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

Preliminary Process Evaluation of the Balancing Incentive Program

October 2015

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PRELIMINARY PROCESS EVALUATION OF THE BALANCING INCENTIVE PROGRAM

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ACRONYMS

The following acronyms are mentioned in this report.

ACA	Affordable Care Act
ADRC	Aging and Disability Resource Center
AIDS	Acquired Immune Deficiency Syndrome
CDS	Core Dataset
CFCM	Conflict-Free Case Management
CMS	Centers for Medicare and Medicaid Services
CSA	Core Standardized Assessment
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-Based Services
HIV	Human Immunodeficiency Virus
I/DD	Intellectual or Developmental Disabilities
LTSS	Long-Term Services and Supports
MFP	Money Follows the Person
NASUAD	National Association of States United for Aging and Disabilities
NWD	No Wrong Door
SEP	Single Entry Point
SIM	State Innovation Model
SMI	Serious Mental Illness
SPA	State Plan Amendment
SUD	Substance Use Disorders
TBI	Traumatic Brain Injury

EXECUTIVE SUMMARY

Long-term services and supports (LTSS) are used by people with disabilities or chronic health conditions who need help with activities of daily living (e.g., bathing, dressing, eating) or instrumental activities of daily living (e.g., preparing meals, managing money). Historically, the financing and delivery of Medicaid LTSS has favored institutional care over home and community-based services (HCBS), despite the fact that people with disabilities generally prefer to live in the community. The 2010 Patient Protection and Affordable Care Act included several provisions designed to increase the provision of Medicaid HCBS and to improve the infrastructure for provision of those services. States that were, in 2009, spending less than 50% of their total Medicaid LTSS expenditures on HCBS were eligible to participate in the Balancing Incentive Program. Participating states are expected to increase the share of LTSS dollars spent on HCBS and to improve the LTSS infrastructure to create a more consumer-friendly, consistent, and equitable system, in exchange for which they 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. States that spent less than 25% of their Medicaid LTSS dollars on HCBS in 2009 were eligible to receive a 5% enhanced federal match rate and were required to meet or exceed the 25% HCBS spending benchmark by the end of federal fiscal year 2015 (September 30). States whose LTSS spending on HCBS in 2009 was at least 25% but less than 50% were eligible for a 2% enhanced federal match rate and were required to meet or exceed the 50% HCBS spending benchmark by September 30, 2015.

States participating in the Balancing Incentive Program 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/single entry point (NWD/SEP) process 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. Although all states were required to implement these infrastructure reforms according to Centers for Medicare and Medicaid Services protocols specifying certain essential elements, they were free to do so in whatever way worked best. This report describes the processes used by participating states early in their efforts to achieve these goals through September 30, 2014. A later report will describe the processes used through the end of the Balancing Incentive Program (September 30, 2015).

Data were obtained through document review, with the key documents being the quarterly progress reports from states participating in the Balancing Incentive Program. Information from these documents was compared against the information from the states' applications and work plans as reported in the baseline report (Wiener et al., 2015) to assess how the actual activities compared to what had been planned. Additional sources of information include notes and supplemental materials from

stakeholder advisory group meetings and summary briefs on state Balancing Incentive Program activities from the technical assistance contractor, Mission Analytics (2015c).

This preliminary process evaluation covers the period from each state's start of its Balancing Incentive Program (April 1, 2012-July 1, 2014, depending on the state) through September 30, 2014. One additional state, Nebraska, began participating in the Balancing Incentive Program on October 1, 2014, and is excluded from this analysis. Pennsylvania, which began participation on July 1, 2014, also is excluded from this evaluation because no data were available for its activities before October 2014.

Findings from this evaluation of the processes used early in the implementation indicate the following:

- States are using a range of Medicaid State Plan options and waiver programs to help attain the goals of the Balancing Incentive Program. All states are using Money Follows the Person and 1915(c) waivers, and many also are using State Plan options. Although many of these programs were in operation in the states before implementation of the Balancing Incentive Program, several states have chosen to expand the programs or to add new programs.

- States also may use funds from the Balancing Incentive Program to help support activities of these other Medicaid programs. For example, some states are using Balancing Incentive Funds to increase 1915(c) waiver slots and reduce waiting lists, or to support the development of health homes.

- The most frequent method of increasing the share of total LTSS dollars spent on HCBS was to increase the number of individuals receiving HCBS (13 states). States also achieved this goal by increasing the services available to current HCBS recipients (ten states) and by increasing the HCBS payment rates (six states).

- States could target efforts to increase HCBS expenditures at specific populations. Most commonly, such efforts addressed people with intellectual or developmental disabilities, older adults, younger adults with physical disabilities, or people with mental health or substance use disorders. People with HIV/AIDS or brain injuries were targeted less often.

- Only two states (Maryland and Missouri) had completed the requirements of the NWD/SEP system by September 14, 2014 (a full year in advance of the program deadline), but other states were making progress. Over half of the states had established a toll-free telephone number (13 states), developed standardized informational materials (11 states), or established an NWD/SEP website (ten states). States reported a variety of delays, despite which several states had achieved various components of the NWD/SEP system.

- Six states had completed the requirements of a CSA. Most (14) states had completed the development of a Level I screen assessment. Fewer states had incorporated the required domains and topics in their assessments (eight states) or had trained staff at the NWD/SEPs in the coordination of the CSAs (also eight states).

- About two-thirds (13 states) had developed protocols needed to remove conflict of interest from case management. Several (six states) reported delays in establishing CFCM, often related to challenges of working with specific provider types.

- Stakeholders were engaged in the Balancing Incentive Program in a variety of ways. About half of the states (11) convened formal advisory boards, comprising primarily LTSS providers and policy makers. Consumers and consumer advocates participated in meetings in seven states.

Together, these findings indicate that participating states are using a variety of strategies and processes to achieve the required rebalancing of expenditures and improvements in infrastructure. Although states have indicated delays and challenges in meeting an ambitious timeline, they are making progress and accomplishing the required goals. A future report to assess the processes used throughout the course of the Balancing Incentive Program may provide insight into which of these approaches are most likely to be successful.

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 are expected to increase the share of LTSS dollars spent on HCBS and to improve the LTSS infrastructure to create a more consumer-friendly, consistent, and equitable system, in exchange for which they 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.

States participating in the Balancing Incentive Program were required to accomplish four goals: increase the percentage of total Medicaid LTSS dollars expended for HCBS to target goals,[1] create a no wrong door/single entry point (NWD/SEP) system 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. Although all states were required to address the same goals, they were free to do so in whatever way worked best for them. This report describes the processes used by participating states early in their efforts to achieve these goals through September 30, 2014. A later report will describe the processes used through the end of the Balancing Incentive Program (September 30, 2015).

