Highlights of State Activities

BALANCING INCENTIVE PROGRAM

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Introduction

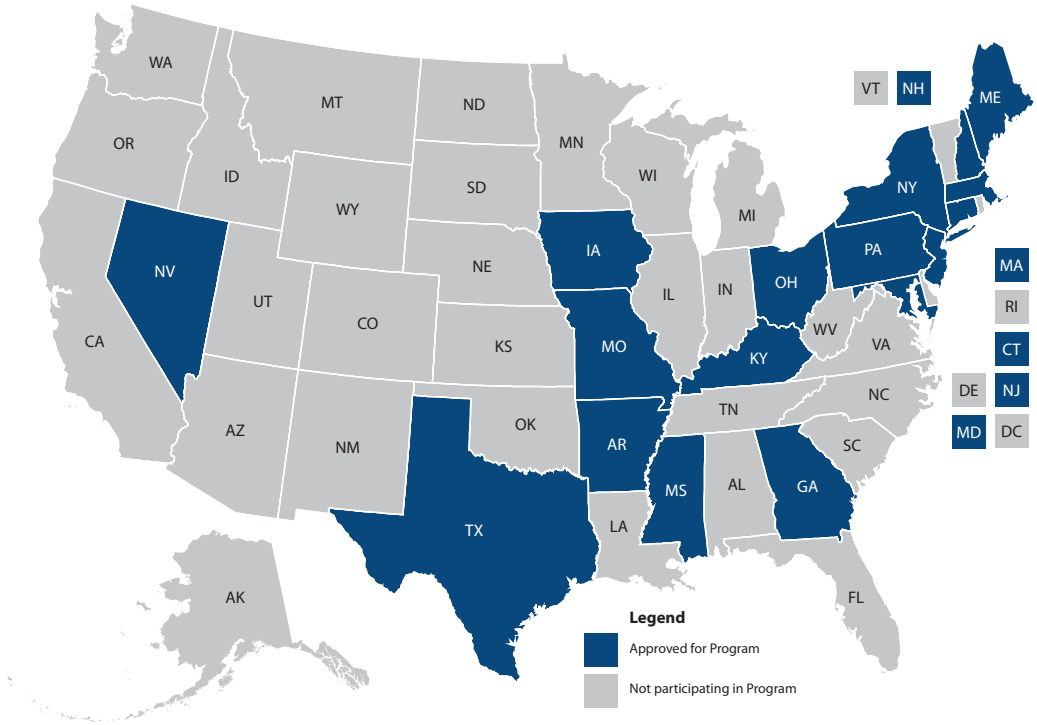
The Balancing Incentive Program, authorized by Section 10202 of the 2010 Affordable Care Act (ACA), aims to improve access to community-based long-term services and supports (LTSS). Through September 30, 2015, participating states receive enhanced Federal Medical Assistance Percentage (FMAP) on eligible services. States that spent less than half of their total LTSS dollars on community LTSS in 2009 receive 2% enhanced FMAP; states that spent less than 25% receive 5% enhanced FMAP.

As part of the Program, participating states are required to:

- Undertake structural changes, including a No Wrong Door (NWD) system, a Core Standardized Assessment (CSA), and conflict-free case management
- Spend Program funds to enhance community LTSS
- Meet the "Balancing Benchmark," i.e., spend a certain percentage of total LTSS dollars on community LTSS, (25% or 50% depending on the 2009 starting point)

States began applying to the Program on a rolling basis in 2011. New Hampshire, the first to enroll, began receiving payments in April 2012. Eighteen states are participating in the Program as it comes to a close in 2015. Over the life of the Program, states will earn approximately $2.5 billion of the $3 billion allocated by Congress. The Program equipped states to improve access to and the quality of community-based LTSS. Through additional Medicaid services and infrastructure supported by the Program, states offered new and enhanced services and increased awareness of these services. States also created more coordinated and standardized eligibility determination and enrollment processes.

This document summarizes state activities related to the structural changes (NWD system, CSA, and conflict-free case management) and the use of enhanced FMAP. All information was pulled from quarterly progress reports, monthly calls with state Program staff, state deliverables, and state work plans.



All eighteen Balancing Incentive Program states (as of 2015)

No Wrong Door (NWD) System

The NWD system aims to provide individuals with information on community LTSS, determine eligibility, and enroll eligible individuals in appropriate services. Although NWD systems can take many different forms, the systems should facilitate three main goals:

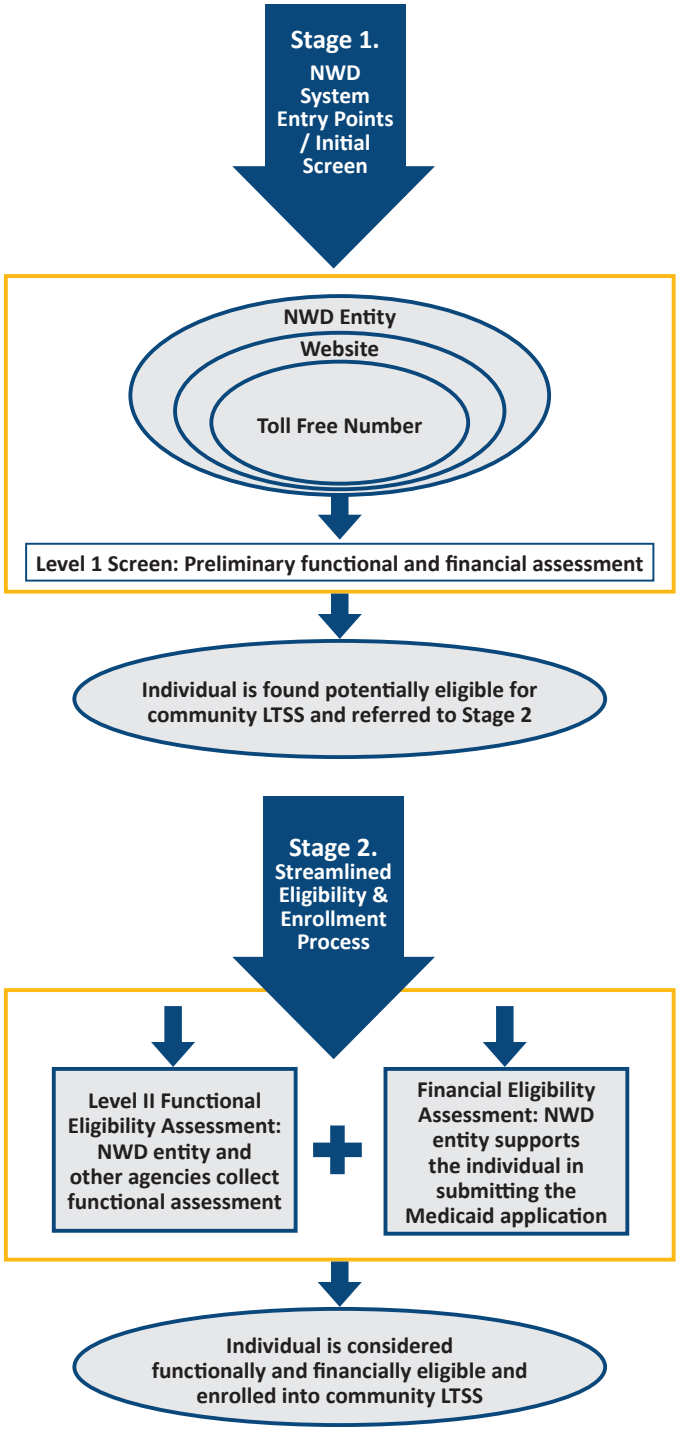
- Increase the accessibility of community LTSS by making it easier for individuals to learn about and be linked to services.
- Provide uniformity in eligibility determination processes across the state.
- Result in a more streamlined and coordinated process from the perspective of the individual.

The figure to the right illustrates an idealized NWD system with two main stages. Within Stage 1, individuals making inquiries about community LTSS can enter the system through three main entry points: a NWD entity physical location, informational website, or toll-free number. They then complete an initial screen (Level I), which collects preliminary financial and functional data and points to potential needs and program eligibility. This screening may be completed online or conducted over the phone or in person by trained, designated NWD staff.

Only applicants who are considered potentially eligible at the Level I screen receive the comprehensive Level II functional assessment during Stage 2. The assessment, completed in person, determines individuals' clinical need for community LTSS. If individuals are also determined financially eligible, they are enrolled in Medicaid-funded community LTSS programs or waivers. If individuals are not considered eligible at this point, they are referred to non-Medicaid services, ideally with the support of the NWD system.

This section discusses state activities regarding the three entry points to the system (NWD entities, toll-free number, and informational website), in addition to state efforts to automate NWD system processes.

No Wrong Door System Flow



NWD Entities

The Balancing Incentive Program requires states to create a network of organizations that serve as physical entry points where individuals can receive comprehensive information on applying for community LTSS. These agencies are referred to as NWD entities.

Expanding the NWD System

In creating a NWD entity network, states considered the overall accessibility of the NWD entities, including where the NWD entities were located relative to individuals seeking services. The geographic area served by a physical NWD entity is referred to as its "service shed." Ohio's service shed areas are depicted in the map below. Ideally, all individuals, including older adults and individuals with disabilities, would be able to travel to the physical NWD entity by car or public transit and return home within a single day. In Massachusetts, 99% of the population is within 50 miles of a NWD entity. Many states converted their pre-existing Aging and Disability Resource Centers (ADRCs) or their Area Agencies on Aging (AAAs) into NWD entities. These ADRCs and AAA centers were already a frequent point of contact for individuals seeking LTSS.

Service sheds of Ohio's Area Agencies on Aging (AAAs)

In order to expand the physical NWD entity network, some states formalized partnerships with non-ADRCs, while others developed new NWD entities through requests for proposals. To create a NWD system, Illinois merged its ADRC network with entities that include Centers for Independent Living, Independent Service Coordination Agencies, and local offices of the Department of Human Services and the Department of Rehabilitation Services. Iowa began the Program with a complete overhaul of its ADRC network, redistricting AAAs from 13 to six to form the foundation of the NWD system. The new AAAs were designated to be the lead agencies in Iowa's ADRC capacity building effort. Simultaneously, Iowa developed Mental Health and Disability Regions (MHDRs) from 99 independent county offices, which were included as the first major network partners with the newly developed AAAs/ADRCs. Other states, such as New York and Texas, identified new organizations interested in becoming NWD entities. In order to ensure 100% state coverage, New York extended an offer to all non-participating counties to participate in NY Connects, New York's NWD system. If a county decided not to participate in the program, New York issued a request for proposals to select an entity to administer the NY Connects Program in that area.

Accessibility

In addition to ensuring geographic accessibility of NWD entities, states were also required to enhance the accessibility of their services. Texas, Maryland, Illinois, and New Hampshire conducted in-depth surveys of the accessibility of their NWD entities. States ensured that their NWD entities included features such as Americans with Disabilities Act (ADA)-compliant restrooms and entrances, translation services, and appropriate signage.

More on New Hampshire's Accessibility Assessment

New Hampshire conducted an Accessibility Assessment of the 44 NWD partner agencies within the state. The assessment evaluated physical accessibility of the NWD entity, organizational availability, cultural accessibility, availability of technical assistance, and communication. Results from a self-reported survey indicated the strengths and needs among the NWD entities. For instance, although 96% of the NWD partner agencies provide home visits, 53% of the agencies indicated they needed assistance in interpreter services.

