

Tipping the Balance: The Balancing Incentive Program and State Progress on Rebalancing Their Long-Term Services and Supports

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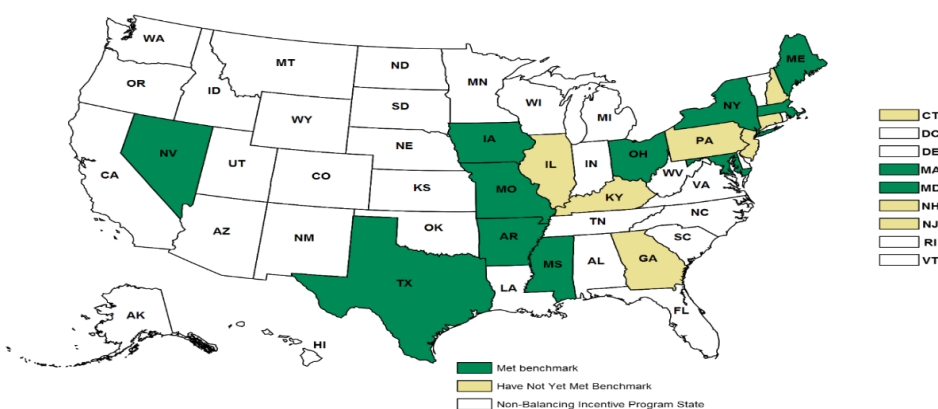
EXECUTIVE SUMMARY

The Balancing Incentive Program, like the Money Follows the Person (MFP) Rebalancing Demonstration, is designed to help states shift the balance of Medicaid long-term services and supports (LTSS) by increasing opportunities for people to receive care in the community rather than in an institution. Authorized by Section 10202 of the Affordable Care Act, the Balancing Incentive Program was established for states that in federal fiscal year (FFY) 2009 were spending more on institutional care than they were on community-based LTSS. In exchange for additional federal funds, Balancing Incentive Program states must implement several structural changes to their LTSS systems and reach the “balancing benchmark” where community-based LTSS accounted for at least 50 percent of total LTSS spending (or 25 percent for Mississippi) by September 30, 2015.

This report provides an early look at state progress toward achieving the balancing benchmark and factors associated with that progress. Key findings include the following:

- Preliminary data suggested that 11 of the 18 participating states had achieved their balancing benchmark a year before the Balancing Incentive Program was scheduled to end.
- The Balancing Incentive Program states have been increasing the share of total LTSS expenditures for community services more quickly than non-participating states.
- Of the Balancing Incentive Program states that had achieved the balancing benchmark by 2014, state plan personal care services represented a notable and growing proportion of expenditures, suggesting that state plan services have made important contributions to states’ rebalancing success.

Figure ES.1. State progress meeting balancing benchmark by FFY 2014



Source: Mathematica analysis of CMS 64 data as presented in Eiken et al. (2015).

About the Money Follows the Person Rebalancing Demonstration

The MFP rebalancing demonstration, first authorized by Congress as part of the Deficit Reduction Act of 2005 and then extended by the Patient Protection and Affordable Care Act of 2010, is designed to rebalance state Medicaid spending long-term services and supports from institutional-based settings to community settings. Congress authorized up to \$4 billion in federal funds to support a twofold effort by state Medicaid programs to (1) transition people living in long-term care institutions to homes, apartments, or group homes of four or fewer residents; and (2) change state policies so that Medicaid funds for long-term care services and supports can “follow the person” to the setting of his or her choice. MFP is administered by the Centers for Medicare & Medicaid Services (CMS), which initially awarded MFP grants to 30 states and the District of Columbia in 2007, another 13 states in February 2011, and 3 more in 2012. CMS contracted with Mathematica Policy Research to conduct a comprehensive evaluation of the MFP demonstration and report the outcomes to Congress.

INTRODUCTION

For several decades, states have been slowly refocusing the emphasis of their LTSS systems from institutional-based care to community-based alternatives. Federal support for this change first started in the 1980s with the introduction of the 1915(c) waiver program, known as the home- and community-based service (HCBS) waivers, and began to accelerate in 1999 with the Olmstead ruling that occurred that year (*Olmstead v. L.C.*), which established the right of people with disabilities to live in the most integrated setting appropriate to their needs. These developments were followed by the Medicaid Infrastructure Grants, authorized by the Ticket to Work and Work Incentives Improvement Act of 1999; the 2001 Real Choice Systems Change grants; and the introduction of the Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program and the Money Follows the Person (MFP) rebalancing demonstration, which were both established by the Deficit Reduction Act of 2005.¹ The Affordable Care Act of 2010 introduced several new LTSS programs designed to make community-based LTSS more accessible to people with disabilities. One of these programs, the Balancing Incentive Program, has been providing states with enhanced federal matching funds, known as enhanced Federal Medical Assistance Percentage (FMAP) payments, on eligible Medicaid-financed community-based LTSS provided to Medicaid beneficiaries. States began earning the enhanced funding once its application for the program was accepted by the Centers for Medicare & Medicaid Services (CMS) and the enhanced funds ended on September 30, 2015.²

Overview of the Balancing Incentive Program. Section 10202 of the Affordable Care Act established the Balancing Incentive Program, which was available to the subset of states that were spending less than 50 percent of total Medicaid LTSS expenditures on

¹ *Olmstead vs. L.C.*, 527 U.S. Supreme Court 581 (1999).

² The Balancing Incentive Program was funded at \$3 billion through September 30, 2015. CMS accepted applications from October 2011 until August 1, 2014.

community-based services in FFY 2009. Participating states agreed to increase the percentage of LTSS expenditures accounted for by community-based LTSS, and to achieve a specified “balancing benchmark” by the end of the program. States that spent between 25 and 49 percent of total LTSS expenditures on community services in FFY 2009 needed to achieve a balancing benchmark that increased that percentage to at least 50 percent by September 30, 2015. These states received a 2 percent enhanced FMAP on all community-based LTSS expenditures. Similarly, states that spent less than 25 percent of total LTSS expenditures on community services in FFY 2009 were eligible for a 5 percent enhanced FMAP and had to spend at least 25 percent of total LTSS expenditures on community-based LTSS by September 30, 2015.

The Balancing Incentive Program Enhanced Funding. For purposes of the enhanced matching funds, the Balancing Incentive Program, used a broad and comprehensive definition of community-based LTSS (see text box), ranging from specific services, such as respite care and case management services, to packages of services provided by programs, such as 1915(c) waivers and Health Home programs. For those states that paid for community-based LTSS on a capitated basis through managed LTSS (MLTSS) programs, the proportion of the capitated payments accounted for by community services were also eligible for enhanced funding by the Balancing Incentive Program.

SERVICES THAT RECEIVED ENHANCED FEDERAL MATCHING FUNDS FROM THE BALANCING INCENTIVE PROGRAM

- All community-based services provided through state 1915(c) or (d) waiver programs or under an 1115 demonstration
- State plan community-based LTSS including, home health, personal care, and rehabilitation services (non-school-based) for mental health and/or substance abuse
- The Program of All-Inclusive Care for the Elderly
- Home and community care services defined under Section 1929(a) (which include homemaker/home health aide, chore services, personal care assistance, nursing care, respite, training for family members, adult day, and day treatment)
- Self-directed personal assistance services provided under 1915(j)
- Services provided under 1915(i)
- Private duty nursing authorized under Section 1905(a)(8)
- Targeted case management
- Case management
- Health Homes for enrollees with chronic conditions
- Community First Choice programs under 1915(k)

Participating states were required to invest the enhanced funds in activities that increased offerings of or access to community-based LTSS for Medicaid beneficiaries. States could flexibly use the enhanced funds in a variety of different ways, such as to finance the direct provision of community-based LTSS; launch a new community-based program, such as a Community First Choice program; strengthen the state’s LTSS infrastructure (for example, by making improvements to LTSS information systems); or conduct research, such as payment rate

studies, to inform future LTSS policy decisions. Mission Analytics Group, the technical assistance provider for the Balancing Incentive Program, have created an inventory of the different ways participating states have used their enhanced funding, which is available at www.balancingincentiveprogram.org (Mission Analytics Group and New Editions Consulting 2015).

