



U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Disability, Aging and Long-Term Care Policy

# **CASE STUDIES OF BALANCING INCENTIVE PROGRAM IMPLEMENTATION PROCESS**

October 2015

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## ACRONYMS

The following acronyms are mentioned in this report.

AAA	Area Agency on Aging
ACA	Affordable Care Act
ACL	Administration for Community Living
ADRC	Aging and Disability Resource Center
ADRN	Aging and Disability Resource Network
CDS	Core Dataset
CFCM	Conflict-Free Case Management
CMS	Centers for Medicare and Medicaid Services
CSA	Core Standardized Assessment
CY	Calendar Year
DHS	Iowa Department of Human Services
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-Based Services
I&R	Information and Referral
I/DD	Intellectual or Developmental Disabilities
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IDA	Iowa Department on Aging
IME	Iowa Medical Enterprise
IT	Information Technology
LOC	Level of Care
LOTISS	Linking Ohioans To Information, Services and Supports
LTSS	Long-Term Services and Supports
MFP	Money Follows the Person
MHDS	Mental Health and Disability Services
MOU	Memorandum of Understanding
NWD	No Wrong Door
OHT	Ohio Office of Health Transformation
PACE	Program of All-Inclusive Care for the Elderly

PHI	Personal Health Information
RFP	Request for Proposal
SEP	Single Entry Point
SFY	State Fiscal Year
SIS	Support Intensity Scale
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families



## EXECUTIVE SUMMARY

The Affordable Care Act included several provisions designed to increase the provision of Medicaid home and community-based services (HCBS) and to improve the infrastructure for provision of those services. States that were, in 2009, spending less than 50% of total Medicaid long-term services and supports (LTSS) expenditures on HCBS were eligible to participate in the Balancing Incentive Program. Participating states receive an enhanced federal match rate for HCBS services. In exchange for the enhanced federal match rate, participating states are required to accomplish four goals: increase the percentage of total Medicaid LTSS dollars expended for HCBS to target goals;<sup>1</sup> create a no wrong door/single entry point for people seeking LTSS; develop a core standardized assessment (CSA) that can be used with all populations; and ensure a conflict-free case management (CFCM) process. This report describes findings from case studies in two states, which describe some of the challenges faced and strategies used to address these requirements. This report serves as a companion document to a process evaluation, which documents approaches to the required goals used in all of the participating states.

Case studies were conducted in two states, Iowa and Ohio. These two states were selected on the basis of information in the Baseline Report of the Balancing Incentive Program evaluation (Wiener et al., 2015a) and the process evaluation report of the evaluation project (Wiener et al., 2015b). Based on those sources of information, Iowa and Ohio were identified as two states that had a significant amount to accomplish at the time they began participation in the Balancing Incentive Program, and which had made significant progress toward the goals of the program. Thus, these states may offer valuable insights for future federal and state policy development. These case studies supplement the process evaluation by providing a more detailed examination of some of the challenges experienced and strategies used in working toward the goals.

Information for the case studies was obtained by telephone interviews with Medicaid officials, state Balancing Incentive Program staff, and a range of stakeholders involved in the Balancing Incentive Program and related initiatives. Stakeholders included representatives of Area Agencies on Aging, provider associations, disability advocates, and others with a connection to the design or implementation of the Balancing Incentive Program. Interviews ranged from 25 minutes to 1 hour, depending on the interviewee's role and level of involvement in the initiative. A total of ten interviews were conducted in each state.

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<sup>1</sup> States spending less than 25% of LTSS on HCBS at baseline received a 5% enhanced federal medical assistance percentage (FMAP) and were required to increase HCBS spending to at least 25% of total LTSS. States spending between 25% and 50% of LTSS on HCBS at baseline received a 2% enhanced FMAP and were required to achieved at least 50% of LTSS spent for HCBS by the end of the Balancing Incentive Program, September 30, 2015.

Key findings from the case studies include the following:

- Both states built on existing initiatives and drew on multiple funding authorities and initiatives to increase the share of LTSS expenditures spent on HCBS.
- Responsibilities for the work on the required infrastructure goals was shared among several state agencies.
- State staff were supplemented with contractors, particularly in ensuring stakeholder engagement. Iowa also used a contractor to assist with the development of the CSA, and Ohio to assist with the development of necessary information technology infrastructure.
- Despite the added help of contractors, stakeholder engagement was identified as a challenge. Stakeholders, including consumers, family members, advocacy groups, and direct care providers, were all recognized as important players. Their input into the development processes were recognized as critical to ensuring successful implementation of the infrastructure changes.
- Both states identified the challenge of ensuring CFCM in rural areas, where the small number of providers means that organizations may routinely provide both case management and direct services.
- Key staff in both states reported that the short period of implementation proved to be a significant challenge. They were confident in their abilities to achieve the required goals, but struggled to do so in the limited time available. Work on the Balancing Incentive Program was made more complicated by the many competing demands of other initiatives happening at the same time.

The picture that emerges from these case studies is of states that are engaged in the process, committed to the outcomes, and working hard to ensure success.

# 1. INTRODUCTION

The Affordable Care Act (ACA) included several provisions designed to increase the provision of Medicaid home and community-based services (HCBS) and to improve the infrastructure for provision of those services. States that were, in 2009, spending less than 50% of total Medicaid long-term services and supports (LTSS) expenditures on HCBS were eligible to participate in the Balancing Incentive Program. Participating states receive an enhanced federal match rate for HCBS services. The rate of the enhanced federal match and the targeted rate of HCBS expenditures are dependent on the baseline spending of the state.

In exchange for the enhanced federal match rate, participating states are required to accomplish four goals: increase the percentage of total Medicaid LTSS dollars expended for HCBS to target goals; create a no wrong door (NWD)/single entry point (SEP) for people seeking LTSS; develop a core standardized assessment (CSA) that can be used with all populations; and ensure a conflict-free case management (CFCM) process. This report describes findings from case studies in two states, which describe some of the challenges faced and strategies used to address these requirements. This report serves as a companion document to a process evaluation, which documents approaches to the required goals used in all of the participating states (Wiener et al., 2015b).

## Methods

In conjunction with the Office of the Assistant Secretary for Planning and Evaluation and Centers for Medicare and Medicaid Services (CMS), RTI International selected Iowa and Ohio as the focus for these case studies. These two states were selected on the basis of information in the Baseline Report of the Balancing Incentive Program evaluation (Wiener et al., 2015a) and the process evaluation report of the evaluation project (Wiener et al., 2015b). Based on those sources of information, Iowa and Ohio were identified as two states that had a significant amount to accomplish based on a “challenge score” as reported in the Baseline Report, and which had made significant progress on developing and implementing the Balancing Incentive Program. Thus, these states potentially could offer valuable insights for future federal and state policy development. These case studies supplement the process evaluation (Wiener et al., 2015b) by providing a more detailed examination of the goals and strategies some states have developed, and the successes and challenges some states have encountered in the implementation of the Balancing Incentive Program initiative.

Interviews were conducted by telephone with state Medicaid officials, state Balancing Incentive Program staff, and a range of stakeholders involved in the Balancing Incentive Program and related initiatives. The evaluation team first contacted

the state Balancing Incentive Program Project Director and Project Manager for interviews, then identified other interviewees as suggested by the people being interviewed. Representatives of the state Medicaid department and other state agencies serving specific populations, such as older people or people with mental health or other disabilities, were interviewed in both states. In each state, we also interviewed additional stakeholders, including representatives of area agencies on aging (AAAs), provider associations, disability advocates, and others with a connection to the design or implementation of the Balancing Incentive Program, including advocacy organizations that represented individuals with physical disabilities, developmental disabilities, mental illnesses, brain injury, and older persons. Interviews ranged from 25 minutes to 1 hour, depending on the interviewee's role and level of involvement in the initiative. A total of ten interviews were conducted in each state. Interviews were conducted between June 22, 2015, and July 18, 2015.