Training

States have also used the Program as an opportunity to train their NWD entity staff on the new NWD system and how to better guide an individual looking for community LTSS. Training components often included the following:

- An overview of the new NWD network
- The process of determining eligibility, including financial and functional eligibility
- Supporting new community LTSS populations (e.g., individuals with mental health needs)
- State-specific community LTSS offerings, such as waivers
- Screenings and assessments for individuals applying for services
- Warm transfers from the toll-free number to the agency responsible for the Level II assessment

In Georgia, all employees working with the NWD system were trained within 30 days of hire on the NWD processes and flows, the new eligibility and enrollment system, Medicaid waivers, call transfers, and other components related to the NWD system. Training was provided through an online webinar hosting service and all of the training materials were available online to the trainees after the training sessions occurred. Other states, such as Ohio, divided training between ADRCs and non-ADRCs. Representatives from each of Ohio's NWD entities meet every two weeks for specific training topics. These individuals review the training with Ohio's Program team and then take the necessary information back to their respective agencies. All of Ohio's training materials are provided online through a portal where staff members can access the materials at their convenience using their own username and password.

Coordination with Financial Eligibility Determination

A key role of the NWD entities is to initiate and coordinate the functional and financial eligibility determination processes for individuals seeking community LTSS. Some states, such as Massachusetts and New Hampshire, hired eligibility coordinators to manage all referrals from individuals interested in applying for community LTSS. These experts on financial eligibility support individuals during the financial application process and travel between the NWD entities and the county or state agencies responsible for determining financial eligibility to follow up on cases

Website

An informational website serves as another entry point for individuals to learn about the range of community LTSS available in the state.

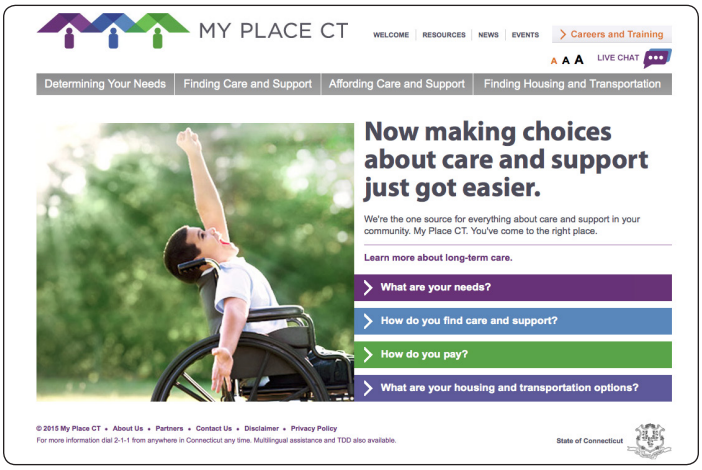
Maryland uses an existing ADRC website, enhanced to meet requirements

To meet this Program requirement, states use an existing website, making enhancements to ensure the website's content is inclusive of all populations, or build a new website. Common features of informational websites include the following:

- NWD site directory
- Toll-free number
- Level I self-screen

- Available programs and services
- Eligibility criteria
- Community LTSS provider directory
- Links to other resources and applications
- Newsletter and updates subscription
- Live chat with NWD entity staff

Nine states have chosen to enhance their existing websites. The existing websites were typically built for the state's ADRC network. Under the Balancing Incentive Program, states are rebranding these websites and adding resources for populations who have historically not used these online platforms, including individuals with mental illness.



My Place CT, Connecticut's new website for community LTSS

Nine states have built or are in the process of building new websites. This process typically involves hiring a private marketing firm to brand the website and accompanying marketing campaign. The "look and feel" of Connecticut's My Place CT website was also used on billboards, posters, and bus ads to encourage users to visit the website.

Although not a Program requirement, 12 states (Arkansas, Connecticut, Georgia, Kentucky, Maine, Massachusetts, Mississippi, Missouri, Nevada, New York, Pennsylvania, and Texas) have or will incorporate Level I self-screens on their community LTSS websites. In Maine, individuals' responses generate a list of resources they can use to access services. In other states, there is a warm handoff, meaning the individual is contacted by the appropriate entity for follow-up.

This requires the individual to create an account by securely inputting personal information. The Missouri Community Options and Resources (MOCOR) website takes this approach. The website allows users to start the Medicaid eligibility enrollment process and indicate their type of disability in addition to the support services they need to stay in the community. If the screening indicates the individual is potentially eligible for community LTSS, the relevant state agency receives an email notification with the individual's contact information for follow-up.

Toll-Free Number

As the third NWD system entry point, the Program requires states to provide a single toll-free number that routes individuals to central NWD staff or to a local NWD entity. The toll-free number is an essential entry point, where individuals can take the Level I screen and find out more about community LTSS options and the next steps in the eligibility determination process. This entry point is particularly important for helping connect individuals who do not have consistent Internet access and/or do not have easy access to a physical NWD entity.

States have taken different approaches to developing their toll-free numbers. Some states, like Connecticut, Maine, and Nevada, have adopted a pre-existing number, such as the 211 hotline, and equipped the hotline to work with all community LTSS populations. In these cases, Program activities typically include contracting additional call center reps and training all reps on administering the Level I screen. Nevada conducted a study to estimate expected NWD system call volume in developing a contract with the 211 vendor.

Other states, such as Ohio, developed a new toll-free number. Ohio contracted with the Cleveland Sight Center, a call center that employs individuals who are blind or who have low vision.

