CHCS Center for Health Care Strategies, Inc.

Technical Assistance Brief

Balancing Incentive Program: Strengthening Medicaid Community-Based Long-Term Services and Supports

By Sarah Barth and Alice Lind, Center for Health Care Strategies

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The states and the federal government recognize the increasing demand for providing long-term services and supports (LTSS) in the community to promote a higher quality of life for Medicaid beneficiaries in the setting of their choice. The Balancing Incentive Program was created by the Affordable Care Act (ACA) to support this goal. The program provides enhanced federal funding for home- and community-based LTSS to states that commit to prescribed structural changes and targets for community-based LTSS expenditures.

States considering this new opportunity can potentially blend Balancing Incentive Program funding with enhanced federal funds from already-established Money Follows the Person (MFP) demonstration programs to increase LTSS capacity in the community.[1] This technical assistance brief from the *Center for Health Care Strategies* (CHCS) describes the structural changes required by the Balancing Incentive Program and outlines state considerations and potential approaches for meeting these requirements as described in their program applications to the Centers for Medicare & Medicaid Services (CMS).

Program Overview

Total funding for the Balancing Incentive Program over four years (October 2011 – September 2015) will not exceed $3 billion in federal enhanced matching payments. To date, CMS has approved Balancing Incentive Program applications for Georgia, Indiana, Iowa, New Hampshire, Maryland, Mississippi, Missouri, and Texas. Rhode Island and Virginia also have expressed interest in submitting applications. Table 1 shows projected funding awards for approved program applications, with sufficient funds remaining for additional states.

The Balancing Incentive Program calls for states to meet three structural requirements. Although states do not need to meet these requirements before applying, they must submit a final work plan within six months of application that describes activities for implementing structural changes. The following structural changes must be in place by September 30, 2015:

1. No wrong door/single entry point system (NWD/SEP);
2. Conflict-free case management; and
3. A core standardized assessment instrument.[2]

IN BRIEF

States are seeking ways to rebalance their system of long-term services and supports away from institutionally-based care and toward home- and community-based services. Participation in the Balancing Incentive Payment program offers states enhanced federal financing to fund non-institutionally based long-term services and supports (LTSS) within their Medicaid programs.

To obtain the enhanced contribution, states must demonstrate that they have three structural elements in their Medicaid LTSS delivery systems: (1) a "no wrong door/single entry point" system; (2) conflict-free case management; and (3) a core standardized assessment instrument. This brief describes these structural elements and provides an overview of states considerations and potential approaches to meeting these requirements.

Balancing Incentive Program Federal Contribution to Medicaid Non-Institutionally Based LTSS

- Five percent FMAP increase for states spending less than 25 percent of FY2009 LTSS expenditures for non-institutional care
- Two percent FMAP increase for states spending less than 50 percent of FY2009 LTSS expenditures for non-institutional care

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Table 1. Projected Funding for CMS-Approved Balancing Incentive Programs

State	Projected Funding (in millions)*
Georgia	$ 64.4
Indiana	$ 78.2
Iowa	$ 61.8
New Hampshire	$ 26.5
Maryland	$ 106.3
Mississippi	$ 68.5
Missouri	$ 100.9
Texas	$ 301.5
Total:	**$ 808**

*Based on actual expenditures for Medicaid non-institutionally based services.

Data Source: Centers for Medicare and Medicaid Services.

No Wrong Door/Single Entry Point

As noted in the Balancing Incentive Program implementation manual, NWD/SEP systems should "provide information on community LTSS, determine eligibility, and enroll eligible individuals into appropriate services."[3] The system must be statewide and provide individuals with the same experience and information wherever they access the NWD/SEP system. The statewide system must include:

- A system of designated NWD/SEPs (for Medicaid program information, eligibility determination, and enrollment assistance);
- A website providing information about LTSS options; and
- A toll-free number that connects individuals to the NWD/SEP.