[1] 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.

2. METHODS

This report describes the processes by which participating states implemented the Balancing Incentive Program. Data were obtained through document review, with the key documents being the quarterly progress reports from states participating in the Balancing Incentive Program. Information from these documents was compared against the information from the states' applications and work plans as reported in the baseline report (Wiener et al., 2015) to assess how the actual activities compared to what had been planned. Additional sources of information included notes and supplemental materials from stakeholder advisory group meetings and summary briefs on state Balancing Incentive Program activities from the technical assistance contractor, Mission Analytics. RTI International and National Academy for State Health Policy team members reviewed these documents for each of the participating states and extracted data using a single set of data summary tools. To ensure a consistent process, the team discussed the data sources used, information found, and questions of interpretation.

This preliminary process evaluation covers the period of time from the start of the Balancing Incentive Program through September 30, 2014. Although 21 states were participating in the Balancing Incentive Program at the time we began this evaluation, Nebraska did not begin participation until October 1, 2014, and is therefore excluded from this preliminary evaluation. Pennsylvania also is excluded from this evaluation. Although Pennsylvania began participation in July 2014, its earliest quarterly report only begins reporting data as of October 2014. This report is therefore limited to 19 states.

As of December 31, 2014, two states (Indiana and Louisiana) had ceased participation in the Balancing Incentive Program. These states are included in this preliminary process evaluation, as they still were participating in the Balancing Incentive Program before October 1, 2014. A third state, Nebraska, ended its participation in March 2015. Nebraska is excluded from this report because, as noted above, it did not begin its participation in the program until after the period covered by this preliminary report.

This process evaluation addresses seven research questions. The questions and the key data sources used to address them are shown in ***Exhibit 1***. Together, these questions address the various processes used by states to work toward the goals of the Balancing Incentive Program.

A companion report describes case studies conducted in two states, which provide additional detail about the types of challenges states experienced and strategies they found helpful.

EXHIBIT 1. Key Research Questions and Data Sources for Baseline Report	
Research Questions	**Data Sources**
Research Question 1: What Medicaid coverage and eligibility options did the state use to implement its Balancing Incentive Program? For example, did the state adopt a new SPA or a HCBS waiver?	• State applications and work plans for the Balancing Incentive Program (CMS Balancing Incentive Program website) (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html) • CMS SPA database (http://medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html) • CMS waiver database (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html) • NASUAD State Medicaid Integration Tracker (http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker) • Mathematica Policy Research MFP program database • CMS Transition Plan Portal (when available)
Research Question 2: Did the state increase HCBS provider rates or expand the type and amount of HCBS available to program participants?	• State applications and work plans for the Balancing Incentive Program • CMS SPA database • CMS waiver database • Mission Analytics' profiles of state programs, including progress reports (http://www.balancingincentiveprogram.org/state-activities) • Mathematica Policy Research MFP program database
Research Question 3: Did the state make other policy changes to its Medicaid program, such as increasing the number of waiver slots or establishing a process for reducing waitlists?	• State applications and work plans for the Balancing Incentive Program • CMS SPA database • CMS waiver database • Mission Analytics' profiles of state programs, including states' quarterly progress reports • Mathematica Policy Research MFP program database
Research Question 4: What actions were taken to address the infrastructure and state-specific goals?	• Previous information collected from state applications and work plans for the Baseline Report • Mission Analytics' profiles of state programs, including states' quarterly progress reports • Mathematica Policy Research MFP program database

EXHIBIT 1 (*continued*)	
Research Questions	**Data Sources**
Research Question 5: Did state activities specifically address one or more subpopulations of individuals who need long-term services and supports (LTSS)? If so, did activities to increase access to and availability of HCBS differ for these subpopulations?	• State applications and work plans for the Balancing Incentive Program • CMS SPA database • CMS waiver database • Mission Analytics' profiles of state programs, including states' quarterly progress reports • Mathematica Policy Research evaluation reports on the MFP program
Research Question 6: Did Balancing Incentive Program policies interact with HCBS benefit options that established before Balancing Incentive Program implementation, and if so, how?	• State applications and work plans for the Balancing Incentive Program • CMS SPA database • CMS waiver database • Mission Analytics' profiles of state programs, including progress reports • NASUAD State Medicaid Integration Tracker • Mathematica Policy Research evaluation reports on the MFP program • Urban Institute Health Homes evaluation • U.S. Department of Health and Human Services report on Community First Choice • Technical Assistance Exchange information on expansion of ADRC programs (http://www.adrc-tae.acl.gov/tiki-index.php?page=HomePage)
Research Question 7: How did the states work with stakeholders (e.g., LTSS providers) when implementing the Balancing Incentive Program?	• State applications and work plans for the Balancing Incentive Program • Mission Analytics' profiles of state programs, including progress reports • Notes from stakeholder advisory group meetings • Public input sections from applicable HCBS waiver applications
NOTE: The link provided above to the University of California, San Francisco Center for Personal Assistance Services is no longer functional. That site has been taken down.	

3. FINDINGS

Research Question 1: What Medicaid coverage and eligibility options did the state use to implement its Balancing Incentive Program? For example, did the state adopt a new SPA or an HCBS waiver?

Although the Balancing Incentive Program set goals for states to achieve and provided some funding through enhanced FMAP, the process for implementing the Balancing Incentive Program was left to the states. States could increase the percentage of their LTSS spending that is for HCBS by broadening service coverage and increasing eligibility through a variety of Medicaid State Plan options and waivers. States could expand on State Plan options and waivers that already were in operation, or could implement new State Plan options or waivers. States used a mix of these approaches. ***Exhibit 2*** shows the HCBS State Plan options and waiver programs that were used to help implement the Balancing Incentive Program goals, and whether these programs were being used before or adopted after the implementation of the Balancing Incentive Program. States used anywhere from three to six types of programs to help implement the Balancing Incentive Program.

At the start of their participation in the Balancing Incentive Program, all states were participating in the MFP program (Wiener et al., 2015). Over half of the states (12 of 19) expanded their MFP programs during the preliminary implementation period reported on here.

All states also had Medicaid Section 1915(c) waivers in place before participation in the Balancing Incentive Program and were able to use those programs to help implement their Balancing Incentive Programs. Most (14) of the participating states expanded use of their existing 1915(c) waivers, either by increasing the number of people served or the range of services covered.

Several State Plan options were available during the initial Balancing Incentive Plan operation. Over half (11) of the participating states were using the State Plan personal care option at the time they implemented the Balancing Incentive Program, and they continued to use that option. None of these states expanded the use of their State Plan personal care option, nor did any state add such an option during this preliminary period.

