Units (29 of 30 are contracted) are responsible for assembling the interdisciplinary teams, consisting of a member and CMU staff (care manager and a registered nurse), that develop individual service plans to meet these objectives. Ultimately, it is the care managers who are charged with creating service authorizations, referral of members to providers, and general oversight responsibilities to ensure that members receive prescribed services and that the quality of services is satisfactory.

A number of CMU's have affiliations with CMO service providers, some of which share common ownership.

During the course of our review we noted that a number of CMU's have affiliations with CMO service providers, some of which share common ownership. Consequently, the care managers, who are involved with determining the type and level of services required by members, may also refer them to

providers affiliated with the CMU. Since the financial viability of many service providers and accordingly, the common owner, hinges on its volume of business under the Family Care Program, a conflict of interest exists between care manager responsibilities to the CMO and clients and loyalty to organizations affiliated with its employer.

The existence of common ownership creates an environment that could diminish care manager objectivity toward service quality issues of an affiliate.

Therefore, the existence of common ownership serves as an incentive for care managers to engage in 'steering' or self-referral, the referral of members to affiliated provider agencies, and creates an environment that could diminish care manager objectivity toward service quality issues of an affiliate.

For instance, a care manager may rationalize the selection of a service that may not be the most cost effective alternative for the member but advocates for it because it is available through an affiliate. As another example, the care manager may observe instances where the level of member service administered by an affiliate provider is substandard but it is overlooked due to real or perceived organizational repercussions. As illustrated by these examples, conflict of interest situations can result in compromised member service selection or quality and also have an adverse fiscal impact on the CMO and the Family Care Program.

During our on-site reviews, discussed earlier, we noted that both Supportive Homecare Options, Inc. (SHO) and New Health Services, Inc. (NHS) were affiliated with agencies contracted by the CMO to provide care management services. Based on Third Party Administrator data, we determined that SHO was among a total of nine affiliated agencies that receive CMO payments. As shown in **Table 1**, these affiliated agencies received nearly \$14 million in payments in both 2003 and 2005.

**Table 1
CMO Payments
Agencies Sharing Common Ownership
with Supportive Homecare Options, Inc.**

<u>Name of Agency</u>	<u>2003</u>	<u>2005</u>
Supportive Homecare Options	\$10,095,123	\$11,051,461
ANEW Fiscal Agent*	\$0	\$67,972
ANEW Health Care CMU	\$2,243,885	\$1,865,893
ANEW Health Care Services	\$1,354,213	\$706,534
ANEW Management LLC*	\$0	\$6,739
Highland Gardens Supportive Living*	\$0	\$10,577
Highland Park Supportive Living	\$116,318	\$29,650
Milwaukee Christian CMU/ANEW	\$101,396	\$111,300
Milwaukee Express Moving	\$24,551	\$36,421
Total	\$13,935,486	\$13,886,547

* No payments in 2003.

Source: KeyLink 2003 payments data table and MCDA-WPS 2005 payments data table.

We learned through an interview with a Family Care Program administrator that the State had similar concerns regarding the conflict-of-interest and self-referral issues associated with affiliated agency relationships. The administrator commented that while the State does not have a policy or rules to address this concern, CMO's should manage the contracts with its providers to ensure that there are no unfair referrals or steering of members to affiliated agencies.

To minimize the potential consequences of conflict of interest scenarios associated with affiliated provider agencies contracted by the CMO, we recommend that MCDA management:

6. *Work with State Family Care Program Administrators to develop a policy that addresses provider conflict of interest, self-referral, and steering issues.*

Provider Contract Administration

The State contract with the CMO requires that “All subcontracts shall be in writing” and that they include the array of provisions specified by the State. Among the provisions specified are those related to insurance, indemnification, certification, and licensure requirements and others that provide for access to provider premises and records and a delineation of the services being provided.

However, due to a multitude of vacancies in the Contract Administration Section of the CMO, including the unfilled positions of manager of the group and contract specialist, the CMO was unable to execute contracts with all of the network providers in 2005, according to CMO management. Contracts were not executed with providers of Title 19 services (e.g. therapy, home health, and nursing home services), where the federal government establishes rates. However, the CMO did execute contracts with those providers with whom it had to establish service rates.

Sound business practices call for the execution of provider service contracts that gives Milwaukee County the ability to protect its interests and those of its clients and also comply with Federal, State, and County requirements. For example, Wisconsin Statute 46.034(4) requires certified audit reports from sub-recipients of State funding in excess of \$25,000 and County Ordinance 46.09 (4)(h) requires that all contracts entered into by or on behalf of the county for the purchase of care or treatment services shall provide for the payment of interest on amounts determined to have been overpaid by the County.

With the hiring of a manager for the Contract Administration area of the CMO late in 2005, contracts were executed with all providers in 2006.

To protect County interests and those of its clients and also comply with Federal, State, and County requirements, we recommend that MCDA management:

7. *Ensure that contracts are executed with all service providers each year.*

Computer System Access Levels--Resource Center

In addition to the CMO contracting issue, we found through our investigation of an unrelated referral to the Department of Audit Fraud Hotline by MCDA management that provider contracts were also lacking for the few smaller programs administered by the Resource Center. In response to the findings associated with the Hotline investigation, MCDA management stated its commitment to strengthen the contracting aspects of Resource Center service acquisition, including a requirement that all providers must sign a service agreement.

MCDA management stated its commitment to strengthen the contracting aspects of Resource Center service acquisition.

