

Is It Working?
Recommendations for Measuring Rebalancing in
Dual Eligible Demonstrations and MLTSS Waivers

Consumer recommendations provided by: *AARP, American Association on Health and Disability, American Association of People with Disabilities, Association of University Centers on Disabilities, the Arc, the Brain Injury Association of America, the Center for Medicare Advocacy, Inc., Community Catalyst, the Consumer Voice for Quality Long-Term Care, Families USA, Lutheran Services in America Disability Network, the National Association of Area Agencies on Aging, the National Association of Councils on Developmental Disabilities, the National Committee to Preserve Social Security and Medicare, the National Council on Aging, the National Health Law Program, National Disability Rights Network, the National Senior Citizens Law Center, the Medicare Rights Center, PHI-Quality Care through Quality Jobs, and United Spinal Association*

A growing number of states are shifting the responsibility for providing long-term services and supports (LTSS) for seniors and persons with disabilities to managed care organizations (MCOs). Some states are making this transition through the Financial Alignment Demonstrations (known as the dual eligible demonstrations) overseen by the Medicare-Medicaid Coordination Office. Others are using Medicaid waiver authority under Sections 1115, 1115A, or 1915(b)/(c).

States and the Centers for Medicare and Medicaid Services (CMS) have indicated that one goal of shifting to a managed care delivery model is to rebalance public spending on LTSS by increasing access to home and community-based services (HCBS). This is a goal that has been widely embraced by beneficiaries and their advocates. Increasing access to HCBS should lead to more people receiving the services and support they need at home and in the community instead of in more costly institutional settings. As more seniors and people with disabilities remain integrated in their communities and avoid institutional placements, Medicare and Medicaid costs will decrease.

Measuring rebalancing efforts is key to evaluating the performance of managed care programs. Simple measures that provide an overview of how the implementation of managed care has shifted LTSS spending will help beneficiaries make decisions about enrollment and policymakers make decisions about program modifications and expansion. Consistently applying measures to all MCOs and in all states will allow for easy comparison and identification of promising and troubling practices.

Unfortunately, the current waiver and dual eligible demonstration program agreements between states and CMS do not establish consistent metrics for comprehensively evaluating

rebalancing. Some agreements do not include any rebalancing measures, while others include incomplete measures. No one state is measuring everything it should. In states where some rebalancing measures do exist, it is unclear how performance outcomes under those measures will be shared publicly.

Building on some of the measures that states are or will be using, this paper outlines four measures that can be adopted by all states to evaluate their MLTSS program's impact on rebalancing. This paper also provides recommendations for sharing rebalancing results with stakeholders.

What is rebalancing?

Nationally, Medicaid spends more on institutional care than on home and community-based care for beneficiaries with LTSS needs. Rebalancing refers to the effort to achieve “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community-based supports.”¹

Why do state demonstrations and waiver programs need rebalancing measures?

States and CMS have indicated that rebalancing is a goal of dual eligible demonstrations and MLTSS waivers.² The only way to measure whether this goal is achieved is to track how the move to managed care impacts LTSS spending and delivery.

Are states measuring rebalancing in dual eligible demonstrations and MLTSS?

Yes, but not in a manner useful for comprehensive evaluation. Recent guidance from CMS, as well as state-CMS agreements, demonstrate some progress in measuring rebalancing. In May 2013, CMS issued guidance to the states on ten elements CMS considers when evaluating state proposals to establish an MLTSS program.³ The guidance requires states establishing managed care systems to support rebalancing⁴ and to develop quality measures focused on outcomes.⁵ Somewhat more detail has been provided by the recently released reporting requirements for the dual eligible demonstration (requiring measurement of nursing facility transitions) and the

¹ CMS provided the rebalancing definition in “Managed Long-term Care and the Rebalancing of State Long-Term Support Systems,” Robert L. Kane, et al. (2007), available at http://www.hpm.umn.edu/ltrsourcecenter/research/rebalancing/attachments/topicpapers/Topic_3_Implications_of_Managed_Long_Term_Care_for_Rebalancing.pdf.

² See, e.g., CMS, “Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs” (May 2013), available at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf (CMS Guidance); CalDuals, Frequently Asked Questions, www.calduals.org/background/faq (“California Governor Jerry Brown announced in January 2012 the Coordinated Care Initiative (CCI) to enhance beneficiary health and satisfaction, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community.”).

³ CMS Guidance.

⁴ CMS Guidance at 9.

⁵ CMS Guidance at 15.

state-specific requirements for the Massachusetts demonstration (requiring evaluation of access to LTSS).⁶ Overall, however, these measures fall short in capturing overall rebalancing progress.

Several state agreements for a dual eligible demonstration do include state-developed measures to evaluate state and plan progress toward rebalancing. Between the duals demonstrations and MLTSS Medicaid waivers, a rough framework of rebalancing measures exists.⁷ However, there is no consistency across states, and no states have implemented the comprehensive set of measures needed to capture the impact managed care is having on rebalancing.