Two other State Plan options were used less often. Section 1915(i) is used by states to provide HCBS as a State Plan service. Section 1915(k), also called Community First Choice, provides enhanced FMAP for states that are providing personal care and support services to people who need assistance to live in the community. Seven states used the 1915(i) State Plan option, with three of those adopting the options after beginning participation in the Balancing Incentive Program and four states implementing a new 1915(i) State Plan option during this period. None

of the states taking part in the Balancing Incentive Program had a Section 1915(k) (Community First Choice) State Plan option in place at the start of its Balancing Incentive Program. One state (Maryland) adopted a Section 1915(k) plan after beginning participation in the Balancing Incentive Program. Two other states taking part in the Balancing Incentive Program (Connecticut and Texas) have indicated plans to implement a 1915(k) plan, but had not done so as of September 30, 2014.

EXHIBIT 2. Medicaid Coverage and Eligibility Options Used by Balancing Incentive Program States

Balancing Incentive Program State	State Plan							
	MFP	1915(c) Waivers	Personal Care	Option 1915(i)	Option 1915(k)	Health Homes	1115 Waivers	Number of Program Types Used
Arkansas	X	X	X				X	4
Connecticut	E	E		X				3
Georgia	X	E						2
Illinois	X	E				N		3
Indiana	E	E		N			X	4
Iowa	E	E		X		E		4
Kentucky	X	E				N		3
Louisiana	E	E	X	X				4
Maine	X	E	X			E		4
Maryland	X	X[a]	X	N	N	N	X	7
Massachusetts	X	E	X					3
Mississippi	E	E		N			X	4
Missouri	E	E	X			X		4
Nevada	X	X	X	N		X		5
New Hampshire	X	E	X					3
New Jersey	E	X[b]	X			N	X	5
New York	X	E	X			X	X[c]	6
Ohio	X	E, N[d]				E		3
Texas	X	X	X				E[e]	4
Total	**19**	**19**	**11**	**7**	**1**	**10**	**7**	**75**
Existing	7	5	11	3	0	3	6	36
Expanded	12	14	0	0	0	3	1	30
New	0	1	0	4	1	4	0	10

NOTES: X = Existed before and continued since start of the Balancing Incentive Program; E = Existed before and expanded since baseline; N = New since implementation of the Balancing Incentive Program.

a. Merged two existing waivers into a single, combined waiver.
b. New Jersey's 1915(c) waivers were subsumed under its 1115 demonstration program and eliminated as separate waivers during this time period.
c. New York's 1115 waiver was in operation at the start of the Balancing Incentive Program, but authority has since expired. An application has been submitted, but not yet approved.
d. Ohio implemented a waiver for an integrated care delivery system as part of its demonstration for dually eligible individuals.
e. Waiver was amended to authorize managed LTSS statewide and add additional HCBS to capitation.

Health Homes, which are a third type of State Plan option, offer integrated and coordinated primary, acute, and behavioral health services and LTSS to Medicaid beneficiaries with chronic conditions, including people with mental health disabilities. Six states had adopted health homes before beginning the Balancing Incentive Program, and half of those expanded their health homes programs during this time. Four other states began health home State Plan programs after beginning the Balancing Incentive Program. Three additional states (Connecticut, Illinois, and Massachusetts) indicated plans to implement a health homes State Plan option sometime after September 30, 2014.

Section 1115 Research and Demonstration Waivers offer states the opportunity to test new and innovative approaches to serving people who may not otherwise be covered by Medicaid; to provide services that typically would not be covered by Medicaid; or to test other service delivery innovations to improve care, decrease costs, and enhance efficiency. Depending on the state, Section 1115 waivers may or may not provide HCBS; many are limited to medical care. At the time that they implemented their Balancing Incentive Programs, seven of the states were operating 1115 demonstration waivers that provide HCBS. One of those states (Texas) expanded its 1115 demonstration waiver following the implementation of the Balancing Incentive Program to add additional types of HCBS to the program and to extend its coverage statewide. Another state (New Jersey) used its 1115 waiver to combine all of its 1915(c) waivers that had been operating before the Balancing Incentive Program and eliminate those as separate programs. Illinois submitted a waiver application in 2014, but it had not yet been approved.

Research Question 2: Did the state increase HCBS provider rates or expand the type and amount of HCBS available to program participants?

Research Question 3: Did the state make other policy changes to its Medicaid program, such as increasing the number of waiver slots or establishing a process for reducing waitlists?

States could meet the requirement to increase the share of LTSS dollars spent on HCBS by increasing expenditures for people already being served (Research Question 2), by increasing the number of people being served (Research Question 3), or by a combination of the two. Because of the interplay of these approaches, we present responses to these two research questions together.

Twelve of the states increased the share of total LTSS expenditures for HCBS through strategies that focused on people already receiving HCBS. Six states did this by increasing the payment rates to HCBS providers, and 11 states did this by increasing the scope of services or amount of benefits for existing HCBS recipients. Five states used both approaches to increasing HCBS expenditures (***Exhibit 3***).

Several methods were used by states to increase the number of people receiving HCBS. Nine states used strategies to increase access to HCBS for people with mental health disabilities. Some states achieved this through implementing new programs, such as 1915(i) State Plan options, while others expanded the number of people served through existing programs. Another method to increase the number of people receiving HCBS was to support the transition of people from institutions into the community. This did not increase the overall number of people receiving LTSS, but merely shifted people from institutions to the community, thereby increasing the number of beneficiaries receiving HCBS. Two states used this approach. Twelve states increased the number of people served by expanding current HCBS programs by serving new populations (eight states), reducing waiting lists (five states), or increasing waiver slots (ten states).

EXHIBIT 3. Strategies Used to Expand HCBS as a Share of Total LTSS Expenditures									
Balance Incentive Program State	**Increase Share of HCBS Expenditures for Current Population (Research Question 2)**		**Increase Number of People Receiving HCBS (Research Question 3)**						
	Increase HCBS Provider Rates	**Increase Scope or Amount of HCBS Benefits to Current Users**	**Expand Mental Health Services**	**Support Transitions from Institutions to Community**	**Expansion of HCBS of Serve More People, New Populations**	**Reduce HCBS Waitlists**	**Increase HCBS Waiver Slots**	**Other Strategies**	**Total Strategies Used by State**
Arkansas[a]									0
Connecticut		X					X		2
Georgia	X	X	X				X	X	5
Illinois	X	X	X	X	X	X	X		7
Indiana			X				X		2
Iowa	X					X			2
Kentucky							X		1
Louisiana		X	X		X		X		4
Maine							X		1
Maryland	X	X	X	X	X	X	X		7
Massachusetts	X	X	X						3
Mississippi		X			X	X	X		4
Missouri					X		X		2
Nevada[b]									0
New Hampshire[c]									0
New Jersey		X	X		X				3
New York		X						X	2
Ohio		X	X		X		X		4
Texas	X	X	X		X	X	X		6
Total	**6**	**11**	**9**	**2**	**8**	**5**	**10**	**2**	**55**