Regarding the focus of the Hotline investigation, we learned that a human service worker had referred her clients exclusively to a provider agency owned by a close relative and in which she had a financial interest. The human service worker ultimately admitted that she had established the agency in the Resource Center provider network and transacted its set-up on the SCRIPTS payment system. While the County was pursuing the employee's discharge for these actions, she resigned and we confirmed that her SCRIPTS access through MCDA has been terminated. We also confirmed that no additional human service workers in MCDA have access to set-up or modify provider attributes for payment through the SCRIPTS system.

However, we subsequently determined that an inordinate number of MCDA staff, including individuals who have no apparent reason to access SCRIPTS, such as the department's human resources coordinator, possess the capability to either set-up or modify MCDA provider attributes for payment through the system, or both. Due to these circumstances, MCDA is in

the position of being particularly vulnerable to the misappropriation of funds.

This issue was recently brought to the attention of MCDA fiscal management who suggested that since the majority of the individuals should not have this type of access, there appears to be a breakdown in the authorization process between MCDA and the Information Management Services Division (IMSD).

To safeguard against the misappropriation of funds due to excessive SCRIPTS system access, we recommend that MCDA management:

8. *Work with IMSD to restrict SCRIPTS access according to MCDA business requirements and develop procedures to ensure that system access is properly maintained.*

Section 2: Oversight of TPA Claims and Payments

Breakdown of Internal Controls Over TPA Payment Process

The CMO contracts with a Third Party Administrator (TPA) to pay providers for services authorized and delivered to its members. Providers submit claims directly to the TPA for payment. In turn, the TPA processes the claims and submits invoices, which include its monthly administrative fee, to the CMO for reimbursement. The CMO is required to post the TPA reimbursement payments and its other financial transactions to the County's Advantage accounting system.

KeyLink Solutions, Inc. served as the TPA until 2004, at which time the CMO contracted with Wisconsin Physicians Service Insurance Corporation (WPS) for this function. During the contract period with KeyLink, the TPA was also responsible for collecting member cost share obligations. The amount of cost share obligations collected were reported on KeyLink invoices as an offset to the reimbursement amount owed by the CMO.

Third Party Administration reimbursement payments had not been fully reconciled to the claims it submitted.

Through our examination of CMO records, we found that KeyLink reimbursement payments had not been fully reconciled to the claims it submitted and that the CMO's recent attempt to reconcile payments by tracing transactions back to the inception of the contract with KeyLink did not prove completely successful.

We also learned that controls were lacking to properly monitor KeyLink's collection of member cost share obligations. For example, CMO staff did not consistently reconcile KeyLink's deposits of cost share collections to ensure that all collections were reported to the County. In addition, we noted instances where there were gaps between the ending and starting dates of the cost share collection periods reported, presenting opportunities for the underreporting of collections.

Finally, based on records associated with the checking account used by KeyLink to pay provider claims, account balances, at times, reached nearly \$10 million. According to CMO fiscal staff, it is unknown if the bank account was interest-bearing and if interest was earned on the account, whether it was credited to the CMO.

Consequently, we have concluded that there had been inadequate fiscal oversight of KeyLink resulting in the inability to determine whether or not it was overpaid by the CMO.

Based on our review of WPS and the current TPA process, CMO oversight of the TPA has improved significantly.

However, based on our review of WPS and the current TPA process, we noted that the cost-share collection function is now performed internally by the CMO and oversight of the TPA has improved significantly.

Data Back-up and Retrieval

While we recognize that the CMO maintains an internal computerized back-up system, we were not given adequate assurance that there is a sound, tested disaster recovery plan in place to ensure that historic payment and member data can be functionally restored in the event of any catastrophic disaster.

To help ensure that stored computerized data is retrievable and available to support operations in a reasonable time period following the occurrence of an event that destroys key CMO data, we recommend that MCDA management:

- 9. Work with IMSD to develop an adequate plan to secure and recover computerized data in a meaningful form following the occurrence of an event that destroys the data.*

Section 3: Identification and Recovery of Overpayments

Certified Audit Review Process

Programs for individuals over age 60 are administered through the CMO, Resource Center, and Area Aging Services Division of MCDA. Although some services are provided directly by MCDA staff, the bulk of services are delivered using contracted providers. While the CMO manages contractual relationships with its providers independently, the Area Aging Services Division (AASD) is generally involved with the administration of the provider contracts for the remainder of the department.

As a recipient of State DHFS grant funds, MCDA bears responsibility to ensure these funds are expended according to State imposed requirements. Among the State requirements are that the funds may only be used for allowable costs and that a certified financial and compliance audit report (certified audit report), issued by an independent CPA, must be submitted to MCDA by care and service providers who receive in excess of \$25,000. The certified audit report includes various financial statements and schedules, including a report on provider compliance with the allowable cost policy and other applicable laws and regulations. Consequently, an in-depth review of certified audit report components is crucial in determining sub-recipient (provider) compliance with the allowable cost policy and ultimately, overpayments made to them.

The Area Aging Services Division and the CMO have incorporated standardized provisions in their respective contracts to address provider compliance with State, MCDA and County requirements. We confirmed that current contract formats used in both areas include provisions requiring compliance with the State allowable cost policy and submission of certified audit reports, where applicable (generally unit-times-unit-price, with limited profit or reserves and reimbursement of allowable costs,

type contracts). The Area Aging Services Division and CMO also follow independent processes for reviewing certified audit reports.

Generally, an effective certified audit report review process should provide assurance that all reports, required financial statements, and schedules have been received, the reports and associated documents are examined to identify reportable conditions, questioned costs, instances of noncompliance, etc., and finally, that efforts to recover and monitor the collection of any overpayments to providers are undertaken.

