State Progress on Balancing Incentive Program and Community First Choice

August 3, 2012
Friday Morning Collaborative

With support from The SCAN Foundation, NCOA leads a coalition of national aging and disability organizations working to protect and strengthen Home and Community-Based Services.

For more information about The SCAN Foundation visit: www.TheSCANFoundation.org
Friday Morning Collaborative

- American Association of People with Disabilities
- AARP
- Alliance for Retired Americans
- American Network of Community Options and Resources
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer’s Association
- Balezon Center for Mental Health Law
- Community Catalyst
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Leading Age
- Lutheran Services in America
- National Alliance for Caregiving
- National Association of Area Agencies on Aging
- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Domestic Workers Alliance
- National Health Law Program
- National PACE Association
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- United Spinal Association
- VNAA – Visiting Nurse Associations of America
Webinar Overview

• Introduction
  – Joe Caldwell (National Council on Aging)
  – Benjamin Salentine (National Council on Aging)

• Speakers
  – Eric Saber, Maryland Department of Health and Mental Hygiene
  – Kristi Plotner, Mississippi Division of Medicaid
  – David Ivers, Easter Seals Arkansas
  – Justin Foley, SEIU

• Questions and Answers
  – 20 – 30 minutes

• Closing Remarks
Questions and Comments

All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Function
Power Point

• Can I get a copy of the Power Point?
• Will an Archive of the webinar be available?

YES!  YES!  YES!

• You will received copies in a follow up e-mail early next week. Please share wit others!
Setting the Stage

• New opportunities in the Affordable Care Act (ACA)

• 6 states have now been approved for Balancing Incentive Program (BIP):
  – New Hampshire, Maryland, Iowa, Mississippi, Missouri, and Georgia

• Two states have applied for the Community First Choice (CFC):
  – California
  – Louisiana

• MANY OTHERS ARE CONSIDERING THESE PROGRAMS
  – Let us know if your state is applying for these programs
Balancing Incentive Program and Community First Choice

Eric Saber
Health Policy Analyst
Maryland Department of Health and Mental Hygiene
Agenda

- Balancing Incentive Program
  - Background
  - Application and Work Plan
  - Maryland’s Structural Changes
  - Spending the Enhanced Match
- Community First Choice
  - Background
  - Maryland’s Proposal
  - Rationale For CFC
  - Current Status
Balancing Incentive Program - Background

• Offers an enhanced federal medical assistance percentage (FMAP) for all HCBS covered during the “balancing incentive period” through September 30, 2015.
  – Maryland awarded a projected $106 million for the Balancing Incentive Program (2% of projected expenditure through 2015).
  – All enhanced federal payments must be used to fund new and expanded Medicaid community-based LTSS.
  – $3 billion in total BIP funding available, only 6 states have been approved; additional funds are still available.

• States must initiate “structural changes” to their LTSS systems that include:
  – Creation of a Single Point of Entry system for LTSS;
  – Development of a Standardized Assessment Instrument;
  – Implementation of Conflict Free Case Management.

• By the end of the BIP period states must:
  – Increase HCBS to 50% of total Medicaid LTSS spending;
  – Implement required structural changes.
BIP – Application and Work Plan

• Time commitment
  – Writing and editing.
    • Use existing grant proposals, operational protocols and program guidance.
  – Meetings and town halls with stakeholders.
  – Coordinate with other agencies.
    • Find strengths and build on them.

• Recommendations
  – Keep to the work plan and forms provided by CMS.
  – Use CMS technical assistance and contact other States.
  – Design a work flow and person flow so everyone in the State accessing LTSS can understand.

• Ongoing Reporting
  – Quarterly status updates based on approved work plan and quarterly submission of CMS 64.
BIP – Maryland’s Structural Changes

• Core Standardized Assessment
  – Reviewed possible assessments and selected with stakeholder input. May use multiple assessments that focus on a certain population.

• No Wrong Door / Single Entry Point
  – Maryland’s ADRC sites are already established around the State.

• Conflict-free Case Management
  – Review regulations and contracts. Consider overall structure of how enrollment, assessment and plans of care affect service provision.
BIP – Spending the Enhanced Match

• Expenditure of BIP funds must meet three criteria:
  – Increase offerings of or access to non-institutional LTSS;
  – Expansion and/or enhancement must benefit Medicaid participants;
  – Be an allowable Medicaid expenditure.