What measures should all states adopt to measure rebalancing?

The following recommendations adhere to CMS' expectations for state quality strategies.⁸ These recommended measures were selected after evaluating the current body of rebalancing measures in CMS-state Memoranda of Understanding (MOUs)⁹ for the dual eligible demonstrations, and state MLTSS waiver approvals. The review identified four measures that should be adopted across all dual eligible demonstrations and MLTSS states to evaluate the impact of programs on rebalancing:

- 1. Number and proportion of beneficiaries receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution.¹⁰**

This basic measure will track how MLTSS is impacting enrollment in HCBS programs relative to placements in an institutional setting. Information should be reported by each MCO and across all MCOs so that state and federal regulators can spot promising as well as potentially harmful trends. Beneficiaries can factor in the MCO-specific information when making enrollment decisions. A baseline for this measure should be set prior to implementation and then tracked on an ongoing basis at least annually.

⁶ CMS, "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements," (effective Jan. 1, 2014), available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf>; CMS, "Final Contract Year 2014 Massachusetts State-Specific Reporting Requirements Appendix," available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014ReportingAppendixMA.pdf>.

⁷ Tables at the end of this paper give examples of rebalancing measures in use.

⁸ See CMS Guidance at 15.

⁹ See State Financial Alignment Demonstration Memoranda of Understanding (MOUs), available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

¹⁰ Institutional settings include a nursing facility (NF), an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/ID), and an institution for mental disease (IMD). See, e.g., Tennessee MCO Contract, pp. 168-69; Ohio MOU, p. 88; New Jersey Draft Quality Strategy, p. 5.

Various states have measures that provide this type of data. A table with examples of existing state measures is found at the conclusion of this paper.

2. Total HCBS and institutional expenditures as a percentage of total LTSS expenditures.

Measuring overall long term care spending is the most basic way to measure rebalancing. Nationally only 7 states spend over 50% of their aging and physical disability LTSS budgets on community-based care, and some states spend as little as 11% on HCBS.¹¹ MCOs have the potential to make considerable progress in rebalancing and to offer real choice to beneficiaries. This measure allows states and CMS to determine whether managed care is leading to a relative increase in expenditures for HCBS services and a relative decrease in institutional spending.

The Kansas MLTSS program provides a good example of this measure: *D=Total dollars spent on HCBS budget vs. N=total number of dollars spent on institutional costs. Report on overall LTC spending to assure an annual percentage shift in spending as a result of an increase in spending on HCBS services and a decrease on institutional spending.*¹²

3. Number and proportion of beneficiaries who transitioned to the community from an institution and did not return to the institution within a year.¹³

Successful demonstration and MLTSS programs will transition individuals out of institutions and back into the community. The transition to a home and community-based setting is only effective if the individual remains safe and healthy in the community and does not need to return to the hospital or facility due to lack of support. This measure helps regulators and MCOs understand whether transition efforts are working.

The Ohio dual eligible MOU suggests measuring this transition over a year: *Reporting of the number of Enrollees who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Enrollees who resided in a NF during the previous year.*¹⁴

¹¹ Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. September 2011, Exh. A7, available at http://assets.aarp.org/rgcenter/ppi/ltc/ltss_scorecard.pdf.

¹² Kansas, Medicaid State Quality Strategy June 2013, Attachment J, p. 81.

¹³ See Ohio MOU, p. 89; New Mexico MCO Contract, App'x B, p. 6; Tennessee MCO Contract, p. 340; New Jersey Draft Quality Strategy, pp. 12-13.

¹⁴ Ohio MOU, p. 89.

4. **Increase or decrease in the authorization of personal care hours.**

Under most dual eligible demonstrations and MLTSS programs, MCOs will have the discretion to increase or decrease personal care hours. Increasing hours for individuals can be an effective way to avoid institutionalization and achieve rebalancing.

Decreasing hours, on the other hand, could be counter to rebalancing goals and increase the chance of institutionalization and hospitalization. This measure should be tracked both at the individual and MCO level.

The Virginia dual eligible demonstration MOU provides a good example of a measure that tracks changes at the individual level: *Percent of waiver individuals who experienced a decrease in the authorization of personal care hours. Percent of waiver individuals who experienced an increase in the authorization of personal care hours.*¹⁵

Sharing measures with policymakers and stakeholders

Once measures are collected, it is important that they be synthesized and shared publicly with all stakeholders so that action can be taken in response to both positive and negative results.

There are at least five unique audiences that would use this data if they were readily and regularly available:

- State and federal policymakers to evaluate a state's MLTSS program when determining waiver renewals, modifications and expansion;
- Regulators to address problems and promote promising practices both at particular MCOs and across the system;
- Providers to assess challenges and achievements in their programs;
- Quality measurement entities to use in developing future measures;
- Advocates to push for program improvements; and
- Consumers to inform enrollment decisions.