Other states use automation, as opposed to live call center reps. In Texas, callers input their ZIP code and are routed to their local NWD entity. Once NWD entity staff talk to the caller and administer the Level I screen, they may initiate a warm handoff to the appropriate population-

specific agency for the Level II assessment. Texas launched a campaign with extensive media coverage promoting its toll-free number; during the first two weeks of the launch, the number received more than 1,000 calls. After two marketing campaigns over a six-month period, the NWD call volume tripled from 1,044 calls in January 2015 to 3,136 calls in June 2015. In New Hampshire, calls are routed automatically based on the local exchange from where the call originates. Out-of-state calls or calls that cannot assigned a local NWD partner are routed to a central call center.

Another strategy states have adopted is establishing a toll-free number that asks the caller a few automated questions before routing the individual to the correct state department or agency. For example, Missouri set up its toll-free number to ask questions from the Level I screen and route the caller to the appropriate population-specific agency for follow-up.

State	Toll-Free Number	Community LTSS Website
Arkansas	(800) 801-3435	https://access.arkansas.gov
Connecticut	211	www.myplacect.org
Georgia	(800) 715-4225	www.georgiaadrc.com
Illinois	Not yet established	Not yet established
Iowa	(866) 468-7887	www.lifelonglinks.org
Kentucky	(800) 635-2570	https://kywaiver.ky.gov
Maine	211	www.maine.gov/mainelink
Maryland	(844) MAP-LINK	www.marylandaccesspoint.info
Massachusetts	Not yet established	Not yet established
Mississippi	(800) 421-4622	www.mississippiaccesstocare.org
Missouri	(855) 834-8555	http://mocor.mo.gov
Nevada	211	Not yet established
New Hampshire	(866) 634-9412	www.nhcarepath.org/
New Jersey	(844) 646-5347	www.adrcnj.org
New York	(800) 342-9871	www.nyconnects.ny.gov
Ohio	(844) 644-6582	Not yet established
Pennsylvania	(800) 753-8827	Not yet established
Texas	(855) 937-2312	www.dads.state.tx.us/care/index.html

Automation of NWD System Processes

States have used the Balancing Incentive Program as an opportunity to develop or enhance IT infrastructure to facilitate community LTSS eligibility determination and enrollment.

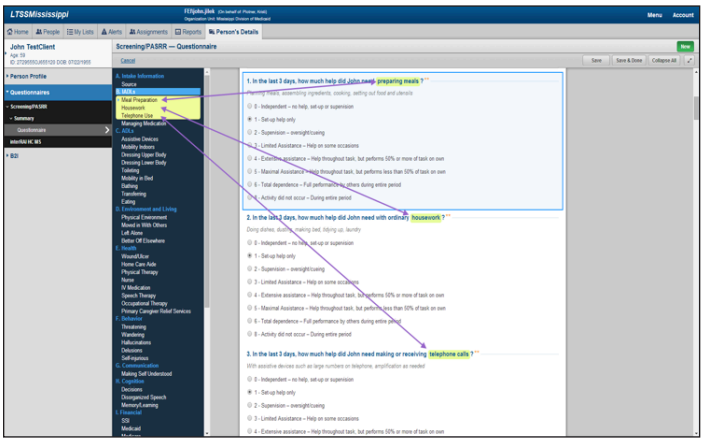
Connecticut: Client and Assessor Portals

Connecticut is working with a third-party vendor to integrate information about consumers applying for community LTSS with the rest of the consumer's health profile. Connecticut is expanding ConneCT, a pre-existing portal developed through the Department of Social Services, to include an LTSS module. Thus, when individuals go to the community LTSS website, MyPlaceCT, looking for community LTSS, they will be directed to ConneCT. On ConneCT, individuals can sign up and create their user profile or use a pre-existing profile. Many individuals already have an account through ConneCT where they view their financial eligibility information. If individuals who have an account through ConneCT apply for community LTSS, all of their financial eligibility information will be readily accessible.

In an upcoming release of the system, ConneCT will provide individuals with a "Consumer Dashboard" where they can view their eligibility status, apply for benefits, complete the Level I screen, and communicate with case managers. Workers and assessors will also have similar dashboards. The LTSS module will also be connected to ImpaCT, the financial component of LTSS eligibility. Connecticut intends to provide expanded integration of the ConneCT profiles with Access Health CT, the state Health Insurance Exchange.

Mississippi: LTSS System

Using enhanced FMAP, Mississippi has developed and implemented *LTSSMississippi*, which captures Level I screen and Level II assessment data and supports the development of the plan of care, quality monitoring, and case management. This system incorporates the automated interRAI suite for Mississippi's aging and physically disabled populations in addition to the Inventory for Client and Agency Planning (ICAP) used for individuals with intellectual disabilities/developmental disabilities (ID/DD). This system supports staff at Mississippi's Access to Care (MAC) sites and state agencies in assessing eligibility, enrolling individuals in waivers, and developing and implementing plans of care.



View of the LTSSMississippi system

Pennsylvania: Automated Waiver Financial Application

While most Program states have online enrollment portals for the modified adjusted gross income (MAGI) Medicaid populations, individuals seeking community LTSS typically have to apply through a financial paper-based application. This is primarily because demonstrating eligibility for waivers requires individuals to substantiate their income and assets. As part of the Program, Pennsylvania is incorporating an online waiver financial application in the state's COMPASS system (www.compass.state.pa.us) to facilitate the financial application process for individuals seeking community LTSS. For programs that have a waiting list for community-based waiver services, a referral is made to the entity that can best assist the person with getting on the waiting list, as well as providing information regarding what support the individual may be able to access while he or she awaits entry into the Home and Community Based Services (HCBS) Waiver Program.

