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

# FINAL PROCESS EVALUATION OF THE BALANCING INCENTIVE PROGRAM

May 2016

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This report was prepared under contract #HHSP23320100021WI between HHS's ASPE/DALTCP and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE Project Officers, Pamela Doty and Jhamirah Howard, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Their e-mail addresses are: Pamela.Doty@hhs.gov and Jhamirah.Howard@hhs.gov.

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May 2016

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHSP23320100021WI

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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 |
| FY | Fiscal Year |
| 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 Disorder |
| 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, engaging in community activities). 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 initiatives designed to increase the use of Medicaid HCBS and to improve the infrastructure for provision of those services, one of which was the Balancing Incentive Program. 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 were 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 received an enhanced federal match rate for HCBS. The rate of the enhanced federal match and the targeted rate of HCBS expenditures were dependent on the baseline (FY2009) 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 percentage point enhanced federal match rate on Medicaid HCBS expenditures and were required to meet or exceed the 25% HCBS spending benchmark by the end of federal FY2015. States whose LTSS spending on HCBS in 2009 was at least 25% but less than 50% were eligible for a 2 percentage point enhanced federal match rate on Medicaid HCBS expenditures and were required to meet or exceed the 50% HCBS spending benchmark by September 30, 2015.

In addition to increasing the percentage of total Medicaid LTSS spending directed to HCBS, participating states were required to meet three infrastructure goals: create a no wrong door/single entry point (NWD/SEP) process for people seeking LTSS; develop a core standardized assessment (CSA) for use 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 (CMS) protocols specifying certain essential elements, they were free to do so in whatever way they determined worked best.

This process evaluation describes the actions taken by states from the time they first began participation in the Balancing Incentive Program (April 1, 2012, through July 1, 2014, depending on the state) through the end of the program, September 30, 2015. Although 21 states were accepted into the Balancing Incentive Program, this report includes data for only 20 of them. Three states ended their participation early. Nebraska began participation in October 2014, but ended participation by March 2015 and did not

submit any quarterly reports describing their activities during the brief time they were involved; it, therefore, is excluded from this report. Two additional states, Indiana and Louisiana, also ended participation in the Balancing Incentive Program early. This report includes information for those two states, from the time of their enrollment to the end of their participation.

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 our baseline report, 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; summary briefs on state Balancing Incentive Program activities from the technical assistance contractor, Mission Analytics; and information from CMS staff based on their knowledge of the participating states.

This process evaluation identified the following strategies used by states to implement and achieve the goals of the Balancing Incentive Program.

- In addition to the Balancing Incentive Program, states were engaged in a range of Medicaid State Plan options, waiver programs and grant activities, which they used to help attain the goals of the Balancing Incentive Program. All states were using Money Follows the Person and Section 1915(c) waivers, and many also were using State Plan options. Although many of these programs were in operation in the states before implementation of the Balancing Incentive Program, several states also expanded or added new programs during this time.

- States also used the enhanced matching funds generated from the Balancing Incentive Program to help support activities of these other Medicaid programs. For example, some states used Balancing Incentive Funds to increase Section 1915(c) waiver capacity and reduce waiting lists, or to support the development of health homes and other HCBS authorities.

- Most states used multiple methods of increasing the share of LTSS dollars spent on HCBS. The most frequently used method was to increase the capacity of HCBS waivers to serve more individuals (14 states). Other commonly used methods included expanding mental health services (12 states), expanding the types of populations served by HCBS (11 states), increasing the services available to current HCBS recipients (11 states), and increasing the HCBS payment rates (ten states), among other means.

- Although state eligibility to participate in the Balancing Incentive Program was based on total, not population-specific, LTSS expenditures, states could target their Balancing Incentive Program efforts to increase HCBS expenditures to specific populations. Most commonly, such efforts addressed the main LTSS populations--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.

- Fourteen states completed all of the requirements of the NWD/SEP system by the end of FY2015. Completion of this task included establishing a toll-free telephone number (accomplished by 17 states), developing standardized informational materials (accomplished by 16 states), training staff on eligibility determination and enrollment processes (accomplished by 15 states), implementing a process to guide individuals through assessment and eligibility determination (accomplished by 16 states), and establishing a NWD/SEP website (accomplished by 14 states).

