Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Recommendations for New York State

March 23, 2012

Executive Summary

The principles for Managed Long Term Care (MLTC) in New York's Medicaid program, as articulated by the Medicaid Redesign Team (MRT), call for services to be provided in "the most integrated setting" as required by the United States Supreme Court in *Olmstead v. L.C.* (527 U.S. 581 (1999)). However, we believe the Managed Long Term Care program as currently proposed should increase incentives and oversight to ensure access to community-based services.

This paper offers several modifications to the proposed system, which we believe will provide incentives for deinstitutionalization and balancing of services. The proposals are in part drawn from MLTC systems developing in other states. The recommendations are as follows:

I. **Modify capitation rate structure to incentivize community-based care for high-need individuals**

II. **Ensure Plans are at risk for nursing facility costs by requiring robust institutional provider networks**

III. **Contracts should include performance measures that incentivize community-based care and ensure timely provision of appropriate services**

IV. **Explore the State Balancing Incentive Payment Program (SBIPP) as a potential source of enhanced federal funding**

The State should establish a three-tier rate structure with a rate cell for the small group of highest-need individuals or, at a minimum, establish stop-loss payments for community-based care for high-need individual, as opposed to stop loss payments for nursing facility care. Performance measures should provide incentives for community-based services and expeditious actions (e.g. enrollment and assessment), as well as sanction Plans for failing to comply with certain benchmarks. Such measures should include supporting nursing facility diversions and transitions; ensuring that the community is the first default; requiring consumer-directed services be the first option for enrollees; supporting the use of assistive technologies that maintain independence in the community; and complying with quality of care and quality of life measures, both medical and social.

States are increasingly recognizing the value of working with stakeholders to garner input on rate models, performance measures and other contractual provisions. We urge New York develop a system for seeking stakeholder input on these and other issues on an ongoing basis. To begin, we request that the State provide a formal presentation on the mechanism for establishing rate structures with opportunities for stakeholders to ask questions and provide input. We believe that this education is essential and, lacking this, we recognize that our proposed rate structure may be incompatible with existing structures. However, the intent of this proposal is predicated on our belief that all reimbursement structures should contain incentives for Plans and providers to prioritize care in the most integrated setting, and to provide services that will help members prevent or transition out of institutions and maintain independence in the community.

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This paper offers several modifications to the proposed system, which we believe will provide incentives for deinstitutionalization and balancing of services. This paper will not address due process and other consumer protection concerns in MLTC, which have been raised in earlier correspondence with the New York State Department of Health (NYSDOH). The proposals are in part drawn from MLTC systems developing in other states.[2] The recommendations are as follows:

I. Modify capitation rate structure to incentivize community-based care for high-need individuals

II. Ensure Plans are at risk for nursing facility costs by requiring robust institutional provider networks

III. Contracts should include performance measures that incentivize community-based care and ensure timely provision of appropriate services

IV. Explore the State Balancing Incentive Payment Program (SBIPP) as a potential source of enhanced federal funding

States are increasingly recognizing the value of working with stakeholders to garner input on rate models, performance measures and other contractual provisions. We urge New York develop a system for seeking stakeholder input on these and other issues on an ongoing basis. To begin, we request that the State provide a formal presentation on the mechanism for establishing rate structures with opportunities for stakeholders to ask questions and provide input. We believe that this education is essential and, lacking this, we recognize that our proposed rate structure (outlined in Part I) may be incompatible with existing structures. However, the intent of this proposal is predicated on our belief that all reimbursement structures should contain incentives for Plans and providers to prioritize care in the most integrated setting, and to provide services that will help members prevent or transition out of institutions and maintain independence in the community. Further, we believe that the proposals in this paper should be included in *any* initiative targeted at the disabled and elderly population, such as the Office for People with Developmental Disabilities' *People First Waiver*.[3]

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1 *Olmstead v. L.C.* [527 U.S. 581 (1999)]

2 Several of these concepts were adapted from *Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services - Recommendations for California*. Prepared for the SCAN Foundation by Leslie Hendrickson, Ph.D., Laurel Mildred, MSW, January 2012. http://www.ihsscoalition.org/documents/Mildred_Flexible_Accounting.pdf
Several of these concepts were adapted from *Considerations Regarding Managed Care, People with Disabilities and 1115 Waivers.* Steve Gold. Information Bulletin # 352 (2/2012) http://www.stevegoldada.com/stevegoldada/archive.php?mode=N&id=351

