BIP 2.0 – Legislative Specs

These specifications can be considered for a legislative proposal that aims to improve State Medicaid programs' connections with other sources of home and community-based services (HCBS) financing and delivery system infrastructure, in order to substantially improve the availability and distribution of cost-effective, community-anchored long-term supports and services. The ideas build on the structure and success of the Balancing Incentive Program (BIP), which attracted red and blue states and helped them accomplish key milestones in HCBS infrastructure enhancement and cost-effective service delivery expansion.

Key Objectives

1. To bolster existing and planned State initiatives aimed at strengthening Medicaid HCBS systems by creating improved infrastructure that links with local organizations, (e.g., Area Agencies on Aging providing personal care, accessible transportation and respite care, as well as housing organizations), and also Medicare-financed programs serving elders and individuals with disabilities who require both medical and support services.
2. To finance these efforts via a modestly enhanced FMAP match (or other type of grant allocation) for those States that work with communities to develop and build out comprehensive medical+behavioral+HCBS delivery systems.

Methodology

Creation of policy anchoring a flexible, streamlined structural and financial framework that has ***aspirational targets*** *and* ***modest funding incentives*** to help States launch the next phase of value-based reforms.

Structural Changes

States must solicit stakeholder input, **select at least three of the following areas**, and submit to the Secretary for approval plans with achievable targets for structural changes that support HCBS.

A) **HCBS Quality and Information Technology** -Development and use of a core set of HCBS outcome and performance measures; Improvements in information technology, including successful application for HITECH 90/10 funding
B) **Implementation of the HCBS Settings Rule;** (Insert language)
C) **No Wrong Door—Single Entry Point System;** Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for

financial and functional eligibility. (This is language from previous BIP; ACL might have better language based on more recent ADRC initiatives)

D) **Employment Supports -** Development of statewide infrastructure to support opportunities for competitive employment for individuals with disabilities.

E) **Workforce and Unpaid Caregiver Supports** -Development of infrastructure to enhance to supply and retention of the direct support workforce; Development of infrastructure to support self-direction, including use of matching service registries and training for consumers who want to self-direct; Development of supports for family caregivers, including use of family caregiver assessments.

F) **Housing Supports -** Development of infrastructure for assessing the supply and availability of accessible housing in communities and across the state, linked to incentives for developers to create more housing suitable for lifelong use.

Financing Incentives:

Background factors:

- Baseline would reflect most recent data on LTSS
- Population categories:
  - Physical Disability and Aging
  - Developmental Disabilities
  - Serious Mental Illness/Serious Emotional Disorder
- Total HCBS spending varies among states, and also varies markedly within states by population
- Nationally, HCBS spending by population is as follows: for
  - Physical Disability & Aging, the range is 13% to 67%; average is 40%;
  - I/DD, the range is 16.5% to 100%; average is 72%
  - SMI/SED, the range is 0% to 100%; average is 36%

Funding factors:

- Formula enhancements aligned to aspirational targets
- States allowed to target by population, and to propose different targets for shifting funding to HCBS based on specific population categories over 5 years
- States must include target populations for which they are currently spending less than the national average of LTSS spending on HCBS
  - Possible higher enhancement percentages allowed for states in the bottom HCBS spending quartile (see table below)
- All states potentially eligible for enhancement funding based on their baseline HCBS spending and coverage rates, and HCBS growth in coverage and spending by population, together with their commitment and ability to achieve streamlining objectives and structural improvements

Evaluation:

- Ongoing required standardized evaluations would assess progress, and whether enhancements were achieving aspirational targets

<u>Additional suggestions on BIP 2.0 financing from Mike Smith, former CMS official who administered the BIP program and now with Mercer:</u>

Due to the fact that there is an 18- to 24-month ramp-up period for the Federal government and a similar period for states to get a BIP program up and running, consider lengthening BIP 2.0 from 5 to 7 years; in this scenario, the program would run from 2019-2025, with the first year of significant funding flowing in 2020.