- Sixteen states, including Louisiana (which ended participation early), completed the requirements of a CSA. This included developing a Level I screen assessment to review a person's financial and functional status and determine likely eligibility for services (accomplished by all states except Indiana, which ended its participation early); incorporating the required domains and topics in their assessments (accomplished by 18 states); and training staff at the NWD/SEPs in the coordination of the CSAs (accomplished by 17 states).

- All but one state (Indiana, which ended its participation early) had developed protocols needed to remove conflict of interest as defined within the Balancing Incentive Program from case management. Several (six states) reported delays in establishing CFCM, often related to challenges working with specific provider types. Challenges also arose in rural parts of states, in which the limited availability of providers could mean that the same organization provided case management and direct care services.

- Stakeholders were engaged in the Balancing Incentive Program in a variety of ways. Three-quarters of the states (15) convened formal advisory boards, which included LTSS providers, policy makers, consumers, and consumer advocates.

Together, these findings indicate that participating states used a variety of strategies and processes to achieve the required rebalancing of expenditures and improvements in infrastructure. Although states indicated delays and challenges in meeting an ambitious timeline, many, although not all, accomplished all the required goals within the designated timeframe. States may yet achieve these goals after the formal end of the Balancing Incentive Program, as many take advantage of the time extension granted by CMS to use remaining funds and complete their work toward the required goals.

# 1. INTRODUCTION

The Affordable Care Act (ACA) included several initiatives designed to increase the use 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 were 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. The rate of the enhanced federal match and the targeted rate of HCBS expenditures were dependent on the baseline spending of the state. States spending less than 25% of LTSS dollars on HCBS at baseline received a 5% enhanced federal medical assistance percentages (FMAP) and were required to increase HCBS spending to at least 25% of total LTSS dollars. States spending between 25% and 50% of LTSS on HCBS at baseline received a 2% enhanced FMAP and were required to spend at least 50% of LTSS dollars on HCBS by the end of the Balancing Incentive Program, September 30, 2015.

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, create a no wrong door/single entry point (NWD/SEP) system for people seeking LTSS, develop a core standardized assessment (CSA) to 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 afforded great flexibility in the means they used to accomplish those goals. This report describes the processes used by participating states to achieve these goals through the end of the Balancing Incentive Program (September 30, 2015).

# 2. DATA AND METHODS

This report describes how participating states implemented the Balancing Incentive Program. Data were obtained through document review, with the key documents being the quarterly progress reports to the Centers for Medicare and Medicaid Services (CMS) from states participating in the initiative. Information from these documents was compared against the information from the states' applications and work plans as reported in our 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; summary policy briefs on state Balancing Incentive Program activities from the CMS's technical assistance contractor, Mission Analytics; and information provided by CMS staff based on their knowledge of the states. 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.

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 Money Follows the Person (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.

This final process evaluation covers the entire period of the Balancing Incentive Program, from the time each state began participation (which, depending on the state, was anytime between April 1, 2012, and October 1, 2014) until the end of the Balancing Incentive Program (September 30, 2015). Although 21 states were accepted into the Balancing Incentive Program, this report includes data for only 20 of them. Nebraska began participation in October 2014, but ended participation by March 2015 and did not submit any quarterly reports describing its activities during the brief time it was involved. Therefore, it is excluded from this report. Two additional states, Indiana and Louisiana, also ended their participation in the Balancing Incentive Program early. This report includes information for those two states, from the time of their enrollment through the end of their participation.

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.

**EXHIBIT 1. Key Research Questions and Data Sources**

| 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)<br>• CMS SPA database (http://medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html)<br>• CMS waiver database (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html)<br>• NASUAD State Medicaid Integration Tracker (http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker)<br>• Mathematica Policy Research MFP program database<br>• 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<br>• CMS SPA database<br>• CMS waiver database<br>• Mission Analytics' profiles of state programs, including progress reports (http://www.balancingincentiveprogram.org/state-activities)<br>• 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<br>• CMS SPA database<br>• CMS waiver database<br>• Mission Analytics' profiles of state programs, including states' quarterly progress reports<br>• 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<br>• Mission Analytics' profiles of state programs, including states' quarterly progress reports<br>• Mathematica Policy Research MFP program database |
| *Research Question 5*: Did state activities specifically address one or more subpopulations of individuals who need 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<br>• CMS SPA database<br>• CMS waiver database<br>• Mission Analytics' profiles of state programs, including states' quarterly progress reports<br>• Mathematica Policy Research evaluation reports on the MFP program |