States also used their enhanced matching funds to implement the three structural changes required by the Balancing Incentive Program: (1) a statewide “No Wrong Door” to LTSS that provides accessible, comprehensive information on available community-based services, as well as a uniform eligibility determination and enrollment process for services; (2) implementation of core standardized assessment (CSA) instruments, to provide a uniform screening process to determine eligibility, identify support needs, and inform service planning; and (3) conflict-free case management to ensure separation of service provision from case management and assessment to reduce conflicts of interest in the provision of services (Mission Analytics Group and New Editions Consulting 2015; and Kako et al. 2013). These structural changes had to address all populations that need community-based LTSS, including older adults; people with physical, intellectual, or developmental disabilities; and people with mental health conditions.

Of the 38 states eligible for the Balancing Incentive Program, 21 (55 percent of all eligible states) applied and participated.³ Of the 21 participating states, Indiana, Louisiana, and Nebraska were no longer participating in the program at the time of this report. This study focuses on the 18 remaining states that were participating in the program as of June 1, 2015.

OVERVIEW OF THIS REPORT

To assess the overall achievements of the Balancing Incentive Program, this report used state aggregate expenditure data presented in Eiken et al. (2015), as well as preliminary expenditure data reported by the states on the CMS 64 form; survey data; program documentation; and qualitative interviews with program representatives in three states. A full description of the methods used can be found in the Methods section at the end of this report.

The primary focus of the study is on state achievement of the balancing benchmark and the factors driving state success on this measure. Research questions that guided the study included:

1. How successful have Balancing Incentive Program states as a whole been at rebalancing their LTSS systems, as measured by changes in the share of LTSS expenditures that are for community-based services since program start through FFY 2014?
2. Which states have been most successful at rebalancing?
3. Are there underlying trends in expenditures for particular types of services that appear to be related to success in the Balancing Incentive Program?

³ The number of eligible states is based on the information available in the application states used when applying for their Balancing Incentive Program grants. Available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/bip-application.pdf>.

4. Which programmatic approaches or other contextual factors seem to be associated with states' ability to rebalance and achieve the goals of the Balancing Incentive Program?

The report first explores the success of state rebalancing efforts, and then assesses state spending on specific LTSS to identify how different services influence states' overall spending patterns. Case studies of three states explore examples of successful initiatives facilitated by the Balancing Incentive Program. The report concludes with a discussion of the programmatic and policy implications of these findings. The methods section at the end of this report provides more information on the data and methods used.

HOW SUCCESSFUL HAVE BALANCING INCENTIVE PROGRAM STATES BEEN AT REBALANCING?

Although all Balancing Incentive Program states were spending less on community-based LTSS than institutional care in 2009 (per program requirements), the starting points of states varied considerably at that time, as well as later on when states actually started their Balancing Incentive programs. Six states (Maine, Maryland, Massachusetts, Mississippi, New York, and Texas) had achieved their balancing benchmark before their programs began (Table 1); consequently, their achievement of the balancing benchmark cannot be attributed to the Balancing Incentive Program.

Table 1. State progress meeting the balancing benchmark

State	Percentage of Medicaid LTSS expenditures spent on community-based LTSS by federal fiscal year						Achieved balancing benchmark by 2014
	2009 ^a	2010	2011	2012	2013	2014 ^b	
Programs Beginning in 2012							
Maryland ^c	37.0	52.0	51.5	52.6	53.6	55.0	Yes
Missouri	40.7	46.8	43.1	43.5	54.5	55.8	Yes
New Hampshire	41.2	42.5	44.7	50.3	53.7	48.4	No
Programs Beginning in 2013							
Arkansas	29.8	40.8	44.5	44.8	48.1	51.0	Yes
Connecticut	44.1	42.3	43.6	43.2	45.1	47.9	No
Georgia	37.4	38.6	42.8	45.3	46.1	46.4	No
Illinois	27.8	37.4	42.3	41.5	41.9	45.4	No
Iowa	39.8	44.2	42.2	43.1	49.1	53.6	Yes
Maine ^c	49.1	49.6	53.7	54.9	53.8	56.4	Yes
Mississippi ^c	14.4	25.0	26.0	27.4	25.5	28.8	Yes
New Jersey	26.0	29.0	28.9	27.4	33.5	41.1	No
New York ^c	46.7	51.1	49.1	51.5	55.2	56.5	Yes
Ohio	32.5	35.0	37.6	40.0	43.3	56.9	Yes
Texas ^c	46.9	49.5	51.7	50.3	54.0	58.3	Yes
Programs Beginning in 2014							
Kentucky	31.1	33.3	37.2	37.5	38.3	43.2	No
Massachusetts ^c	48.5	46.8	54.8	56.9	59.8	60.1	Yes
Nevada	41.6	53.8	54.2	48.5	48.5	51.0	Yes
Pennsylvania	33.0	37.3	37.3	41.2	41.9	43.7	No

Source: Mathematica analysis of the 2009 expenditure data reported in the Balancing Incentive Program application available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/bip-application.pdf>, the 2010 through 2013 expenditure data from Eiken et al. (2015), and 2014 expenditure data from the Medicaid Budget and Expenditure System (MBES) extracted on June 3, 2015.

^aEligibility to participate in the Balancing Incentive Program was based on the community share of total LTSS expenditures in 2009, which was calculated in 2011 and is presented here for FFY 2009. More recent estimates for FFY 2009 in Eiken et al. (2015) will differ because of lags in state reporting and subsequent state updates.

^b2009 through 2013 data are FFY percentages, based on community-based LTSS expenditures as reported in Eiken et al. (2015). To calculate 2014 percentages we used MBES data and summed total LTSS spending and community-based LTSS spending for each quarter of FFY 2014, then divided total community-based LTSS spending by total LTSS spending.

^cState met community-based LTSS expenditure benchmark before joining the Balancing Incentive Program.

Another four states (Arkansas, Georgia, New Hampshire, and Nevada) were within 5 percentage points of their benchmark in the year before their programs launched. The states that needed to achieve the most progress were the eight that needed to increase the share of community-based LTSS expenditures by more than 5 percentage points (Connecticut, Illinois, Iowa, Kentucky, Missouri, New Jersey, Ohio, and Pennsylvania). Three states (Kentucky, New Jersey, and Ohio) needed to increase their community-based LTSS share by 10 percentage points or more. Of all the participating states, New Jersey had the most to do to achieve its balancing benchmark; in the year before beginning its program, community services accounted for only 27 percent of total LTSS expenditures, which meant that New Jersey needed to increase the community-based LTSS share by approximately 23 percentage points.