3 The *People First Waiver* is the proposed 1115 managed care waiver currently in development at the New York State Office for People with Developmental Disabilities. As people with disabilities shift throughout the whole

I. Modify Capitation Rate Structure to Incentivize Community-Based Care for High-Need Individuals

It is critical that NYSDOH make adjustments to the capitation model for the relatively small number of consumers with high needs in order to remove disincentives to providing community-based care. While we are pleased that NYSDOH plans to implement risk corridors, we do not believe that risk corridors alone will provide sufficient incentive to balance the program, for the following reasons.

First, risk corridors are a temporary initiative for use during transition to mandatory enrollment in MLTC. When risk corridors are phased out, the system will revert to a pure capitation model, which we believe fails to incentivize community-based care for the high-needs population.

Second, under risk corridors as proposed, the Plan's maximum risk is capped at the premium minus 4.5%, regardless of whether the Plan provides services in the community or in a nursing facility.[4] Thus, while the risk corridors protect Plans against the potential costs of high need consumers, they do not incentivize the Plans in favor of community care over nursing facility care. We propose some additional mechanisms to adjust rates to provide appropriate incentives below.

A. Establish a Special Rate Cell for the Highest Need Individuals

NYSDOH could establish a three-tier rate structure with a rate cell for the small group of highest-need individuals. The primary goal of this adjustment would be to provide a mechanism that allows individuals with the most significant needs to be served in the most integrated setting in accordance with the *Olmstead* decision. Individuals would be assigned to different rate groups as follows:

Low to Moderate-Needs Individuals. For these enrollees, the rate structure would blend two composite rates, with the total amount calculated based on the percentage of members in each rate group:

- **Tier 1** would be the lowest rate cell for those individuals who fall below a nursing facility level of care. This would include the population currently receiving only housekeeping Level I cases.

- **Tier 2** would provide a higher rate for individuals who are assessed to be at a nursing facility level of care (excluding the Tier 3 high-need outliers, which would be defined with stakeholder input as described below). This tier would include people who need 16 hours/day or less of facility care or combinations of other services. Enrollees in this group would have a wide range of mental and physical functional impairment.

High-Needs Individuals. The State should carve out the high-needs outliers and create a separate enhanced rate cell for those who need 16-hour care up through 24-hour care, whether live-in or "split-shift" in two 12-hour shifts, due to physical and/or psychiatric or cognitive disabilities. The State recently amended the regulations for personal care (18 NYCRR 505.14) and consumer directed personal assistance (18 NYCRR 505.28) to reflect that, in these models, continuous care means 16 hours[5].

New York Medicaid system, which is bound to occur, there must be consistent impetus toward community-based care.

[4] *Risk Corridor Presentation.* Presented by the Department of Health, February 2, 2012 http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_risk_corridor.pdf

[5] CDPAP Emergency Regulations Change Summary, Department of Health, October 4, 2011. "Paragraph (3) of subdivision (a) of section 505.14 is repealed and a new paragraph (3) is added to read as follows: (3) Continuous personal care services means the provision of uninterrupted care, by more than one person, for more than 16

- **Tier 3** functional criteria should be developed with stakeholder input. The rate would be set based on average regional costs of care for this population, which may, in many localities, be more than nursing facility care. The rate should also take into account the difference in costs for those who self-direct their care *and* those who do not.

The Plan would not be eligible to receive this rate for a consumer placed in a nursing facility. Moreover, if the Plan institutionalized an individual for which it had been paid this rate, the Plan would not only lose the high rate for the balance of the year but the State would recoup the high rate for the entire year or performance period.

If enrollees in Tier 1 or 2 developed increased needs, and qualified for the "Tier 3" outlier rate cell, the Plan would receive that rate, but only if the care is provided in the community as stipulated by Tier 3. The Tier 3 rate cell would thus incentivize the managed care entities to provide services in the community because this enhanced rate would not be available for institutional care. Tier 3 would also protect the Plans by ensuring sufficient payment for community-based care for higher need individuals.