CMS would like states to develop NWD/SEP systems that:

- Increase the accessibility of LTSS by providing information to individuals about programs and linking them to services.
- Offer a community LTSS enrollment system that increases uniformity across the state regarding how individuals are evaluated for services and how service needs are assessed.
- Provide a more streamlined experience for individuals using the system regarding information collection and exchange.[4]

States are at different points in developing statewide, uniform enrollment systems for LTSS. When considering their ability to meet the NWD/SEP structural requirement states should build on the current strengths of their systems. For example, states that already have longstanding entry points into the system may consider using established community organizations such as Aging and Disability Resource Centers (ADRCs) and Area Agencies on Aging to provide information and direct applications. Developing or enhancing working relationships with sister agencies on aging and those overseeing programs for individuals with physical or intellectual disabilities or mental health conditions to collaboratively build NWD/SEP systems is critical. For example, Georgia, one of the eight states with a CMS-approved application, was well-positioned for a Balancing Incentive Program because of progress it had already made toward developing a no wrong door approach and strong relationships with sister agencies.

Conflict-Free Case Management

The Balancing Incentive Program manual uses the following characteristics to define conflict-free case management:

- There is separation of case management from direct service provision.
- There is separation of eligibility determination from direct service provision.
- Case managers do not establish funding levels for the individual.
- Individuals performing evaluations and assessments or developing plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers with certain responsibilities.[5]

Few if any states have a completely conflict-free system per the above criteria. Thus, states operating fee-for-service LTSS systems as well as those with managed LTSS delivery systems may have concerns about meeting the requirements for conflict-free case management. Below are two scenarios that describe current case management structures that states will need to adjust or build in protections to meet Balancing Incentive Program requirements.

Applying for the Balancing Incentive Program: Georgia Continues Rebalancing Efforts

Georgia viewed the Balancing Incentive Program as a natural fit with its MFP program in its efforts to rebalance the LTSS system. With significant progress already made toward a no wrong door approach, Georgia was well-positioned to apply. The state already had an interagency agreement in place to provide options counseling with the Georgia State Unit on Aging within the Department of Human Services. Options counseling was already provided in all 12 regional Area Agencies on Aging (AAA) through Aging and Disabilities Resource Centers (ADRCs). Georgia also was receiving 90/10 federal funding made available via CMS' final rule "Medicaid: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities" to build a web-based model for submitting program eligibility applications. The web-based system will enable any entity throughout the state with approved access to assist with providing information for LTSS program eligibility.[6,7] The state leveraged existing collaborative relationships between the five partner organizations listed below to develop an integrated program strategy within its Balancing Incentive Program application:

- Department of Behavioral Health and Developmental Disabilities;
- Department of Human Services, Division of Aging Services;
- Council on Developmental Disabilities;
- Council on Aging; and
- Association of Area Agencies on Aging.

SCENARIO 1: Fee-for-Service - *Provider Develops Care Plan and Provides Services*

- Initial assessment conducted by state contracted county/local staff. Consumer selects a personal care provider from a list provided by local county staff.
- Personal care provider conducts a follow-up assessment and develops a care plan including service hours.
- Number of hours authorized is sent to prior authorization contractor for sign-off. Review is conducted with a copy of the initial assessment conducted by local county staff.
- Direct services are provided by the personal care provider that developed the care plan.

SCENARIO 2: Managed LTSS - *Case Management, Level of Funding and Direct Services Provided by Same Entity*

- State/AAA/ADRC does initial assessment for LTSS eligibility and conducts options counseling regarding setting of care (institution versus community). Client chooses institutional or community-based provider(s).
- Client choice is communicated by state/AAA/ADRC to managed care organization (MCO).
- MCO conducts assessment for care plan and determination of hours.
- MCO conducts case management.
- MCO network provider coordinates direct services.
- MCO identifies change in condition/need and adjusts plan.
- Annual eligibility redetermination (nursing facility level of care) is conducted by state or its contractor.