• Discuss with CMS ideas to spend the grant.
  – There is no formal submission and approval process.
  – Maryland is considering pilot programs, start-up costs to new programs, rates, waiver slots and more.

• Staffing
  – Increased staffing needs after approval
    • Maryland plans to have a project officer and contractual staff to manage contracts and structural changes.
Community First Choice - Background

- **State Plan Option**
  - To provide person-centered home and community-based attendant services and supports statewide.

- **Increased Federal Match**
  - Provides the State with a 6 percent increase in federal match for the CFC program.

- **Participant Eligibility**
  - Participant must meet institutional level of care for a nursing facility, ICF-ID, hospital, institution for psychiatric services under the age of 21 or an IMD for individuals over 65, and be eligible for Medicaid under an eligibility group that provides nursing facility services.
  - Maryland will cover all State Plan and waiver participants that meet the above criteria. CFC will not create a new financial eligibility group.
CFC - Maryland’s Proposal

- To carve out all allowable CFC services from three existing programs (two waivers and the State Plan program) into one CFC program:
  - Personal / Attendant Care;
  - Personal Emergency Response Systems (PERS);
  - Voluntary training for participants;
  - Transition Services; and
  - Services that increase independence or substitute for human assistance.

- Provide nurse monitoring and supports planning under CFC.
- Run a parallel program for those persons needing personal care but do not meet institutional level of care criteria.
- Maryland predicts some overlap with other waiver programs, but, due to program structure, does not predict an increase in participants from other waivers.
CFC – Rationale For CFC

- More services offered to our current State Plan Personal Care participants and no interruption of services for the waiver participants.
- Federal match pays for the additional services and increased rate.
  - By consolidating services within three programs, Maryland will leverage expenditures to get the most of the increased match.
  - Trended clients, units and expenditure for the past 4 years and adjusted for policy changes. Projected total budget, hours served and usage for additional services in our State Plan program. Rates to be determined based on budget and projected hours served.
- Offers a path to make consistent policy decisions and rates across programs.
CFC – Current Status

• Implementation council:
  – Helping to identify program roles and plan self-direction.
  – Meets when necessary (once or twice each month) but will have a standard schedule when the program begins.

• Writing State regulations using current programs as a template and applying lessons learned from consumers on the council.

• Developing methodology to enroll providers through regulations or contracts.

• Writing State Plan Amendment to be submitted later this fall to CMS.
Visit our website or E-mail

- [http://mmcp.dh mh.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Reform.aspx](http://mmcp.dh mh.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Reform.aspx)

- DHMH.LTCREFORM@maryland.gov
Opening Doors to Community-Based Care

Kristi R. Plotner, LCSW
Mississippi Division of Medicaid

August 3, 2012
National Council on Aging Webinar

Mississippi-at-Home
a Balancing Incentive Program

Mississippi Division of Medicaid
Office of the Governor
Walter Sillers Building, Suite 1000
550 High Street
Jackson, MS 39201
Uniquely Mississippi

• 5% FMAP savings
totals about $68.5 M over 3.25 yrs
• Increase community-based care to 25% of overall LTSS
• Lead agency- Medicaid

Mississippi-at-Home

Opening Doors to Community-Based Care
Why Apply?

– Previous slide
– Great opportunity to reinvest savings in community based care
Coordination with other projects:

- Bridge to Independence (MFP)
- Housing Planning Grant and 811 Project Rental Assistance Grant (pending)
- Aging and Disability Resource Center Grant to Department of Human Services (pending)
- Adult Health Quality Measure (considering)
- Waiver renewals
Required Structural Changes

• No Wrong Door
• Conflict-Free Case Management
• Core Standardized Assessment Instruments

Mississippi-at-Home

Opening Doors to Community-Based Care
Additional Structural Changes

• A Multi-Year HCBS Research Project
• HCBS Quality Assurance Improvements
• Public Health Communication Plan
• A Strategic HCBS Plan
HCBS Research Project

• Analyze the current HCBS delivery system to identify and explain service territory vacuums and administrative “red-tape” barriers to HCBS expansion

• Determine prevalence of disabilities and chronic health conditions that most commonly lead to institutionalization and analyze social and environmental contributing factors