We also recommend that the tiered rate system be constructed by basing capitation rates on prior year utilization data. Wisconsin utilizes this approach, achieving incentives through use of a blended capitation rate which is based on prior year utilization of acute care, home and community-based services and nursing facility care. Plans save money in the current year when they reduce nursing facility services because their current rate contains funding for their higher historical nursing facility utilization. Through the use of these rate incentives (and targeted performance measures), Wisconsin has decreased its nursing facility utilization significantly, from a nursing facility population of 38,430 in December of 2001 to 29,794 in December of 2011.[6]

B. Establish Stop-Loss Payments for High-Need Individuals

As an alternative to the aforementioned rate structure, the State could consider the establishment of stop-loss payments for community-based care for high-need individual, as opposed to stop loss payments for nursing facility care.[7] If a service is subject to a stop-loss, that service is incentivized. In the context of mainstream managed care and managed long term care, stop-loss should be used to incentivize home and community-based services and not nursing home stays—even short-term stays. This could prevent individuals from being institutionalized because they are out of their homes for a period that causes them to lose their homes, as well as prevent short term stays from becoming long term placements.

C. Set Risk-Adjustment Across Plans to Prevent Segregation of High-Need Individuals

In New York's health insurance marketplace, it some Plans avoid high-need individuals while others become the repository for high-need individuals—placing these plans at greater financial risk. NYSDOH should set risk-adjustment across Plans to prevent the segregation of people with significant disabilities into a cluster of Plans.

The Severity Index by Long Term Care Program in New York State demonstrates that different kinds of care programs (i.e. MLTC, nursing facility, personal care, home health care, and the Long Term Home

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hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted."

6 Conversation with Wisconsin Health Services staff as reported in the Hendrickson report, p.38.

7 For more information on how stop-loss is currently used for nursing facility services, see: https://www.emedny.org/ProviderManuals/ManagedCare/PDFS/ManagedCare-StopLoss.pdf

Health Care Program) undoubtedly serve different populations. We believe that this is most likely the case across Plans. We have learned that some Plans are able to avoid serving high-needs people by fostering a culture that is unwelcoming or difficult to navigate for that population, while other Plans that have higher scores for severity of disability have waiting lists.

A "reinsurance" mechanism was created to address this in the private insurance market for individuals and small groups. Plans were allowed to identify and submit high cost claims (over a specific threshold) on a retroactive basis for reimbursement from a pool created in the Health Care Reform Act (HCRA). Using this model, NYSDOH could explore redistributing resources across Plans to permit Plans to identify such individuals (based on the continuous care definition) and provide for prospective reinsurance of costs above a given threshold. Contributions to the reinsurance pool could be made by the plans whose membership reflect avoidance of High-Need individuals. NYSDOH may want to explore using Plan's SAAM data to craft this adjuster.

II. Ensure Plans are at Risk for Nursing Facility Costs by Requiring Robust Institutional Provider Networks

NYSDOH intends Plans to be at risk for nursing facility costs and thus requires Plans to provide nursing facility services as part of their service package. We support this approach but we are concerned that, as a practical matter, Plans will be able to avoid the cost of nursing facility care quite easily, particularly during the initial phase of implementation. This is highlighted by two concerns.

The first concern pertains to Medicaid enrollees currently in the community but at risk of institutionalization. The system as designed allows Plans to limit their network of nursing facilities. If the Plan intends to institutionalize a member, and the member is not satisfied with any of the nursing facilities in the Plan's small network, the member will disenroll in order to go to their preferred, out of network, nursing facility. Once institutionalized, the member will not be required to enroll in an MLTC Plan, at least during the initial phase of the program, and the nursing facility will be able to access the fee-for-service Medicaid rate. Even after nursing facility residents are phased into mandatory MLTC, Plans will be able to avoid costs if members disenroll because of limited network choices.

The second problem pertains to Medicaid consumers with high-needs who are already residing in nursing facilities and who will not be subject to mandatory enrollment until a later phase of the mandatory roll-out. This process opens the door for Plans to avoid assuming the costs of consumers who are already receiving nursing facility care but may be appropriate for transition into the community. This fact, coupled with the fact that funding for nursing facility transition services outside of MLTC is likely to decrease, could cause New York to lose ground in its current rebalancing efforts, particularly upstate where dependence on facilities is already strong.