Core Standardized Assessment (CSA)

The Balancing Incentive Program requires that states adopt a standardized functional assessment process and instrument(s) for a given community LTSS population to determine whether an individual is clinically eligible for Medicaid-funded community LTSS and/or to inform the individual's care plan. In addition, the assessment instrument(s)—referred to as a Core Standardized Assessment (CSA)—must contain a Core Dataset (CDS), a set of required topics, including items related to medical needs, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and mental and behavioral health needs.

In many cases, states are meeting the CSA requirements by using a set of instruments, as opposed to a single instrument, often administered at different times during the assessment process. Although assessment processes vary significantly across states and even across populations within a state, there are some fundamental commonalities, as illustrated in the figure below. The initial Level I screen triggers an eligibility assessment, including a clinical component. Once the individual is deemed eligible for Medicaid-funded community LTSS through a second assessment, a third more comprehensive functional assessment is conducted to develop the plan of care.

Standardized and **comprehensive** assessment processes help ensure that:

- Care plans address all of an individual's relevant needs
- Individuals with the same needs receive the same eligibility determinations, care plans, and funding allocations

Although some states started the Program with this structural change nearly completed, others adopted new instruments and revamped processes. Of the 18 Program states:

- Four already met CSA requirements upon entry
- Seven adopted at least one new instrument
- Seven only modified existing instruments

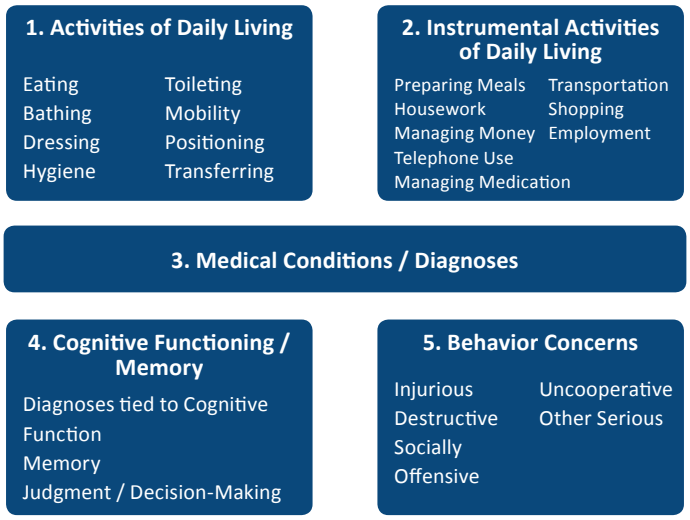
Common model of a multi-staged CSA process

States are using the following approaches so assessment findings better inform care planning and eligibility determination processes:

- Conduct assessments in person
- Use a strengths-based, person-centered approach
- Automate data collection to facilitate eligibility determination and analysis

Modifying Instruments to Add Topics

Most Program states were satisfied with their pre-existing tools and needed to make only minor modifications. In some cases, these modifications were straightforward. For example, Maine's Medical Eligibility Determination (MED) tool, used for individuals who are older adults and/or physically disabled, was missing a question about employment. Since connecting individuals to employment was one of the state's priorities, the additional question was an obvious change. Nevada, which administers the Comprehensive Social Health Assessment (SHA) for all community LTSS populations, refined question responses on mental health to include issues related to uncooperative behavior and memory loss.



Required components of a Core Standardized Assessment

Some programs worked closely with other health and human services agencies and stakeholders to ensure questions had the right tone for the specific community LTSS population. Texas found that its assessment instrument, predominantly used for older adults, did not sufficiently capture issues related to mental and behavioral health. Because questions that focus on identifying the presence of mental health needs are highly sensitive, the state's mental health agency helped develop the additional questions and provided input into assessor training.

Potential Questions for Assessing Mental Health in the Elderly

When you become angry, do you scream at, attempt to fight, or throw objects at others?

Do you have a history of wandering or hurting yourself or others?

Most Program states struggled with meeting the CSA requirements for individuals with mental health needs. Assessment instruments commonly used by states, such as the Level of Care Utilization System (LOCUS) and the Child Assessment of Needs and Strengths/Adult Needs and Strengths Assessment (CANS/ANSA), do not contain the Program's required ADLs and IADLs. These instruments were developed to assess whether an individual suffers from a mental illness and, if so, the severity of that mental illness. They were not developed to determine whether individuals are eligible for Medicaid-covered community LTSS and/or the types of support that would benefit individuals in their homes or communities. States addressed this issue in various ways. Missouri, for example, incorporated a detailed list of ADLs/IADLs in its Level I screen. Maine and Illinois are supplementing the LOCUS with more comprehensive instruments for cases in which the LOCUS indicates the potential need for community LTSS. New Hampshire has continued to utilize the same assessment documentation tools while offering provider training on the core domains and conducting a comprehensive whole person assessment.

Adopting New Instruments

Seven states adopted new instruments for at least one population. Ohio was the only state that developed its own instrument, a process that required extensive feedback from state and external stakeholders. Most states, however, preferred to use an instrument already tested and validated. Connecticut went through the most comprehensive change, replacing multiple homegrown instruments with a single instrument based on the interRAI Home Care Assessment. Illinois and Mississippi also replaced current assessment instruments with the interRAI, leaving the ICAP in place for individuals with ID/

DD. Kentucky adopted an instrument developed by the Wisconsin Department of Health Services.

Several states needed to adopt new instruments because their assessment processes were not standardized across providers. In these cases, the state provided guidance to community LTSS providers on assessment requirements—such as a list of topics that must be covered—but did not dictate which instrument to use. This structure was most common for individuals with mental health needs, for whom community LTSS providers were also responsible for assessing individuals for their service needs. Georgia and Maryland used the Balancing Incentive Program as an opportunity to engage their mental health agencies in a process to select a single assessment instrument across all providers. Before entering the Program, Missouri did the same for its individuals with mental health needs. Missouri worked closely with its providers to identify an instrument that adequately captured current needs and how those needs change over time, while not placing an excessive data collection burden on providers. As a result, the state now can collect more standardized and refined assessment scores from providers, allowing the state more insight into client outcomes and oversight of provider assessments.