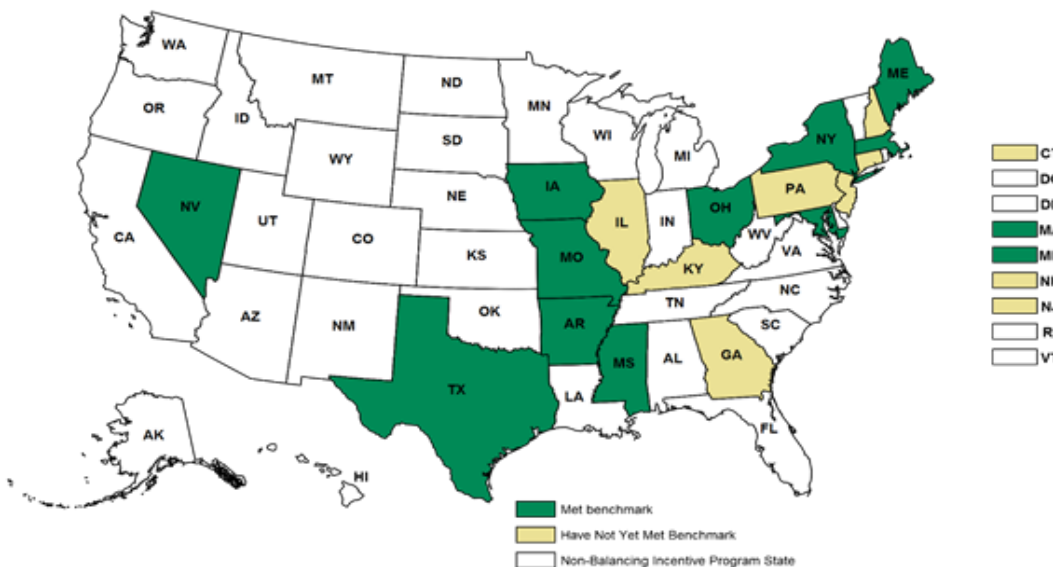
Based on preliminary CMS 64 data for FFY 2014,⁴ of the 12 states participating in the Balancing Incentive Program that had not already achieved their balancing benchmark before participating in the program, 5 had achieved the balancing benchmark by the end of FFY 2014 (Figure 1). Together, 11 of the 18 states had achieved their balancing benchmark one year before the program end date.

Based on the trajectory of spending observed from 2010 through 2014, it seems likely that most, if not, all states are on the path to meeting their balancing benchmark by the end of FFY 2015, as required by the program. Among the seven states that had not yet achieved their benchmark, the 2014 community-based LTSS share ranged from 41 percent in New Jersey to 48 percent in New Hampshire. The increase in the community share between the year before program participation and 2014 varied among these seven states, ranging from a 1.1 percentage

⁴ Data for FFY 2014 were extracted from the MBES on June 3, 2015.

point increase in Georgia to a 13.7 percentage point increase in New Jersey, indicating that some states are moving faster than others towards their balancing benchmark.

Figure 1. State progress meeting balancing benchmark by FFY 2014



Source: Mathematica analysis of CMS 64 data as presented in Eiken et al. (2015).

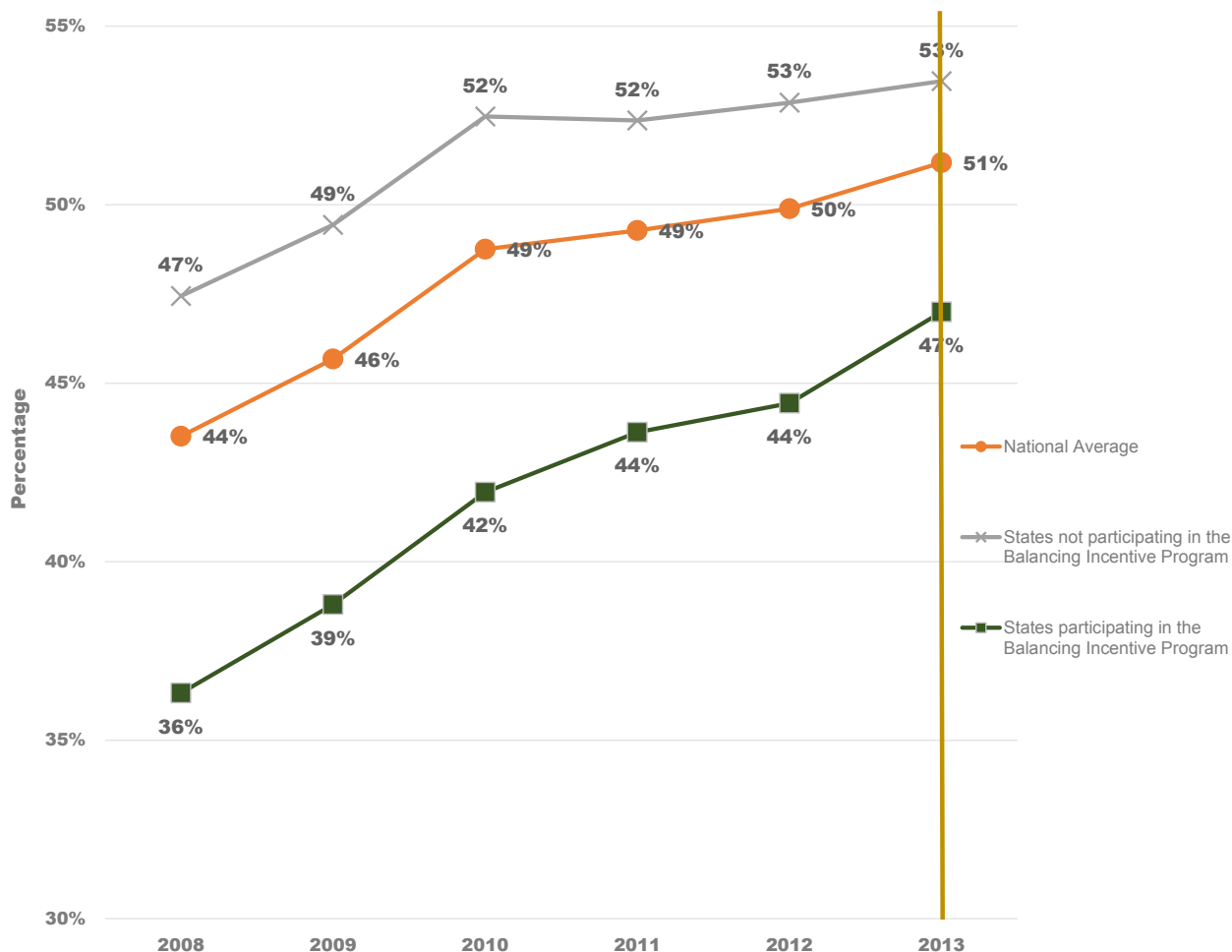
To characterize state progress under the Balancing Incentive Program, we analyzed changes in the share of community-based LTSS spending using several metrics. Using the balance of LTSS spending in the year before program participation as the state’s baseline, we analyzed relative and absolute increases in the community share from the year before launching the program relative to the balance achieved in each quarter of participation in the Balancing Incentive Program. (See the Methods Appendix for a more detailed explanation of our methods.) We also considered the absolute increase in the balancing benchmark between the year before participation in the Balancing Incentive Program and FFY 2014. Regardless of the method chosen, four states-Iowa, Missouri, New Jersey, and Ohio-stood out for the progress they made rebalancing their LTSS expenditures since launching their Balancing Incentive Programs. All four states needed to increase their community-based LTSS expenditures by more than 5 percentage points, and they did so within two years of launching their programs. These four states were considered “high-performing states.”

HOW DOES PROGRESS IN THE BALANCING INCENTIVE PROGRAM STATES COMPARE TO PROGRESS IN OTHER STATES?