We are pleased to learn, and hope that the State will confirm, that members may select any nursing facility for short-term rehabilitation, and that the Plan must pay the Medicare co-insurance, if any, for up to the full 100 days of Medicare coverage. However, once Medicare coverage ends, if the member is to be placed long-term in a facility, we fear that the above scenarios will play out and the Plan will be able to avoid taking on the cost of the long-term nursing facility costs, thereby removing the incentive to bring the resident back to the community. In order to address the potential for Plans to avoid the costs of nursing facility care in Medicaid MLTC, NYSDOH must require Plans to contract with any nursing facility that meets specified standards. Standards could reflect criteria such as placement in the top 60 percent of nursing facilities based on NYSDOH Quality Measure Performance Rankings, or nursing facilities with Medicaid rates within a specified range of the median cost for the region.[8]

[8] See http://nursinghomes.nyhealth.gov/nursing_homes/about_quality/#ranking.

III. Contracts Should Include Performance Measures that Incentivize Community-Based Care and Ensure Timely Provision of Appropriate Services

Performance measures should be expanded, publically reported in a manner that allows for meaningful comparisons, and linked to NYSDOH actions. Plans should not only be rewarded to provide the appropriate service in the appropriate setting and at the appropriate speed, but Plans should also be sanctioned for failing to comply. Several changes to current reporting would be required to accomplish these goals.

First, all performance measures should have a targeted value. For example, nursing facility utilization should be benchmarked *against industry accepted standards*; not simply reported. Second, data should be reported and then be publicly and timely reported by NYSDOH in a standard manner that provides for easy comparisons across Plans using a table format or something similar. Finally, there must be sanctions for Plans that fall below benchmarked standards as well as requirements for corrective action.

Contracts should be amended to include the following performance measures:

1. **Nursing Facility Diversion and Transitions**. This measurement could target the percentage of MLTC members who were long-term residents of nursing facilities at the time they enrolled in the Plan and then transitioned to the community during the measurement period. In order to ensure that Plans have an incentive to provide critically important nursing facility diversion and transition services, contracts should call for the following:

   - A transition allowance that the Plan provides for residents in order secure housing. Whether this is calculated as part of capitation or is separate can be decided. The transition allowance should not be limited to NHTD waiver individuals. This is currently offered in Tennessee.
   - A comprehensive *transition plan* that focuses specifically on transitioning people from nursing facilities, which should include a requirement to contract with entities that provide transition services as well as a special unit within the Plans.

     Several states, including New Mexico, Hawaii and Tennessee, are incorporating these features into their MLTC programs. New Mexico includes a "community reintegration" measure for their Plans[9]. Arizona currently requires public reporting of these types of performance measures. New York must start now incentivizing Plans to work with the currently voluntary enrollee population of nursing facility residents, so that they are ready to work with nursing facility residents once they are phased in to mandatory enrollment.

2. **Community-first Default**. In addition to measuring transitions from nursing facilities to the community, the program should measure how a Plan performs at the critically important task of maintaining enrollees in the community. With the influx into MLTC of people who have been stable on long-term personal care, home health services, or Lombardi program services, Plans should be required to report on the number of members who were living in the community at the beginning of the performance period and who, at the end of the performance period, were in nursing facilities permanently, or who were in the hospital or in short-term rehabilitation with the expectation of transferring to a nursing facility for long-term care.

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[9] New Mexico's managed long term care program: Coordination of Long-Term Services (CoLTS). See: http://www.hsd.state.nm.us/pdf/LegislativeSession/2011/CoLTS%20A-2%20Cost%20Effect.pdf. For information on NM nursing facility extended stay and community transition, see: http://senioragendari.org/ltc/Charles%20Milligan%20Presentation.ppt

These performance measures should differentiate those who were recently auto-assigned or enrolled in the Plan during the present performance period, versus longer term members of the Plan. This information should be monitored on a regional basis so that the State can assess for trends and determine if there are Plans that have a disproportionate amount of nursing facility enrollments and to which facilities.

In order to ensure that Plans have an incentive to make community-based services the default system, contracts should be amended to include the following:

- A requirement for a nursing facility diversion program in the hospitals that works with the individual and coordinates with the individual's hospital discharge planning teams to prevent discharges to nursing facilities. This could be a part of case management.
- A requirement to track and report discharges to nursing facilities, as well as those discharges that result in long-term placements versus rehab stays.
- A sanction for Plans when an individual receiving services in the community, enters a nursing facility on a permanent basis.[10] Once an individual enters into a nursing facility (beyond a rehab stay), there should be a mechanism to trigger the *transition plan* as outlined under #1 above.
- Incentives to provide assistance with securing accessible and affordable housing and other services to promote independent living, beyond those covered in the service package.