Given the length of time needed to select new instruments (a process that often requires working closely with fellow state agencies, research on available options, and vetting with stakeholders), many states will just barely have instruments in the field when the Program ends. Iowa, for example, has been conducting extensive vetting sessions with its stakeholders. Iowa chose to focus on implementing the Supports Intensity Scale (SIS) for its adult ID waiver population and plans to implement the other selected instruments for other waiver populations soon.

Common Assessment Instruments

Although several states, including Arkansas, Connecticut, and Nevada, use a single instrument or a suite of instruments, most states opted for a different assessment instrument per population. State staff who manage the Balancing Incentive Program often promoted the concept of a universal assessment instrument as a way to further remove community LTSS population silos and address the needs of individuals who have co-occurring conditions. However, state staff often faced resistance from sister agencies and stakeholders who wanted to ensure that the unique needs of a given population would be addressed.

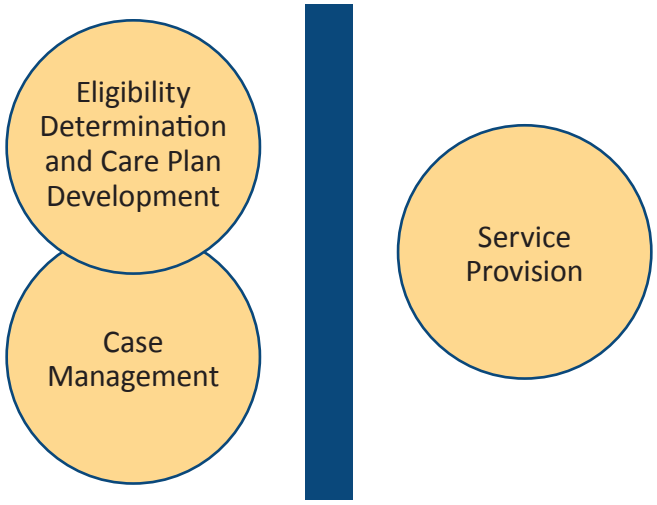
Most common assessment instruments

Many states use "homegrown" tools, developed internally to meet local population and agency needs. Of the off-the-shelf products, interRAI's Home Care (HC) tool and Community Health Assessment (CHA) were the most popular tools for individuals who are older adults and/or physically disabled. The SIS and the ICAP were most commonly used for individuals with ID/DD, while the LOCUS, Daily Living Activities Scale (DLA-20), and CANS/ANSA were commonly used to assess individuals with mental health conditions.

10 of the 18 Balancing Incentive Program states use instruments within the interRAI suite. Many states, including New York, New Jersey, and Arkansas, were already using the interRAI when they entered the Program, while others adopted the instrument as a way to meet requirements.

Conflict-Free Case Management

As the third structural change, the Balancing Incentive Program requires that states implement conflict-free case management. In its ideal form, this means that the agency that provides community LTSS cannot also determine eligibility, develop the care plan, or provide case management to the client as the care plan is implemented.



Ideal form of conflict-free case management

Conflict-free case management ensures that:

- Assessors don't have financial incentives to enroll individuals in unnecessary programs or services
- Care plans are based on individuals' true needs
- Providers are selected based on individual choice and need, not provider convenience for financial gain
- Providers "work themselves out of a job"—i.e., promote independence instead of trying to retain individuals as clients

If states are unable to conform to the "gold standard" described above, they can meet requirements through mitigation strategies—processes or protocols that reduce the impact of conflict. In some cases, states are unable to implement completely conflict-free systems due to a lack of providers in rural areas. In other cases, however, service delivery systems were deliberately built with an overlap of functions in order to promote care coordination and reduce the time to access services. This structure was most commonly seen in service delivery systems for individuals with mental health needs, where community mental health centers often conduct the assessment, provide services, and manage the case.

The Balancing Incentive Program and the HCBS Final Rule: A Staged Approach

Under the HCBS final rule, case management must be conducted by a different entity than the provider that renders direct services, unless there are no other willing or qualified entities. In the case of no other willing or qualified entities, the state must devise conflict of interest protections, which must be reviewed and approved by CMS. Just because the state's processes meet Balancing Incentive Program requirements does not mean that the state meets requirements under other authorities. States may view these different requirements as a staged process, where they first come into compliance with Balancing Incentive Program requirements and then gradually come into compliance with the conflict of interest requirements of other authorities.

The mitigation strategies most commonly implemented by states to encourage individual choice and appropriate use of services include the following:

- **State oversight of provider activities,** including an analysis of referral patterns, an audit of assessments, and processes for evaluating the quality of care. They may include surveys of beneficiary experience with case managers, including specific questions about perceptions of provider choice.
- **Administrative firewalls** between service provision and case management functions within a given agency. For example, these functions may be located in different departments with different supervisory chains.
- **Standardized and data-driven assessments.** By capturing assessment data electronically and through standardized response options, states can more easily assign individuals eligibility scores and monitor the accuracy of the assessment findings.
- **Beneficiary complaint systems**. Beneficiaries are made aware of their right to choose providers and have access to beneficiary complaint systems. In addition, active participation of consumers on agencies' boards or through advisory groups can serve as an important mitigation strategy.

State Models of Conflict-Free Case Management

Although some states are predominately conflict-free with mitigation strategies employed for one or two populations (Pennsylvania, Maine, and Maryland), others rely more heavily on mitigation strategies to meet requirements.