## 2. FINDINGS

The findings of the case studies are presented for each state, with comparisons drawn to highlight commonalities and differences in their experiences.

### Background

Both states were well underway toward increasing the share of LTSS funds expended for HCBS at the point of application to the Balancing Incentive Program, and viewed their participation in that program as part of a larger strategy. The states were using multiple Medicaid grant programs or authorities to achieve those aims, including Money Follows the Person (MFP), Medicaid Section 1915(c) waivers, the Health Home State Plan option (Ohio), and 1915(i) State Plan options for adults with serious mental illness (Iowa) (*Exhibit 1*). States also were in the process of applying for additional HCBS authorities, including Health Homes in Iowa and a 1915(i) State Plan option in Ohio.

<b>EXHIBIT 1. Case Study States' HCBS Authorities at Time of Balancing Incentive Program Application</b>		
State	HCBS Authorities	
Iowa	<ul style="list-style-type: none"> <li>• 1915(c) HCBS waivers</li> <li>• 1915(i) State Plan option</li> </ul>	<ul style="list-style-type: none"> <li>• MFP demonstration</li> </ul>
Ohio	<ul style="list-style-type: none"> <li>• 1915(c) HCBS waivers</li> <li>• PACE</li> <li>• MFP demonstration</li> </ul>	<ul style="list-style-type: none"> <li>• Section 2703 health homes</li> <li>• Financial Alignment demonstration</li> </ul>

In addition to these other Medicaid funding streams, states also were undertaking a variety of system redesign initiatives that addressed goals of uniformity in access and assessment. Participation in the Balancing Incentive program involved multiple state agencies and offered an opportunity for these agencies to share resources and streamline processes. In some cases, these efforts went beyond typical operating agency relationships. For example, Iowa’s Medicaid agency (Iowa Medicaid Enterprise) worked with the state’s Department of Transportation to incorporate the Department of Transportation’s work on providing transportation services to veterans.

***Iowa***

Iowa’s participation in the Balancing Incentive Program was undertaken at the instruction of the Iowa State Legislature. The Iowa Department of Health Services submitted an application for the Balancing Incentive Program in April 2012. Application to participate in the Balancing Incentive Program was in keeping with other rebalancing initiatives underway in Iowa. In 2009, the year used to determine eligibility for the Balancing Incentive Program initiative, Iowa spent \$1.3 billion on LTSS, 39.8% of which

went toward HCBS (Eiken et al., 2014). By 2012, the year Iowa submitted its Balancing Incentive Program application, the proportion of its LTSS expenditures spent on HCBS had increased to 43.4%. At the time of the application, Iowa was operating several programs intended to expand HCBS, including seven Medicaid Section 1915(c) waivers and MFP (Wiener et al., 2015). Iowa was also applying for funding for the development of the Health Home State Plan option and had a 1915(i) State Plan option for adults with severe emotional disturbance. Furthermore, the state was in the midst of a redesign of its Mental Health and Disability Services (MHDS) system, to transition from a 99-county system to a regional system regulated at the state level. The goal of the MHDS redesign was to ensure consistency in access, services, and assessment across regions.

These existing efforts reflected a strong commitment to promoting HCBS throughout the state, and the capacity to undertake the infrastructure changes required by the Balancing Incentive Program. State officials believed the Balancing Incentive Program initiative closely aligned with the state's vision of providing more community LTSS options and offered an opportunity to obtain additional funding to further Iowa's rebalancing efforts.

Iowa's Balancing Incentive Program required the participation and partnership of several state agencies and numerous stakeholders. The Iowa Medical Enterprise (IME), the state Medicaid agency, is the oversight agency for the Iowa Balancing Incentive Program. IME's Long-Term Care Division bureau chief is the Balancing Incentive Program Project Director. IME partnered with several other state agencies to accomplish the goals of the Balancing Incentive Program initiative. These agencies included the Department of Health Services' MHDS Division and the Iowa Department on Aging (IDA), both of which coauthored the Balancing Incentive Program application. The MHDS Division became the primary operating agency, while IDA became the cooperating agency for the Balancing Incentive Project. Staff in the MHDS Division recognized the potential for sharing of resources, streamlining processes, and building on the MHDS redesign to meet core infrastructural requirements for the Balancing Incentive Program initiative. IDA leadership recognized the opportunity for collaboration on NWD/SEP activities, as IDA was already part of conversations and initiatives to integrate the state Information and Referral (I&R) systems. At the time of the Balancing Incentive Program application, Iowa's I&R network comprised three separate parts (i.e., for general human services, disability services, and older persons), each with its own call center and website. IDA was especially well positioned to integrate these systems, as it was working with AAAs to implement regional Aging and Disability Resource Centers (ADRCs), and previously had created a website under a federally funded ADRC project to provide an SEP into services for individuals ages 18 and over. The Iowa Department of Transportation was later brought on as an NWD/SEP partner after it received funding from the U.S. Department of Veterans Affairs to create a one-click, one-stop system of accessing transportation services for veterans.

## **Ohio**

Prior to submitting its Balancing Incentive Program application in 2013, Ohio had been engaged in multiple efforts to rebalance the Medicaid long-term care system and to increase HCBS expenditures. Central to these rebalancing efforts was the state's MFP program, known as HOME Choice, which initiated much of the activity that would later be expanded through the Balancing Incentive Program. For example, efforts under the MFP program to develop new Medicaid LTSS assessment tools and revise the process used to determine individuals' functional and medical eligibility for LTSS aligned with the Balancing Incentive Program's requirements to develop a CSA. Other initiatives, including the demonstration to integrate care for Medicare and Medicaid enrollees and health homes for individuals with serious and persistent mental illness, also contributed to the rebalancing efforts through increased care coordination, among other activities.

These efforts reflected a commitment by the Governor's office and Medicaid to expand HCBS and rebalance LTSS, which was further demonstrated in the state's budget for the 2012-2013 biennium, which increased state spending on Medicaid HCBS waivers by \$200 million, thereby increasing HCBS funding from 36% of Medicaid LTSS spending in SFY 2011 to 40% in SFY 2013 (Ohio Balancing Incentive Program Application). The 2012-2013 budget also placed Medicaid expenditures for HCBS and nursing facilities in the same budget line item, as proposed in the Governor's budget request (Legislative Service Commission, 2013, p.52). These budgetary actions enabled the state to eliminate waiting lists for five HCBS waivers based on nursing facility level of care (LOC). The state also operated four HCBS waivers for individuals with intellectual or developmental disabilities (I/DD), and Program of All-Inclusive Care for the Elderly (PACE), and Section 2703 health homes for individuals with severe mental illness.

In light of these preexisting initiatives, state officials interviewed for this case study reported that they viewed the Balancing Incentive Program as a good opportunity to advance the rebalancing agenda and finance structural changes to the LTSS system. One official stated that "[Ohio] had already started down this road with MFP and had begun developing a new assessment tool. It was a natural fit to then use the Balancing Incentive Program to look at how the front end works and how people access the system to get through the door to even get to the assessment." Other stakeholders also noted that they believed the state was well positioned to achieve the goals and structural changes required by the Balancing Incentive Program because of the work conducted as part of MFP.

The state's decision to pursue the Balancing Incentive Program opportunity was supported by a wide range of stakeholders who viewed the Balancing Incentive Program as an opportunity to fund services, upgrade the state's Medicaid information technology (IT) infrastructure, and improve the LTSS system so that it would be easier for consumers to navigate.