3. **Consumer Directed Personal Assistance**. Performance in this area will be of great interest to consumers. Although NYSDOH will require Plans to offer the Consumer Directed Personal Assistance benefit, Plans should be incentivized to offer self-directed services as the *first* choice of appropriate service. Comparisons of this service utilization across Plans should be readily available to consumers. This is reportedly currently utilized in Texas.

4. **Quality of Care and Quality of Life Measures.** Many of the measures used to compare quality for nursing facility care would be beneficial to apply for MLTC programs – and would apply to members including those in nursing facilities. In addition to the importance of assessing an individual's medical condition, Plans should be required to assess an individual's full independence and integration in the community. A model for this is Kansas.

   Medical Measures[11]

   - *Skin breakdown/ decubitus condition* – For MLTC members, including nursing facility residents, who had a decubitus condition observed during the preceding measurement period, the percentage of this group who in the current measurement period:
     - Exhibited (1) an improvement in the condition, (2) the same condition or (3) deterioration of condition[12], or
     - Who required hospitalization for this condition

[10] Hendrickson report, page 13

[11] While it is not essential to list all of the quality measures here, additional quality measures that are assessed in nursing facilities, such as percent of members with a Urinary Tract Infection, percent of members who were physically restrained, percent of members who lose too much weight, and percent of members have had a catheter inserted and left in their bladder, can be found here: http://nursinghomes.nyhealth.gov/nursing_homes/about_quality/#m1.

[12] These are three distinct measures.

- *Falls* – Percentage of MLTC members, including nursing facility residents, who had falls and the percentage who were hospitalized due to falls during the measurement period.
- *Other accidents* – Percentage of MLTC members, including nursing facility residents, who had accidents other than falls during the measurement period, including burns, lacerations, and fractures, etc. during the measurement period.
- *Independence and Functional Level* – Plans should be required to report on the percentage of MLTC members, including nursing facility residents, whose need for assistance doing basic daily tasks during the measurement period has increased from the last period. Daily activities for this measure could include:
    - Feeding oneself
    - Moving from one chair to another
    - Changing positions while in bed
    - Going to the bathroom alone

Social Measures

In addition to the aforementioned quality of care measures as they pertain to an individual's physical health and functioning, there are also quality measures that can be formally tracked and reported pertaining to positive social outcomes.[13] For example: satisfaction with one's ability to participate in the community, number of enrollees who are employed, or number of enrollees pursuing higher education. While Plans will not be financially sanctioned for the status of enrollees' employment, the State could build in certain mechanisms to promote positive social outcomes that take into account an individual's full independence. Kansas' proposed 1115 waiver[14] includes some groundbreaking incentives to promote employment for people with disabilities – recognizing that employment can lead to an "off-ramp" from Medicaid – as follows:

- "Reducing disincentives to work by enhancing Working Healthy and WORK program
- Creating a disability preference for state employment State of Kansas 8 January 26, 2012
- Leveraging state purchasing and incentive policies to encourage contractors to hire people with disabilities
- Establishing cash incentives for businesses that hire people with disabilities who are currently receiving state services
- Increasing awareness of the Kansas Use Law, intended to help provide employment for Kansans who are blind or severely disabled."[15]

New York State recently developed a statewide, cross-agency, employment database[16] that is predicated on performance-based outcomes, which would be a perfect match to track employment and integration measures of enrollees. The infrastructure exists now to crosswalk enrollees to this system.

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[13] In accordance with the Americans with Disabilities Act "to assure equality of opportunity, full participation, independent living, and economic self-sufficiency." 42 USC § 12101

[14] State of Kansas Section 1115 Demonstration, "KANCARE," Concept Paper. January 26, 2012 http://www.kdheks.gov/hcf/medicaid_reform_forum/download/Kansas_1115_Waiver_Concept_Paper.pdf

[15] Ibid

[16] The New York Employment Services System (NYESS) is a cross-agency initiative but is currently spearheaded by the Office for Mental Health. See: http://www.nyess.ny.gov/

For the older population, as well as for younger people with disabilities, performance measures would assess and provide incentives for various social determinants of health – wellness activities, services that reduce social isolation, assistance with obtaining affordable and accessible housing, and assistance with obtaining other vital benefits and services that promote independent living – such as accessing rent subsidies, Food Stamps and other benefits. Simply maintaining enrollment in Medicaid and Medicare Savings Programs can require extensive case management services with this vulnerable population, and should be tracked and incentivized with performance measures.