Identification of Overpayments

We noted that both MCDA Fiscal Services and AASD Contract Administration staffs are involved, to varying degrees, with the review of certified audit reports associated with contracts administered by the Area Aging Services Division. MCDA Fiscal Services initiates the review process and completes a checklist for documenting the receipt of the audit report, accompanying financial statements and schedules, and for noting reportable items and questioned costs. However, according to management, the in-depth financial analysis necessary to identify and develop findings that could lead to the recovery of overpayments has not been conducted in the past few years for AASD providers due to a shortage of technical resources and a level of ambiguity regarding the responsibilities between the two staffs.

The in-depth financial analysis necessary to identify and develop findings that could lead to the recovery of overpayments has not been conducted in the past few years.

Furthermore, we noted that the 2005 single audit of Milwaukee County contained a finding stating that the CMO did not receive certified audit reports on a timely basis. The finding indicated that for 15 of the 25 provider files tested, certified audit reports had not been received within the contractually required timeframe of 180 days. Management responded to this finding by employing a number of measures, including the suspension of payments due providers, to enforce timely submission of the

certified audit reports, according to corrective actions cited in the single audit.

Timely receipt of certified audit reports is essential to enabling MCDA to complete its reviews. The sooner the reviews are completed, the sooner MCDA can initiate action to collect overpayments. This in turn, enables the timely execution of collection action, which enhances MCDA's potential for success with its recovery efforts. Ultimately, to promote the timeliness in the recovery of overpayments, the progress of each of these activities should be closely monitored by management.

To enhance the success in the recovery of overpayments we recommend that MCDA management:

10. Develop an effective mechanism to monitor the timely receipt and review of certified audit reports and collection of overpayments.

During our inquiry into concerns expressed in a recently adopted County Board resolution about the potential dismissal of amounts due from providers by MCDA, discussed later, we identified two instances where potential overpayments had not been addressed. In these two instances, we noted that although MCDA was in the process of pursuing recovery of overpayments made to a transportation provider in 2004, no apparent efforts had been initiated to recover overpayments totaling \$225,202 made to this provider under identical criteria, for the years 2002 and 2003. Following our inquiry, MCDA sent written notification to the provider for full repayment.

However, due to issues involving the application of the State's allowable cost policy to the certified audit reports of this provider, MCDA management has obtained guidance from the Office of Corporation Counsel and State Officials. Consequently, MCDA has requested additional financial information from the provider to determine the amount, if any, that is owed to the County.

In addition, during our examination of the provider receivables collection process, discussed later, a CMO fiscal staff member indicated that while full reviews were completed for a portion of the 2002 certified audit reports, those identified as having a lower risk of overpayment received only a cursory review due to inadequate fiscal staffing.

To increase the recovery of overpayments and enhance provider contract compliance, we recommend that MCDA management:

11. Enlist the necessary technical resources to conduct the in-depth financial analysis of certified audit reports necessary to identify and develop findings leading to recoverable amounts. For agencies where problems are detected, this analysis should be applied retroactively as far back as contract provisions allow review of provider records.

Segregation of Duties

Earlier in this section, we emphasized the importance of conducting in-depth financial reviews of certified audit reports. To ensure that all reviews are performed, it is essential that all providers that are required to submit certified audit reports are included for review. For contracts administered by AASD and the CMO, only one individual from each area compiles the list of providers required to submit the audit reports. Performance of this task in this independent manner provides greater opportunity for error or fraud to occur without detection.

For example, a provider that should have submitted a certified audit report could be overlooked in error or a provider that has knowingly been overpaid could be intentionally excluded from the list of those subject to certified audit submission as part of a fraudulent 'kick-back' arrangement. In either case, since these providers are not identified as being required to submit a certified audit report, there is no trigger that a review should be conducted and any overpayment amounts would remain undiscovered.

We noted another internal control weakness involving a lack of segregation of duties in respect to the employee who conducts certified audit reviews for the CMO. This individual, while involved with determining the initial receivable amounts owed by providers, also maintains provider payment schedules and handles provider checks. Under this practice, provider payments could be easily diverted to personal use without detection.

To safeguard against errors and the misappropriation of fiscal resources associated with the certified audit report review process we recommend that MCDA management:

- 12. Independently verify that the list of providers subject to submission of certified audit reports compiled by fiscal staff is comprehensive using County financial information systems data.*
- 13. Assign responsibility for provider payment record keeping to a separate fiscal staff member and restrict access to provider checks by individuals who conduct certified audit report reviews and record keeping.*

Collection of Overpayments

We previously discussed deficiencies relating to the timing and lack of an in-depth review of certified audit reports for the purpose of identifying findings, particularly those involving overpayments by MCDA, and internal control weaknesses associated with the review process. In contrast, this section addresses concerns expressed in a recently adopted County Board resolution (File No. 06-83) that the CMO may have dismissed payments owed by vendors, specifically involving instances of overpayments to contracted providers of residential facility and transportation services. The resolution authorized and directed a formal audit of the MCDA CMO, including but not limited to write-offs of outstanding debt and/or overpayment to contracted providers and to recommend steps that should be taken to ensure all receivables are acquired.

In our attempt to conduct testing designed to determine whether concessions were made by MCDA in establishing original overpayment amounts or in respect to its recovery of amounts owed, MCDA was unable to produce a number of key source documents. These included promissory notes and amortization schedules underlying some of the original amounts and outstanding balances for receivables established during 1999 - 2002. As a result, we were unable to draw firm conclusions about whether concessions have been made regarding receivables established during this period. Because of the lack of source documentation, management is unable to provide assurance regarding the accuracy of the outstanding balances of these receivables and therefore, that all amounts owed are properly tracked and amounts due have been collected.

MCDA fiscal management has deployed staff to locate source documentation and verify the accuracy of the older receivable balances and to reconstruct them when necessary. While some of the documents have since been located, MCDA may have to obtain copies from providers in other instances to complete this work.