To serve these audiences, rebalancing measures should be reported in a simple and concise form at least quarterly. Data should be presented both by MCO and on a statewide basis to help identify whether positive or negative trends are MCO-specific or program-wide. Using consistent measures across states will also allow for state-to-state comparisons that will help federal policymakers identify promising practices. Finally, performance on rebalancing measures should be incorporated into MCOs' overall quality ratings, reflected in an MCO's

¹⁵ See Virginia MOU, p. 95.

Medicare Star Rating for dual eligible demonstration plans or other rating system for Medicaid-only MLTSS programs.

Conclusion

Measures that evaluate the extent to which dual eligible demonstrations and MLTSS programs are impacting rebalancing are essential to holding these new programs accountable and verifying positive results. Basic measures exist, but these measures must be standardized and applied consistently across all states. These standard measures can serve as a floor upon which states can add more detail to test unique elements of their programs. In all cases, transparency and access to data are essential. No combination of measures will be effective in improving MLTSS unless the public has access to the information.

**Examples of Existing Rebalancing Measures in
Dual Eligible Demonstrations and MLTSS Programs**

What Is Measured	State	Language
Measure 1: LTSS in Community Versus Institution	Ohio MOU, p. 88	Reporting of the number of Enrollees who did not reside in a NF as a proportion of the total number of Enrollees in an ICDS [Integrated Care Delivery System] Plan. Numerator: of those Enrollees in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Enrollees in an ICDS Plan eleven out of twelve months during the current measurement year. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.
	New Jersey Draft Quality Strategy, p. 5	Number of members receiving HCBS and NF services just prior to implementation.
	South Carolina MOU, p. 122	Number and percentage of all enrollees referred to LTSS. Number and percentage of all enrollees referred to HCBS. Number and percentage of all enrollees referred to a long term care facility.
Measure 2: Total Spending for HCBS and Institution	Kansas State Quality Strategy, p. 81	D=Total dollars spent on HCBS budget vs. N=total number of dollars spent on institutional costs. Report on overall LTC spending to assure an annual percentage shift in spending as a result of an increase in spending on HCBS services and a decrease on institutional spending.
Measure 3: Transition to Community	New Mexico MCO Contract, App'x B, p. 6	Number of consumers who transition from NF placement that are served & maintained w/community-based services for six months.

What Is Measured	State	Language
Measure 3: Transition to Community	Ohio MOU, p. 89	<p>Reporting of the number of Enrollees who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Enrollees who resided in a NF during the previous year. <u>Long Term Care Rebalancing Rate:</u></p> <p><u>Numerator:</u> of those Enrollees in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year.</p> <p><u>Denominator:</u> Enrollees enrolled in ICDS plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months.</p> <p><u>Exclusions:</u> Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>
	Tennessee MCO Contract, p. 340	<p>The report shall include information, by month, on specified measures, which shall include but not be limited to the following:</p> <p>(1) Number of CHOICES members transitioned from a nursing facility</p> <p>(2) Of members who transitioned from a nursing facility, the number and percent of members who transitioned to:</p> <p>(a) A community-based residential alternative facility</p> <p>(b) A residential setting where the member will be living independently</p> <p>(c) A residential setting where the member will be living with a relative or other caregiver</p> <p>(3) Of members who transitioned from a nursing facility, the number and percent of members who:</p> <p>(a) Are still in the community</p> <p>(b) Returned to a nursing facility within ninety (90) days after transition</p> <p>(c) Returned to a nursing facility more than ninety (90) days after transition</p>

What Is Measured	State	Language
Measure 3: Transition to Community	New Jersey Draft Quality Strategy, p. 12-13	<p>MLTSS Members transitioned from NF to the Community: Numerator, Denominator and % of MLTSS members who transitioned from NF to the community.</p> <p>MLTSS Members transitioned from NF to Community who returned to the NF within 90 days: Numerator, Denominator and % of MLTSS members transitioning from NF to community who returned to the NF within 90 days.</p> <p>MLTSS Members transitioned from the Community to the NF for greater than 180 days: Numerator, Denominator and % of HCBS members transitioning from the community to the NF for a stay of greater than 180 days.</p> <p>HCBS Members transitioned from the Community to NF for less than or equal to 180 days: Numerator, denominator and % of HCBS members transitioning from the community to NF for a stay of less than or equal to 180 days. (NF Short Stay)</p>
	Medicare- Medicaid Capitated Financial Alignment Model Reporting Requirements p. 88	<p>Total number of nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the <i>previous</i> reporting period.</p> <p>Total number of members who did not reside in a NF for more than 100 continuous days during the <i>current</i> reporting period.</p>
Measure 4: Increase or Decrease of Personal Care	South Carolina MOU, p. 123	<p>Percent of enrollees receiving HCBS who experienced a decrease in the authorization of personal care hours. Compared across years of Demonstration.</p> <p>Percent of enrollees receiving HCBS who experienced an increase in the authorization of personal care hours. Compared across years of Demonstration.</p>
	Virginia MOU, p. 95	Percent of waiver individuals who experienced a decrease in the authorization of personal care hours. Percent of waiver individuals who experienced an increase in the authorization of personal care hours.