CMS encourages states with case management systems that currently may not meet Balancing Incentive Program requirements to still apply and submit a work plan for meeting conflict-free case management requirements. States may establish mechanisms to mitigate conflict of interest. The Balancing Incentive Program Implementation Manual identifies the following protections that may be established:

- Assuring that individuals can advocate for themselves or have an advocate present in planning meetings.
- Documenting that the individual has been offered choice among all qualified providers of direct services.
- Establishing administrative separation between those doing assessments and service planning and those delivering direct services.
- Establishing a consumer council within the organization to monitor issues of choice.
- Establishing clear, well-known, and easily accessible means for consumers to make complaints and/or appeals to the state for assistance regarding concerns about choice, quality, and outcomes.
- Documenting the number and types of appeals and the decisions regarding complaints and/or appeals.

- Having state quality management staff oversee providers to assure consumer choice and control are not compromised.
- Documenting consumer experiences with measures that capture the quality of case management services.

Core Standardized Assessment Instrument

States that receive Balancing Incentive Program funds are required to develop "core standardized assessment instruments." Notably, states are *not* required to develop a single assessment tool, but rather to establish assessment processes that are standardized across the state "to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs."

The Balancing Incentive Program requires states to design uniform processes for:

- Determining eligibility for Medicaid-funded LTSS;
- Identifying individual's supports needs/assessment; and
- Providing information to identify and inform beneficiary's service and support planning needs (plan of care).

As detailed in the Balancing Incentive Program Implementation Manual, states are requested to develop a two-stage process of screening and assessment (called Level I and Level II assessments).[8] While some content overlaps across Level I and Level II assessments, the Level II assessment is more detailed. It should be performed in person (ideally in the home), and goes into the depth needed to develop the plan of care. The manual provides helpful guidance on the assessment process (Core Standardized Assessment or CSA) and the required core elements (Core Data Set or CDS), as well as providing multiple examples of states that use standardized tools for their LTSS population. CMS offered states the opportunity to use a prototype CSA, but still gives states the flexibility to develop their own assessment tool, as long as it includes the required elements in the CDS.

The Balancing Incentive Program Implementation manual offers a crosswalk that states can use to compare their existing assessment tool to the required data set. It is also available as an interactive online form through the Balancing Incentive Program technical assistance website.[9] Domains for the CDS include: (1) Activities of Daily Living; (2) Instrumental Activities of Daily Living; (3) Medical Conditions; (4) Cognitive Functioning; and (5) Behavior. Within these domains, the manual offers sample questions from state assessment tools for each focus area of data collection. For example, NY COMPASS is used as a source of questions about mobility; Wisconsin's LTC Functional Screen is used for questions about transferring; and MN Choices is used for questions about shopping. The manual's appendices (G and H) include a crosswalk outlining how states used CDS elements, including references and links to the tools cited.

Implementing Core Standardized Assessments: Plans from Three States[10]

Proposals from states indicate their plans for moving to a CSA using standardized data collection instruments:

Iowa has stakeholder support to begin using the Supports Intensity Scale (SIS)[11] for individuals with Intellectual and Developmental Disabilities (I/DD), and the Level of Care Utilization System[12] for people with mental illness. These are proprietary tools that support care planning for specific populations. They can be used in combination with other state instruments but are not modifiable. Both tools are described as reliable when used according to instructions by trained professionals.

Maryland has piloted and plans to continue using the SIS for its persons with I/DD under its MFP program. Under the Balancing Incentive Program, the state is planning to implement the interRAI-Home Care tool[13] as its CSA for most populations. The interRAI-HC is a proprietary, validated instrument that is designed for assessment and care planning for individuals in home and community settings. Maryland's Balancing Incentive Program application includes plans for training ADRC and local health department staff in the use of the interRAI-HC and automation of the tool during 2013. Maryland's plan to integrate the nursing facility Minimum Data Set collection into the automated LTSS assessment system is a promising practice that should enable smoother transitions from facility-based care to home and community settings. An additional tool, the interRAI-Community Mental Health, is also under consideration to implement in Maryland. Notably, the state has collected stakeholder feedback through public meetings on the choice of instruments.