On average, the Balancing Incentive Program states have been increasing their community-based LTSS spending as a share of total LTSS expenditures more quickly than states not participating in the program. For example, between 2012 and 2013, Balancing Incentive

Program states increased their average community share by 3 percentage points, compared to an average increase of 1 percentage point among non-participating states (Figure 2).

Figure 2. Average percentage of total LTSS expenditures accounted for by community-based LTSS by participation in the Balancing Incentive Program: 2008-2013



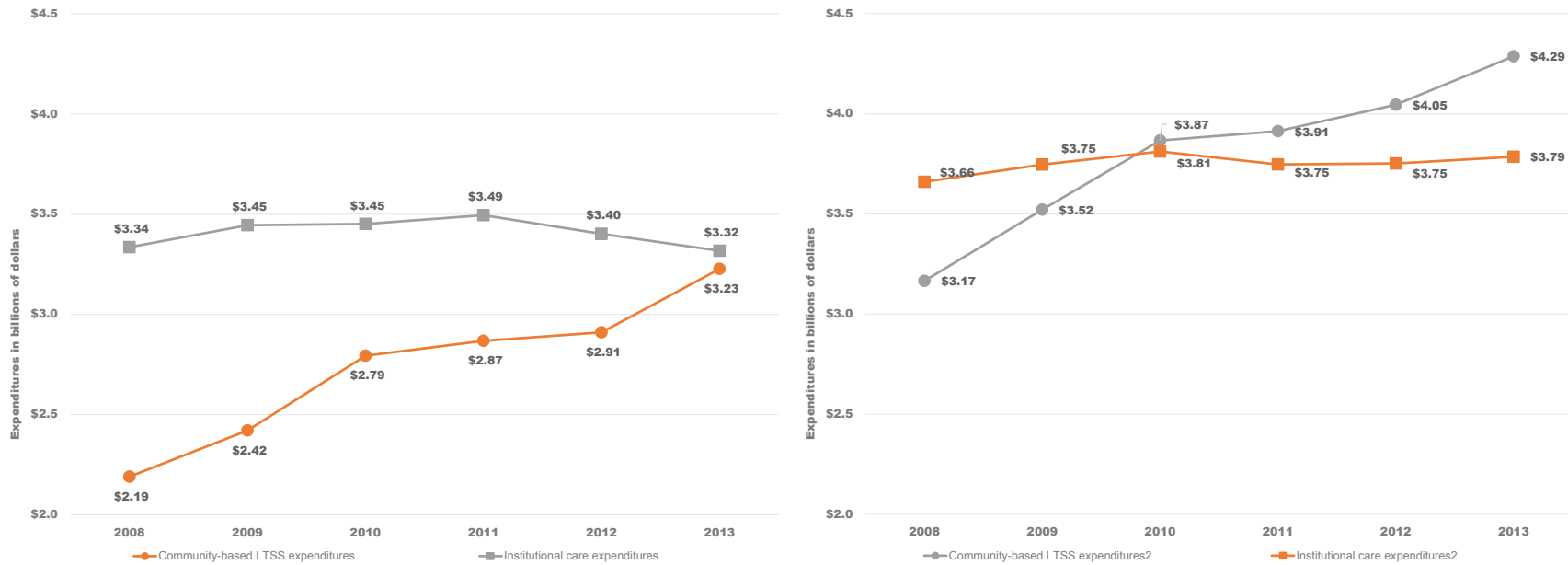
Source: Mathematica analysis of annual LTSS expenditure data presented in Eiken et al. (2015)

Note: The vertical bar indicates the year the majority of states began participating in the Balancing Incentive Program.

LTSS = long-term services and supports.

The increase in the average community-based LTSS share among Balancing Incentive Program states was driven by increases in total spending for community services and small declines in institutional care expenditures. In contrast, non-participating states experienced slight increases in their institutional care expenditures in the last years of data available for this study (Figure 3).

Figure 3. Spending on LTSS by location of care and by participation in the Balancing Incentive Program: 2008-2013



Source: Mathematica analysis of annual LTSS expenditure data presented in Eiken et al. (2015).

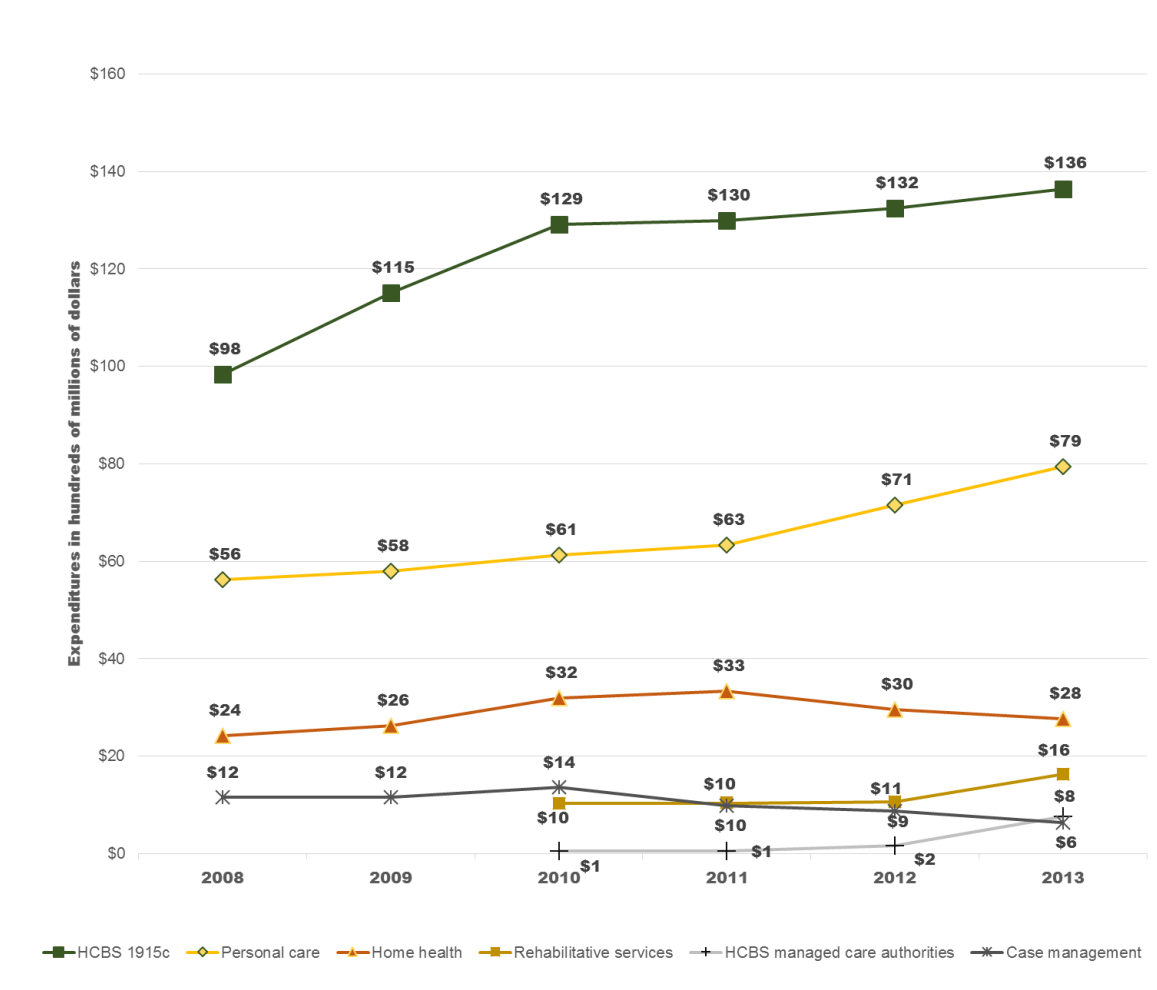
Note: The figure on the left includes only the Balancing Incentive Program states, and the figure on the right includes only non-participating states.