• Package data collection across studies to allow for data-driven financial decisions regarding HCBS service
Quality Assurance Improvements

- Evaluate Medicaid’s compliance review policies and procedures across HCBS program areas
- Implement risk mitigation policies and procedures
- Clear practices for holding providers accountable
- Enforce discharge planning policies to slow “revolving door” phenomenon
Public Health Communication Plan

- Create a cultural shift in thinking whereby institutional placement is considered the option of last resort
- Coordinate with physicians to identify solutions for assessing and treating people with chronic health and psychiatric conditions in the community
- Implement a strategic beneficiary education campaign addressing solutions to social, economic, environmental, and health challenges to HCBS
- Convene LTSS stakeholders
Strategic HCBS Plan

• Evaluate waivers for opportunities to streamline and consolidate where appropriate to simplify the process for consumers
• Evaluate potential for true “conflict-free case management” where care/service plan development and service delivery are performed by separate agencies
• Build on new policies in recent IL and E&D waiver renewals
• Streamline administrative functions where possible
We’ve already:

• Included self-direction policies in 2012 E&D and IL waiver renewals
• Continued growth of HCBS compared to overall LTC
•Began moving people to the community with:
  • Transition to Community Referral through Nursing Facility Minimum Data Set
  • Bridge to Independence
• Initiatives in place to improve care/service plan compliance review in HCBS programs
• Met with State Agency Partners to build consensus
We will build it together, working with stakeholders

Work plan development:

CMS allows a 6-month window to develop a finalized work plan. DOM has until Nov. 1, 2012, to deliver the plan to CMS.
Stakeholder Involvement

Learning Collaborative

• Engages stakeholder subgroups in available Technical Assistance
• Allows detailed work by experts and interested parties focused on specific areas
• Looks at the whole picture for Rebalancing by including all efforts under one umbrella
• Has a governing Advisory Board
• Kickoff is August 2012
Financing, Saving & Spending

- **Financing**
  - MFP Funds
  - Other related projects

- **Saving**
  - Special fund set aside for savings to track savings and spending

- **Spending**
  - Considering waiver capacity (slots and services), training for direct care professionals, rates, pilot programs and more
  - Decisions will be made with input from Learning Collaborative and State Agencies providing the match (sustainability is consideration)
Having the conversation....

• Have information
• Be ready to help
• Advocate for Agency budgets that prioritize LTSS
Opening Doors to Community-Based Care

THANK YOU!

Mississippi-at-Home

| www.Medicaid.ms.gov |
CFC – At a Glance

- Offers states additional flexibility to finance home and community-based services (HCBS) attendant services and supports.
- Provides 6% enhanced federal match (permanent).
- State plan, not waiver, so services must be provided statewide, to all who qualify (entitlement).
- Services must be provided without discrimination based on age, type or severity of disability, or form of services required.
- State must spend as much or more on HCBS as in prior year.
- Requires Development and Implementation Council with majority elderly, people with disabilities, and representatives.
CFC and Advocates

- Culture of protection has grown up around “waiver” services.
- No state plan equivalent (before CFC) and waiting lists are often long.
- States can use Development & Implementation Council to help with transition.
Providers still trying to understand CFC.
Providers not used to this much change.
Providers feel there must be a “catch.”
States need to share data with providers and encourage realistic proposals.
Providers must work together -- CFC does not work unless providers cross traditional silos.
• CFC most affordable for those states that offer fairly extensive personal assistance through state plan personal care or 1915(c) waivers
• Offers potential for state and providers to gain efficiencies through standardization, reduced administrative hassles
• Promotes greater integration of programs, funding, and state administration
In Arkansas, preliminary figures show the state could serve existing beneficiaries and those in developmental disabilities waiver with enhanced match.

DD typically has greater per person average costs and wait list, so may have most to gain.