As a possible alternative to original proposal that used Medicaid FMAP financing, funds for BIP 2.0 could be provided through non-competitive grants based on spending on services in the established BIP Categories from the CMS 64, so that funds would be awarded each year based on the previous year's spending. This would allow for greater flexibility in the use of funding by states for creating infrastructure that connects Medicaid to other programs, i.e., non-Medicaid programs that advance Medicaid objectives. Under the non-competitive grant approach, the grant amount would be calculated and adjusted annually based on adjustments to the CMS-64. This approach would allow states to receive quarterly draws similar to BIP 1.0 but have more flexibility as provided under Money Follows the Person (MFP) grant funding and would directly link to how a state is advancing the HCBS program.

From program inception to the 5th year of the program, state eligibility and payment amounts would hinge on achieving certain percentage targets of HCBS expenditures. Below is the schedule for funding states based on the current spending pattern at the time of BIP 2.0 implementation:

- .25% Increase for states already at 65% HCBS expenditures;
- .50% Increase for states already at 50% - 64% HCBS expenditures;
- 2.0% Increase for states already at 35% - 49% HCBS expenditures;
- 5.0% for states below 35%.

Beginning in the 6th year of the program, the following HCBS enrollment criteria would be added to ensure that HCBS program expenditures impact and improves the number individuals being served:

- .25% Increase tied to expenditures threshold above, & 85% of people served in the community;
- .50% Increase tied to expenditures threshold above, & 75% of people served in the community;
- 2.0% Increase tied to expenditures threshold above, & 65% of people served in the community;
- 5.0% Increase tied to expenditures threshold above, & 50% of people served in the community.

***NOTE:** The intent of this requirement in years 6 and 7 is to incentivize states to focus on managing the types of service being offered to improve community integration and not just increasing HCBS increase expenditures. Year 6 implementation ensures the ability of the states to accumulate several years of sound enrollment and encounter data for calculation of the percentages of people being served in the community -- something that has long been a seriously lagging indicator.

Additional accountability requirements could be considered in BIP 2.0 and incorporated into CMS' implementation process, with general language in the bill allowing for a portion of BIP 2.0 funding to be used for "activities necessary for administrative oversight" that would allow some flexibility in the management of the program.

Suggested considerations for CMS to consider for states that say they wish to participate in the program:

- **Data -** Transformed Medicaid Statistical Information System (TMSIS) must contain robust, timely, and accurate and submit T-MSIS files in this manner no less than 85% of the time; and
- **Coordination -** Agreement on metrics to measure Medicare and Medicaid coordination with states reporting annually on a set of basic metrics established between CM and CMCS and supported by CCSQ to measure this coordination.
- **Technology and Interoperability -** At least one of several congressionally passed mandates for community-based infrastructure for service delivery such as developing the IT infrastructure to address the continued growth and coordination of HCBS systems into the greater healthcare IT ecosystem, e.g., advancing connectivity with electronic health records (EHRs) or leveraging technology as a supportive service extender to create greater independence for individuals. All use of funding would need to be utilized in accordance with the Office of the National Coordinator for Health Information Technology (ONC) interoperability roadmap work and CMS quality strategy, i.e., including specifically adopting a tested and validated experience of care survey processes, or adoption of the National Aging Programs Information System (NAPIS) for all incident management for people in HCBS. All quality work would need to be aligned with the work of the NQF and CMS' Quality Strategy.
- **Workforce -** Plans for workforce development and coordination all LTSS programs. Currently institutional and HCBS systems are employing the same staff; however, most staff in the HCBS settings is paid lower wages and has fewer benefits. Workforce development is critical to sustain the growth of HCBS programs and services.
- **Evaluation -** After resources necessary to achieve the objectives required under the program have been addressed, states can designate the remaining funds special projects that benefit Medicaid HCBS beneficiaries in other aspirational target areas. For funds that are requested to be spent outside the realm of traditional Medicaid approved programs, like for example, services addressing the social determinants of health – an evaluation plan would need to be submitted in addition to the work plan. Evaluation funding could be drawn from the BIP 2.0 grant funding.
- **Design -** Evidence of human/person-centered design would be required to launch each of the items in the work plan, e.g., stakeholder engagement that is reflected in the design of programs and activities undertaken with grant funding that would enable people with disabilities and older adults to live "everyday lives."

***NOTE:** BIP 2.0 is designed to further develop Medicaid programs in a way that creates cross-program infrastructure for HCBS LTSS populations regardless of balance. Washington/Oregon and states in the forefront of rebalancing have few financial resources to move from the

institutional side of the ledger but can use this resource to strengthen program quality and community integration. This proposal allows for additional balancing funds to help these states as well.