WHICH CATEGORIES OF COMMUNITY-BASED LTSS EXPENDITURES APPEAR TO BE ASSOCIATED WITH AN INCREASE IN OVERALL SPENDING ON COMMUNITY-BASED SERVICES?

To understand whether any specific categories of spending seemed to be associated with the overall growth in community-based LTSS expenditures, we analyzed annual community-based LTSS expenditure data as reported in Eiken et al. (2015). We disaggregated the analysis by whether the state had achieved its balancing benchmark by FFY 2014 to identify whether growth in any particular category of community services seems to be instrumental to the overall achievement of state success.

Across all Balancing Incentive Program states, expenditures for 1915(c) waiver services made up the largest share of spending, and spending on waiver services continued to increase (see Figures 4 and 5). Among Balancing Incentive Program states that had met the balancing benchmark by 2014, the growth rate for 1915(c) waiver spending appeared to slow somewhat beginning in 2010. However, these states also reported large and growing expenditures for state personal care services (Figure 4). Spending on rehabilitation services and managed care authorities also increased modestly among these states. In contrast, in states that had not yet met their benchmark, the growth in 1915(c) waiver expenditures appeared to continue at the same rate through 2013, and expenditures for waiver services dominated all the other categories. State plan personal care services did not stand out in terms of spending compared to other services. Rehabilitation services for substance abuse and mental illness increased slightly among these states, but remained low.

Figure 4. Spending for select community-based LTSS expenditure categories among Balancing Incentive Program states that met their balancing benchmark by 2014

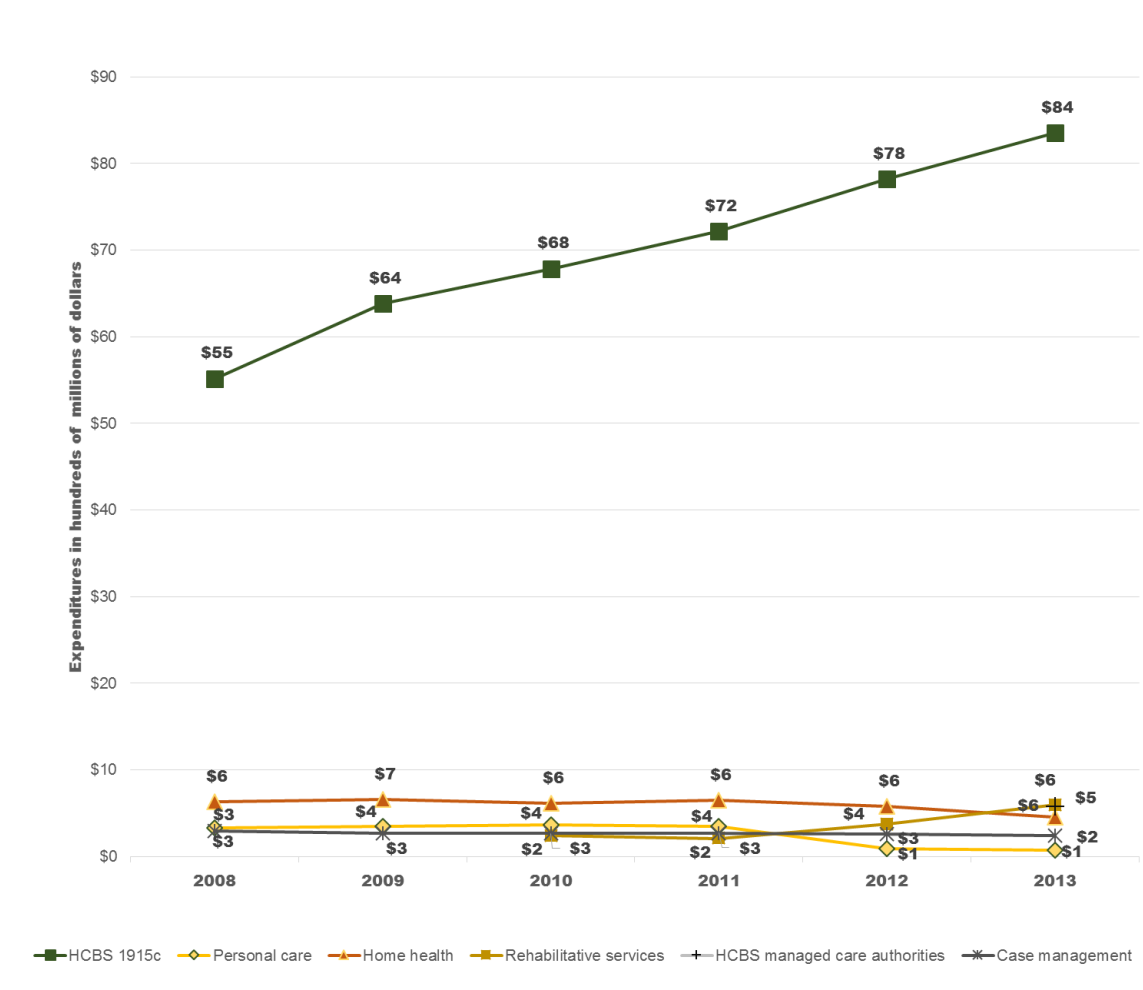


Source: Mathematica analysis of CMS 64 quarterly data extracted from the MBES on June 3, 2015.

Note: The HCBS managed care authorities expenditures represents the portion of the monthly capitated payments states pay to health plans that represent the costs for community-based LTSS. The expenditures for rehabilitative services are for substance abuse and mental health services only. Balancing Incentive Program states began reporting both categories of these expenditures as separate line items in 2010.

N = 11 states (Arkansas, Iowa, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nevada, New York, Ohio, and Texas).

Figure 5. Spending for select community-based LTSS expenditure categories among Balancing Incentive Program states that did not meet their balancing benchmark by 2014



Source: Mathematica analysis of CMS 64 quarterly data extracted from the MBES on June 3, 2015.

Note: The HCBS managed care authorities expenditures represents the portion of the monthly capitated payments states pay to health plans that represent the costs for community-based LTSS. The expenditures for rehabilitative services are for substance abuse and mental health services only. Balancing Incentive Program states began reporting both categories of these expenditures as separate line items in 2010.

N = 7 states (Connecticut, Georgia, Illinois, Kentucky, New Hampshire, New Jersey, and Pennsylvania).

HOW DID THE BALANCING INCENTIVE PROGRAM AND OTHER LTSS INITIATIVES CONTRIBUTE TO INCREASES IN THE SHARE OF COMMUNITY-BASED LTSS?

To explore how the Balancing Incentive Program, and other programs and strategies, contributed to state rebalancing efforts, we conducted interviews with personnel from three states: Iowa, Mississippi, and Ohio. These three states were chosen to represent a range of experiences among states that had achieved their balancing benchmark. The three states varied by the amount of growth they had achieved since participating in the program, where they started in terms of the share of total LTSS expenditures accounted for by community-based services, and their use of MLTSS.⁵

Ohio: Building on state support for rebalancing

State context and overall progress. Ohio had strong growth in rebalancing before the Balancing Incentive Program, which was driven by a robust MFP program and supported by state budget allocations for LTSS. For example, beginning in 2011, Ohio was able to eliminate waiting lists for all of its waivers for individuals with nursing home level of care needs as a result of budget allocations by the governor’s office. Furthermore, state staff explained that “the economy in Ohio recovered much more quickly than in other states,” and therefore “in a period when some states were having to cut services, we were able to increase access to services.”