We also examined a schedule containing provider receivables prepared by the external auditors in conducting the County's Single Audit for 2004. We noted that the schedule contained a column of adjustments labeled *dismissed* that reduced provider receivable amounts by a total of \$97,538. While documentation has been provided to support some of the reductions, it could not be produced for approximately two-thirds of the adjustment total.

Due to the issues relating to the accuracy of 1999--2002 receivables balances and the reductions made in 2004, the CMO has been unable to fully reconcile its provider receivables to the account balance maintained in the County's Advantage system.

To ensure that all provider receivables are acquired and receivables amounts are properly reflected in the Advantage system, we recommend that MCDA management:

14. Reconcile provider receivables to Advantage and going forward, ensure that proper documentation is maintained and amortization schedules are properly managed for all provider receivables.

We found that overpayments had not been dismissed/waived in determining amounts owed by providers.

Due to the documentation issues with overpayments from earlier years and because the 2005 certified audit report reviews were in the early stages of completion, we focused our examination on those completed for 2003 and 2004. We examined a sample of 21 completed reviews from these years and found that established receivable amounts equaled the calculations resulting from the reviews in all instances, an indication that overpayments had not been dismissed/waived in determining amounts owed by providers.

However, we noted in one instance a non-interest bearing promissory note was negotiated with a provider to reimburse MCDA for a \$21,047 overpayment. County Ordinance 46.09(4)(h) requires that "All contracts entered into by or on behalf of the County for the purchase of care or treatment services shall, unless waived by the county board, provide for the payment of interest on amounts determined to have been overpaid by the County." The amount of interest waived under this arrangement totals approximately \$2,731 over the two-year term of the promissory note. According to management, the waiving of interest was an isolated incident that occurred due to the lack of awareness of the ordinance.

However, on a broader scale, we learned that the Department of Health and Human Services (DHHS), as a practice, does not charge interest on provider repayments. This practice is evidenced by DHHS standard provider contract language which reads "The County reserves the right to charge interest on

outstanding repayments due County from Contractor as set forth in section 46.09(4)(h), Milwaukee County General Ordinances.”

In the private sector, debtors are encountered that are unable to fully meet their obligations. Where debtors are likely to avoid a significant portion of the debt by such means as going out of business or through bankruptcy, it is often prudent for creditors to grant concessions, such as forgiving a portion of the debt, waiving interest, or extending the repayment period, in order to minimize the amount of uncollectable debt.

It could prove to be in the best interest of the County to negotiate concessions with providers when it is likely to maximize recoveries.

Likewise, it could prove to be in the best interest of the County to negotiate concessions with providers when it is likely to maximize recoveries. However, beyond County Ordinance 46.09(4)(h), which mandates the charging of interest on overpayments to providers, there is no formal policy to ensure consistency and reasonableness is exercised in the recovery of overpayments.

For instance, while the term of majority of repayment periods are set at one or two years, we noted that a four-year repayment period had been offered to one provider. Although MCDA consulted with the Office of Corporation Counsel and a number of factors were taken into account in considering the extended repayment period, this illustrates the need for standards to guide departments in setting repayment terms.

We also learned of a pending situation where MCDA management, again following consultation with the Office of Corporation Counsel, is giving consideration to a settlement proposal from a provider who is claiming a financial hardship. While the circumstances of this situation may warrant a settlement, we were unable to find a County ordinance that explicitly grants the authority to departments to accept settlements for less than amounts owed by providers. Therefore, we believe that these decisions require County Board action.

Consequently, guidelines should be developed for MCDA and DHHS in establishing repayment terms with providers. For instance, in addition to the requirement for the charging of interest on outstanding amounts, a maximum term for repayment could be set at a specific number of years.

These guidelines should also be practical and take into account factors and circumstances commonly encountered in the recovery of provider overpayments. For example, both MCDA and DHHS management have stated that a number of providers are smaller entities that struggle with repayment because they rely on the County for the bulk of their income. Since it may take a year or more for the overpayment amount to be determined, these providers must fund repayments with revenue earned in subsequent years.

Ultimately, if departmental management believes it to be in the County's best interest to accept repayment terms that fall outside of established guidelines, a recommendation should be presented to the County Board for review and approval.

To achieve consistency and strengthen oversight relating the recovery of provider overpayments, we recommend that MCDA management:

- 15. Work with DHHS management to develop and submit for County Board consideration, guidelines for the departments to follow in pursuing repayment from providers of care or treatment services.*
- 16. If guidelines are approved, prepare a draft ordinance that requires departments to seek County Board approval of settlements involving the recovery of overpayments that fall outside of these guidelines.*

Supervisory Review

As mentioned earlier, the process of reviewing certified audit reports involves a calculation to determine how much, if any, has been overpaid to a provider. The results of the calculations are often revised due to the receipt of additional information from providers. Eventually, conclusions are reached about overpayments. However, the repetitive nature of this aspect of the process provides additional opportunity for errors or fraud to be transacted, emphasizing the importance of supervisory oversight.

Current practice calls for supervisory review of the calculations in instances where an overpayment is identified.

We learned through interviews that current practice calls for supervisory review of the calculations in instances where an overpayment is identified. However, because of the increased potential for error and opportunity for fraud, supervision should include an examination of all completed calculations, including those cases where the results show no overpayment is owed.