Ohio's Department of Medicaid is the lead agency responsible for the Balancing Incentive Program. In addition to the Balancing Incentive Program project director, who also serves as the MFP project director, Medicaid hired four full-time staff members to help design and operate the program: a program manager, a contract manager, a data and quality manager, and a training manager. An intern was also hired to assist with memoranda of understanding (MOUs) and contract development, among other tasks. In addition, a Department of Aging staff member works full-time on Balancing Incentive Program activities such as preparing training and education materials for NWD/SEP entities.

Since the program's inception, Medicaid has worked in close collaboration with other state agencies and government offices to implement the Balancing Incentive Program, including the Department of Aging, the Department of Developmental Disabilities, and the Department of Mental Health and Addiction Services, and the Governor's Office of Health Transformation (OHT). The four-person staff of OHT provides leadership on health policy, coordination between departments, and communications with the legislature and stakeholders. These agencies were engaged to help develop the vision for improving the LTSS system and to design the NWD/SEP structure and other delivery system changes. The Balancing Incentive Program funding opportunity built on partnerships between sister state agencies that had been in place prior to submitting the Balancing Incentive Program application and that in some instances had grown out of the MFP demonstration. Because the existing Aging and Disability Resource Networks (ADRN)s operating under the Department of Aging's auspice were slated to be the backbone of the NWD/SEP system, the Department of Aging had a major role in developing that aspect of the Balancing Incentive Program. The Department of Mental Health and Addiction Services also contributed to the development of the assessment tool by identifying evidence-based screening tools and providing recommendations for the referral process. Several state officials credited this collaboration among agencies and support from the OHT with the success of the Balancing Incentive Program initiatives. One official stated:

I have never seen an administration support a program like they've supported this. The Governor's Office and the Medicaid agency supported it, all of the major state agencies have provided support and really pushed this forward. You don't see that very often.

## **Stakeholder Engagement**

In addition to the state agencies engaged in the Balancing Incentive Program implementation, each state sought to involve a variety of stakeholders including people receiving services, family members, advocacy agencies, and others outside of the agencies direction involved in implementing the Balancing Incentive Program. Stakeholders were involved at different times and for different purposes, and using a variety of methods for engagement. In Iowa, stakeholders (beneficiaries, families, and others outside of the involved agencies) were not involved in the application process, but were engaged in discussions about infrastructure changes, particularly the content



and accessibility of the NWD/SEP system and the selection of CSAs. A different approach was developed for each target population, with input from each population as to the method of communication that would work best. Approaches included webinars, listening session, and surveys.

In contrast, Ohio used two main vehicles for stakeholder engagement: a committee structure that includes Advisory and Implementation Committees and workgroups formed to address specific topics and process improvement activities. Unlike Iowa, in which each population was addressed separately, and through regional efforts, Ohio brought together officials, stakeholders, and Balancing Incentive Program contractors in a week-long intensive session, and in meetings of the advisory committee and workgroups.

Both states used consultants to assist with obtaining stakeholder input. Some interviewees in each of the states believed that more could have been done to engage stakeholders at various times. However, several interviewees praised Ohio's efforts, reporting that they resulted in a highly transparent design and implementation process.

### ***Iowa***

Because of the short timeframe for completing the Balancing Incentive Program application, consumers, families, and stakeholders were not engaged in the Balancing Incentive Program submission process. Stakeholders have been engaged in work related to development of the NWD/SEP system and the development of the CSAs, with different approaches used for each of those.

Stakeholder involvement in the development of the NWD/SEP has focused on providing input on content and accessibility of that system. Stakeholders reported that at the start of the Balancing Incentive Program, the state developed workgroups to introduce the Balancing Incentive Program to stakeholders and to work with them to strategize on the different infrastructural requirements. The workgroup meetings included a variety of stakeholders, some of whom were part of existing advisory groups including the state's Olmstead Consumer Taskforce, Mental Health Planning Council, and the Governor's Developmental Disability Council. These workgroups specifically provided input on the content and accessibility of the NWD/SEP system. Stakeholders reported that these workgroup meetings were no longer taking place because the state had transitioned from the planning phase to the implementation phase of NWD/SEP.

Iowa also used an extensive stakeholder engagement process to guide the development of the CSA; however, the process used to engage stakeholders in the CSA development was quite different from that used to obtain input into the NWD/SEP. Stakeholder engagement in the CSA development has been led by the state's consultant, Telligen, which has organized stakeholder engagement sessions for each of several distinct beneficiary populations, including people with I/DD, people with physical disabilities, people with brain injury, and older adults. For each population, Telligen has sought input from an advisory group to determine the optimum stakeholder engagement

strategy. This has led to a variety of methods to engage stakeholders. In-person stakeholder sessions were conducted for stakeholders of people with I/DD. For stakeholders concerned with people with physical disabilities, Telligen conducted webinars and an online forum. For stakeholders of survivors with brain injury, Telligen conducted six listening sessions across the state. For older persons, Telligen conducted webinars and distributed statewide surveys through senior centers and case managers. Regardless of the specific approach used, input has been provided primarily by family members, case managers, and service providers, with limited participation by consumers. For other special populations, the stakeholder engagement process was either in process or is still being planned. Telligen summarizes its findings for each group and submits a report to the state.

Stakeholder input into the CSA development has involved either learning sessions, designed to educate and train case managers and providers on selected assessment tools, or listening sessions, designed to gather input on assessment tools under consideration. Whether Telligen conducted a learning or listening session for any given population depended on the status of the decision making with regard to the CSA. For example, the state legislature had selected the Support Intensity Scale (SIS) as the CSA tool for the I/DD population prior to contracting with Telligen to conduct stakeholder sessions. Therefore, Telligen conducted learning sessions with I/DD during which case managers and providers were introduced to the SIS tool and trained on how to use it. In contrast, for the brain injury population, a standardized assessment tool had not been determined by the state, so listening sessions took place to gather stakeholder input.

Although stakeholders were engaged in the early stages of planning for NWD/SEP and attended stakeholder sessions for the CSA, many observers thought that there needed to be a more coordinated effort from the state to communicate about the Balancing Incentive Program. Stakeholders interviewed were largely unaware of current Balancing Incentive Program activities and expressed a desire to be more involved. Some recommended more online documentation or informational meetings so that the public can be made aware of Balancing Incentive Program progress. Stakeholders also noted that there are several competing initiatives in Iowa right now, including Medicaid Modernization (Iowa's transition into Medicaid managed care) and Integrated Health Homes. With so many initiatives occurring simultaneously, stakeholders and beneficiaries find it challenging to distinguish the Balancing Incentive Program from other efforts and to keep up with how these initiatives will affect care.

## **Ohio**

The Ohio Department of Medicaid has engaged stakeholders on Balancing Incentive Program design and implementation through two main vehicles: a committee structure that includes Advisory and Implementation Committees and workgroups formed on specific topics and process improvement activities.

**Process improvement techniques.** Ohio used “lean management techniques” to develop an improved process for individuals accessing LTSS. The effort was facilitated

by consultants from the LeanOhio Office, a state agency that helps improve the efficiency of state government. They began by mapping the current work flow, followed by a Kaizen event. A Kaizen event is a week-long intensive session to improve quality or productivity. Ohio brought together state officials, stakeholders, and Balancing Incentive Program contractors for a Kaizen event to improve the Medicaid Level II assessment process. One state official said the improved process had greatly reduced the number of steps for a consumer to access LTSS and another said the new process “will save all kinds of money” by reducing staff time and diverting more LTSS applicants from institutions to HCBS. Several stakeholders praised the Kaizen, and said it had promoted teamwork and stakeholder engagement and developed a much more efficient process.