5. **Assistive Technology Devices and Services**. There should be an incentive to promote the use of assistive technologies that help individuals maintain independence at home and integration in the community. Assistive technologies should include a full spectrum of mobility, communications, and cognitive tools. These devices, and training in their use, should include but not be limited to wheeled mobility equipment, walkers, canes, emergency response systems, and telehealth. These have been shown to assist with activities of daily living and instrumental activities of daily living.[17] Assistive technology has been shown to "improve quality of life and reduce dependence for older persons with disabilities."[18]

6. **Expeditious Actions**. There should be an incentive to promote timely actions by Plans to enroll, assess and initiate services. Timelines should be specified in the contract but also tracked and reported, with penalties for failure to comply[19]. MLTC should streamline access to care; not add further barriers and delay. In order to ensure that Plans have an incentive to provide timely access (based on the reporting period), contracts should require the following:

   - Percentage of prospective MLTC members either requesting assessments or referred by MAXIMUS for assessments who are enrolled, assessed and provided with services within specified number of days. Arizona requires 30 days and Tennessee imposes a penalty for delays over 10 days.
   - Percentage of members who requested or received a referral for transportation (e.g. to a medical appointment, day care or day-hab) and were/were not provided with transportation for the requested event within a specified time frame.
   - Percentage of members who requested or were given a referral for durable medical equipment for which an evaluation is needed (e.g. customized or motorized wheelchair), and did/did not received the evaluation(s) within a specified timeframe.
   - Percentage of members who requested or who were given a referral for other services covered by a Plan (dental, audiology, optometry, podiatry, etc.) and were/were not given an appointment within a specified time frame.
   - Percentage of members assisted and the percentage of those members who did/did not receive timely eligibility determinations and enrollment, and, for those who do not yet have Medicaid when they seek to enroll in the Plan, the percentage of prospective members for whom the Plan did

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[17] *Managing Activity Difficulties at Home: A Survey of Medicare Beneficiaries*. Dudgeon BJ, Hoffman JM, Ciol MA, Shumway-Cook A, Yorkston KM, Chan L., Department of Rehabilitation Medicine, University of Washington, Seattle, WA Arch Phys Med Rehabil. 2009 Jul;89(7):1256-61.

[18] *Reconsidering Substitution in Long-Term Care: When Does Assistive Technology Take the Place of Personal Care?* Agree EM, Freedman VA, Cornman JC, Wolf DA, Marcotte JE. Department of Population and Family Health Sciences, Hopkins Bloomberg School of Public Health, Baltimore MD 21205. J Gerontol B Psychol Sci Soc Sci 2005 Sep; 60(5):S272-80.

[19] Hendrickson report, page 13

not file a Medicaid application within a specified time. We are already hearing about significant delays, even in advance of mandatory enrollment.

We strongly believe that adjustments to the capitation model and additional performance measures, such as those we have proposed, are needed to incentivize community-based care on a permanent ongoing basis. New York would not be the first state to implement such initiatives, as is evident from the examples we cite in our proposals. According to a recent *Kaiser*[20] inventory of state's proposed models to integrate care for the dually eligible population, California provides another example in a proposal that "would blend HCBS funding with acute and LTC institutional funding to align incentives to stay out of institutions." Kaiser also reports that Vermont is exploring incentive payments for those difficult to serve.

Federal funding is available under the Affordable Care Act to assist with implementation of rebalancing initiatives, such as those we have outlined above. This is discussed further below.

IV. Explore the State Balancing Incentive Payment Program (SBIPP) as a Potential Source of Enhanced Federal Funding

NYSDOH should explore whether New York State would be able to use additional federal funds under the Affordable Care Act's State Balancing Incentive Payment Program (SBIPP) to offset the cost of providing a higher rate to serve individuals with significant needs in the community.