We noted one instance from our sample transactions, previously discussed, where it appears supervisory review might not have been completed since the calculation was performed incorrectly. In this case the CMO had separate contracts for each of five facilities owned by a single company. Since each contract specified its own unit rate, a calculation should be done for each contract to determine whether any overpayments were made. Four of the five calculations showed that a refund was owed and the remaining calculation showed that the facility was within the allowable costs. When aggregating these individual amounts we calculated that the amount overpaid to the provider totaled \$32,149. However, the figure calculated by CMO staff of \$31,013 was based on a weighted average unit rate rather than the individual unit rate specified by each of the contracts.

According to MCDA staff, the calculation was done in this manner because it was the practice followed by a predecessor.

It appears that this issue has been corrected based on our review of calculations involving 2004 transactions.

A review of the calculation would have likely caught this type of error. However, since there is no sign-off by supervision we were unable to determine if the review was performed.

To safeguard against errors and decrease the opportunity for fraud resulting in the loss of recoveries from providers, we recommend that MCDA management:

17. Require supervisory review of all calculations performed to determine provider overpayments and documentation of this action with a signature and the date of the review noted on the completed calculation forms.

Audit Scope

As a result of work performed in a previous audit, we had concerns regarding controls over Department on Aging Care Management Organization (CMO) vendor payments. Consequently, this report focuses on the oversight of CMO provider payments, budgeted at \$148.8 million for 2006.

The objectives of this audit were to:

- Determine whether internal controls related to the CMO vendor payment system are in place and functioning as intended;
- Assess the adequacy of supporting documentation for vendor claim payments;
- Evaluate the effectiveness of the CMO contract administration function; and
- Address County Board concerns regarding the potential dismissal of amounts owed by providers as a result of overpayments by the CMO.

The audit was conducted under standards set forth in the United States Government Accountability Office *Government Auditing Standards (2003 Revision)*, with the exception of the standard related to periodic peer review. Limited resources have resulted in a temporary postponement of the Milwaukee County Department of Audit's procurement of a peer review within the required three-year cycle. However, because the department's internal policies and procedures are established in accordance with Government Auditing Standards, and because this audit was performed in compliance with those policies and procedures, the absence of a peer review did not affect the results of this audit.

We limited our review to the areas specified in this Scope Section. During the course of the audit, we:

- Reviewed applicable State Statutes, regulations, and other requirements related to the CMO.
- Reviewed past audit reports, County budgets, and County ordinances.
- Reviewed CMO contracts and examined related policies and procedures.
- Obtained payment data files from the CMO's Third Party Administrator and determined the reasonableness and integrity of data.
- Analyzed CMO and Advantage financial transactions, payment data, and related reports.
- Conducted random sampling of provider and CMO records to facilitate provider review.

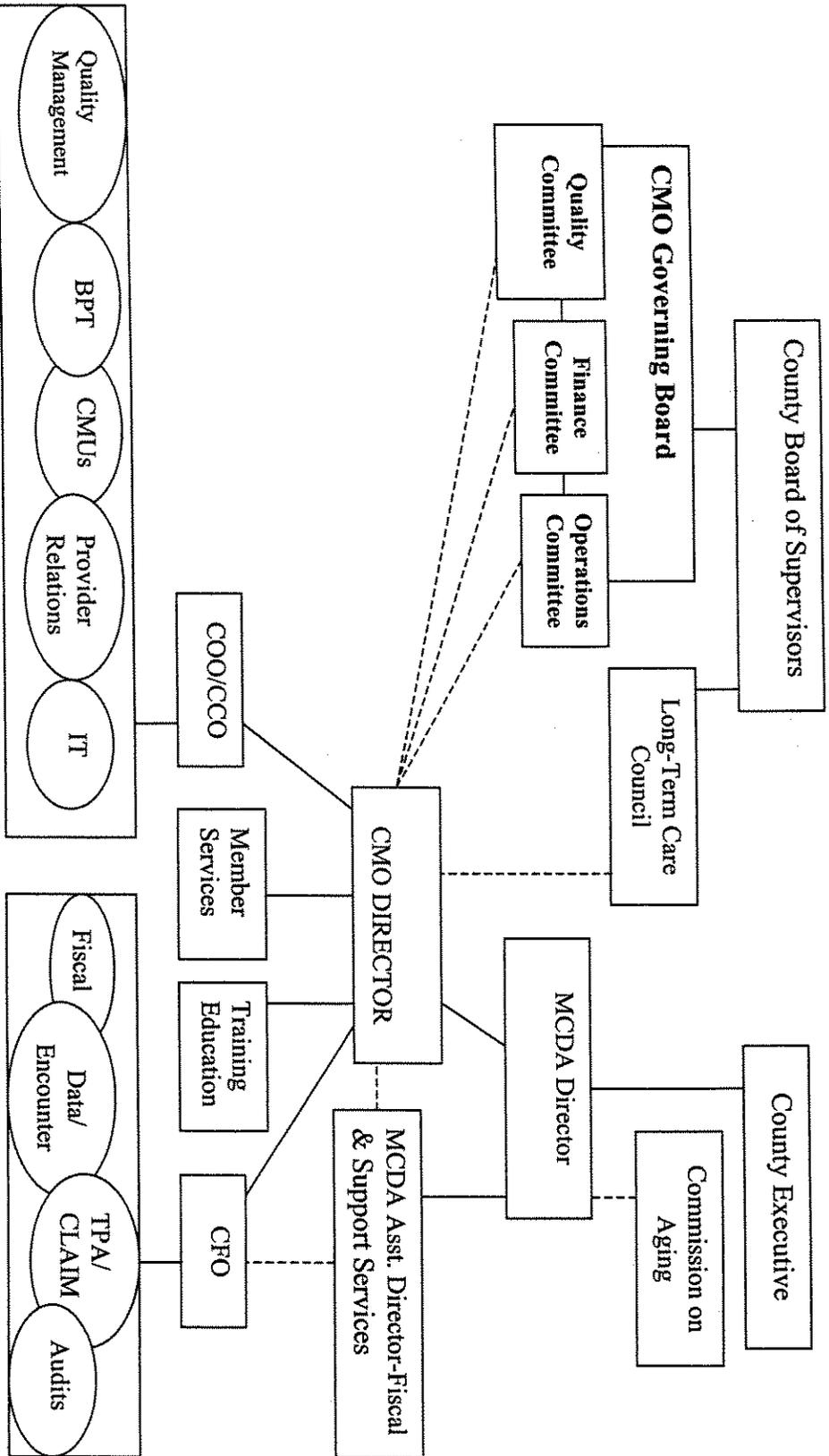
- Examined provider contracts and provider/member records and files.
- Interviewed CMO management and staff, State Family Care Program administrators, providers, and others.

