Maryland Is Second State Approved for Medicaid's Balancing Incentive Payments Program

Maryland is the second state to receive federal approval under the Balancing Incentive Payments Program (BIPP) to shift state Medicaid spending towards community-based care.[1] Beginning this April, the Centers for Medicare and Medicaid Services will provide Maryland with over $106 million over three years. In return, the state will make specified programmatic changes in an attempt to increase its Medicaid funding for *community-based* long-term services and supports (LTSS) from 37 to 50 percent of the state's total LTSS funding.

BIPP was enacted as part of the Affordable Care Act. In making a BIPP application to CMS, a state commits itself to spend either 25 or 50 percent (or more) of its LTSS Medicaid budget on community-based services The 25-percent target applies to those states currently under 25 percent; the 50 percent target applies to those states currently between 25 and 50 percent. The planned strategies for meeting these targets must include a no-wrong-door entry point system, conflict-free case management, and a standardized assessment agreement.

As is true for many states, Maryland has multiple preexisting programs to promote community-based care: these include nine Medicaid waiver programs and a Money Follows the Person program, along with personal care services authorized by the state's Medicaid state plan. As also is true in many other states, however, Maryland's programs are vexed by coordination difficulties and a complexity that frustrates consumers.

No-Wrong-door Requirement

Maryland currently maintains a system of Aging and Disability Resource Centers, which it terms Maryland Access Point (MAP) sites. Under the state's BIPP proposal, the MAP sites will add a statewide toll-free number and improve an existing website. Based on information obtained over the phone or website, the MAP sites will conduct preliminary functional and financial assessments; subsequently, second-level eligibility screens will be performed by local health department offices.[2] The MAP sites currently provide services for an area including approximately 90 percent of the state's population; this coverage is expected to approach 100 percent of the state by the end of fiscal year 2012.[3] Also, the state will step up its outreach and education services to hospitals, nursing facilities, and others.[4]

National Senior Citizens Law Center
www.nsclc.org
nsclc@nsclc.org
1444 Eye St., NW, Suite 1100
Washington, DC 20005-2210
202-289-6976 • Fax: 202-289-7224
3701 Wilshire Blvd., Suite 750
Los Angeles, CA 90010
213-639-0930 • Fax: 213-368-0774
1330 Broadway, Suite 525
Oakland, CA 94612-2522
510-663-1055 • Fax: 510-663-1051

Case Management

The state acknowledges potential conflicts of interest in its current processes and commits to resolving those conflicts although, at this time, without any comprehensive plan on how to do so. The state's work plan sets as one goal that a plan of care be created separately from any determination of the participant's available funding. Also, the state intends that family members and paid caregivers not be part of functional eligibility determinations, unless absolutely necessary.[5]

Standardized Assessments

Maryland intends to base its assessment processes upon the interRAI-Home Care tool, and will add financial question to the screening process. Also, the state expresses its interest "in using the interRAI-HC assessment to designate a case-mix and provide guidance to the number of hours and dollar amount available for each individual." Relying on the tool in this way, and moving from subjective to objective evaluations, will reduce conflicts for the person performing an assessment, according to the state. The state, however, acknowledges the potential conflict between an algorithm-derived budget and a person-centered care plan, and statutes that the system would assure that all of a participant's needs are met.[6] The state has convened an assessment workgroup to ensure that a change in assessment processes will have minimal impact on the outcome of clinical eligibility determinations.[7]

Overall, Maryland's application evidences a public-policy enthusiasm for the various community-based options provided by the federal government in recent years. For example, the application expresses an intent to consolidate waiver services and state-plan person care services within the Affordable Care Act's Community First Choice Option.[8]

Questions can be directed to NSCLC attorney Eric Carlson at ecarlson@nsclc.org.

[1] The first state was New Hampshire; its application was approved on March 2, 2012. See NSCLC Health Network Alert. The relevant documents for Maryland's application can be found at http://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Reform.aspx.
[2] *See* Md. Application at 34-37.
[3] *See* Md. Application at 52.
[4] *See* Md. Application at 53-54.
[5] *See* Md. Application at 30.
[6] *See* Md. Application at 30-31.
[7] *See* Md. Application at 46.
[8] *See* Md. Application at 18; *see also* Affordable Care Act, § 2401.