Nevada: A Conflict-Free System

Nevada is a Balancing Incentive Program state that comes the closest to a completely conflict-free system. A third party, either a contracted vendor or an ADRC, conducts the functional assessments for determining eligibility and developing care plans, while state staff perform all case management functions. To make the Adult Day Healthcare Program conflict-free, Nevada is requesting an additional six staff members to assume the development of care plans.

Arkansas: Mitigation Strategies to Ensure Independent Care Plans

More commonly, states have completely conflict-free systems only for a subset of populations. In Arkansas, for example, nurses employed by the Division of Aging and Adult Services (DAAS) conduct the assessment to determine the level of care needed and develop care plans for individuals who are frail and older. The nurses also manage the care plan, ensuring the service providers are completely independent from the process.

For individuals with developmental disabilities, two assessments are conducted. One assessment is conducted by the provider to create the person-centered service plan. Another assessment is conducted independently by a separate contractor, to determine resource allocation. To ensure that a person's freedom of choice is not negatively impacted by a service provider's financial interest, the state assures:

- Individuals receiving services and their advocates actively participate in meetings, assessments, and the development of the person-centered service plan.
- The Department of Developmental Services (DDS) offers the individual choice of setting of care, as well as choice among all qualified providers of case management and all direct services.
- There are clear, well-known, and easily accessible means for persons receiving services to make complaints regarding services or to appeal adverse actions to the state regarding concerns about choice, quality, and outcomes.

Conflict-Free Case Management in a Managed Care Environment

Many states are moving from a fee-for-service LTSS financing model to managed care (MLTSS), which aims to integrate and coordinate all services—acute and LTSS—in order to enhance quality of care and reduce costs.

CMS provides the following guidance to states regarding conflict-free case management in MLTSS environments:

- Managed care entities (MCEs) can provide case management and perform functional assessments. However, if MCEs provide direct services, they cannot also provide case management unless they are the only willing and qualified provider. (This is typically not a concern, as MCEs primarily contract external agencies for services.)

Innovations in Mitigation Strategies

- **Iowa**: The state's Medicaid Program Integrity office runs quarterly algorithms to identify case management entities that also provide direct services and the number of overlapping members. Algorithms also evaluate patterns of high utilization of services in areas where there is overlay of these functions.
- **Maine**: An independent Single Assessing Agency conducts all assessments to determine individuals' eligibility for services. In addition, for the mental health population, where there is overlap in service provision and case management, a provider can make self-referrals only 25% of the time.
- **Mississippi**: A rate study reduced reimbursement for home-delivered meals to equal the cost of the service in addition to a 20% fee for administration. Rates were adjusted to ensure home-delivered meals were delivered to individuals who needed the meals most, and there were no incentives for enrolling other individuals in the home-delivered meal program.

- MCEs cannot determine eligibility for programs. If an MCE performs direct assessments that result in scores that determine level of care, the state must perform representative sampling to ensure the accuracy of the scores.
- An appeals process must be in place to avoid decreases in care. Entities outside MCEs should support the appeals process to avoid conflict of interest.

States are implementing diverse MLTSS models, with state agencies, MCEs, and contracted service providers playing different roles in the assessment and case management process.

New Jersey: Standardized Assessments and Data Sharing

New Jersey moved all of its LTSS populations into managed care in July 2014, under the state's Comprehensive Waiver. If an individual is new to Medicaid, the state conducts a functional assessment to determine eligibility. Once an individual is enrolled in the MCE, the MCE uses the same assessment instrument to conduct annual redeterminations. The MCEs share re-redetermination assessment data with the state, so the state can closely monitor beneficiary service needs. To ensure that "members receive services to meet their identified care needs in a supportive, effective, efficient, timely, and cost-effective manner," the state requires that MCE staff who are responsible for providing care management do not provide direct services.

Texas: MCE Responsibility for Utilization Control

In Texas's MLTSS system, individuals with serious mental illnesses can access services from mental health providers within the MCE network. The provider administers a uniform functional assessment to the individual and sends the recommended level of care to the MCE for service authorization. After MCE approval, the provider collaborates with the individual and/or his or her family to develop an individualized care plan. Service coordination is performed by the provider as a billable Medicaid service or by a service coordinator employed by the MCE. The MCEs are responsible for their own utilization review of their contracted service providers. They conduct utilization reviews of service to identify and monitor patterns of over-utilization, under-utilization, and other utilization issues that may compromise care or lead to the inappropriate use of resources. The state oversees the quality of care offered by MCEs through quarterly reports, ongoing monitoring of the MCE through desk reviews and on-site reviews, complaint systems, appeals processes, the Office of the Ombudsman, and beneficiary surveys.

Use of Funds

States must spend the enhanced FMAP earned through the Program on activities that enhance community LTSS, target Medicaid beneficiaries, and are an allowable use of Medicaid funds. Typically, states use funds to directly expand services or to support structural changes that facilitate access.

Timeline for Spending Funds

When the Program initially started in 2012, participating states were required to spend funds by the end of the Program on September 30, 2015. However, as states struggled to meet this deadline, CMS changed its guidance. Currently, if approved by CMS, states have until September 2017 to spend Program funds.

Examples of spending delays include the following:

- New programs, such as Community First Choice (CFC), take time to implement
- Prolonged procurement process
- Slow rollout of new waiver slots
- Low take-up of voluntary services
- Concerns with sustainability

Expansion of Services

Although some states are directly expanding services through new services and waiver slots, others are developing the community LTSS provider market through rate increases and trainings.