Overview of Cost Estimates and State Funding Projections:

The table below was developed to illustrate how much the program might generate for states based on FY 2016 Medicaid Expenditures for HCBS Long-Term Services and Supports in FY 2016. For example, Oregon expenditures of $1.9 billion dollars on HCBS which would make the state eligible for $4.76 million annually in BIP 2.0 grant funding within the .25% range. For states that underperformed previously can apply again but CMS should have the ability to design the BIP percentage accordingly to incentivize participation which would allow states to make the investments in HIT, quality and workforce activities, i.e., the percentage for these states gets reduced to the next highest tier. A state that did not make their benchmark in round one might not be eligible for the 2.0% increase but only the .50%. In addition to make improvements to HCBS programs and systems of support, this initiative would improve the overall quality of reporting that is actually necessary to implement the program. If every state was eligible and participated in the program, $826 million would be needed to fund the program in the first year of grant funding. States may be slow to take advantage of the program and some will not want to meet the requirements to participate.

Reminder of Calculations:

- .25% Increase for states already at 65% HCBS expenditures;
- .50% Increase for states already at 50% - 64% HCBS expenditures;
- 2.0% Increase for states already at 35% - 49% HCBS expenditures;
- 5.0% for states below 35%.

Medicaid Expenditures for Long-Term Services and Supports, FY 2016						
State	Total Institutional	**Total HCBS**	**Total LTSS**	Percent HCBS	**BIP 2.0 Percent**	**Projected BIP 2.0 Funding**
Oregon	$439,360	**$1,903,310**	$2,342,670	81.2%	**0.25%**	**$4,758**
New Mexico	$303,212	**$1,109,023**	$1,412,235	78.5%	**0.25%**	**$2,773**
Minnesota	$1,174,293	**$3,661,192**	$4,835,485	75.7%	**0.25%**	**$9,153**
Massachusetts	$2,075,580	**$4,967,291**	$7,042,871	70.5%	**0.25%**	**$12,418**
Arizona	$517,388	**$1,229,504**	$1,746,892	70.4%	**0.25%**	**$3,074**
Vermont	$123,754	**$293,319**	$417,073	70.3%	**0.25%**	**$733**
Washington	$1,000,068	**$2,168,820**	$3,168,888	68.4%	**0.25%**	**$5,422**
Colorado	$787,844	**$1,553,312**	$2,341,156	66.3%	**0.25%**	**$3,883**
Wisconsin	$1,107,869	**$2,182,360**	$3,290,229	66.3%	**0.25%**	**$5,456**
Alaska	$194,649	**$347,847**	$542,496	64.1%	**0.50%**	**$1,739**
New York	$9,865,668	**$16,588,511**	$26,454,179	62.7%	**0.50%**	**$82,943**
Missouri	$1,459,620	**$2,050,979**	$3,510,599	58.4%	**0.50%**	**$10,255**
Montana	$201,024	**$279,998**	$481,022	58.2%	**0.50%**	**$1,400**