The Balancing Incentive Program built on this momentum by providing a mandate to achieve structural changes such as the program’s No Wrong Door requirement. Although Ohio’s community-based LTSS share has been increasing steadily year by year, state program administrators believe the program helped Ohio reach the tipping point in the state’s LTSS system. Preliminary data suggest that, in 2014, after participating in the Balancing Incentive Program for one year, the state’s spending on community services increased by 14 percentage points, reaching nearly 57 percent of total LTSS expenditures, compared to 43 percent in 2013.

Ohio noted that, from the beginning, it focused not only on the transition component of the MFP program, but also on the rebalancing objective, stating: “We were actively engaged in system reform and rebalancing as part of MFP before the Balancing Incentive Program came along.”

A foundation based on the MFP demonstration. Ohio began transitioning people under MFP in 2008; by June 2015 the state had transitioned 6,607 participants,⁶ making it the second-largest MFP program after Texas. State staff expect that, in 2015, they will achieve the largest number of transitions in one year since they began participating in the program.

Furthermore, in addition to its MFP transition program, Ohio focused on the rebalancing component of MFP and was engaged in system reform efforts when it applied for

⁵ Ohio began implementing a MLTSS program in 2014, Iowa has plans to implement MLTSS in 2016, and Mississippi is not currently planning an MLTSS program.

⁶ MFP Semi Annual Progress Reporting System: January through June 2015 period.

the Balancing Incentive Program. For example, the MFP project had a “front door” work group, which the Balancing Incentive Program has used to develop the state’s No Wrong Door concept.

The Balancing Incentive Program also gave the state the impetus to create the No Wrong Door system it had been discussing for years. “When we became a Balancing Incentive Program state, we had a deadline for creating the No Wrong Door system, so there was an impetus for stakeholders to come to a consensus on a model for the no wrong door.”

Although this work started under MFP, there was “no agreement on how or what it would look like.” In another example of how the two programs worked together, hospital associations involved in the “front door” group for MFP also participated in testing the new level of care assessments developed under the Balancing Incentive Program.

Ohio began work developing standardized assessments as part of MFP, which would inform the development of the core standardized assessment for the Balancing Incentive Program. Under the Balancing Incentive Program, Ohio built three new assessment tools using an extensive stakeholder process and rigorous testing of their reliability and validity. State staff believe

one of the best features of these new tools is that they will assess the full range of a person’s needs during the initial assessment, which will result in people being connected to key services earlier, which will, in turn, help more people remain in the community. For example, under the current assessment system, the evaluation of behavioral health and substance abuse issues is not as comprehensive as it will be under the revised process. State staff predict the new instruments “will be transformational” in their ability to keep more people in the community and reduce delays in connecting people to appropriate services, which in turn should reduce the likelihood a beneficiary will be institutionalized.

Potential of the No Wrong Door data collection to support policy decisions. Ohio is optimistic about the value of its forthcoming electronic No Wrong Door system and “having data at their fingertips.” The system will capture assessment, care planning, and service use data, and the state noted that “having all that data will help inform policy in the future.” For example, if the Medicaid agency ever wants to make changes to the level of care criteria or analyze how many people meet the state’s level of care criteria because they need hands-on assistance with toileting, that information will be available and easily accessible to state staff. In addition, if the state wants to consider policies and procedures relating to medication administration, state personnel will be able to run a report on how many people are using this service, where they live, and their characteristics.

Iowa: The effect of federal funding and mandates, and the potential of conflict-free case management practices

State context and overall progress. In Iowa, state staff reported that the enhanced federal match under the Balancing Incentive Program “made a big difference in tight budget times.” In addition, the state’s commitment to achieve the rebalancing and system transformation goals of

The impact of the “federal government, not just advocates” pushing to increase the share of spending on community services helped establish expectations around the move away from institutions as the default setting for LTSS.

the program helped counter the influence of the powerful nursing home lobby in the state. State staff explained that “the Balancing Incentive Program helped strengthen the perception that things are changing.” The impact of the “federal government, not just advocates” helped establish expectations for increasing access to and use of community-based LTSS. Based on preliminary data, the state’s community-based LTSS share grew approximately 5 percentage points, from 49 to 54 percent, between 2013 (the first year the state began participating in the program)

and 2014.

Conflict-free case management and core standardized assessment process. Iowa listed implementation of conflict-free case management practices and a core standardized assessment as the second most important factor (after the extra funding provided by the program) contributing to rebalancing. Iowa adopted the Supports Intensity Scale (SIS) as their core standardized assessment for individuals with developmental disabilities. State staff explained that, previously, when case managers conducted assessments, they usually developed a care plan that reflected the services they knew were available under Medicaid. In contrast, under the new conflict-free process, independent assessors (procured through a competitive bidding process) conduct the assessment. The combination of an independent assessor and the “strengths-based” SIS instrument results in “an objective look at what the person needs to live in the community” rather than “trying to fit the person into existing services.” After a care plan is developed using the SIS, the person’s case manager is responsible for coordinating all services in the care plan, including services not funded by Medicaid (for example, transportation, meal delivery, or job coaching provided through private pay, state, or county-funded services). State staff explained that Iowa “already had a lot of conflict-free strategies in place,” but the Balancing Incentive Program “gave them the push to formalize what they were doing.” The state anticipates that the new assessment process will lead to more people receiving all the supportive community services they need, and consequently, more people will be able to remain in the community longer.

Although Iowa achieved important strides in developing a conflict-free system, the system is poised to change again because the state is planning to implement MLTSS in 2016. Under MLTSS, the managed care organizations (MCOs) will be required to use the SIS instrument. However, because MCOs will conduct needs assessments, care planning, and case management and provide services, the plans will need to implement administrative firewalls to maintain a conflict-free system.

No Wrong Door System, progress and challenges. Iowa has made progress developing its No Wrong Door system, but ran into challenges with data sharing and with purchasing and implementing the software required to support the system. The state has developed the toll-free number and website, and identified the Area Agency on Aging (AoA) offices as the physical location of its No Wrong Door system. However, the state has not yet been able to get approval to share data between the Medicaid office, which conducts the financial assessment, and the AoA offices, which conduct functional assessments. The inability to share information has prevented the state from using the electronic system to streamline eligibility and enrollment as planned.

Currently, Iowa is pursuing a business associate agreement and enabling legislation to make the AoAs a Medicaid-covered provider and allow the necessary data sharing to occur. At the time of the interview, state staff also noted that the details of how this system will be adjusted after managed care is implemented were not clear.

Using MFP funds to help shift the balance of LTSS spending. Iowa is using MFP funds to transform an intermediate care facility for individuals with intellectual and developmental disabilities (ICF-IID) into a community-based care setting, and to retrain its staff as community providers, which will contribute to further rebalancing of the state’s LTSS system. One of the ICFs-IID in the state is currently deactivating its license to operate and refitting to support its transition to being a community-based LTSS provider. The MFP program is funding the cross-training of staff, as well visits to the new community setting by current ICF residents to “try it out and do an overnight.”