NOTES:

a. Arkansas was working on several plans, but none had been implemented at the time of this report. Strategies in the works included planning for a 1915(i) State Plan option (implementation on hold); health homes for participants in the I/DD, physical disabilities, and aging waivers, and individuals with SMI (implementation on hold); and a draft Community First Choice SPA that was submitted to the CMS and was awaiting review. One of the goals of the Community First Choice plan was a reduction in waiting lists for people with I/DD. Rate increases were proposed for waiver attendant services and adult day care, and were awaiting legislative and budgetary review. Other planned activities included HCBS outreach to rural residents and provider recruitment.

b. Nevada began implementation of their Balancing Incentive Program in April 2014 and had not yet undertaken any of these strategies.

c. New Hampshire provided trainings to staff at community mental health centers to enhance their capacity to serve adults and children with serious mental or emotional disturbance, but did not directly support the expansion of mental health services.

Eleven of the states used both general types of approach, increasing expenditures for current HCBS recipients and increasing the number of HCBS recipients.

Research Question 4: What actions were taken to address the infrastructure and state-specific goals?

As part of the Balancing Incentive Program legislation, each state is required to meet three structural reform goals--establishment of an NWD/SEP system, creation and implementation of a CSA, and a process to ensure CFCM. In addition, some states set additional goals for themselves beyond those required of all participating states.

3.1. No Wrong Door/Single Entry Point

One of the structural requirements is the establishment of an NWD/SEP. The purpose of this initiative is to make it easier for beneficiaries to access the service system. The required NWD/SEP system has five key components:

1. Standardized informational materials.
2. Training staff on eligibility determination and enrollment processes.
3. Implementing a process to guide individuals through assessment and eligibility determination.
4. Establishing a NWD/SEP website.
5. Establishing a NWD/SEP 1-800 number.

For each of these components, states reported the percentage completed and whether they had experienced any delays (***Exhibit 4***). Understanding which of the components were completed first provides insight into the likely ease of the process. The number of states experiencing delays indicates which components were most difficult to address.

Overall, the states had made the most progress toward establishing a 1-800 number associated with their NWD/SEP, with an average completion rate of 89% and 13 states having completed that task as of September 30, 2014. Six states reported that they had delays in implementing their 1-800 numbers. Illinois, for example, had requested an extension from the Centers for Medicare and Medicaid Services (CMS) on the deliverable to allow time for a vendor to be selected and branding to be developed specific to the 1-800 number. Despite delays, Arkansas and Missouri successfully established their 1-800 numbers.

Over half (11 of 20) of the states reported that they had completed the task of developing standardized informational materials that their NWD/SEPs could provide to individuals. On the other hand, only three states had reported completing a process to guide individuals through the state's assessment and eligibility determination. On average, states had completed only 38% of the work needed to meet that criterion.

EXHIBIT 4. Status of NWD/SEP Requirements as of September 30, 2014										
Balancing Incentives Program State	**Develop Standardized Informational Materials**		**Train Staff on Eligibility Determination and Enrollment Processes**		**Implement Process to Guide Individual Through Assessment and Eligibility Determination**		**Establish NWD/SEP Website**		**Establish NWD/SEP 1-800 Number**	
	Percentage Completed	**Delays Experienced**	**Percentage Completed**	**Delays Experienced**	**Percentage Completed**	**Delays Experienced**	**Percentage Completed**	**Delays Experienced**	**Percentage Completed**	**Delays Experienced**
Arkansas	100	No	50	No	40	No	100	Yes	100	Yes
Connecticut	100	No	100	No	15	No	100	No	100	No
Georgia	100	No	100	No	95	No	100	No	100	No
Illinois	40	Yes	20	No	0	No	35	Yes	75	Yes
Indiana	75	Yes	25	Yes	10	Yes	80	Yes	100	No
Iowa	100	No	80	Yes	0	Yes	75	Yes	100	No
Kentucky	75	Yes	30	No	20	Yes	50	Yes	100	No
Louisiana	100	No	0	No	0	No	75	No	100	No
Maine	70	Yes	0	No	40	No	40	No	40	No
Maryland	100	No	100	No	100	No	100	No	100	No
Massachusetts	30	Yes	5	No	15	No	20	Yes	90	Yes
Mississippi	100	No	60	Yes	50	Yes	100	No	100	No
Missouri	100	Yes	100	Yes	100	Yes	100	No	100	Yes
New Hampshire	100	Yes	100	Yes	10	Yes	100	No	100	No
New Jersey	100	Yes	90	No	50	Yes	100	No	95	Yes
New York	a	Yes	a	Yes	a	No	a	Yes	100	No
Nevada	25	No	25	No	100	No	100	No	10	No
Ohio	20	No	20	No	5	Yes	5	Yes	75	Yes
Texas	100	No	a	Yes	a	No	100	No	100	No
Total States										
100% complete	11		5		3		10		13	
Average percentage completed	80		53		38		77		89	
Total States Experiencing Delays		**9**		**7**		**8**		**8**		**6**

NOTE:
a. Percentage complete not reported.

3.2. Core Standardized Assessment

A second required component of the Balancing Incentive Program is the use of a CSA. States may use a variety of assessments for different populations, with the assessment used for any given population required to be consistent across the state. Additionally, all of the assessments used across populations must include a core set of domains and items. Successful development of a CSA includes the following three criteria:

- **Criterion 1**: Develop a Level I screen assessment. This assessment is used when a person first makes inquiry about services to assess their financial and functional status and determine likely eligibility for services.

- **Criterion 2**: Incorporate additional domains and topics into assessments as needed to ensure that components of the CMS-required Core Dataset (CDS) are addressed. States are not required to use a single assessment for all populations; they may use different assessments tools for different population groups. However, all of the assessment tools used must include a minimum set of domains and topics that make up the CDS.

- **Criterion 3**: Train staff at NWD/SEPs in the use of the CSA.

Six of the states (Arkansas, Connecticut, Georgia, Missouri, New Hampshire, and Texas) reported that they had met each of these criteria by September 30, 2014. States were most likely to have completed development of the Level I Screen Assessment. Fourteen of the 20 states had completed that activity. Ten states had experienced delays in completing the task, but six of those ten had completed it despite the delays. Kentucky, which had made the least progress (50%) toward meeting this criterion, reported delays in ensuring that there was consensus in the applicability of the assessment across all of its programs (***Exhibit 5***).