***Advisory and implementation committees.*** The Balancing Incentive Program stakeholder engagement structure comprised two committees. One is the Balancing Incentive Program Advisory Committee, which includes a broad cross section of state agencies and stakeholders such as groups representing community and nursing facility providers, disability advocates, AAAs, behavioral health organizations, county developmental disability boards, and Olmstead Task Force representatives. The other structure is the Implementation Committee, comprising state agencies and current and prospective SEPs. Implementation Committee members provide feedback and recommendations to Medicaid on various aspects of the NWD/SEP design and implementation. These are then brought to the Balancing Incentive Program Advisory Committee for further discussion. Medicaid also established workgroups focused on assessments and eligibility determination, marketing and education, and CFCM.

Stakeholders interviewed said that these engagement activities and communication pathways have made for a highly transparent design and implementation process, and commended state officials for their responsiveness. Stakeholders were very positive about the participatory nature of the “front door” workgroup, which developed the CSAs, incorporating many stakeholder suggestions. Some stakeholders stated, however, that although the state listens to stakeholder suggestions, it does not always act on these recommendations. For instance, one stakeholder shared that although the state made some adjustments to its approach to CFCM based on stakeholder feedback, consultation with stakeholders about the initial NWD/SEP design was limited.

## **Use of Enhanced Federal Medical Assistance Percentage**

Both states used the enhanced Federal Medical Assistance Percentages (FMAP) funds to expand the availability of HCBS, increasing the number of people served. In both states, much of the increased service was targeted to people with I/DD. Iowa also used the enhanced FMAP funding to expand services to people with mental health disabilities, increase Medicaid payment rates for several providers, and to conduct outreach and education activities for providers.

## **Iowa**

State officials reported that the state focused its enhanced FMAP funds on expanding the availability of community-based services through increasing HCBS waiver slots and reducing the number of people on HCBS waiting lists, particularly for individuals with intellectual disabilities. The state also increased provider rates for several HCBS providers, including an increase in the state's home health rate by 2%, which roughly covered inflation. State officials noted that although the increase in provider rates resulted in additional providers participating in Medicaid, it also allowed current providers to serve more Medicaid beneficiaries because the additional funding allowed the providers to add more staff to serve the new beneficiaries. The enhanced FMAP funding also enabled the state to expand habilitation services available under their Section 1915(i) State Plan option and provide more community-based services for people with mental health issues.

State officials and stakeholders noted that there were challenges involved with adding more individuals to the I/DD waivers, particularly among individuals formerly residing in Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) who tend to have high needs for support during the initial transition period. Stakeholders reported that the additional Balancing Incentive Program funding was valuable in supporting MFP staff to develop individualized plans needed to help people with high behavioral health needs transition into the community.

Iowa also has used its enhanced FMAP funding for outreach and educational activities directed at LTSS providers or organizations that offer HCBS waiver services and organizations that the state would like to see moving toward an increasing role in HCBS (e.g., ICFs/IID). The state funds the Iowa Association of Community Providers to provide technical assistance and training through in-person and online learning opportunities for direct care providers, whether or not they are members of the Association. The Association conducts four trainings across the four regions of the state each year of the Balancing Incentive Program, providing education to 1,660 people across about 100 organizations about best practices, developing increasing competency, and the providers' abilities to support and adopt more HCBS options for the people they serve. The Association does direct outreach and marketing with the institutional-based providers to help them find the resources needed to expand their services into community-based settings.

The association also manages an online learning system, which provides free courses to providers, to improve their work on HCBS. Trainings are developed and conducted by other organizations (Elsevier, Relias Learning) and have addressed such topics as reducing turnover among direct care staff and improving HCBS for people with mental health diagnoses. Stakeholders mentioned that they do not generally come across many providers, even institutional-based providers, who do not want to encourage services in community-based settings for their participants. The training by the Association helps support providers in making the needed changes to better support HCBS.

## **Ohio**

Ohio used all of its enhanced FMAP to fund expanded HCBS. The state reported that the largest portion, 44%, was spent on Medicaid HCBS waivers for individuals with intellectual disabilities. State officials said that initially they understood that none of the enhanced FMAP could be used for structural changes, so they paid for all structural changes and Balancing Incentive Program staff positions from state funds and used enhanced FMAP for HCBS.

## **Rebalancing of Expenditures**

Both Iowa and Ohio have achieved the rebalancing goal, with HCBS expenditures exceeding 50% of total LTSS expenditures. Both states achieved their rebalancing goal by combining the enhanced FMAP with other funding streams, including MFP and other state initiatives.

Informants in both states noted a variety of challenges to achieving the rebalancing goal. Iowa stated that the challenges of serving people in the community varies by the type of disability the person has and how that has affected their life experiences, expectations, and skills. In Ohio, a key challenge was resistance to expanding HCBS by the nursing home association and some legislators who believed an emphasis on institutional care was appropriate. Strong leadership from the governor and Medicaid director addressed this challenge by showing legislators that they could reduce nursing facility rates, expand HCBS waiver slots, and still generate savings.

## **Iowa**

**Achievement.** In 2009, Iowa's share of LTSS expenditures spent on HCBS was 39%. At the time of the case study, the state had increased the HCBS share to 52% of total LTSS expenditures. State officials noted that the share of HCBS of the total LTSS expenditures tended to fluctuate slightly over time. They suggested that the fluctuation may be in part due to the biannual rebasing of nursing facility rates, which may increase the cost of institutionally based care and therefore increasing the share of total LTSS expenditures spent on institutional care.

**Strategies.** Iowa is meeting the requirement to increase the share of LTSS dollars spent on HCBS by increasing both the costs of units of service provided to individuals and increasing the number of individuals with LTSS needs being served. In addition to using the enhanced FMAP to expand HCBS, the state also relies on funding support outside of the Balancing Incentive Program to meet its expenditure targets. Some of these additional funding streams include support from the MFP demonstration and the Department of Transportation One Click/One Call program. State officials also noted that they are working with the state-funded autism program, a state-funded behavioral

health managed care entity, and the social service block grant to help expand community services.

Iowa is also moving toward transitioning all of its Medicaid populations into a managed care delivery system. As the state contracts with managed care organizations, the state includes several outcome requirements that the plans have to meet, including incentivizing the use of HCBS and more appropriate use of nursing facility services.

**Challenges.** Stakeholder and state officials noted the challenges involved when transitioning individuals from institutions into the community to increase the share of HCBS expenditures, particularly among those individuals residing in ICFs/IID. The expenditures for individuals who have resided in ICFs/IID for a long time are sometimes higher when moved to the community, especially for the first year or two of the transition. One reason for the increase in overall expenditures is because of the differences in staffing ratios needed to meet the increased community needs, which are very different than institutional staff requirements.

State officials also identified individuals with traumatic brain injury as facing more challenges in maintaining or becoming independent, especially when compared to the elderly population. State officials opined that the differences in experience stem from the support needs of the various populations. Individuals who are aging often require support to delay a decline in function or to regain a prior level of independence. Individuals with I/DD and individuals with brain injury may have more significant support needs because of their specific level of disability and circumstances.

## **Ohio**

**Achievement.** Ohio achieved a significant shift in Medicaid LTSS expenditures during the Balancing Incentive Program project period, with the HCBS share of expenditures increasing from 42.7% in the final quarter of CY 2013, to 61.6% in the first quarter of CY 2015.

**Strategies.** Ohio officials and stakeholders said the Balancing Incentive Program project built on a trend of increasing HCBS expenditures. Over the past 4 years the state has been able to eliminate waiting lists for HCBS waivers for individuals requiring nursing facility LOC. The state is also addressing waiting lists for HCBS waivers for individuals with I/DD, which are financed with a combination of federal, state, and local funds. State officials reported that the budget for the 2016-2017 biennium includes state funding for 3,000 new HCBS waiver slots for individuals with I/DD, including 1,000 earmarked for individuals transitioning or diverted from ICFs/IID.