**Glossary of Family Care Program
Related Terms**

<u>Term</u>		<u>Descriptions</u>
AASD	Area Aging Services Division	MCDA unit that provides a comprehensive network of support services to older adults funded through the Older Americans Act and State funding for elderly services.
CMO	Care Management Organization	MCDA division certified under State Statutes and contracted by the State to coordinate the provision of the comprehensive package of Family Care Program benefits in the County.
CMU	Care Management Unit	Team of specialists that provide support and service coordination to CMO members.
DAS	Department of Administrative Services	County department created pursuant to WI Statutes and Chapter 32 of County Ordinances that administers procurement, information management, fiscal affairs, risk management and human resources functions.
DHFS	Department of Health and Family Services	State agency responsible for administration of social service programs including the Family Care Program.
DHHS	Department of Health and Human Services	County department that provides social services to individuals under the age of 60.
Family Care	Family Care Program	The State's comprehensive and flexible long-term care program that serves the elderly and for Counties outside Milwaukee County, also serves people with physical and/or developmental disabilities.

ISP	Individual Service Plan	A document prepared by the CMO interdisciplinary team based on member needs that are identified through functional screening and comprehensive assessment that contains the type, amount, frequency, and duration of prescribed services and supports.
MCDA	Milwaukee County Department on Aging	A county department that plans, develops, provides, purchases, and coordinates services for the County's older adult population as outlined in Chapter 53 of County Ordinances. The Department is the designated Resource Center and Care Management Organization in Milwaukee County under the State's Family Care initiative.
Member	Care Management Organization Member	A person who meets Family Care eligibility and is enrolled in the Care Management Organization.
RAD	Resource Allocation Decision	A state sanctioned process used by the CMO and intended to assure, among other things, cost-efficiency in all resource expenditures.
Resource Center	Family Care - Resource Center	MCDA division that acts as the entry point for Department's Family Care benefit. The Resource Center is the primary source of information and services for persons 60 years of age or older.
TPA	Third Party Administrator	A fiscal agent contracted to process and pay CMO provider claims.

MCDCA CMO Organization Chart



Committees will provide oversight and assistance to CMO management particularly in the area of fiscal accountability, quality assurance and operations. MCDCA Assistant Director for Fiscal & Support Services and a member of the Audit Department and/or Department of Administrative Services will serve as members of the Finance Committee in addition to others designated.

Source : MCDCA Management



DEPARTMENT ON AGING

Milwaukee County

STEPHANIE SUE STEIN Director
(414) 289-5950

sstein@milwaukeecounty.com



FAX: (414) 289-8590
TTY: (414) 289-8591
ELDERLINK: (414) 289-6874
TOLL FREE: 1-866-229-9695
www.milwaukee.gov/county/aging

Milwaukee County
Commission on Aging

Karen Robison
Chairperson

Beverly Njuguna
Vice Chairperson

Bob Haase
Secretary

Barbara Bechtel
Irene M. Brown
Jean E. Davidson
Supervisor Marina Dimitrijevic
Sr. Lucina Halbur
David L. Hoffman
Gwen T. Jackson
Elliot M. Lubar
Lee S. Martinez
Peggy Montez
George E. Schneider
Paul F. Soczynski
Virginia Verduyn

Date: November 27, 2006

To: Jerry Heer, Director of Audits
Paul Grant, Audit Supervisor
Joe Williams, Lead Auditor
Amos Owens, Audit Compliance Manager
Jim Felde, Auditor Manager

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.

The findings and recommendations herein will assist the Milwaukee County Department on Aging in its further path to operational excellence. The challenges of designing and operationalizing a multi-million dollar pilot program were many. While some solutions were easier than others, all recommendations are of help as we continue forward in providing quality services to the older adults of Milwaukee County.

Cc: Maria Ledger, Assistant Director, CMO
Gail Cheatham, Assistant Director, Area Agency on Aging
David Hopkins, Assistant Director, Fiscal
Jim Hennen, Program Coordinator, CMO
Jim Hodson, Chief Financial Officer, CMO
Bill Bethia, Chief Information Officer, CMO
Jack Melton, Chief Operating Officer/Clinical Officer, CMO
Bud Borja, Chief Information Officer, Information Management Services Division

Reuss Federal Plaza • 310 West Wisconsin Avenue • Milwaukee, WI 53203

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
DEPARTMENT ON AGING

1. Develop written policies and procedures for the verification and validation of worker and member signatures to ensure that workers provide service and members attest to service delivery.
 - a. Family Care is a voluntary program requiring member signature on enrollment forms and service plans. MCDA will develop a process to obtain member signature at the time of enrollment and provide copies of the member signature to authorized providers for purposes of verification and validation.
 - b. Responsible Party: Jim Hennen
 - c. Time Frame: June 2007