States were further behind on the remaining stages of the development of the CSA. Only eight reported completing their incorporation of the required domains and topics into their assessments. Ten states reported delays in completing this task. Two of the ten states that had been delayed had since completed that task. Other states, however, had made as little as 25% progress toward the goal. Iowa reported facing some challenges around identifying CSAs that could be generalized across the state's populations with disabilities.

States also had made less progress toward accomplishing the necessary training of staff to coordinate the CSA activities. Eight states had completed that task, and nine states had encountered delays. Two of the states (Georgia, Missouri) that had experienced delays had, however, since completed that task. The inability to train staff is understandable because it logically can only occur after completion of the CSA

development. Delays and difficulties in incorporating all of the required elements into the CSA will necessarily delay the training of staff in its use.

EXHIBIT 5. Status of CSA Requirements as of September 30, 2014						
Balancing Incentives Program State	Develop Level I Screen Assessment		Incorporate Additional Domains and Topics into Assessments		Train Staff at NWD/SEP to Coordinate CSA	
	Percentage Completed	Delays Experienced	Percentage Completed	Delays Experienced	Percentage Completed	Delays Experienced
Arkansas	100	No	100	No	100	No
Connecticut	100	No	100	No	100	No
Georgia	100	Yes	100	Yes	100	Yes
Illinois	100	No	35	No	0	No
Indiana	75	Yes	25	Yes	a	Yes
Iowa	85	Yes	50	Yes	75	Yes
Kentucky	50	Yes	50	No	0	No
Louisiana	100	No	95	Yes	100	No
Maine	100	No	100	No	0	No
Maryland	100	Yes	80	Yes	80	Yes
Massachusetts	100	No	95	No	100	No
Mississippi	100	Yes	40	Yes	40	Yes
Missouri	100	Yes	100	No	100	Yes
New Hampshire	100	Yes	100	Yes	100	No
New Jersey	75	Yes	75	Yes	90	Yes
New York	100	No	100	No	a	Yes
Nevada	95	No	70	Yes	a	No
Ohio	100	Yes	75	Yes	5	Yes
Texas	100	No	100	No	100	No
Total States						
100% completed	14	10	8	10	8	9
Average percentage completed	94		78		68	
Total States Experiencing Delays		**10**		**10**		**9**

NOTE:
a. Percentage complete not reported.

3.3. Conflict-Free Case Management

The key component for achievement of CFCM is the establishment of protocols for removing potential conflict of interest regarding conducting assessments and care plans and the provision of services. In some states, care providers both develop the care plan and provide the services, which creates an incentive for the provider to includes services they provide in the care plan. A majority of the states (13 of 19) have met the requirement around CFCM, and only six states reported facing delays in developing a protocol for removing conflict of interest. Two of the states that reported delays had completed the requirement (***Exhibit 6***). The remaining states that had not completely finished establishing their protocol reported that they had completed over half of the requirement. Among states that faced delays in establishing the CFCM protocol, some states described additional effort required to work with certain providers. For example, Maryland reported that it had faced some delays with working to ensure that there was no conflict of interest among their behavioral health programs.

EXHIBIT 6. Status of CFCM as of September 30, 2014		
Balancing Incentives Program State	**Establish Protocol for Removing Conflict of Interest**	
	Percentage Completed	**Delays Experienced**
Arkansas	100	No
Connecticut	100	No
Georgia	100	Yes
Illinois	100	No
Indiana	50	Yes
Iowa	90	Yes
Kentucky	75	No
Louisiana	100	No
Maine	85	No
Maryland	65	Yes
Massachusetts	100	No
Mississippi	100	Yes
Missouri	100	No
New Hampshire	100	No
New Jersey	100	No
New York	a	Yes
Nevada	100	No
Ohio	100	No
Texas	100	No
Total States		
100% complete	13	
Average percentage completed	93	
Total States Experiencing Delays		**6**
NOTE: a. Percentage completed not reported.		

3.4. State Discretionary Goals

In addition to the required goals, states had the opportunity to set a variety of other goals at the time of their application. The available reports vary in the detail provided about activities related to these goals, but suggest several types of activities in which states are engaged and ways in which the enhanced funds from the Balancing Incentive Program are being used. In several cases, the optional state goals can be understood as discretionary methods of attaining required goals. Optional state goals such as increasing waiver slots, implementing State Plan options, and funding activities to support transition from institutions to the community, for example, can be understood on their own, but also are strategies for helping to increase the share of LTSS expenditures for HCBS (***Exhibit 7***).

EXHIBIT 7. Discretionary Goals Set by Balancing Incentive Program States							
Balancing Incentive Program State	**Expand Waiver Slots/ Eliminate Waiver Waiting Lists**	**Expand State Plan HCBS to Serve More Individuals, New Populations**	**Expand Mental Health Services**	**Increase Rates for HCBS**	**Support Transitions from Institutions to Community**	**Improve Quality Measurement**	**Other**
Arkansas		X	X[a]				X[b]
Connecticut	X	O					O
Georgia	X		X	X			X
Illinois	X		X		X[c]	X	X
Indiana	X		O		O		
Iowa	X			X			
Kentucky	X						
Louisiana	X		X				
Maine	X						X[d]
Maryland	X	X		X			O, X[e]
Massachusetts	O			X	X		X[f]
Mississippi		X		O		X[g]	
Missouri						X[h]	O
Nevada	O						
New Hampshire						O[i]	
New Jersey					O[g]		
New York[j]		O	O	O	O		O
Ohio	X		X				X[k]
Texas[l]	X	O		X	O		X[m], O[n,o]
Total Number of States	**13**	**6**	**7**	**7**	**6**	**4**	**12[p]**
Work is underway	11	3	5[q]	5	2	3	8
No activity yet/status unknown	2	3	3	3	4	1	5

NOTES: X = work on goals began before September 30, 2014. O = no evidence exists to show that work had begun on these goals as of September 30, 2014. Blank cells indicate that the state did not have any such goal.

a. Planning for 1915(i) is now on hold.
b. Offering substance abuse treatment services.
c. Using MFP for people with mental health disabilities.
d. Developing Olmstead Request for Proposal, establishing a Shared Living Demonstration, conducting the Personal Support Specialist Rate Study.
e. Adding personal care services for people in group homes for people with mental health disabilities.
f. Enhancing services for elders and individuals with autism.
g. 20% complete.
h. 80% complete.
i. No progress yet. Has stated plan for what they want to do, but 0% complete.
j. New York has spent most of their enhanced FMAP for "enhancement of community services offered under waivers/managed care." It is unclear exactly what has been done and how it meets these goals.
k. Expanding the Program of All-inclusive Care for the Elderly.
l. Texas reports having used enhanced FMAP for "service expansion," but does not provide detail about which services have been expanded, waiver or State Plan.
m. Actively working to expand I/DD behavioral health intervention teams, using funds from MFP. Also actively working to develop I/DD managed care pilots and to implement "electronic life records" for people with I/DD living in state-supported living centers.
n. Recovery support centers--status unclear.
o. Status of planned efforts to increase data sharing between Texas Department of State Health Services and homeless program is unclear.
p. One state, Maryland, had begun work on some discretionary goals, but not on others. It is counted only once in the total.
q. Two states that began activities have now placed them on hold, including Louisiana, which has withdrawn from the program.

