Balancing Incentive Program (BIP)

The Balancing Incentive Program, authorized by Section 10202 of the 2010 Affordable Care Act (ACA), provided financial incentives to offer Long Term Services and Supports (LTSS) as an alternative to institutional care.

Overarching BIP Goals:

* Rebalance the delivery of LTSS towards community-based care.
* Promote enhanced consumer choice.
* Provide information for eligibility determination and enrollment processes.
* Improve access to and expand community LTSS.
* Provide essential services in the least restrictive setting.

In addition, under BIP, NYS was required to implement three structural changes:

1.) Enhance No Wrong Door/Single Entry Point System for access to LTSS information.
2.) Continue implementation of Comprehensive Assessment Instruments that capture a Core Data Set for determining eligibility for non-institutionally-based LTSS for all populations.
3.) Ensure Conflict-Free Case Management.

Innovation Fund

The BIP Innovation Fund was created to support programs offering services solutions that align with consumer preference and foster community inclusion. The fund offered a unique opportunity to engage New York's broad network of highly qualified providers, advocates, and community-based LTSS across all populations of Medicaid beneficiaries in New York State. Fifty-four Innovation Fund grants were awarded on a competitive basis, totaling $52,750,000.

Innovation Fund Grant Awardees

Advance Care Alliance of NY
Buffalo Federation of Neighborhood Services
The Carter Burden Center for the Aging
Catholic Charities of Broome County d/b/a Roman Catholic Diocese of Syracuse
Catholic Managed Long Term Care
Center for Disability Services
Central Nassau Guidance and Counseling
Chautauqua County Chapter, NYSARC d/b/a The Resource Center
Children's Home of Jefferson County
Consumer Directed Personal Assistance Association of NYS
Coordinated Behavioral Care
Corning Council for Assistance and Information for the Disabled
Council of Senior Centers and Services of NYC
Elant at Goshen
Erie County Department of Senior Services
Family Residences and Essential Enterprises
God's Love We Deliver
The Hebrew Home for the Aged at Riverdale
The Hillside Children's Center
The Institutes of Applied Human Dynamics
Jewish Association for Services for the Aged
Jewish Home Life Care, NYC Chapter
Jewish Home Life Care, Sarah Neuman Center
Kids Oneida
Lifespan of Greater Rochester
Menorah Home and Hospital for the Aged and Infirmary
Mental Health Association of NYC
New Alternatives for Children
New Horizon Counseling Center
The New York Foundling Hospital
New York Memory Center
Niagara Falls Memorial Medical Center
NYSARC, Capital NYC Chapter
Odyssey House
Paraprofessional Healthcare Institute
Parker Jewish Institute for Health Care and Rehabilitation
Regional Center for Independent Living
The Research Foundation for the SUNY, UAlbany
Resource Center for Independent Living
Rockland Independent Living Center
Selfhelp Community Services
Services of the Underserved
St. Mary's Hospital for Children
Tompkins County Office for Aging
Total Senior Care
United Cerebral Palsy of New York City
Visiting Nurse Association of Central New York
VNS Association of Schenectady County d/b/a VNS of Northeastern NY
Yeshiva University & Montefiore Medical Center

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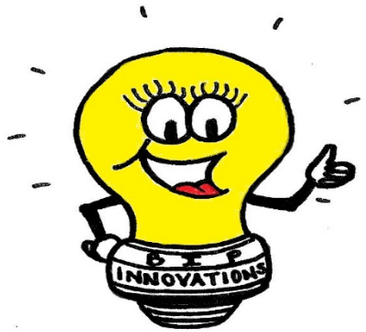
NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State
Department of Health
Balancing Incentive Program (BIP)

Innovation Fund Grants Results Meeting

Thursday, September 22, 2016
1-4 pm
Empire State Plaza, Room 6
Albany, NY



Innovation Fund Grants Results Meeting

Agenda

Welcome

Andrew Segal, *Director, Division of Long Term Care*

Opening Remarks

Laurie Lucinski, *Acting Director, Balancing Incentive Program*

Phyllis Howard, *Grant Project Lead*

Presentations

Questions/Discussion

Closing Remarks

Featured Presentations

Urgent Care for People with Intellectual and Development Disabilities

Advance Care Alliance of NY

Worked to improve access to and quality of primary/specialty outpatient medical and behavioral health care for people with I/DD. It reduced avoidable ER visits and admissions through the provision of telehealth medical triage with access to same/next day medical appointments and off-hours urgent care teams. Also provides tele-monitoring with Interactive Choice Response (IVR) and patient activation coaching.

BIP Healthcare Coordination

Lifespan of Greater Rochester

The Community Care Connection program increased access to community-based medical, disability, and aging services for individuals with difficulty navigating LTSS due to barriers such as low health literacy, lack of support, transportation, and financial challenges. It decreased hospitalizations, ER visits, and caregiver stress by connecting individuals with community-based health care and support services and educating them about their healthcare needs.

Therapeutic Crisis Respite Program (TCRP)

Children's Home of Jefferson County

The TCRP program stabilizes and secures a safe alternative to hospitalization for children aged 10-17 with social and emotional disturbances by providing short-term crisis respite with 24-hour supervision. It is providing care coordination, as well as follow-up care, to strengthen and support individuals and their families during times of crisis.

Remote Patient Monitoring for Children with Medical Complexity

St. Mary's Hospital for Children

Focused on reducing the need for more intensive medical care among children with multiple chronic conditions by using remote patient monitoring. It uses an Interactive Voice Response (IVR) to check on medication adherence, falls, occurrences of major medical events, and other changes in condition. Follow-up is conducted over the phone or in-person depending on the individual's response.

Highlight Presentations

A PACE for Seniors with I/DD

Catholic Managed Long Term Care

Integrated the I/DD population into an existing PACE program, which provides comprehensive, integrated, managed health care and supportive services by a specialty trained staff. The presentation will be highlighting their "Special Needs Alert" that is given to their participants to communicate pertinent information to medical providers.

The "Extroverted" ADRC

Erie County Department of Senior Services

The 'Ready Set Home' program reduced utilization of inappropriate levels of care and failed discharges into the community. It targeted low acuity residents of skilled nursing facilities and individuals receiving sub-acute care following a hospitalization, who were at risk of institutional placement. The program assisted them in overcoming obstacles and provided bridge services while waiting for MLTC coverage.

LGBT Older Adult Initiative Expanding Community Awareness and Options in Care

The Hebrew Home for the Aged at Riverdale

The SAGEDAY program addressed the unique social and health care needs of the aging LGBT community and developed a LGBT competent training curriculum for Adult Day Services program staff. The project increased the number of LGBT aging individuals served in non-institutional settings.

ParkerCare Geriatric Mobile Care Management and Referral Program

Parker Jewish Institute for Health Care and Rehabilitation

The Parker At Your Door (PAYD) program reduced unnecessary ER visits and hospitalizations by providing home-based primary care and case management services to high-need seniors. It provided individuals in the community and those discharged from Skilled Nursing facilities with a 24/7 assistance hotline to improve access to community-based LTSS.

The Medically Tailored Food and Nutrition Expansion Project

God's Love We Deliver

Expanded the NYC-based home-based nutrition service into Nassau and Westchester counties, diverting more at-risk individuals from institutionalized care and providing the long-term support individuals need to stay healthy. Also created the 'Food and Nutrition Services Referral Tool' to identify need and standardize determination, and educated MLTC staff on the tool and the Food and Nutrition Services (FNS) benefit.