Other groups want greater variety of services, increased flexibility and simply better reimbursement.
CFC Advantages

- CFC likely to bring about
  - increased flexibility (rules have to accommodate all populations),
  - fewer admin hassles (if state integrates admin functions),
  - perhaps greater variety of services but with caps,
  - better integration of services across populations (esp. helpful for elderly DD or MI; DD with MI; and so on).
Published May 7, 2012 at 77 Federal Register 26828, effective July 6, 2012.
Considerable flexibility for states
All individuals must meet inst. LOC – reversed position in proposed rule – more complex analysis now
Design Decisions

- For those who do not meet inst. LOC --
  - Do not provide services
  - Offer same services without 6%
  - Offer more limited package
CFC and Cost Containment

- State can limit amount, duration, and scope if non-discriminatory
- May be key to containing costs if universal assessment does not
CFC Service Models

- Agency–provider model
- Self–directed model
- Other, if approved by CMS
CFC Eligibility Issues

- If income greater than 150% FPL, must be in eligibility category that includes nursing facility services

- Catch–22: How to maintain eligibility for individuals with income above regular Medicaid threshold if state eliminates waiver?
CFC’s Inherent Tension

“States may not differentiate the benefit package; however, services must be provided to individuals based on their needs.” (Final Rule)
CFC Provider Concerns

- Licensure/Competition
- Desire to maintain specialized services
- Giving up segregated funding across populations
- Limits on amount, duration, and scope
**CFC Budgetary Analysis**

- **Create flowchart:**
  - Does service qualify as CFC?
    - Yes – continue
    - No -- exclude
  - Is the service currently offered to all populations? If not, could it be?
    - Yes – continue
    - No -- exclude
  - Do additional populations have to be added? If yes – cost.
  - Is it a State Plan or waiver service now?
    - If State Plan, what % of beneficiaries meet ILOC? (6% FMAP gain for those)
    - If waiver, everyone currently served means 6% gain
    - If waiver, anyone on waiting list means additional cost.
    - “Woodwork” due to entitlement, enhanced services? If yes – cost.
Practical CFC Considerations

- Must crosswalk old state plan and waiver programs into CFC
- Requires comparing each state plan and waiver program with services that could qualify as CFC and then regrouping chosen ones under CFC
- Must identify “gaps” – populations/ages not served currently
Many if not most in MI population unlikely to meet ILOC
1915(i) offers more promise
CFC + BIP

- States permitted to stack CFC + BIP
- CFC can be used to build BIP work plan
- Universal assessment a key feature of both CFC and BIP
Reimbursement Modeling Under the State Balancing Incentive Payment Program (BIPP)

—or—

“How much more money could we get?”

For the NCOA Friday Morning Collaborative, 8/3/12
What states can get it?

• Based on FY09 LTSS spending

• MOE requirement equal to 12/31/10

• What counts:
  • **Institutional**: NF, ICF-MR, IMD, Medicare LTC hospitals, non-IMD psych hospitals
  • **HCBS**: Waiver services, State Plan HH & PC, more
  • Managed Long Term Care services (could be either)
  • CMS indicates flexibility
Estimating a $ figure

- Assumes basis of same total LTSS spending
- Annual figures assume all four years
- Total presented is annual average
- This is what you may get - not what you’ll have to spend to get it
**Method 1 – Adding on FMAP Bump**

Estimate using state at 2009 43% HCBS (2% FMAP)
Method 2 – HCBS Replaces Institutional

HCBS Goal (50%)

HCBS

Institutional

Total LTSS

2008  2009  2010  Y1  Y2  Y3  Y4
Method 3 – HCBS Growth, Institutional Flat

- HCBS Goal (50%)
- HCBS
- Institutional
- Total LTSS

2008 2009 2010 Y1 Y2 Y3 Y4
## Annual $ (avg. Methods 2 and 3)

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Data source: Center for Medicaid and Medicare Services, Patient Protection and Affordable Care Act, Section 10202, State Balancing Incentive Payment Program, Initial Announcement, Attachment C. 

Justin Foley, SEIU Healthcare
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To Ask A Question
Use the Chat Function
Continue the Conversation

Join to discuss what you learned today!

www.NCOACrossroads.org/HCBS

• Online community with over 300 aging and disability advocates across country interested in home and community-based services
  – Listserv and message board functions
  – Share information and resources with others
  – Post questions and discuss issues

• Please complete follow up survey
Next Webinar

State Advocate Experiences in Managed Long-Term Services and Supports
August 17 2:00 – 3:30 PM ET

- Gordon Bonnyman, Tennessee Justice Center
- Valerie J. Bogart, Evelyn Frank Legal Resources Program, Selfhelp Community Services, Inc.
- Mitch Hagopian, Disability Rights Wisconsin