Texas	$4,514,753	**$6,280,550**	$10,795,303	58.2%	**0.50%**	**$31,403**
Virginia	$1,343,801	**$1,841,278**	$3,185,079	57.8%	**0.50%**	**$9,206**
Kansas	$507,689	**$664,326**	$1,172,014	56.7%	**0.50%**	**$3,322**
Nevada	$302,245	**$395,408**	$697,654	56.7%	**0.50%**	**$1,977**
Maryland	$1,361,800	**$1,748,754**	$3,110,554	56.2%	**0.50%**	**$8,744**
Dist. of Columbia	$358,265	**$457,793**	$816,058	56.1%	**0.50%**	**$2,289**
Idaho	$292,380	**$363,896**	$656,276	55.4%	**0.50%**	**$1,819**
Rhode Island	$380,643	**$470,426**	$851,069	55.3%	**0.50%**	**$2,352**
Maine	$479,175	**$558,816**	$1,037,991	53.8%	**0.50%**	**$2,794**
Tennessee	$1,148,161	**$1,314,933**	$2,463,094	53.4%	**0.50%**	**$6,575**
Connecticut	$1,624,582	**$1,836,515**	$3,461,098	53.1%	**0.50%**	**$9,183**
Nebraska	$418,306	**$465,989**	$884,294	52.7%	**0.50%**	**$2,330**
Ohio	$3,616,958	**$4,024,858**	$7,641,816	52.7%	**0.50%**	**$20,124**
Utah	$275,510	**$305,530**	$581,040	52.6%	**0.50%**	**$1,528**
Arkansas	$999,573	**$1,086,255**	$2,085,829	52.1%	**0.50%**	**$5,431**
Iowa	$1,055,519	**$1,076,377**	$2,131,896	50.5%	**0.50%**	**$5,382**
Wyoming	$141,954	**$141,268**	$283,222	49.9%	**2%**	**$2,825**
Illinois	$2,124,434	**$2,077,663**	$4,202,098	49.4%	**2%**	**$41,553**
Pennsylvania	$5,050,818	**$4,710,413**	$9,761,231	48.3%	**2%**	**$94,208**
Delaware	$293,119	**$268,560**	$561,678	47.8%	**2%**	**$5,371**
New Hampshire	$390,912	**$355,882**	$746,793	47.7%	**2%**	**$7,118**
South Dakota	$176,677	**$160,601**	$337,278	47.6%	**2%**	**$3,212**
Oklahoma	$722,499	**$648,430**	$1,370,929	47.3%	**2%**	**$12,969**
Georgia	$1,380,579	**$1,234,336**	$2,614,915	47.2%	**2%**	**$24,687**
North Carolina	$2,022,003	**$1,658,960**	$3,680,964	45.1%	**2%**	**$33,179**
West Virginia	$773,925	**$624,043**	$1,397,967	44.6%	**2%**	**$12,481**
Kentucky	$1,133,780	**$866,408**	$2,000,188	43.3%	**2%**	**$17,328**
Alabama	$1,032,698	**$769,927**	$1,802,626	42.7%	**2%**	**$15,399**
North Dakota	$351,756	**$252,342**	$604,098	41.8%	**2%**	**$5,047**
Hawaii	$305,774	**$217,041**	$522,815	41.5%	**2%**	**$4,341**
Michigan	$1,897,657	**$1,266,735**	$3,164,392	40.0%	**2%**	**$25,335**
New Jersey	$2,579,515	**$1,634,160**	$4,213,676	38.8%	**2%**	**$32,683**
Louisiana	$1,458,744	**$796,280**	$2,255,024	35.3%	**2%**	**$15,926**
Florida	$4,096,640	**$2,061,694**	$6,158,335	33.5%	**5%**	**$103,085**
Indiana	$2,637,867	**$1,237,211**	$3,875,078	31.9%	**5%**	**$61,861**
Mississippi	$1,074,197	**$398,216**	$1,472,413	27.0%	**5%**	**$19,911**
South Carolina**	$822,605	**$793,556**	$1,616,161	49.1%	**0.25%**	**$1,984**
California **	$3,874,839	**$11,006,830**	$14,881,669	n/a	**0.25%**	**$27,517**
Total	$72,272,684	**$94,407,727**	$166,680,410	56.6%		**$826,484**

Truven Data Notes:

Data for several states include expenditures for Medicaid Upper Payment Limit programs or provider taxes.

IMD for people under age 21 or age 65 and older, case management, rehabilitative services, private duty nursing, state plan HCBS, self-directed PAS, and Health Homes data do not include services provided through managed care organizations.

Data are presented based on state reporting. No further explanation of trends is available for the purposes of this report.

Data do not include expenditures for managed care programs in California and South Carolina. Percent HCBS is not calculated for California because a significant portion of data is missing. Michigan data do not include the state's smallest managed care program.

BIP 2.0 Notes:

Information provided in the table is presented to illustrate how the payments can be constructed and approximate the cost of the proposal. CMS would determine ultimately which data source to use and what expenditures to include and exclude from the calculation.

CMS 64 Reporting was modified in 2016 to start to capture HCBS expenditures as a portion of the Managed Care expenditures in states. The use of the lines in the CMS 64 report was voluntary, however, under the extension of this program all states would be responsible for completing these lines accurately if they want to participate in the grant offering.