Expand Mental Health Services. Several states identified goals related to expanding mental health services and were engaged in activities toward that end. Some states were doing this through expanding the services offered. For example, Arkansas and Texas both were focused on providing support for substance abuse treatment. Maryland was planning to add personal care to services for people receiving support in

group homes for people with mental health concerns, and Georgia was supporting a variety of plans to expand services for people with mental health needs (rehabilitation, home health, and targeted case management). Other states were engaged in similar initiatives to expand services to this population.

Improve Services for People with Intellectual or Developmental Disabilities (I/DD). Two states (Illinois and Texas) were focused on improving services for people with I/DD using a variety of means. Both states were working to increase the capacity of their adult waivers to serve people with I/DD. Texas also was planning for a pilot test of managed care for people with I/DD.

Other discretionary goals have no direct linkage to the required Balancing Incentive Program goals, but are consistent with the desired aims of the program. Efforts to improve access to HCBS through community health workers in rural areas (Arkansas), for example, may not directly link to the NWD/SEP requirement, but can help to achieve the desired goal of getting necessary information to the people who may benefit from services. Other discretionary goals have no explicit connection to the Balancing Incentive Program goals. The development of quality measures and quality reporting systems, for example, are such discretionary measures.

> ***Research Question 5***: Did the state target one or more specific subpopulations of individuals who need LTSS? If so, did activities to increase access to and availability of HCBS differ for these subpopulations?

Although states are not permitted to target the required structural changes to specific populations, the activities that states used to increase the share of LTSS expenditures for HCBS may be targeted to specific populations. At the time of their application, most states had indicated two or more populations of focus for HCBS efforts (Wiener et al., 2015). Most common among those populations were adults or children with I/DD, individuals age 65 or older, adults younger than 65 with physical disabilities, and people with serious mental illness (SMI) or substance use disorders (SUD). Thirteen of the 20 states discussed in this report planned to focus on all four of these populations (***Exhibit 8***).

Some states (Iowa, Kentucky, Maryland, Massachusetts, and Mississippi) had implemented programs or activities that targeted a subpopulation they had not identified in their original application. Of these states, two added a focus on people age 65 and over, two added adults younger than 65 with physical disabilities, one added adults or children with I/DD, three added people with HIV/AIDS, and one added people with traumatic brain injury (TBI).

States used a variety of strategies to target subpopulations. Strategies generally could be considered methods of increasing access to services, methods of increasing payment for services, or other methods. Methods of increasing access include increasing the number of people served under existing waivers or adopting new HCBS waivers or State Plan options. States most commonly sought to increase access. This

was the most common strategy used for each population, except people with SMI/SUD, where a variety of other means were used.

Nine of the states used more than one of these strategies overall, and seven states used more than one strategy for a given population. Older adults were nearly as likely to be targeted through increased payment (five states) as by increased access (six states). By contrast, efforts targeting people with I/DD were much more likely to focus on increased access (13 states) than increased payment (three states). Similarly, states that targeted people with physical disabilities were more likely to use strategies to increase access (nine states) than strategies to increase payment (five states). Increased access for older adults was accomplished primarily through increasing the number of waiver slots. For people with I/DD, increased access was achieved either by increasing the number of waiver slots of existing waivers or by adopting new waivers or State Plan options.

Individuals with SMI/SUD were less commonly targeted by states, but when they were, most states used other means, such as specific grants or initiatives or other strategies. Individuals with HIV/AIDS were also not heavily targeted by states, but when they were, states either increased waiver slots or adopted new wavers or State Plan options. Only one state increased provider payment rates to target individuals with TBIs. Other subpopulations included individuals with chronic conditions, dual eligibles, and children. States that targeted these subpopulations adopted new waivers or State Plan options or increased provider rates.

EXHIBIT 8. Strategies Used to Increase HCBS Expenditures by Subpopulations

Balancing Incentive Program State	Population						
	Strategy	Age 65+	Physical Disabilities	I/DD	SMI/SUD	Other	Total
Arkansas	Increase access						0
	Increase payment						0
	Other	X	X				2
Connecticut	Increase access		X	X			2
	Increase payment						0
	Other						0
Georgia	Increase access	X	X	X	X		4
	Increase payment	X	X			X	3
	Other						0
Illinois	Increase access			X	X	X	3
	Increase payment						0
	Other	X	X	X	X	X	5
Indiana	Increase access				X		1
	Increase payment						0
	Other				X		1
Iowa	Increase access			X			1
	Increase payment	X	X	X	X	X	5
	Other						0
Kentucky	Increase access			X		X	2
	Increase payment						0
	Other						0
Louisiana	Increase access	X	X	X			3
	Increase payment						0
	Other				X		1
Maine	Increase access		X	X			2
	Increase payment						0
	Other						0

EXHIBIT 8 (*continued*)							
Balancing Incentive Program State	**Population**						
	Strategy	**Age 65+**	**Physical Disabilities**	**I/DD**	**SMI/SUD**	**Other**	**Total**
Maryland	Increase access	X	X	X			3
	Increase payment	X	X				2
	Other						0
Massachusetts	Increase access						0
	Increase payment	X	X	X	X	X	5
	Other	X		X	X		3
Mississippi	Increase access	X	X	X		X	4
	Increase payment						0
	Other						0
Missouri	Increase access		X	X			2
	Increase payment						0
	Other						0
Nevada	Increase access						0
	Increase payment						0
	Other						0
New Hampshire	Increase access						0
	Increase payment						0
	Other						0
New Jersey	Increase access			X	X		2
	Increase payment						0
	Other						0
New York	Increase access						0
	Increase payment						0
	Other	X	X	X	X		4
Ohio	Increase access	X	X	X		X	4
	Increase payment						0
	Other	X			X		2
Texas	Increase access	X	X	X			3
	Increase payment	X	X	X			3
	Other				X	X	2
Total	**Increase access**	**6**	**9**	**13**	**4**	**4**	**36**
	Increase payment	**5**	**5**	**3**	**2**	**3**	**18**
	Other	**5**	**4**	**3**	**8**	**2**	**22**

NOTES: "Other" populations include people with HIV/AIDS, people with TBIs, and others.
Strategies to increase access include increasing waiver slots, reducing waiting lists, or creating new waivers or State Plan options. Strategies to increase payment are based on increasing the payment rates to providers. Other strategies include the development of provider-specific grants or initiatives.
Nevada began implementation of its Balancing Incentive Program in April 2014 and had not yet undertaken any of these strategies.