One important strategy was to use a state budget crisis to gain legislative approval for cutting nursing facility rates and reinvesting some of the savings in HCBS waivers slots. Ohio's MFP program, HOME Choice, ranks second in the nation in the number of transitions and leads the nation in transitioning individuals with mental illnesses, according to the state. Officials said the MFP project has contributed to rebalancing

efforts by identifying barriers and gaps in services and developing new strategies for transitioning individuals to the community. Other initiatives state officials noted that helped increase the HCBS share of LTSS expenditures include implementation of behavioral health homes, downsizing of state developmental disability institutions, and encouraging providers to transition residents of private ICF/IIDs to HCBS waiver services. State officials expect the state's Financial Alignment Initiative demonstration, MyCare Ohio, to contribute to further rebalancing by changing financial incentives and integrating Medicare and Medicaid services for dual eligible beneficiaries.

State officials also credited the state's use of a single budget line item for LTSS expenditures with making it easier for HCBS expenditures to grow as expenditures for institutional services decline. The state has reinvested savings resulting from reduced use of institutional care into community services, including a program called Transitions Take A Community, which helps individuals with mental illness remain in the community by providing flexible supports after MFP demonstration services end.

**Challenges.** A strong nursing facility association opposed to expansion of HCBS is one of the challenges faced by the state, according to interviewees. One respondent also said that many legislators still feel that an emphasis on institutional care is appropriate. Both officials and stakeholders credited strong leadership from the Governor, his OHT, and the Medicaid director for making HCBS a priority and working for legislative approval of LTSS initiatives. Officials also cited good public relations work by the Medicaid communications office as a factor in building support for rebalancing.

Eliminating waiting lists for HCBS waivers for individuals with I/DD has been a challenge because waiver services for that population are financed in part with revenue from county tax levies earmarked for I/DD services. In addition to financing issues, many families have added children to lists so they will reach the top of the list by adulthood. State officials are addressing this issue by adding 3,000 new waiver slots with all matching funds provided by the state, using Balancing Incentive Program funds to finance waiver slots, and encouraging I/DD providers to transition residents of private intermediate care facilities to HCBS waivers by allowing the beneficiaries' institutional funding to be used for waiver services. Officials said there is also an effort underway to differentiate between individuals who are interested in HCBS waiver services in the future and those who are eligible now.

## Balancing Incentive Program Structural Requirements

In addition to requirements that states increase the share of LTSS dollars spent for HCBS, all participating states must develop three key aspects of LTSS infrastructure to support their efforts to shift services to HCBS. These infrastructure components include the use of an NWD/SEP approach for individuals needing help with and possibly applying for LTSS, the establishment of a CSA tool for determining eligibility for services, and the development of CFCM for planning and monitoring services (*Exhibit 2*).

## **No Wrong Door/Single Entry Point**

Both states still are working toward a fully functional NWD/SEP system. Their efforts have involved building on their existing ADRCs/ADRN, and working with other state agencies as well. Both states have received Administration for Community Living (ACL) grants in the past to develop and support their ADRCs. In both cases, the state has found it helpful to have dedicated staff to assist with the planning, coordination, and training efforts.

Both states reported major challenges to achieving the NWD/SEP goal. Coordinating information from multiple data systems was a challenge to both. In Iowa, part of the challenge was the inability to share information across agencies, without legislation to enable shared access to personal health information (PHI). Ohio also experienced challenges in coordinating information across multiple IT systems, although they did not identify the same concern about sharing of PHI. Ohio also noted concerns about taking on new functions for an SEP in the face of uncertainty about continued funding. The state was able to successfully identify and address these concerns.

### **Iowa**

**Achievement.** Iowa continues to work through the full implementation of the required NWD/SEP system. The state has identified the state ADRCs as the SEP for individuals accessing LTSS. Although information regarding LTSS options has been streamlined through the state ADRCs, they are still in the process of expanding their network and building the capacity to include all LTSS for all eligible populations. The website and toll-free number are up and running as well.

<b>EXHIBIT 2. Infrastructure Reforms Required Under the Balancing Incentive Program</b>	
<b>Required Infrastructure Reform</b>	<b>Description</b>
No Wrong Door/Single Entry Point	Designed to ensure that everyone seeking information about Medicaid-funded HCBS receives the same information and experiences the same process wherever they enter the system. Individuals experience a coordinated process of eligibility assessment, options counseling, and enrollment. Includes a toll-free telephone number and website for obtaining information.
Core Standardized Assessment	Ensures a uniform assessment process across all populations. States may or may not use a single assessment form for all populations; but all assessment tools must include a CDS that includes required domains and topics: activities of daily living, instrumental activities of daily living, cognitive function and memory/learning difficulties, medical conditions, and behavioral difficulties.
Conflict-Free Case Management	This process separates determination of clinical/functional eligibility from direct service provision and ensures that those people assessing a person's need for services do not have any financial conflicts of interest. Safeguards and oversight are in place to mitigate risks of any potential conflicts, and to provide clear pathways for consumers to submit grievances or appeals.



**Strategies.** The ADRCs are collaborating with the AAAs and MHDS system in establishing the NWD/SEP. AAAs were recently legislatively required to be ADRCs, so the state is working to incorporate them as NWD/SEP ADRCs. The ADRCs are also partnering with the MHDS regions as part of expanding the NWD/SEP network. The MHDS system provides HCBS to adults (under age 65) with disabilities. All MHDS regions have to have local access points within their regional-based systems. The ADRCs are building partnerships between MHDS regions and the ADRCs, which are also regionally based. Some of the MHDS regional sites have MOUs with the ADRCs while others have contracts in place. The state is considering having LTSS options counselors trained at local access points in the MHDS regions and in the ADRCs. The MHDS regions are not technically ADRCs but they are working collaboratively with ADRCs and can access the same web-based systems, including the NWD/SEP website, and toll-free number.

**Challenges.** State officials noted that one of the biggest challenges to developing the NWD/SEP system is the coordination required across the various different state agencies involved with providing LTSS. The Iowa Department of Human Services (DHS) includes the Iowa Medicaid Enterprise, which administers the state Medicaid program and funds the Balancing Incentive Program, and the MHDS Division, which oversees the MHDS regional sites. The IDA, which is outside of DHS, co-administers and manages the Balancing Incentive Program together with the MHDS Division; it also oversees the state ADRCS and AAAs. The IDA must also coordinate with the Department of Transportation, which has a grant from the U.S. Department of Veterans Affairs to run a call center to provide non-emergency transportation services to veterans. The NWD/SEP call system administered by the ADRCs coordinates with the Department of Transportation call system for veterans. The Iowa DHS signed an MOU with the Iowa Department of Transportation in February 2015 to foster this coordination.

The state found it challenging to shift the system overall toward HCBS while ensuring that all the participating state players' interests were aligned and moving toward the same. As one stakeholder commented, shifting the system toward HCBS is not necessarily about having enough funding, but also about how funding should be blended [within federal and state requirements] and who has responsibility for what. In the case of Iowa, the AAAs and MHDS regions provide similar services of offering local access points. Care needed to be taken to ensure that the two organizations were meeting their goals in ways that were efficient, and made best use of available funds. The state used an outside project management group to help with some of the interdepartmental planning issues.

In addition to coordinating across state agencies, the state also faced challenges in developing a comprehensive and integrated database. At this point, the state has two main databases that are not yet integrated. The Compass database, which is managed by the University of Iowa, focuses on individuals with disabilities of all ages. The second, separate database, Lifelong Links, is managed by the Iowa Association of AAAs and includes information about individuals over the age of 60. State efforts to

implement an automated Level I screen that would share information among state agencies to streamline the eligibility process has been hampered by concerns about the exchange of PHI. The exchange of PHI among state agencies would require enabling legislation.