2. Develop and implement a formal and cohesive risk-based provider oversight process.
 - a. Contracts staff will continue to provide oversight of provider compliance with the terms and conditions of the provider contract. Contracts staff and Placement Team will conduct site visits of all providers at least annually, in response to received provider complaints and as determined necessary based on risk analysis for provider types. Risk analysis for fiscal solvency and quality performance will include analysis from fiscal and operational staff and in accordance with the state-approved quality plan.
 - b. Responsible Party: Jim Hennen, Jim Hodson, Dr. Jack Melton
 - c. Time Frame: April 2007

3. Invoke the mass override of service authorization and payment controls only as a last resort and if necessary, implement alternative controls, such as payment thresholds, an expiration date for the override, and other strategic actions to mitigate the impact of the override and facilitate recovery.
 - a. CMO Management recognizes the need for stronger controls in the area of service authorization overrides. The fiscal department will work with operations to establish stronger process to include payment thresholds and procedures for overrides.
 - b. Responsible Party: Jim Hodson, Bill Bethia
 - c. Time Frame: March 2007

4. Implement a comprehensive monitoring and utilization review process to improve member outcomes and manage service costs through improved cost effectiveness.
 - a. CMO management agrees with the audit recommendation and has been working to improve monitoring and utilization review, and to enhance care management practices within the constraints imposed by the state.



MILWAUKEE COUNTY DEPARTMENT ON AGING

The new CMU administration has developed and submitted a Quality Management Plan for 2006 to the CMO Governing Board and to the Department of Health and Family Services, which addresses, in part at least, some of the points raised by the auditors. Additionally, since the plan was approved by the CMO Governing Board and accepted by DHFS, additional steps have been identified that are intended to accomplish the aim noted in the audit recommendation. The bullet points below summarize the actions that have already been taken or are in process.

- i. The backbone of any utilization management process is randomized record reviews. Compared to baseline of 117 records that were reviewed by MetaStar, the state's External Quality Review Organization, during its 2005 Annual Quality Review, the CMO expanded the number of records reviewed by the Best Practice Team, the CMO's quality monitoring arm, to 672 on an annual basis beginning in February 2006. That number was predicated on 2 cases per month per Care Management Unit and represented the limit that available resources would permit. However, in October 2006, the review process was refined and the number of records reviewed randomly on a monthly basis was increased to 5% of active members for each CMU, not to exceed 10 cases per month. That number translates to approximately 23 % of the entire Family Care population being served by the CMO
 1. Responsible Party: Dr. Jack Melton
 2. Time Frame: Completed
- ii. The CMO established a written protocol that sets forth 10 functional areas, including 16 specific utilization activities, which are evaluated on a monthly basis during the record review. A minimum acceptable threshold for of 95% compliance for each functional area was initiated. CMUs are provided feedback on their performance monthly and are offered technical assistance to help address identified concerns. A series of progressive disciplinary action have also been developed for CMUs that consistently do not meet their obligations.
 1. Responsible Party: Dr. Jack Melton
 2. Time Frame: Completed
- iii. Best practices forums will be implemented, most likely in the form of the brown bag lunches and will be scheduled at least quarterly. The intent is to offer all CMUs exposure to information on how the most successful organizations have designed and implemented efficient business practices.



MILWAUKEE COUNTY
DEPARTMENT ON AGING

1. Responsible Party: Dr. Jack Melton
 2. Time Frame: February 2007
 - iv. An Education and Training Steering Committee has been created and charged with the task of evaluating, expanding and enhancing the CMO's training and education program, including the RAD tool referenced in the audit report.
 1. Responsible Party: Dr. Jack Melton
 2. Time Frame: Completed
 - v. CMO administration and the Best Practice Team are attempting to revise an existing tool borrowed from another organization and retrofit it for use in documenting long-term care needs. If successful in revamping the tool, the CMO will be able to match each member's documented needs with the number of care management hours they're receiving to insure service utilization is appropriate, and that they are not being over- or under-served.
 1. Responsible Party: Dr. Jack Melton
 2. Time Frame: February 2007
 - vi. Finally, CMO administration is seeking permission from the state to change reimbursement strategies for CMUs in an effort to align the parties' interests and priorities. The CMO is proposing to subcapitate the CMU's in an effort to establish a greater sensitivity for cost-effectiveness and accountability in decision-making.
 1. Responsible Party: Maria Ledger, Dr. Jack Melton
 2. Time Frame: January 2007
5. Establish a policy requiring that all instances of service authorized outside the Family Care benefit must first be reviewed and approved by the CMO. Ultimately, statistics and costs associated with these types of services should be tracked, summarized and reported to the State in an attempt to seek reimbursement.
 - a. MCDA has developed policies and procedures for the review and approval of services provided that are not included in the family care benefit package or are provided by non-network vendors. All services authorized in accordance with this procedure are recorded and reports generated will be reviewed by MCDA at least quarterly.
 - b. Responsible Party: Jim Hennen
 - c. Time Frame: Completed



MILWAUKEE COUNTY
DEPARTMENT ON AGING

6. Work with State Family Care Program Administrators to develop a policy that addresses provider conflict of interest, self-referral, and steering issues.
 - a. MCDA's Contract Administrator participates regularly with State Family Care Program Administration and Contract Administrators from other CMOs throughout the state to develop standards for the Provider Network, including standards for compliance with program expectations for cost effective member choice. The MCDA will initiate planning with state and other CMOs regarding policies related to conflict of interest and self-referral with the Provider network Workgroup commencing in January 2007.
 - b. Responsible Party: Jim Hennen
 - c. Time Frame: Spring 2007

7. Ensure that contracts are executed with all service providers each year.
 - a. All providers within the MCDA Family Care network have signed contracts. The MCDA contract specialists assigned to each provider monitors assigned providers and the addition of providers to assure that a signed contract is in effect.
 - b. Responsible Party: Jim Hennen
 - c. Timeframe: Completed

