

Managed long-term care plans in New York state: Critical factors for financial viability



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In July 2012 (assuming there are no further delays) New York state will roll out a mandate that individuals receiving community-based long-term care services funded by Medicaid must enroll in managed long-term care plans. This mandate will be implemented gradually, starting with the five boroughs of New York City and spreading across the state over time.

Many long-term care providers in New York state are now starting their own managed long-term care plans in order to maintain their autonomy in this new system. Provider organizations need to be aware that managed long-term care plans are funded using a capitation mechanism in which they receive a lump sum per member from which they must pay most long-term care and other ancillary expenses. The risk shifts from the Medicaid program to the plan. Running a successful managed long-term care plan therefore requires significantly more investment in risk management, financial management, and strategic planning than do fee-for-service arrangements. Health plans and home healthcare agencies that were successful under fee-for-service reimbursement need to understand and plan for these changes, which will ultimately result in reduced utilization per long-term care patient. The financial realities of the

new system could make it more challenging for smaller plans and providers to be profitable.

An additional consideration is that some companies may be entering the managed long-term care market based on experiences with plans created before the 2006 moratorium. State reimbursement at that time was much higher than it is likely to be under the new managed long-term care mandate. It is important to analyze financial feasibility based on today's rules and today's economic realities rather than past experience.

HOW MANAGED LONG-TERM CARE DIFFERS FROM FEE-FOR-SERVICE MEDICAID

In traditional fee-for-service Medicaid, the financial risk is largely borne by the payor, in this case, the state of New York. Utilization can be managed through benefit coverage rules, but ultimately, covered services are paid for by the state without the utilization management scrutiny that a managed care plan would bring to bear. This provides little incentive for long-term care providers to manage utilization.

The tightening budget has led the state to move funding toward managed long-term care plans where a capitation payment, or lump sum, is paid to a plan. The plan must deliver mandated services and pay for administrative overhead from the capitation payment. This places virtually all the financial risk per eligible member with the plan and requires the plan to manage utilization in order to break even.

By forcing plans to manage utilization, the state hopes to reduce its total Medicaid outlay for long-term care services and more accurately forecast annual expenses.

The move from Medicaid fee-for-service to managed long-term care will be challenging for many provider organizations that were not previously responsible for managing utilization. It requires a change in mindset from *maximizing use of services* to *rationalizing use of services* and from *providing care* to *managing care*. Insurance companies that enter the managed long-term care market will have a competitive advantage over provider organizations entering this market because insurers typically have much of the infrastructure in place to project, track, and manage utilization and medical costs.

MONITORING AND MANAGING UTILIZATION IS CRITICAL

To be successful, managed long-term care plans must aggressively monitor and manage utilization. Utilization that

KEY FACTS ABOUT THE MANAGED LONG-TERM CARE MANDATE

- Mandatory enrollment from July 2012 for dual-eligible (Medicare and Medicaid) individuals, age 21+, requiring more than 120 days of long-term care
- Covered benefits include long-term care services (home health, adult day care, and nursing home care) plus ancillary and ambulatory services including dentistry, optometry, eyeglasses, and medical equipment
- Revenue comes in the form of a risk-adjusted, partially capitated Medicaid payment
- Managed long-term care plans do not manage or provide Medicare services
- Cultural and language accommodations are required

exceeds targets will quickly create funding challenges as demonstrated by the simplified income statements shown in the two tables in Figures 1 and 2. The table in Figure 1 shows a managed long-term care plan with utilization under control. The *unit cost* can be thought of as an hourly wage for a home healthcare worker, while the *Units PMPM* can be thought of as the monthly number of home healthcare worker hours used by the average member of a managed long-term care plan. In Figure 1, members are receiving approximately 30 hours per week of personal care services at a rate of \$17.50 per hour.

In the table in Figure 2, members are using closer to 37 hours per week of personal care services—a difference of about an hour per day compared to the plan in Figure 1. Such a relatively small rise in utilization translates into significant losses.

FIGURE 1: MANAGED LONG-TERM CARE PLAN WITH UTILIZATION UNDER CONTROL

	UNITS PMPM	UNIT COST	NET CLAIM COST PMPM	% OF REVENUE
REVENUE			\$4,026.00	100%
EXPENSES				
PERSONAL CARE	122	\$17.50	\$2,135.00	
HOME HEALTH	22	\$24.00	\$528.00	
NURSING FACILITY	0.8	\$272.00	\$217.60	
TRANSPORTATION / NON-EMERGENT	3.7	\$32.60	\$120.62	
OTHER EXPENSES			\$199.78	
TOTAL			\$3,201.00	79%
CARE MANAGEMENT			\$316.00	8%
ADMINISTRATIVE EXPENSES			\$353.00	9%
NET PROFIT			\$156.00	4%