Mississippi: Using the Balancing Incentive Program to mandate and fund long desired changes to the LTSS system

State context and overall progress. In 2009, Mississippi spent just 18 percent of all LTSS expenditures on community-based LTSS, the only state that spent less than 25 percent of LTSS expenditures on community services. Based on Truven’s 2013 annual data (Eiken et al. 2015), Mississippi spent 26 percent on community-based LTSS by 2012, two years before it began participating in the program, exceeding the required 25 percent benchmark even before starting its Balancing Incentive Program. Preliminary expenditure data suggest that community-based LTSS had grown to approximately 29 percent of total LTSS expenditures by 2014.

Having the external pressure of the Olmstead rulings, and then of the Balancing Incentive Program, “helped get people on board” and support the rebalancing effort. Furthermore, having money to spend as a result of the enhanced FMAP received through the program “opened up doors” to dialogue about rebalancing efforts, where previously everything was “doom and gloom.”

Providing funding and changing expectations.

State staff explained that having the external pressure of the 1999 Olmstead ruling, and then the legitimacy of a large national grant program like the Balancing Incentive Program, gave notice to state personnel that working to rebalance the state’s LTSS system was a critical issue and needed attention. Crucially, the Balancing Incentive Program provided funding to increase the number of people served under waivers and to implement the Balancing Incentive Program structural changes. Beyond the use of federal funds to expand their 1915(c) waiver program, interviews with program staff revealed a variety of factors they felt had contributed to their success.

Implementing conflict-free case management.

Before the Balancing Incentive Program, state staff had concerns about conflict of interest in their case management processes. For example, they found that, when the case management agency was also a provider of home-delivered meals, everyone had home-delivered meals in their care plan, regardless of need. However, without a clear and generally accepted definition of conflict-free case management, they felt they lacked the support to address this issue. As state staff put it, through the Balancing Incentive Program, CMS for the first time “spoke clearly” about conflict of interest in case management; having a definition and a mandate to address it through the program gave Mississippi justification to implement systems to mitigate conflict of

interest for the first time. Under the Balancing Incentive Program, Mississippi has been able to separate assessment and care planning from service provision in most cases, and feels this will remove the incentive to provide unnecessary care.

A No Wrong Door system to expedite eligibility and enrollment, and support quality and conflict-of-interest monitoring. Mississippi is the only Balancing Incentive Program state that has implemented its electronic No Wrong Door system. As required under the Balancing Incentive Program, every No Wrong Door system must have a website with information on available services and contacts for more information. Mississippi's e-No Wrong Door system also allows people to complete an initial self-assessment and exploration of available services by entering their age, needs for assistance with activities of daily living, and basic financial information. Based on this information, the system produces a list of services the person might be eligible for and contact information for follow up. Users may then go to a No Wrong Door physical location to have a full functional assessment. The completed functional assessment is entered into the e-No Wrong Door system and, if the assessor is connected to the internet, is immediately uploaded to the electronic system. It can then be shared with other relevant agencies (such as agencies that operate a waiver program) or providers as appropriate, eliminating the need for duplicate data collection by separate agencies or providers and expediting the process for determining eligibility and enrollment into services. Because Mississippi's system collects, stores, and enables sharing of individual eligibility, assessment, service use, and case management data across agencies, it has allowed the state to streamline enrollment processes, connect people to services more quickly, and to monitor service provision.

Mississippi's e-No Wrong Door system supports oversight of service delivery through an EVV system. State staff monitor the system to ensure people are receiving the services in their care plan and to identify any patterns in care that might suggest inappropriate referrals due to conflicts of interest.

The electronic No Wrong Door system also supports state oversight and quality monitoring. For example, after a person is enrolled in a waiver, home visits are monitored through an electronic visit verification (EVV) system, and the data are shared with state agency staff. Monitoring the EVV data allows the state to ensure that people are receiving the services in their care plan and protect against fraud. By comparing assessments, care plans, and service use data collected by the system, state staff can determine any inappropriate use of particular services or providers.

STATE SURVEY OF FEATURES CONTRIBUTING TO REBALANCING

Based on our analysis of data from a survey the technical assistance provider for the Balancing Incentive Program (Mission Analytics Group) administered to all states participating in the Balancing Incentive Program in spring 2015, the strategies respondents thought had the greatest impact on rebalancing were (1) MFP or other transition programs, (2) an increase in the number of people the state could serve in a 1915(c) waiver program, and (3) implementation of a No Wrong Door system.⁷ For the most part, these findings were reflected in our interviews with the three case study states. Ohio, one of the most successful states at rebalancing, credited MFP

⁷ A summary of the survey results is available at www.balancingincentiveprogram.org (Mission Analytics Group 2015a).

as the backbone of its rebalancing progress. All three states used the extra funds to expand waiver slots and Mississippi spoke about the importance of the extra FMAP in tight budget times. Both Mississippi and Ohio also spoke about the perceived importance of the contribution their No Wrong Door systems have made to rebalancing.

Table 2. Top features cited by states as contributing to rebalancing success

Feature	Number of states citing feature as high or moderate impact
Supporting transitions out of institutions into the community through MFP demonstration or other transition programs	16
Additional waiver slots for the population with intellectual disabilities	14
No Wrong Door system (more entry points and/or streamlined assessment and enrollment processes)	13
Additional waiver slots for the elderly population	12
Additional waiver slots for other populations	9
Capitation rates that incentivize institutional diversions/transitions or the implementation of MLTSS	9
New services (for example, crisis reduction services, assistive technologies, or substance abuse services)	9
Closure of intermediate care facilities	8
Health homes	7
Conducting rate studies to determine appropriate rates for institutional and community LTSS providers	6

Source: Mathematica analysis of Mission Analytics Group 2015 Balancing Incentive Program state survey.

Note: This table only includes features that were rated as high impact by at least five states.

How states are using the Balancing Incentive Program enhanced FMAP funds

Ohio had a large amount of support from state general funds, and it used these funds to implement the Balancing Incentive Program structural changes. The state then used all the enhanced FMAP funding from the Balancing Incentive Program to expand community-based LTSS, including 1915(c) waiver slots and case management services.

Iowa used the enhanced FMAP from its Balancing Incentive Program to expand slots in all seven of its 1915(c) waivers, build the No Wrong Door system, develop its core standardized assessment, increase provider rates by 2 percent, and increase the number of people receiving services through its 1915(i) program.

Mississippi has used most of the enhanced FMAP from the program to expand the state's 1915(c) waivers. Other uses have included training for direct service workers, a rate study, expanding the No Wrong Door physical locations, development of the electronic No Wrong Door system, and expansion of its 1915(i) waiver program. Mississippi also spent funds on a children's collaborative to integrate behavioral and physical health, and a training program for community physicians to increase their capacity to serve individuals with intellectual disabilities. Finally, Mississippi is exploring how it could add an autism pilot to the state plan.

Notable examples of how the MFP demonstration has contributed to the success of Balancing Incentive Programs

Mississippi's housing locator service, which contributes to rebalancing by helping people obtain affordable community housing, was first provided as an MFP service and has been sustained with MFP rebalancing funds. People transitioning out of institutions with the help of the MFP program receive preference on housing waiting lists. Furthermore, Mississippi's Balancing Incentive Program stakeholder group was an off shoot of a group originally started in 2001 in response to the Olmstead ruling. It was repurposed for MFP and "kept growing" under the Balancing Incentive Program.

Ohio state staff explained that MFP formed the foundation for much of the work achieved under the Balancing Incentive Program. The two programs have the same project director, to ensure coordination. Ohio built on the work its MFP "front door" work group did to create the state's No Wrong Door system. The state also began working toward conflict-free case management under MFP, and built on the firewalls developed for the MFP program to meet Balancing Incentive Program requirements.