8. Work with IMSD to restrict SCRIPTS access according to MCDA business requirements and develop procedures to ensure that system access is properly maintained.
 - a. A survey/format should be conducted to find out who needs access to Scripts based on their working activities with approval of their immediate supervisor. Then with cooperation with IMSD establish and remove proper access to the System. For the future, any new staff manager should fill a form to request access to MCDA system available.
 - b. Responsible Party: David Hopkins
 - c. Time Frame: March 31, 2007

9. Work with IMSD to develop an adequate plan to secure and recover computerized data in a meaningful form following the occurrence of an event that destroys the data.
 - a. IMSD is currently in the process of implementing Hotsite Disaster Recovery plan. The objective for this project is to enable IMSD to recover all business critical applications at an external facility within 72 hours of a site disaster.
 - b. IMSD is currently in phase I of this plan, developing an RFP for a provider for these hotsite recovery services. IMSD expects the RFP



MILWAUKEE COUNTY
DEPARTMENT ON AGING

- process to be completed in Q1 2007, and anticipate an architectural test of the recovery process by Q4 of 2007, and a measured test of the recovery process approximately Q2 of 2008. Dept. on Aging applications will be included in the list of the business critical applications included in our test.
- c. All of data is currently being backed up nightly so it can be restored. The backup system is located at the City of Milwaukee data center, and the department on Aging servers are at the Courthouse, so that provides IMSD with an additional level of protection.
 - d. Responsible Party: Bud Borja
 - e. Time Frame: 2nd quarter of 2008 for full implementation
10. Develop an effective mechanism to monitor the timely receipt and review of certified audit reports and collection of overpayments.
- a. MCDA-Fiscal Management has developed Provider/Agencies Audit policy and procedures to ensure the timely receipt, review, and collection of overpayments and the timely coordination with Contract Staff for Providers/Agencies who are delinquent.
 - b. The 2007 contract with providers has been revised to more clearly identify audit expectations as to timeliness of audits and timely review upon receipt.
 - c. Responsible Party: Jim Hodson, Jim Hennen
 - d. Time Frame: Completed
11. Enlist the necessary technical resources to conduct the in-depth financial analysis of certified audit reports necessary to identify and develop findings leading to recoverable amounts. For agencies where problems are detected, this analysis should be applied retroactively as far back as contract provisions allow review of provider records.
- a. MCDA-Fiscal Management concurs with the findings and has allocated the necessary technical resources to conduct an in depth financial analysis for all Providers/Agencies whose payments exceed minimum State and County requirements (\$25,000) for all contract periods ending 2005.
 - b. Responsible Party: Jim Hodson
 - c. Time Frame: Completed
12. Independently verify that the list of providers subject to submission of certified audit reports compiled by fiscal staff is comprehensive using County financial information systems data.
- a. MCDA-Fiscal Management is responsible for compiling comprehensive control lists of payments made to all Providers/Agencies utilizing the



MILWAUKEE COUNTY
DEPARTMENT ON AGING

- internal databases of MCDA. The Provider/Agencies Audit policy and procedures refers to the use of internal databases to establish a control list.
- b. Responsible Party: Jim Hodson
 - c. Time Frame: Completed
13. Assign responsibility for provider payment record keeping to a separate fiscal staff member and restrict access to provider checks by individuals who conduct certified audit report reviews and record keeping.
- a. MCDA-Fiscal Management has reviewed existing responsibilities of staff and has re-assigned duties to ensure proper segregation to include separation of review of audits, collections of payments, and maintenance of Provider/Agencies receivable balances as outlined in the Provider/Agencies Audit policy and procedures.
 - b. Responsible Party: Jim Hodson
 - c. Time Frame: Completed
14. Reconcile provider receivables to Advantage and going forward, ensure that proper documentation is maintained and amortization schedules are properly managed for all provider receivables.
- a. MCDA-Fiscal Management has assigned a staff member to maintain on an ongoing basis the Provider/Agencies receivable balances, proper recording and monthly reconciliation to the County's financial system (Advantage)
 - b. Responsible Party: Jim Hodson
 - c. Time Frame: Completed
15. Work with DHHS management to develop and submit for Board consideration, guidelines for the departments to follow in pursuing repayment from providers of care or treatment services.
- a. MCDA's contract Administrator meets periodically with representatives of adult services and the behavior health division of DHHS to review contract requirements with shared providers. The MCDA Contract Administrator will work with DHHS to develop consistent contract expectations with providers contracting with multiple county agencies or divisions.
 - b. Responsible Party: Jim Hodson, Jim Hennen
 - c. Timeframe: June 2007
16. If guidelines are approved, prepare a draft ordinance that requires departments to seek board approval of settlements involving the recovery of overpayments that fall outside of these guidelines.



MILWAUKEE COUNTY
DEPARTMENT ON AGING

- a. MCDA's Contract Administrator will assist in development of a draft ordinance if MCDA and DHHS develop consistent contract policies uniform policies for the collection of overpayments.
 - b. Responsible Party: Jim Hodson, Jim Hennen
 - c. Timeframe: Dependent upon outcomes of #15
17. Require supervisory review of all calculations performed to determine provider overpayments and documentation of this action with a signature and the date of the review noted on the completed calculation forms.
- a. Currently all Provider/Agencies audits reviews, adjustments and calculation of payments (over/under) are performed by Fiscal Staff. Their immediate Supervisors review all work for completeness and accuracy authorizing final approval with their signature and date.
 - b. Responsible Party: Jim Hodson
 - c. Time Frame: Completed