

Balancing Incentive Payments (BIP) Program

Purpose of BIP Program

- Assist states in creating greater access to non-institutionally based long-term services and supports (LTSS) and in transforming their long-term care systems.
- Help states that need assistance starting up their rebalancing initiatives by offering increased FMAP.
- Improve systems performance and efficiency, create tools to facilitate person-centered assessment and care-planning, and enhance quality measurement and oversight.

The 3 main structural changes required by BIP:

1. No Wrong Door/Single Entry Point (NWD/SEP) system
2. Conflict-free case management services
3. Core standardized assessment (CSA) instrument

FMAP

5% increase in FMAP if less than 25% of the total LTSS expenditures under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS.

2% increase in FMAP if less than 50% of the total LTSS expenditures under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS.

Ohio falls into the 2% FMAP category. Ohio would begin earning increased FMAP at the beginning of the next full quarter after program participation approval.

Services for which enhanced match may be earned include:

- HCBS under 1915 (c) or (d) or under an 1115 Waiver
- State plan home health
- State plan personal care services
- State plan optional rehabilitation services
- The Program of All-Inclusive Care for the Elderly (PACE)
- Home and community care services defined under Section 1929(a)
- Self-directed personal assistance services in 1915 (j)
- Services provided under 1915(i)
- Private duty nursing authorized under Section 1905 (a)(8) (provided in home and community-based settings only)
- Affordable Care Act, Section 2703, State Option to Provide Health Homes for Enrollees with Chronic Conditions
- Affordable Care Act, Section 2401, 1915(k) - Community First Choice (CFC) Option

States must achieve a benchmark of 50% of total Medicaid expenditures on home and community-based (HCBS) LTSS, and complete the required structural reforms no later than September 30, 2015. It is anticipated that Ohio will be able to achieve the 50% benchmark within the required timeframe. As long as funding from the \$3 billion grant remains available, increased FMAP would be available even if Ohio achieves the 50% expenditure benchmark before September 30, 2015. A work plan for the implementation of structural changes must be submitted within 6 months from the date of application

submission. Applications may be submitted through August 1, 2014 or until the full provision of the \$3 billion dollars in funding has been projected to be expended, whichever date is earlier.

Program Requirements

1. No Wrong Door/Single Entry Point (NWD/SEP) system:
 - Development of a No Wrong Door/Single Entry Point System (NWD/SEP) for long-term care services and supports. The system must include three components:
 - i. A set of designated Single Entry Point (SEP) agencies
 - ii. An informative website about LTSS options in the State
 - iii. A statewide 1-800 number that connects individuals to the SEP agencies or their partners.
 - Create a statewide system of LTSS that ensures that all individuals have the same access to information and resources on LTSS, regardless of their first point of entry into the system.
 - Assure that individuals are assessed once for the entire range of LTSS for which they may be eligible.
 - CMS encourages States to consider incorporating an online self-assessment into their NWD/SEP system, and ideally one that allows data to be passed forward to the SEP agency.
 - States are encouraged to consider other structural changes, such as optional presumptive eligibility.
 - SEP system is required to have both functional and financial components for Medicaid eligibility determination. CMS is asking states to consider co-locating functional and financial eligibility determination staff. If states do not co-locate both components, then states are required to create a way to allow SEP staff to access both functional and financial data sets.
 - CMS encourages States to set up systems by which individuals are able to have an initial evaluation completed via the 800 number.
2. Conflict-free case management services:
 - States will establish conflict of interest standards for the independent evaluation and independent assessment.
 - The plan of care must be based only on medical necessity, not on available funding.
 - Payment to the independent agent for evaluation and assessment, or qualifications to be an independent agent, cannot be based on the cost of the resulting care plans.
 - CMS may require that States develop "firewall" policies, separating staff that perform assessments and develop plans of care from those that provide any of the services in the plan and meaningful and accessible procedures for individuals and representatives to appeal to the State. States should not implement policies to circumvent these requirements by suppressing enrollment of any qualified and willing provider.
3. Core standardized assessment (CSA) instrument:
 - In practice, CMS anticipates that States will implement a CSA that involves two parts: an initial evaluation and a comprehensive evaluation. Only those who "test positive" on the initial evaluation will undergo the comprehensive evaluation.
 - By 2014, states will upgrade their eligibility systems to process Medicaid enrollment using a simplified eligibility determination process for most non-aged, non-disabled beneficiaries, as well as support integrated eligibility determination among insurance

affordability programs. CMS is encouraging states to consider the relationship between their Affordable Care Act-related system changes, and how they plan to accommodate eligibility verification and enrollment (including functional and financial eligibility) for LTSS programs.

States may not restrict eligibility for LTSS more than eligibility standards, methodologies, or procedures in place as of December 31, 2010. This maintenance of eligibility is similar to that required under other programs.

Strengths for Ohio

- Ohio is moving in the direction of significant system reform efforts consistent with the requirements of BIP.
 - Front Door Work/ Development of Aging and Disability Network/Continued Connect Me Ohio Website Development
 - Level of Care Criteria Changes/Single assessment tool,
 - Transition program (i.e., HOME Choice)
 - Streamlined Medicaid Eligibility
- Ohio is currently working on other system reform efforts including a unified waiver for individuals with a NF level of care, an integrated care delivery system for and dual and dual-like eligibles and health homes for certain target populations.
- Program gives states flexibility in developing innovative community based programs. States can ask that certain statutory requirements such as comparability and state wideness be waived. This would enable Ohio to target certain populations and possibly control costs.