Iowa used MFP grant funds to transform an ICF into a community-based LTSS provider to support community living. MFP funds were used to retrain staff and to re-purpose the facility, as well as to deactivate its ICF license. MFP is also funding visits to the re-purposed facility by current ICF residents.

CONCLUSIONS AND DISCUSSION

The majority of states in the Balancing Incentive Program (11 of 18) achieved their balancing benchmark before the program ended, and those still working to achieve it during the final year of the program are making progress. Overall, the Balancing Incentive Program states are increasing the share of total LTSS expenditures devoted to community services and as a group, they are on the path to reaching the 50 percent benchmark. They are doing this by increasing their community-based LTSS share and by achieving small decreases in spending for institutional services.

The 1915(c) waiver expenditures have historically made up the majority of community-based LTSS expenditures across all states and changes in waiver expenditures will influence a state's ability to rebalance its LTSS system (Eiken et al. 2015). It is notable then, that spending on 1915(c) waiver programs had slowed in recent years among the Balancing Incentive Program states that had met their balancing benchmark by 2014. At the same time, expenditures for state plan personal care services in these states made up a large and growing proportion of spending for community-based LTSS. In these 11 states, state plan personal care services represented 28 percent of total community-based LTSS in 2014, compared to less than 1 percent in the participating states still working to achieve the balancing benchmark. These expenditure patterns among the early achieving states suggest that state plan services, particularly personal care services, which are available to all Medicaid beneficiaries who need LTSS, may play an important role in rebalancing. These results are also consistent with how states used their enhanced matching funds to support the development of new community-based LTSS programs,

including Community First Choice programs, which allow states to offer community-based personal attendant services and supports as a state plan service; and 1915(i) waivers for populations with mental illness or intellectual or developmental disabilities (Mission Analytics Group 2015b), a new optional program established by the Affordable Care Act that allows states to offer community-based LTSS as state plan services to targeted populations. Of the five states that used the enhanced funding from the Balancing Incentive Program to develop and implement a Community First Choice program, four (Arkansas, Maryland, New York, and Texas) had achieved the balancing benchmark by 2014. Six states used the Balancing Incentive Program funds to establish 1915(i) waiver programs, and four (Arkansas, Iowa, Mississippi, and New York) had achieved the balancing benchmark at least a year before the program ended. Even if the new programs were not large enough to affect community-based LTSS expenditures during the period studied, these early achieving states have demonstrated a strong commitment to strengthening community services.

This preliminary analysis suggests that the Balancing Incentive Program has played an important role in helping several states rebalance their LTSS systems. The three case study states cited federally mandated targets for rebalancing benchmarks, definitions of the structural changes required under the program, as well as dates to achieve these milestones, as factors that helped states move more quickly toward their rebalancing goals. The extra FMAP seems to have been particularly helpful to states such as Iowa and Mississippi that did not have strong state funding support for rebalancing efforts.

All 18 Balancing Incentive Program states participate in the MFP demonstration, and both the survey results and interviews suggest that the MFP rebalancing demonstration has been a key factor in the success of their rebalancing initiatives. These states have identified many ways that they braided together the funding from both programs to accomplish more than they could have with only a single program (Lester et al. 2013). Because states were already pushing to expand their community-based LTSS and provide beneficiaries with more options on where they receive these services, it was not surprising to find that some states were able to meet their balancing benchmark before they started their Balancing Incentive Program. These states could then use the additional funding and support from the Balancing Incentive Program to further strengthen and expand the LTSS systems.

Most, if not all, the states are expected to meet their balancing benchmark by the time the program ends on September 30, 2015; however, final analyses of program outcomes must wait until all states have completed their reporting of LTSS expenditure information. In addition, as this study notes, several states have used the additional funding from the Balancing Incentive Program to expand 1915(c) waiver programs and support the provision of other community-based LTSS. The concern is what will happen to these service expansions when the enhanced funding ends. Will all the states be able to maintain these service expansions, or will they have to contract in some way to accommodate state budget concerns? Studies that track the provision of community services relative to institutional care after the Balancing Incentive Program ends would inform this question and shed additional light on the overall effects of the demonstration. In the meantime, this preliminary analysis suggests that the Balancing Incentive Program has likely helped “tip the balance” of spending in some states. Our analysis also suggests that federal programs that supply extra funding that states can use for infrastructure building as well

as direct services, combined with defined deadlines and milestones can help to push states faster along the rebalancing path.

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METHODS AND DATA

Expenditures. We used annual LTSS expenditure data from Eiken et al. (2015) to analyze state LTSS expenditures through 2013 for all states. To develop community-based LTSS percentages for FFY 2014 for the Balancing Incentive Program states, we used CMS 64 quarterly data, downloaded from the MBES on June 3, 2015. We used two files to create our analytic file for the 2014 data: (1) the Financial Management Report (Net FMR) files, and (2) the detailed “Feeder files.” The Net FMR data were available for all states and they contain detailed expenditure information for all services provided by Medicaid programs at the quarterly level. We only used the Feeder files for the Balancing Incentive Program states and then only used the line items for capitation payments that these states were required to report beginning in 2013. We first classified each spending line item as either as community-based LTSS or institutional care, or neither. Those classified as community-based LTSS or institutional care were summed across the four quarters of FFY 2014 by line item, then totals for community expenditures were calculated separately from the totals for institutional care expenditures. We then created the community-based LTSS share by dividing the total for community service expenditures by the grand total for community and institutional care expenditures.

FFY 2014 data are preliminary. Because some providers may report claims up to a year after services are delivered, and states may submit updated CMS 64 data at any time, these data may change as state reporting becomes more complete. In addition, these data have not been adjusted by any methods (such as those used by Truven Health Analytics when developing their annual LTSS expenditure reports).

Identification of high-performing states. To characterize state progress during the Balancing Incentive Program period, we analyzed changes in the share of community-based LTSS spending using a variety of methods. Ultimately, we considered the state community-based LTSS share of expenditures in the year prior to program participation as the baseline and analyzed relative and absolute increases in the community share from the year before program participation to each quarter of program participation through calendar year 2014. We ranked states by the average absolute change, then ranked them a second time by the average relative change. We then created a ranking of rankings, a composite ranking that took each into account. The four highest ranked states were considered the high-performing states. These four ranked highly in the overall growth in the community-based LTSS share of total LTSS expenditures in both absolute and relative terms.

Case study methods. We selected the three case study states to represent a variety of starting points for state community-based LTSS expenditures before program participation, the increases achieved during the program in the community share of total LTSS expenditures, and differences in their use of MLTSS. We conducted telephone interviews with the three case study states in July 2015. Two state staff, including the Balancing Incentive Program project director of each state, participated in each interview.

Mission Analytics Group survey of Balancing Incentive Program states. Mission Analytics Group provided the raw data from a survey they administered to all Balancing Incentive Program states in June 2015. In this survey, states were asked to rank rebalancing strategies as low, moderate, or high impact. We analyzed these data to determine the factors most often cited as having either a high or moderate impact on rebalancing. Factors rated as having a high impact in at least five states were selected for inclusion in our analysis and are displayed in Table 2. To streamline the analysis, we combined items that described similar efforts into a single item (for example, we combined two separate items ranking the importance of MFP and of other transition programs into a single item).

Other data. In addition to interviews with states, and an analysis of the raw data from the survey of all Balancing Incentive Program states, we reviewed state “dashboards,” which are descriptive summaries of each state’s program, provided to us by Mission Analytics Group (2014). We used this data source to obtain information on the characteristics of the Balancing Incentive Program in each state.