Mississippi already uses an automated system of assessment for most of its home- and community-based services (HCBS) waiver programs. Under the Balancing Incentive Program, it plans to standardize and automate the assessment process for its I/DD population, bringing its assessment under a single CSA process with other waiver programs.

Balancing Incentive Program Reinvestment in Community-Based LTSS

The Balancing Incentive Program's enhanced federal financial match will enable states to reinvest in LTSS delivery systems and support a greater number of individuals in need of LTSS in the community rather than institutions. States may also use MFP Administrative and Rebalancing Funds, with CMS approval, to meet many of the goals of the Balancing Incentive Program and rebalance their LTSS community-based programs.[14] The eight states currently participating in the program have varying strategies and levels of detail in their Balancing Incentive Program applications to increase LTSS HCBS capacity in the community.

Georgia plans to use its Balancing Incentive Program-enhanced federal match to further rebalance the state's LTSS community-based delivery system by:

- Expanding the number of slots in 1915(c) Medicaid waiver programs;
- Providing increased reimbursement for pediatric home health services;
- Funding three new community-based services (case management, rehabilitation-targeted employment services, and community living supports to people with serious and persistent mental illness) subject to CMS approval, for Medicaid recipients with persistent behavioral health needs;
- Expanding intensive community-based services to youth with serious emotional disturbances and their families;
- Expanding their pediatric program's medically-fragile day care service through slot expansion and age expansion;
- Adopting ADRCs as the primary point of entry for HCBS; and
- Providing web-based training on community-based LTSS available to targeting referral.

Conclusion

The Balancing Incentive Program provides states with an opportunity to build on and align current efforts to rebalance LTSS systems to community-based settings. The enhanced federal funds currently available through MFP and the 90/10 match available via CMS final rule "Medicaid: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities" can be maximized by participation in the Balancing Incentive Program. These initiatives and the structural changes required by the Balancing Incentive Program fit together to create a more person-centered and accessible LTSS community-based delivery system. When considering applying for the Balancing Incentive Program, states do not need to have all the required structural elements (NWD/SEP, conflict-free case management and capturing CDS during assessments) in place before submitting an application. States should look to build on current initiatives, work with CMS to identify needed changes, and develop a work plan to meet the requirements by September 2015.

Endnotes

[1] Forty-three states and the District of Columbia states have created MFP demonstration programs to date. MFP provides services and administrative and rebalancing funds to strengthen community-based systems that complement the Balancing Incentive Program's required structural changes and enhanced federal matching funds to enable states to strengthen the administration, design and delivery of LTSS in the community.
[2] *The Balancing Incentive Program: Implementation Manual.* Mission Analytics Group, October 2011. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/Balancing-Incentive-Program.DOCX.
[3] *The Balancing Incentive Program: Implementation Manual*, op. cit.
[4] *The Balancing Incentive Program: Implementation Manual*, op. cit.
[5] *The Balancing Incentive Program: Implementation Manual*, op. cit.
[6] *The Balancing Incentive Program: Implementation Manual*, op. cit.
[7] Georgia Department of Community Health Application for Balancing Incentives Program Grant. March, 2012.
[8] *The Balancing Incentive Program: Implementation Manual*, op. cit.
[9] Mission Analytics Group. Balancing Incentive Program. "Crosswalk between Core Standardized Assessment (CSA) and Core Dataset (CDS)." Available at:http://www.balancingincentiveprogram.org/resources/crosswalk-between-core-standardized-assessment-csa-and-core-dataset-cds.
[10] Mission Analytics Group. Balancing Incentive Program. "State Applications." Available at: http://www.balancingincentiveprogram.org/resources/state-applications.
[11] American Association on Intellectual and Developmental Disabilities. "Supports Intensity Scale." Available at: http://www.siswebsite.org/.
[12] Deerfield Behavioral Health, Inc. "Deefield Locus." Available at: http://www.dbhn.com/index.cfm/software/
[13] inter-RAI. Available at: http://www.interrai.org/index.php?id=94.
[14] *The Balancing Incentive Program: Implementation Manual*, op. cit.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. Its program priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. For more information, visit www.chcs.org.

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