## **Ohio**

**Achievement.** Ohio has completely overhauled its siloed systems for accessing LTSS services according to a state official, who described this as the “heaviest lift” of the Balancing Incentive Program project. Launch of the new system was postponed several times because of delays in completing the required IT system, but at the time of the interviews state officials were preparing to begin training and expected to launch the NWD/SEP system during September 2015. The new system will use AAAs as lead entities to organize a network of SEPs in each region, with organizations from other delivery systems participating as SEPs, including centers for independent living, Easter Seals agencies, county developmental disabilities boards, and community mental health centers. The system will have sustainable funding through Medicaid, and standardized procedures will increase consistency between regions. Individuals who call the new toll-free number will be routed to one of the SEPs in their region using a rotating, round-robin system.

SEPs will conduct the Level I screen and provide support navigation, which may include connecting people with the appropriate agency for a Level II assessment. Individuals may also call an SEP directly, visit in person, or access information and complete a Level I screen online on the new Ohio Benefits Long-Term Care website (<https://benefits.ohio.gov/>). SEPs and partner agencies will coordinate and track individuals’ progress from the front door to service delivery through Linking Ohioans To Information, Services and Supports (LOTISS), a new IT system developed under the Balancing Incentive Program. LOTISS will interface with the state’s new financial eligibility system, enabling SEPs to track both financial and functional eligibility. LOTISS will also be used for nursing facility LOC assessments and case management for nursing facility level HCBS waivers. The Department of Developmental Disabilities’ information system will continue to be used for the I/DD system’s assessments and case management, and it will also interface with LOTISS to share information about individuals.

The state has given the NWD/SEP system the same name as the website, Ohio Benefits Long-Term Care, and it is being promoted with marketing materials such as fact sheets, magnets, and sticky notes. Ohio is promoting the system through outreach to a primary audience of health care providers and “helper agencies.” The general public will be a secondary target.

**Strategies.** Ohio used a number of strategies to implement its NWD/SEP system, including hiring staff with specialized skills, close collaboration among state agency partners, building on the existing ADRN network, and careful planning of procurement. The existing ADRNs were built around the AAAs under contracts with the Department of

Aging, and the state leveraged that system for the SEPs. The state used a request for information process to solicit organizations interested in becoming SEPs. Responses were forwarded to the AAAs, which contracted with the SEPs for their region, minimizing the state's role in contracting. SEPs will be paid by Medicaid for completion of Level I screens and for providing navigation support.

Ohio used an request for proposal (RFP) process to select contractors to develop the IT system, the website, and the 800 number. State officials considered developing the website internally but chose to contract out both website development and maintenance based on a previous experience with a state-operated website that had to be shut down. Procurement for the 800 number call center resulted in selection of a Cleveland-based community rehabilitation agency that employs individuals with disabilities at a living wage. The state's full-time Balancing Incentive Program training coordinator is supported by a contractor with expertise in developing training videos. State officials chose to develop advertising materials in-house because the Medicaid communications office designed their logo and had the capacity to design other materials.

The quality measurement system was developed by the Scripps Gerontology Center at Miami University, a state university. This system measures performance of the SEPs and other entities in helping individuals access LTSS services. Quality measurement tools are incorporated into the LOTISS system and include a brief survey of individuals at the time of their SEP contact, a longer survey after they receive services, and measures of response times that use data generated by the system.

Medicaid's partner state agencies supported the NWD/SEP effort in several ways. A staff member at the Department of Aging worked full-time on Balancing Incentive Program and developed model SEP contracts and SEP manuals. All of the partner agencies participated in development of the Level I screen. Stakeholders were engaged in planning and implementation through the Implementation Committee, whose members were SEPs and state agencies, the larger advisory committee, and an advertising workgroup.

**Challenges.** Procurement was a major challenge for implementing the NWD/SEP system despite the state's careful planning. State officials said it is difficult to do any type of procurement and complete deliverables within deadlines for a time-limited program like the Balancing Incentive Program because the RFP process and contracting are so time-consuming. Another challenge was coordinating two major new IT systems that were under development at the same time--the LOTISS system and Ohio Benefits, the state's new IT system for public benefits programs, including Medicaid, TANF, and SNAP. State officials said the Balancing Incentive Program manager spent most of her time in 2014 maintaining coordination between the two systems, as a change in one system required a change in the other system. State officials said it would have been much easier to coordinate the new LOTISS system with an existing eligibility system.

There were also some challenges in recruiting prospective SEPs because of concerns about taking on a new function with uncertain funding. The state addressed those concerns by developing projections of SEP activity and revenue, designing Medicaid rates that would adequately compensate SEPs, and providing some startup funding. As a result, the state officials said they had been able to recruit a diverse group of new SEPs to supplement the existing network of AAA SEPs.

## Core Standardized Assessment

Both Iowa and Ohio chose to develop separate CSAs for different target populations (i.e., there is no uniform assessment across populations). CSA development and testing has been completed for some populations and is still underway for others. The development and testing of the CSAs has involved extensive stakeholder engagement in both states. The stakeholders have helped to ensure face-validity of the instruments and to address stakeholder concern about the maintenance of eligibility.

### *Iowa*

**Achievement.** The state did not have any CSA when starting the Balancing Incentive Program but developed a plan to implement separate CSAs specific to particular populations. The state legislature had mandated CSAs for the MHDS regions in the redesign legislation, which focused on populations with developmental disabilities, brain injury, and those with mental illnesses. The state had previously tested the Supports Intensity Scale (SIS) tool for individuals with I/DD and the Level of Care Utilization System for individuals with mental illness as result of the MHDS redesign legislation.

At this stage of Balancing Incentive Program implementation, the state is using the SIS for individuals with I/DD. Among the I/DD population, the state will have done 5,500 assessments by the end of July 2015, which is almost half of the intellectual disabilities waiver population. State officials reported that families appreciated these assessments, which has educated and refocused them to thinking about what an individual really needs instead of just what services are necessary to keep them safe.

**Strategies.** The state continues to move forward with developing CSAs for other subpopulations. The state has officially selected an assessment instrument for persons with physical disabilities (InterRAI Home Care Assessment) and are close to selecting the assessment instrument for the elderly. They have not yet selected an assessment instrument for people with brain injury or mental health diagnoses, but the contractor has completed brain injury stakeholder engagement and is designing the mental health stakeholder engagement session now. The stakeholder groups include individuals who are receiving or helping to provide services, including individuals with LTSS needs, families, providers, or case managers.

As described previously, Iowa hired a contractor (Telligen) to guide the development of the CSAs by engaging in a variety of stakeholder engagement activities, including webinars, informational letters, and in-person meetings. The contractor has used different engagement processes for each subpopulation. For example, for the elderly population, the contractor conducted surveys and webinars as a means of engaging the stakeholders. The contractor used two surveys--one for family or beneficiaries and the other for case managers or providers. The surveys provided some background information on assessments being considered by the state and asked the survey participants if they preferred a specific assessment instrument that had been described. In general the contractor heard the most comments about the assessment process, such as how should assessments take place, who should be involved, and who decides who is involved, rather than selection of the actual tool. Although the contractor has had difficulty in engaging actual beneficiaries, it has been able to reach the people who work with beneficiaries.

Based on results from community outreach, the state worked on altering its messaging when conducting the CSA. The state emphasized that the assessment is for determining an individual's LOC and informs the case manager of the services an individual needs when forming a plan of care in a separate process, but does not itself result in a plan of care. The assessors have also adapted and learned from experience to be sensitive to how the questions are perceived by the individual and family.