Research Question 6: Did Balancing Incentive Program policies interact with HCBS benefit options that were established before Balancing Incentive Program implementation, and if so, how?

Before implementation of the Balancing Incentive Programs, states were making progress toward increasing the share of LTSS provided through HCBS (Wiener et al., 2015). Understanding which options states have been using provides an important context for recognizing both the resources available to them and the level of interaction they may have with the Balancing Incentive Program. Before implementing the Balancing Incentive Program, all participating states had at least one Section 1915(c) waiver and were implementing MFP initiatives. States also were engaged in a variety of other programs, including State Plan personal care, the 1915(i) State Plan option, the 1915(k) State Plan options (Community First Choice program), and health homes. States could use activities under these programs to help further the goals of the Balancing Incentive Program, and states could undertake activities through the

Balancing Incentive Program that were independent of any of these other HCBS options.

To determine whether, how, and how much state Balancing Incentive Program actions interacted with the existing HCBS options, we examined state applications and work plans for provisions that specifically mention planned collaboration between the different coverage options. We also consulted the quarterly progress reports for state reporting of any interaction with other HCBS programs. For HCBS benefit expansions funded through MFP programs, we also consulted data provided on that program. The National Association of States United for Aging and Disabilities' (NASUAD's) State Medicaid Integration Tracker, which pulls together information from a variety of CMS and state Medicaid websites on state LTSS programs, also provided information on state HCBS activities. Our review of these materials focused on whether and how other HCBS programs are used by states to further progress toward the expenditure and infrastructure goals of the Balancing Incentive Program.

Money Follows the Person (MFP) Program. All states participating in the Balancing Incentive Program also are participating in the MFP program, resulting in several areas where the programs support and build off of each other. Many states are using Balancing Incentives Program funding to further the goals of their MFP programs. For example, Georgia is using Balancing Incentive Program resources to build on an outreach plan developed under their MFP program that educates nursing facility staff and residents about community-based supports available for transitioning MFP residents. Similarly, Missouri is using funds from the Balancing Incentive Program to train providers at nursing facilities, potential MFP participants and guardians, public administrators, and the judicial system on available community living options for nursing home residents who are seeking to return to the community (Lester et al., 2013). Two states reported planning to use their Balancing Incentives Program funding to expand the MFP program to additional populations. Indiana expanded its MFP program to include transitioning children and adolescents with serious and emotional disturbances from psychiatric residential treatment facilities into the community (Irvin et al., 2015). New York planned to expand its MFP program to individuals with I/DD with Balancing Incentives Program funding (Lester et al., 2013).

Some states also used the MFP program to further the goals and requirements of the Balancing Incentive Program. In their applications to the Balancing Incentive Program, eight states (Connecticut, Maryland, Mississippi, Missouri, New Hampshire, Texas, Louisiana, and New York) referenced using MFP funds to support the initial costs of implementing the three required structural changes under the program. Arkansas, Iowa, and Maryland reported using MFP funds for the development of assessment tools, training on use of these tools or implementation of tools statewide to meet the CSA requirements. For example, Arkansas used MFP funds to pay for implementing its interRAI assessments, which it used to meet Balancing Incentive Program CSA requirements. Connecticut has used MFP funds to build on its expedited system for determining eligibility for MFP and enrollment into the program, expanding it from the Balancing Incentive Program to statewide for all Medicaid-funded programs.

Connecticut also used MFP funds to develop the set of questions the state will use for its CSA and has tested the online assessment system to access its NWD/SEP system with MFP participants and staff (Lester et al., 2013). Many states are relying on their stakeholder groups established through MFP to support system change activities for the Balancing Incentive Program (Mission Analytics, 2015a).

1915(c) HCBS Waiver Programs. All states had Section 1915(c) HCBS waiver programs before the implementation of their Balancing Incentive Programs. ***Exhibit 3*** shows that several states used Balancing Incentive Program funds to increase HCBS waiver spots, reduce HCBS waitlists, and increase Medicaid payment rates for providers participating under HCBS waivers. For example, Georgia has used its enhanced FMAP to fund increased services and additional slots for several of its 1915(c) waivers, including the New Options, Elderly and Disability, Comprehensive Supports, and Community-Based Alternatives for Youth waivers.

1915(i) and 1915(k) (Community First Choice) State Plan Options. Some states used the Balancing Incentive Program funding to plan and implement new programs, including the 1915(i) State Plan and 1915(k) State Plan options (Community First Choice program). Five states (Arkansas, Connecticut, Iowa, Mississippi, and New York) are using Balancing Incentive Program funding to implement their 1915(i) State Plan programs (Mission Analytics, 2015a). In addition, some states are using Balancing Incentive Program funds for their Community First Choice program. Maryland reported using Balancing Incentive Program funding to implement its Community First Choice program, including funding for self-direction training among Community First Choice participants (Maryland September 30, 2014, Progress Report).

Health Homes. As reported in the Baseline Report, four states (Maine, Missouri, New York, and Ohio) had health homes before implementing their Balancing Incentive Program (Wiener et al., 2015). Several other Balancing Incentive Program states established health homes after implementation of the Balancing Incentives Program. In Iowa, the Balancing Incentive Program higher federal match has been used to increase Medicaid payment rates by 2% for providers participating in health homes. A Mission Analytics report noted that Arkansas was also using Balancing Incentive Program funding to support development of its health homes (Mission Analytics, 2015b).

Aging and Disability Resource Centers (ADRCs). Several states have reported working with ADRCs to implement their NWD/SEP systems. On one hand, the Balancing Incentive Program is used to support and enhance current ADRCs. For example, Georgia's Balancing Incentive Program funding was used for structural enhancements to the ADRCs across the state. Illinois reported that its Balancing Incentive Program funds were used for improving the ADRCs' branding, including additional populations and strengthening relationships with ADRC stakeholder groups. In New Hampshire, on the other hand, the state used the existing ADRC website and phone number to meet the requirements to have a designated NWD/SEP website and phone number (New Hampshire September 30, 2014, Quarterly Progress Report).

State Innovation Model (SIM) Demonstrations. Several of the states are also participating in the SIM Initiative demonstrations, which are state-led programs to test the development of programs to integrate funding and service delivery across payers. Illinois' Alliance for Health LTSS Subcommittee, which is supported by its SIM initiative, collaborated with the Balancing Incentive Program stakeholder group on developing CFCM guidelines (Governor's Office for Health Innovation and Transformation, 2014).