FIGURE 2: MANAGED LONG-TERM CARE PLAN WITH EXCESSIVE UTILIZATION

	UNITS PMPM	UNIT COST	NET CLAIM COST PMPM	% OF REVENUE
REVENUE			\$4,026.00	100%
EXPENSES				
PERSONAL CARE	150	\$17.50	\$2,625.00	
HOME HEALTH	22	\$24.00	\$528.00	
NURSING FACILITY	0.8	\$272.00	\$217.60	
TRANSPORTATION / NON-EMERGENT	3.7	\$32.60	\$120.62	
OTHER EXPENSES			\$199.78	
TOTAL			\$3,691.00	91%
CARE MANAGEMENT			\$316.00	8%
ADMINISTRATIVE EXPENSES			\$353.00	9%
NET PROFIT			(\$334.00)	-8%

Managing utilization in managed long-term care plans is not a trivial matter. Managed long-term care plans must invest in systems to track, analyze, and report the most current utilization data at their disposal. They will need to build an annual budget that includes utilization targets as well as costs. Utilization should be monitored and compared to utilization targets on a monthly basis. If problems are identified, they should be investigated and remedied quickly. The systems required to track and manage utilization involve significant fixed costs, which should be taken into account when estimating administrative costs for a managed long-term care program.

RISK-ADJUSTMENT PROCESS

Capitation payments to managed long-term care plans in New York will be risk adjusted to reflect the relative health or sickness of a given plan population. Currently, the risk-adjustment process is expected to be fully phased in by April 2013.

Risk adjustment is undertaken by adjusting revenue by an aggregate risk score for each plan. Today, the risk score is developed from the member information collected through the Managed Long-term Care (MLTC) Semi-Annual Assessment of Members (SAAM). The assessment is performed every six months for each member. This tool is expected to be replaced in September 2012 by the web-based Uniform Assessment System for New York (UAS-NY).

The average risk score of the current managed long-term care population of New York state will be considered the norm and will be given a score of 1.00. Each managed long-term care plan will be scored relative to that norm, with a score of less than 1.00 indicating a healthier population and a score of more than 1.00 indicating a sicker population. The capitation rate paid to a given plan will be the base capitation rate times the risk score. Plans with sicker members will receive a higher capitation payment, and plans with healthier members will receive a lower capitation payment.

Plans should note the following when considering the effect of the risk-scoring process on their financial and strategic planning:

- Plans should expect to receive a risk score of 1.00 in the first year of the new managed long-term care system.
- The risk-adjustment process is somewhat of a blunt instrument. It is unlikely to account for 100% of risk profile differences. The most successful plans will have their own internal risk metrics that will allow them to plan for gaps between the capitation payments and the risks of their populations.
- Mandatory enrollment could change the risk profiles of plans. Members currently reenrolled in managed long-term care plans enrolled voluntarily. As a rule, healthier individuals are more likely to voluntarily enroll in a managed care plan. Once enrollment is mandatory, all eligible individuals will be required to enroll. As a result a plan could see its overall plan score deteriorate.
- The New York managed long-term care population norm will be recalculated every year, making it difficult to predict what the risk adjustment will be each year.

THE APPEAL PROCESS CREATES ADDITIONAL RISK FOR MANAGED LONG-TERM CARE PLANS

Managed long-term care plans face an additional challenge in the form of the care adequacy appeal process. Members have the right to appeal changes in care and the plan must maintain the member's current level of care until the appeal process is finished. While this process is necessary to protect the rights of members, it will make aggressive utilization management very challenging.

- New enrollees are likely to be coming from high-utilization care plans created during the fee-for-service era. Managed long-term care plans paid on a capitation basis will need to manage utilization in a population that is accustomed to rich benefits.
- Plans will have to pay for the costs of participating in the appeal process, which may be expensive and time-consuming.

We have seen examples of members moving into a managed care environment with an existing plan that is more costly than the managed care plan has budgeted. Such occurrences are likely to become more common when mandatory enrollment in managed long-term care plans comes into effect. Fortright and consistent communication with members and working closely with them to develop a mutually acceptable care plan may help reduce the number of cases that reach the formal appeal process.

BIGGER CAN BE BETTER: HIGH FIXED COSTS OF MANAGED LONG-TERM CARE PLANS MEAN ECONOMIES OF SCALE ARE IMPORTANT

All of these needs—financial projections, risk management, utilization monitoring and management, fair hearing appeals, member assessments, and such—add up to major investments in administrative infrastructure for managed long-term care plans. While expenses such as member services, intake and enrollment, and utilization management increase as membership grows, a large part of a plan's other administrative expenses, such as rent, management information systems, medical director salary, etc., are fixed—in other words, they do not vary greatly based on the number of members in the plan and cannot be reduced by changing utilization or medical costs. Managed long-term care plans will require a large up-front investment of capital to cover these fixed costs. Larger plans are able to create economies of scale in which higher enrollment reduces the per-member-per-month levels of fixed costs. In fact, managed long-term care plans will probably require a minimum level of enrollment to be financially viable.