The Affordable Care Act expressly targets SBIPP funds to states that are working to create incentives for the use of community long term care services in place of nursing facility services.[21] According to Section 10202:

> "(4) USE OF ADDITIONAL FUNDS- The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program."
>
> Subsection (f)(1)(B) clarifies the type of covered services and states, "Non-institutionally-based long-term services and supports: Services not provided in an institution, including the following: (i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act **or under a waiver under section 1115 of such Act**." [Emphasis added][22]

States must be actively engaged in developing three fundamental program features – no wrong door, conflict free case management and uniform assessment instruments – in order to qualify for the program. New York satisfies these criteria.

The state of New Hampshire provides an example of what can be done with SBIPP funding to create balancing incentives within a state's long term care program. New Hampshire will be receiving

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[20] Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look *at the 15 State Design Contracts Funded by CMS. Kaiser Commission on Medicaid and the Uninsured. August 2011.* http://www.kff.org/medicaid/upload/8215.pdf

[21] P.L. 111-148, § 10202.These funds sunset in 2015. See, P.L. 111-148 § 10202 (f)(2).

[22] Id.

approximately $26.5 million in federal funding over three years.[23] Its application received relatively quick action on their application by CMS (the application was submitted on the last work day of 2011 and approved little more than two months later). New Hampshire will use SBIPP funds for several key activities that are desperately needed in New York.

First, New Hampshire proposes to use the federal money to strengthen its no wrong door initiative and create a standardized and automated assessment tool for use by the state's Aging and Disability Resource Centers (ADRC), community mental health centers and Medicaid district offices.

Second, New Hampshire proposes several measures to improve the size and quality of the workforce for community-based services, through training and increased reimbursement. The workforce would be cross-trained to recognize the wide variety of symptoms and issues presented by the relevant population.

Third, New Hampshire acknowledges the importance of consumer perceptions and attitudes, and proposes a social marketing campaign to promote community-based care as the first option for people who need services and supports to live independently. As a crucial component of that campaign, the state proposes an online tool consumer tool for evaluating potential eligibility for services, and the choices that exist for accessing those services.

Clearly, New York could benefit from an infusion of federal funds to strengthen its own "no wrong door" program, particularly now with new requirements for screening disabled and elderly Medicaid applicants in order to determine which are subject to mandatory enrollment in MLTC. NYSDOH should partner with the independent living center community, a federally-authorized network, to develop an effective "no wrong door" system that is inclusive of the disabled as well as the elderly.

Workforce development is also desperately needed in New York, particularly upstate, if consumers are to have a meaningful choice to remain in the community as their service needs increase. Finally, Plans, consumers and other stakeholders would greatly benefit from an enhanced awareness of New York's commitment to rebalancing community and nursing facility care, complete with contract incentives and consumer tools for comparing options.

We urge New York State to explore tapping into the available $3 billion at the federal level that is solely dedicated to help states expand community-based services. New York should begin work now on a BIPP proposal in order to enhance its Medicaid MLTC program and increase the state's likelihood of success in both decreasing costs and enhancing the quality of life for Medicaid consumers.

Next Steps

While we understand that the Managed Long Term Care model contracts have already been submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) – unfortunately, without the benefit of stakeholder input – we believe it is not too late for New York to take advantage of the opportunity to advance the *Olmstead* decision by making some adjustments to its program in order to build in financial incentives to provide community-based services.

New York State must engage stakeholders in ongoing program design, including contracts and rate mechanisms. Dr. Hendrickson, author of the report *Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services - Recommendations for California*, referenced in footnote 2, provided guidance in the development of this

[23] New Hampshire's approved Balancing Incentive Program application and other relevant documents are posted online at www.dhhs.nh.gov/dcbcs/bip/bip.htm

proposal and is available to work with the Department to identify best practices from other states and help advance the goal of rebalancing community and nursing facility services within the new MLTC program.

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ARISE
Bronx Independent Living Center
Cardozo Bet Tzedek Legal Services Clinic, Cardozo Law School
Catskill Center for Independence
Center for Disability Rights
Center for Independence of the Disabled, New York
Consumer Directed Personal Assistance Association of New York State
Empire Justice Center
Harlem Independent Living Center
Independent Living Center of the Hudson Valley
Medicare Rights Center
New York Association on Independent Living
New York Legal Assistance Group
New York State ADAPT
Resource Center for Accessible Living, Inc.
Regional Center for Independent Living
Rockland Independent Living Center, Inc.
Selfhelp Community Services, Inc.