**Challenges.** The state officials described the development of a CSA for individuals with brain injury as a particular challenge. The state was unable to determine one instrument that included the items required by the Balancing Incentive Program's Core Dataset (CDS), and also captured the behavioral and cognitive issues that the stakeholders felt are most important to people with brain injury. The stakeholders representing individuals with mental health conditions acknowledged the challenges in identifying mental health assessment that will be appropriate for the entire population with mental health conditions. The state has tried to accomplish this task many times before without much success. Some of the biggest pushback to identifying a CSA for individuals with mental illness comes from the mental health provider community. Many of these providers use their own assessments and are reluctant to change because they have been serving individuals for years and have collected much data with their assessments.

State officials also reported concerns by beneficiaries about the relationship between the CSAs and service availability, because the State Plans to move to a tier-based system for resource allocation. Some state officials believe that concerns about the effect of CSAs on resource allocation will be alleviated after the implementation of managed care for all populations that is planned for early 2016.

## **Ohio**

**Achievement.** Ohio completed development of CSAs to determine qualifying institutional LOC for three populations: adults requiring nursing facility services; children

requiring nursing facility services; and individuals with I/DD requiring intermediate care facility services. The adult nursing facility LOC tool will replace two assessments and various other assessments sometimes used by nursing facilities. The state did not previously have a nursing facility assessment tool specifically for children, while the other assessments were revised and expanded to include the CDS. Ohio also redesigned the process for assessments and LOC determinations, cutting the number of steps by 85% and shaving an estimated 10 days off the decision process.

**Strategies.** State officials and stakeholders described a lengthy and highly participatory process for developing and testing the assessment tools and improving the assessment and eligibility determination process. A wide range of stakeholders actively participated in the “front door” workgroup, including nursing facility providers, HCBS advocates, case management agencies, and state officials. The tools were extensively tested by the state’s contractor and LTSS providers for inter-rater reliability and face-validity. They were also tested for maintenance of eligibility to ensure that individuals determined eligible under the old system would be likely to be eligible under the new system. An LTSS provider stakeholder said the testing found a very close correlation between results from the old and new instruments, which was reassuring to providers. In addition to improving the assessment tools, Ohio used lean management techniques to develop an improved process for individuals accessing LTSS, as described earlier.

**Challenges.** One challenge for this structural change was the time and effort required to develop and test the new tools. State officials said they were glad they had started working on the assessments before the Balancing Incentive Program project period began and that the support of their contractor was invaluable. Stakeholder groups had several concerns about this change, the most significant of which was the added burden that conducting the new assessments will place on case managers and community providers. Nursing facilities often conduct the initial assessments for new residents with the LOC determination made by desk review. Nursing facilities also had concerns about whether the new assessments will result in fewer individuals approved for their services, but their concerns were alleviated by participation in the process, including the participation of some nursing facilities in testing the new assessment tools.

## Conflict-Free Case Management

Both states addressed issues of CFCM early in the process. Firewalls already existed in the states as part of other initiatives, and could be readily integrated to meet the Balancing Incentive Program requirements. However, each state also expects CFCM practices to continue to evolve. Iowa is planning a move to statewide managed care, which will change the responsible entities and require new rules to ensure CFCM. Ohio anticipates revising the CFCM requirements implemented under the Balancing Incentive Program to meet more stringent requirements under the Medicaid HCBS rule.

The two states identified similar challenges to CFCM in rural areas, where resources are more limited. Some rural providers offer both case management and

direct services. Even where the organizations providing case management (often, the AAAs) do not provide direct services, the communities and labor force are small, so that case managers may have relationships with providers that could present conflicts of interest. The states have worked hard to ensure that firewalls are in place and understood, with clear lines of authority and reporting.

## ***Iowa***

***Achievement.*** Iowa Balancing Incentive Program officials were in agreement that the requirement for CFCM “was an area of strength in Iowa to begin with.” Even before the Balancing Incentive Program, one state official said that it had been made clear to case management organizations that they had to be able to document separate entities within their organizations that were completing assessments and providing services. These firewalls for the case management agencies that were also providing services to clients were intended to remove the conflict of ordering and providing more services that patients needed. Part of the state’s programmatic oversight includes running algorithms to “see if there are patterns of over or under utilizations within areas of case management.”

As part of the CSA implementation, Iowa removed the assessment responsibility from case managers, giving it to a separate contractor. As one Iowa Balancing Incentive Program official said, “it seemed like a great first step to make [the assessment] objective [and] uniform by giving it to one entity statewide.” Beginning in 2016, case management will not be through the state anymore, but will be conducted by managed care entities. Iowa is currently writing rules for these entities.

***Strategies.*** The existing case management agencies (AAAs, DHS Targeted Case Management, County-Based DHS, and private entities) were all brought to the table for input on CFCM. They were asked to model the processes that they had in place, and the state used that as a starting point to formalize the processes. According to state officials the development of the CFCM processes “worked out nicely.”

The CSA contractor implemented an attestation of accuracy from the respondents of the assessment at the time of the assessment to prevent people from changing their responses at a later date if they do not like the outcome of the assessment. The contractors believed that because the attestations emphasize the importance of accuracy, they are a part of making the assessments both accurate and conflict-free.

***Challenges.*** The organizations with the most conflicts of interest to resolve were the AAAs, where as one state official said, “They would do the assessment for case management [services], develop the care plan, and oftentimes had other services they provided to members [beneficiaries] that were within the AAA.” Because the AAA provided both case management services and other HCBS, the firewalls that the state developed were more challenging for the AAAs to implement than other organizations.

One state official said the most challenging part of implementing CFCM was helping case management organizations understand the meaning of the “firewall” (i.e., clear separation of providers of case management services and providers of HCBS) and making clear the “lines of authority and reporting” (i.e., who makes the decisions regarding level of services provided). Other challenges were found in rural parts of the state, where the limited number of providers and case managers creates the potential for conflicts of interest. This has been an ongoing issue and something the state has been trying to address even before the Balancing Incentive Program.

## **Ohio**

**Achievement.** Ohio established protocols for removing conflicts of interest by July 2014, which required developing and implementing firewalls for case management in the aging network, and incorporating conflict-free tenets into managed care plan contracts for Ohio’s Financial Alignment Initiative demonstration.

**Strategies.** Ohio already had CMS-approved firewalls in place for case management of developmental disability services. Those documents were used as templates to develop firewalls for case managers serving older adults. It was not necessary to develop firewalls for other HCBS programs according to state officials, but the state incorporated conflict-free guidelines into contracts with case management organizations and managed care organizations.

**Challenges.** A state official said that the required firewalls had created problems for some rural AAAs. Although they are not direct service providers, the local labor force with LTSS experience is often small, and case managers may have previously worked for a provider organization or have family ties with providers or LTSS users. A stakeholder group indicated that several AAAs had to restructure to meet the requirements, but most already had firewalls in place. State officials said that the HCBS rule on community settings proposed more stringent CFCM requirements than required under Balancing Incentive Program and will require the state to revise the requirements developed under the Balancing Incentive Program project.

## **Looking Toward the Future**

As the Balancing Incentive Program nears the end of its implementation period, both Iowa and Ohio have yet to fully complete the required structural changes, although they both have made progress toward achieving those changes. Work remains to launch the NWD/SEP systems and to implement CSAs in all populations. Both states, however, are confident in their abilities to achieve these goals. They believe that stakeholders generally are supportive of the changes being made and wish to see them continue.