The tables in Figures 3 and 4 compare two managed long-term care plans with similar expenses but different enrollment figures. The table in Figure 3 shows a managed long-term care plan with 2,000 members. Administrative expenses are \$353.00 per member per month, resulting in a profit/surplus of \$156.00 per member or 4% per month. The 500-member plan in the table in Figure 4 has similar fixed costs as the plan in Figure 3, but fewer members. Variable costs for the 500-member plan are one-quarter the variable costs of the 2,000-member plan because the size varies directly with the size of enrollment. The fixed costs for the 500-member plan are lower, as one would expect. In this example, fixed expenses are a little less than half those of the 2,000-member plan. This reflects the fact that some functions such as information technology systems must be in place no

EVOLUTION OF MANAGED LONG-TERM CARE IN NEW YORK STATE

- **2006:** Moratorium placed on the development or expansion of managed long-term care plans
- **2011:** Moratorium removed and replaced with mandatory enrollment in managed long-term care plans
- **April 2012:** Original effective date for mandatory enrollment for five boroughs of New York City
- **July 2012:** New effective date for mandatory enrollment, dependent on approval of a waiver from the Centers for Medicaid and Medicare Services. Individuals new to service will be enrolled immediately. People in service will be phased in through October 2012 and given 60 days to choose a managed long-term care plan.
- **Future:** As capacity grows, mandated enrollment will roll out to the rest of the state, starting with the most populous counties of New York state. It is also anticipated that previously ineligible groups, such as Traumatic Brain Injury Waiver participants, will become eligible as programs are developed.

matter what the size of the plan. For the 500-member plan shown in Figure 4, the resulting per-member per-month administrative expense is 12% of revenue, resulting in a net profit/surplus of only 1% per month.

FIGURE 3: MANAGED LONG-TERM CARE PLAN WITH 2,000 MEMBERS

	NET CLAIM COST PMPM	% OF REVENUE
REVENUE	\$4,026.00	100%
EXPENSES	\$3,201.00	79%
CARE MANAGEMENT	\$316.00	8%
ADMINISTRATIVE EXPENSES	\$353.00	9%
NET PROFIT	\$156.00	4%

FIGURE 4: MANAGED LONG-TERM CARE PLAN WITH 500 MEMBERS

	NET CLAIM COST PMPM	% OF REVENUE
REVENUE	\$4,026.00	100%
EXPENSES	\$3,201.00	79%
CARE MANAGEMENT	\$316.00	8%
ADMINISTRATIVE EXPENSES	\$490.22	12%
NET PROFIT	\$18.78	1%

Plans should project the minimum enrollment that will result in financial sustainability based on the capitation payment and estimated administrative expenses. Additionally, they will need to manage administrative expenses by streamlining operations.

MANAGED LONG-TERM CARE PLANS NEED KNOWLEDGE TO SURVIVE

The state of New York must cut the cost of Medicaid long-term care services, and it has chosen to do so using a managed care model that places the financial risk as well as the responsibility for managing utilization squarely on the shoulders of long-term care providers through capitation-based payments. The financial realities of managed care are radically different than the fee-for-service model, and any company wishing to survive and prosper in this new environment will need to fundamentally change the way it does business. This will include:

- Intensively monitoring and managing utilization in a timely manner
- Investing in and maintaining substantial administrative infrastructure
- Preparing regular financial projections to monitor the financial health of the plan
- Achieving and maintaining sustainable enrollment numbers
- Collaborating closely with members to manage care expectations and develop mutually acceptable plans that can be paid for within capitation budgets
- Navigating the fair-hearing appeals process and its potential consequences for the bottom line

It is unquestionably a challenging marketplace. Actuarial consultants can perform the analytical tasks necessary to manage utilization, project enrollment, manage risk, and maintain competitiveness. It is likely that the system will evolve over time as the financial realities become clear to the state, managed long-term care plans, and plan members. Companies with strong missions and strong leadership will take the steps necessary to survive and continue providing high-quality care to their members.

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ROLE OF THE CASE MANAGER IN MANAGED LONG-TERM CARE PLANS

The financial success of a managed long-term care plan depends on efficient management of each beneficiary's use of managed long-term care covered services, with the goal being to maintain patients at an optimal level of functioning in their homes and to avoid nursing home placement. This is the role of the case manager, who is expected to keep the cost of managed long-term care covered services within a fixed budget by authorizing a clinically appropriate and cost-efficient mix of long-term care services. The ideal mix of services is based on each beneficiary's clinical needs, personal care needs, and available social and family support.

Unlike a typical Medicare population or commercially insured population in which a small subset of the population requires case management, all managed long-term care beneficiaries need a case manager to monitor and manage clinical and social care needs. Case managers in a managed long-term care plan need both a financial and clinical focus to prevent unnecessary utilization of managed long-term care covered services. When left unmanaged, the utilization of these services can escalate rapidly, as it does in a fee-for-service environment. Managed long-term care case managers have a particular challenge when new beneficiaries enroll who have been receiving unlimited services that may not be clinically or socially necessary. The case manager will need to work with the beneficiary and family to rationalize the mix and amount of services that will be authorized, particularly for personal care, home healthcare, adult day care, and social day care.

Key elements of effective case management for managed long-term care plans include:

- Ongoing patient risk stratification tied to authorization of covered services
- Setting and monitoring utilization targets for each beneficiary
- Authorization guidelines for each covered benefit
- Adequate staffing—consider distribution of risk levels
- Effective case management IT platform
- Effective training
- Efficient workflows
- Adequate clerical staff support
- Management reporting
- Staff productivity reporting