Other Funding Sources. Through the CMS initiative Enhanced Funding for Eligibility Enrollment Systems (90/10), CMS covers 90% of the costs of the design, development, and installation or enhancement of Medicaid eligibility determination systems. Both Texas and Connecticut reported that they are using these federal matching funds to cover much of the costs of the NWD/SEP information technology systems that are included in the requirements of the Balancing Incentive Program (Mission Analytics, 2015a).

Research Question 7: How did the states work with stakeholders (e.g., LTSS providers) when implementing the Balancing Incentive Program?

The changes required under the Balancing Incentive Program have the potential to affect many stakeholder groups, including policy makers, service providers, consumers, and advocates. ***Exhibit 9*** indicates the types of stakeholders (e.g., policy makers, care providers, consumers, and advocates) each state worked with while implementing the Balancing Incentive Program, and the ways in which input was sought from each (e.g., public meetings, requests for written public comment, advisory groups).

EXHIBIT 9. Stakeholders Who Provided Input on Balancing Incentive Program Implementation

Balancing Incentive Program State	Type of Input					
	Stakeholder Group	Advisory Board	Meetings	Pilot Test	Written Comment	Total
Arkansas	Providers	X	X			2
	Policy makers		X			1
	Consumers/advocates	X	X	X	X	4
Connecticut	Providers					0
	Policy makers	X				1
	Consumers/advocates					0
Georgia	Providers	X				1
	Policy makers	X				1
	Consumers/advocates	X				1
Illinois	Providers		X			1
	Policy makers		X			1
	Consumers/advocates		X			1
Indiana	Providers					0
	Policy makers					0
	Consumers/advocates					0
Iowa	Providers		X			1
	Policy makers		X			1
	Consumers/advocates		X			1
Kentucky	Providers					0
	Policy makers					0
	Consumers/advocates					0
Louisiana	Providers		X			1
	Policy makers		X			1
	Consumers/advocates		X			1
Maine	Providers		X			1
	Policy makers	X				1
	Consumers/advocates		X			1

EXHIBIT 9 (*continued*)						
Balancing Incentive Program State	**Type of Input**					
	Stakeholder Group	**Advisory Board**	**Meetings**	**Pilot Test**	**Written Comment**	**Total**
Maryland	Providers	X				1
	Policy makers					0
	Consumers/advocates	X				1
Massachusetts	Providers					0
	Policy makers					0
	Consumers/advocates			X		1
Mississippi	Providers	X				1
	Policy makers	X				1
	Consumers/advocates	X				1
Missouri	Providers	X				1
	Policy makers					0
	Consumers/advocates	X				1
Nevada	Providers	X				1
	Policy makers					0
	Consumers/advocates					0
New Hampshire	Providers		X			1
	Policy makers		X			1
	Consumers/advocates		X			1
New Jersey	Providers		X			1
	Policy makers	X				1
	Consumers/advocates	X	X			2
New York	Providers					0
	Policy makers	X				1
	Consumers/advocates					0
Ohio	Providers	X	X	X		3
	Policy makers					0
	Consumers/advocates	X	X	X		3
Texas	Providers	X				1
	Policy makers	X				1
	Consumers/advocates	X				1
Total States	**All stakeholders[a]**	**9**	**8**	**3**	**1**	**17**
	Providers	**7**	**8**	**1**	**0**	**13**
	Policy makers	**6**	**5**	**0**	**0**	**10**
	Consumers/advocates	**7**	**8**	**3**	**1**	**1**

NOTES: We were unable to find evidence of stakeholder engagement for Indiana or Kentucky.

a. The total number of states across all stakeholders may not equal the sum of states by stakeholder group, as states may have used the same method with more than one stakeholder group.

Information about stakeholders' interaction with the state around Balancing Incentive Program activities was limited in the documentary record and may be incomplete. On the basis of available information, nine states had created formal advisory boards. For example, Connecticut reported in its progress reports that it convened a global communications workgroup to assist with the NWD/SEP advertising strategies. Eight states reported that they held meetings with stakeholder groups. Each of those states held meetings of providers and meetings of consumers and their advocates. These meetings may have been conducted jointly or separately. For example, Maine reported that it had several focus groups through the state for providers, advocates, and consumers with mental health conditions to determine and better understand the barriers to access, information, and service for people with mental health conditions, and so to improve the process by which this population obtains determinations of program eligibility. Three states reported that they worked with

stakeholders who represented several LTSS populations to test or pilot proposed actions or assessments for the state LTSS system. For example, Connecticut reported in its progress reports that it tested its Level I screen for its assessment with consumers to make sure that the screen was simple enough for consumers to complete it and be appropriate routed. Only one state (Arkansas) reported seeking written comments.

4. DISCUSSION

The Balancing Incentive Program established by the ACA is designed to help states provide a greater share of LTSS through HCBS while improving the LTSS infrastructure to create a more consumer-friendly, consistent, and equitable system. This report describes the processes used by 19 of the participating states in the early days of the implementation to work toward these goals. Findings from this preliminary process evaluation indicate the following:

States are engaged in a wide range of activities to achieve the required expenditure and infrastructure goals. States are continuing activities that they began before the Balancing Incentive Program and implementing new activities to reach the required goals. Activities include those that are designed to better serve people who were receiving HCBS before the Balancing Incentive Program and others that are designed to expand services to people who were not previously receiving HCBS.

States are combining activities and funding from a range of Medicaid programs to achieve the goals of the Balancing Incentive Programs and the goals of these other programs. All states are using MFP and 1915(c) waivers to help achieve the expenditure goals of the Balancing Incentive Program. States also are using other Medicaid programs, such as State Plan options and 1115 demonstration programs, to help increase the use of HCBS. Funds from the Balancing Incentive Program also are helping to support these other programs by such means as increasing waiver slots, reducing waiting lists, and supporting the development of health homes.

States are making progress toward infrastructure development. Few states had completed work toward any of the required infrastructure goals by the end of fiscal year 2014, but they were making progress despite delays. States had made the most progress toward CFCM.

States also are making progress toward optional goals. As part of their application, states had the opportunity to identify optional goals. Often, these optional goals were also methods of achieving the required goals. For example, expanding waiver slots or eliminating waiting lists for waivers was an optional goal of 13 states. This activity, while valuable in its own right, also supports efforts to increase the share of LTSS expenditures for HCBS. Most other optional state goals also can help increase the share of LTSS expenditures for HCBS. The notable exception is a goal, identified by four states, to improve quality measurement.

Together, these findings paint a picture of states that are highly engaged in rebalancing efforts and are employing numerous strategies to achieve the required improvements in service and infrastructure. The range of strengths, challenges, and strategies being used offers opportunities throughout the evaluation to learn much about what approaches are most successful and to offer guidance for future efforts.

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