The states share concerns about sustainability of the infrastructure changes, especially the NWD/SEP. To that end, both are seeking other sources of funding, such



as funding from other Medicaid initiatives or collaboration with other state-based grants. Other changes in the states will be affected by ongoing changes in Medicaid HCBS. Iowa and Ohio are planning for a statewide move to managed care, while Ohio is expanding HCBS waiver slots for people with I/DD and planning for a 1915(i) program to serve people with behavioral health needs.

People in both states highlight the importance of good communication to engage stakeholders as key to program success. Stakeholders include the range of people affected, from policy makers and service providers to advocates, family, and consumers. The changes required by the Balancing Incentive Program are far reaching, and require input from multiple stakeholders and coordination across programs and agencies. People in Iowa cautioned about the need for careful planning, and adequate time for implementation.

## ***Iowa***

***General view.*** In general, stakeholders like the changes being brought about by the Balancing Incentive Program and would like funding for these improvements to continue. One stakeholder is concerned about the types of outreach related to the NWD/SEP not reaching the right populations. Their suggestion was that “on an ongoing basis, [Iowa] survey the potential door [that] people go through to make sure they’re aware of opportunities through Balancing Incentive Program.”

Funding and state budgeting was a concern for the future shared by one state official. The suggested that continued enhanced FMAP would be helpful, as Iowa is “in a budget crisis.” The IDA received an NWD sustainability planning grant from the ACL last year and is applying for another 3-year project.

***Future plans and next steps for Iowa include expanding the CSA to other populations.*** The CSA for older adults is expected to be implemented in October 2015, with expansion still coming for the subpopulations of people with mental illness or with brain injury. The state’s contractor will conduct trainings for case managers and providers and will design written materials to be sent to consumers prior to assessment.

Iowa is working to integrate the two databases used for information referral as part of the NWD/SEP requirement. Additionally, work is progressing toward implementation of local access points and a toll-free phone number.

***Recommendations for CMS and for other states.*** State officials and other stakeholders had two primary recommendations. The first concerns the amount of time required to implement the changes required by the Balancing Incentive Program. People emphasized the importance of having realistic expectations and adequate planning and implementation time. One state official commented that an implementation planning period such as CMS provides for other projects or grants would have been very helpful. Also, a longer period of time for implementation of the Balancing Incentive Program would be helpful in this official’s opinion, primarily concerning the NWD

component, although they concluded that “maybe we were too ambitious.” Another state official echoed the concern about ambition, suggesting that other states considering changes such as those under the Balancing Incentive Program should consider “the ambition of your work plan carefully before underestimating the amount of time [required].” Their suggestion was to build in more time and resources than seem necessary. One stakeholder suggested that flexibility is important in implementing a program like Balancing Incentive Program, especially related to the timeline. Their recommendation was to spread out the planning process.

The second key recommendation was to ensure the active and continual engagement of stakeholders, especially consumers. One state official noted that “if we’re not designing with our consumers, we’re probably designing a system that is not as effective as it could be.” Another person emphasized the importance of regular engagement of stakeholders, “bring[ing] them back to the table to answer their concerns immediately and thoroughly, because real change is difficult.”

## **Ohio**

**Continuing state efforts to enhance LTSS.** At the time of our interviews, Ohio had not launched the NWD/SEP system, but expected to implement it by September 30, 2015, the end of the Balancing Incentive Program project period. State officials expressed confidence about the implementation of the required structural changes. An immediate next step was implementation of the training plan, with modules on a wide range of topics and trainings planned for LOC assessors, case managers, LTSS providers, and staff from state agencies, and the primary audience--SEP staff.

State officials were also confident about the sustainability of the Medicaid-funded SEPs and continued progress on rebalancing LTSS expenditures. At the time of the interviews, the Governor had just signed SFY 2016-2017 budget legislation which included funding for 3,000 new HCBS waiver slots for individuals with I/DD. State officials also noted that they have begun planning a 1915(i) community-based behavioral health services program for individuals with serious mental illnesses.

**Key factors in Ohio’s progress on rebalancing.** State officials and stakeholders identified key factors they believe contributed to the success of the Balancing Incentive Program in Ohio. The Governor, the OHT, and the Medicaid director were credited by both state officials and stakeholders with providing strong leadership on rebalancing expenditures and supporting the Balancing Incentive Program structural changes. The Balancing Incentive Program project leadership team was praised for convening the right stakeholders and listening to them, strong communications, and a commitment to rebalancing and community living. Several stakeholders also praised the Kaizen method for process improvement and setting a positive tone for teamwork and stakeholder engagement. State officials said that assembling a strong Balancing Incentive Program project team and using good consultants had contributed to their success.

### 3. DISCUSSION

The Balancing Incentive Program established by the ACA is designed to help states provide a greater share of LTSS through HCBS, while at the same time improving the LTSS infrastructure to create a more consumer-friendly, consistent, and equitable system. This report presents case studies of two states, Iowa and Ohio, which began their participation in the initiative facing considerable challenges, and have made significant process since then. These case studies serve as a companion piece to a process evaluation, which describes the preliminary actions taken by 19 states. The case studies provide greater detail of some of the challenges faced and strategies that states may find most helpful. Findings from these case studies include the following:

***The states used a variety of Medicaid programs to help support the rebalancing of LTSS toward HCBS.*** The states were well underway toward this goal at the time they began participation in the Balancing Incentive Program. They were using multiple Medicaid programs or authorities to support that goal, including MFP, Section 1915(c) waivers, and other programs.

***System redesign activities required the participation of multiple state agencies.*** State activities to design and implement a NWD/SEP system, select or develop CSAs, and ensure that CFCM involved multiple state agencies. These collaborative efforts provided opportunity for agencies to share resources and streamline processes.

***Participation in the Balancing Incentive Program reflected states' commitments to HCBS.*** Support from the governors and state legislatures was critical to addressing challenges and supporting expansion of HCBS.

***Stakeholder engagement is critical to ensure success.*** Key stakeholders include consumers, family members, advocates, and direct care providers. The states engaged stakeholders in different ways and at different times. Both used contractors to assist with stakeholder engagement, and both states recognized the importance of strong stakeholder engagement. Individuals in both states identified the importance of this involvement and recommended a strong commitment to input from consumers at all phases of development.

***Development of an NWD/SEP has been challenging.*** Both states are building on their existing ADRCs/ADRN, and both have received ACL grants to help with the development of ADRCs. Despite this support and prior work, states report major challenges to achieving this goal. The coordination of information from multiple systems, historically used by different populations, is a particular challenge.

**CSA development is time-consuming.** Both Iowa and Ohio chose to develop separate CSAs for different populations. Progress within these populations has been mixed, with CSAs developed and tested for some populations and as yet underway for others. Stakeholders are especially concerned about the development of CSAs. Active and ongoing engagement of and communication with stakeholders takes time, but is necessary to ensure successful development.

**CFCM is challenging in rural areas.** The two states were able to address CFCM early in the implementation process, because policies and firewalls already existed as part of other initiatives and could be readily adopted for the Balancing Incentive Program. However, both states identified similar challenges in rural areas, where resources are more limited. Some rural providers offer both case management and direct services. Even where the case management organizations do not provide direct services, the communities and labor force are small, so that case managers may have relationships with providers that could present conflicts of interest. States are working hard to address these concerns.

**States are concerned about sustainability.** Both states identified concerns about the sustainability of the infrastructure changes, especially the NWD/SEP. Both are seeking other sources of funding, such as other Medicaid initiatives or collaboration with other state-based grants, to support this. Anticipated changes in state Medicaid programs, such as Iowa's planned move to statewide managed care, will have implications for sustainability as well.

Overall, results of these case studies found two states that worked hard to achieve success. Commitment of upper-level policy makers, state agencies, and stakeholders has helped to move states forward to achievement of the goals. Adequate planning time and stakeholder engagement also are critical to success.

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