Direct Expansion

Missouri, New Jersey, Ohio, and Pennsylvania are using *all* Program funds to allow more individuals to be served in the community. Fourteen states are using at least some funds on service expansion. Examples include the following:

- Adding waiver slots: Iowa is improving access to its ID waiver, which now operates without a waiting list. Missouri has allowed almost 3,000 more participants to become eligible for community LTSS through new slots in four waivers; Kentucky and Illinois are using funds to each add 500 slots to their ID/DD waivers.
- Services supporting transitions or diversions: Many states are developing and offering new services that support individuals transitioning from nursing homes, state psychiatric facilities, or other institutions (Illinois, Mississippi, New Jersey, and New York). Housing support, enhanced care management, and crisis stabilization help ensure that individuals have the support they need to remain in the community. Within a 24-Hour Stabilization Services program, Illinois is using Program funds to cover services provided in centers that temporarily house individuals at risk of institutionalization.
- New services: While Texas is expanding the array of services offered to individuals with acquired brain injuries through several HCBS waiver programs to include specialized therapies, New York is using funds to help cover the costs of assistive technologies and environmental home modifications. As another example, through the Program of Assertive Community Treatment (PACT), New Jersey is providing enhanced treatment to people with serious mental illness in the community.
- 1915(i) expansions: Connecticut, Iowa, Mississippi, and Ohio are using funds to support an expansion in the number of individuals accessing the states' 1915(i) state plan options.
- Community First Choice (CFC): While Maryland has used Program funds to support CFC enrollment activities, Texas and Connecticut have started using funds to directly cover the services offered under CFC.

Improving the Provider Market

States are often limited by the availability of qualified providers that can treat individuals with complex medical and behavioral needs in the community. New York, Iowa, and Texas have raised the rates for providers in multiple community LTSS categories. Maine has begun a study to determine the appropriate rates for providers. New Hampshire and Mississippi have implemented provider training programs. With Program funds, New Hampshire has provided core competency trainings to hundreds of provider staff and trained Area Agencies to address children's behavioral and psychiatric problems at an early age and enable them to continue to live with their families. Mississippi has trained all direct care workers through its College of Direct Support.

Structural Changes

Thirteen states are using funds to support their structural changes. The most costly endeavor supported by funds is the development of IT systems that capture and share Level I screen and Level II assessment data and support enrollment and case management functions. While Mississippi, Illinois, and Nevada are paying for these systems almost entirely with Program funds, other states, such as Arkansas, Connecticut, New Hampshire, and Texas, are using the Program to supplement Enhanced Funding for Eligibility and Enrollment Systems (90/10 federal matching funds).

Other NWD system endeavors that are smaller in scope include tablets for assessors to conduct assessments in individuals' homes (Maryland), enhancements to the state's toll-free number, so calls are routed to the individual's local ADRC (Georgia), and advertising campaigns (Connecticut and Texas). Massachusetts used funds to hire ADRC staff to support options counseling and eligibility determination activities.

New York: Innovation Grants and Performance Awards

New York has the largest Balancing Incentive Program grant award at approximately $600 million. While the majority of these funds are directly supporting service expansion, New York has implemented several innovative programs.

The **Temporary Rate Enhancement Pool** (TREP) awards up to $50 million to MCEs that meet transition and diversion targets compared to a baseline period.

With $47 million, the **Innovation Fund** is supporting 54 providers and advocacy and community groups in addressing systematic barriers to community placement. Examples of funded programs include:

- The Roman Catholic Diocese of Syracuse is using early intervention strategies to support individuals after their first episode of psychosis to avoid hospitalization and institutionalization.
- Catholic Managed Long Term Care Inc. is piloting a Program of All-inclusive Care for the Elderly (PACE) for seniors with Intellectual and Developmental Disabilities.
- Corning Council for Assistance and Information for the Disabled is providing crisis intervention services and immediate supports (medical, behavioral, or environmental) to the aging population and people with disabilities who face immediate risk of institutionalization.
- Niagara Falls Memorial Medical Center implemented a care transitions program for its hospital and skilled nursing facility (SNF), which includes education and training for the patient and caregiver and links to Health Home enrollment and community-based services.

Conclusion

Although states stop earning enhanced FMAP after September 30, 2015, the activities implemented under the Program will have long-lasting reach. States that have used Program funds to directly expand services are committed to maintaining those additional waiver slots and services with state funds into the future. In addition, the infrastructure, instruments, and processes linked to the structural changes should facilitate access to community LTSS long past the Program's sunset.

That said, many of the structural changes are just now getting off the ground. The sometimes slow pace of procurement and partnership-building means that the true impacts of the Program are currently unknown. CMS plans to continue monitoring the progress of states that are still using Program funds.

The Balancing Incentive Program does not operate in a vacuum. States are implementing many other initiatives to "balance" their LTSS systems. In a May 2015 survey, participating states reported that, on average, they are implementing 6.7 initiatives to reduce institutional expenditures and 7.2 initiatives to increase community LTSS expenditures. These efforts are helping states to meet and surpass the "balancing benchmark"—the percent of total LTSS dollars spent on community LTSS. On the institutional side, states reported that programs to support transitions out of institutions into the community, such as Money Follows the Person, are having a "high" impact on balancing. To reduce some institutional expenditures, states also reported that they are adjusting institutional rates based on client acuity, requiring a certificate of need before institutions offer new or expanded services, and setting managed care capitation rates to incentivize transitions and diversions.

These efforts, along with those directly supported by the Balancing Incentive Program, are moving the dial from expenditures on institutional LTSS to expenditures on community LTSS. Since many states are committed to maintaining this momentum, we expect to see the share of LTSS dollars spent on community LTSS continue to increase. As a result, more and more individuals with long-term care needs are receiving care and living in the communities of their choice, among friends and family, with control over their own lives and futures.