| EXHIBIT 1 (*continued*) | |
|---|---|
| **Research Questions** | **Data Sources** |
| *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? | • State applications and work plans for the Balancing Incentive Program<br>• CMS SPA database<br>• CMS waiver database<br>• Mission Analytics' profiles of state programs, including progress reports<br>• NASUAD State Medicaid Integration Tracker<br>• Mathematica Policy Research evaluation reports on the MFP program<br>• Urban Institute Health Homes evaluation<br>• U.S. Department of Health and Human Services report on Community First Choice<br>• 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<br>• Mission Analytics' profiles of state programs, including progress reports<br>• Notes from stakeholder advisory group meetings<br>• Public input sections from applicable HCBS waiver applications |

# 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 State Plan Amendment (SPA) or an HCBS waiver?

Although the Balancing Incentive Program set goals for states to achieve and provided funding through enhanced FMAP, the specific process for implementing the Balancing Incentive Program was left to the states within broad CMS guidelines. States could increase the percentage of their LTSS spending used for HCBS by broadening service coverage and increasing eligibility through a variety of Medicaid State Plan options and waivers. They could do this by expanding on State Plan options and waivers that already were in operation, or by implementing 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 seven types of programs to help implement the Balancing Incentive Program. States primarily expanded existing programs (especially MFP and Section 1915(c) waivers) rather than developing wholly new programs. Depending on the state, program expansion was accomplished by broadening the range of services covered, increasing the number of people served (and sometimes the types of populations served), or both.

At the start of their participation in the Balancing Incentive Program, all states were participating in the MFP program (Wiener et al., 2015). Nearly half of the states (nine of 20) expanded their MFP programs during the implementation period to serve greater numbers of people.

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 (15) of the participating states expanded use of their existing Section 1915(c) waivers, either by increasing the number of people served or the range of services covered. New Jersey, however, eliminated its 1915(c) waivers, subsuming the covered services and populations into its 1115 demonstration program.

Several State Plan options were available during the initial Balancing Incentive Program 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. One of these states (New Hampshire) expanded the use of this option.

| 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 Research and Demonstration Waiver** | **Number of Program Types Used** |
| Arkansas | X | X | X | | | | X | 4 |
| Connecticut | E | E | | X | N | | | 4 |
| Georgia | X | E | | | | | | 2 |
| Illinois | X | E | | | | N | N[f] | 4 |
| Indiana* | E | E | | N | | | X | 4 |
| Iowa | E | E | | E | | N | | 4 |
| Kentucky | X | E | | | | | | 2 |
| 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 | E | X | X | N | | X | | 5 |
| New Hampshire | E | E | E | | | | | 3 |
| New Jersey | E | X[b] | X | | | N | X | 5 |
| New York | X | E | X | | N | X | X[c] | 6 |
| Ohio | X | E, N[d] | | | | E | | 3 |
| Pennsylvania | X | E | | | | N | | 3 |
| Texas | X | X | X | | N | | E[e] | 5 |
| **Total** | **20** | **20** | **11** | **7** | **4** | **10** | **8** | **80** |
| Existing | 11 | 5 | 10 | 2 | 0 | 3 | 6 | 37 |
| Expanded | 9 | 15 | 1 | 1 | 0 | 2 | 1 | 29 |
| New | 0 | 1 | 0 | 4 | 4 | 5 | 1 | 15 |

**NOTES**: X = Existed before and continued since start of the Balancing Incentive Program; E = Existed before and expanded since start the state's participation in the Balancing Incentive Program; N = New since the state began participation in the Balancing Incentive Program.

* Participation in the program ended early.

a. Merged 2 existing waivers into a single, combined waiver.
b. New Jersey's Section 1915(c) waivers were subsumed under its Section 1115 demonstration program and eliminated as separate waivers during this time period.
c. New York's Section 1115 waiver was in operation at the start of the Balancing Incentive Program, but authority has since expired. A new Section 1115 application has been submitted, but was not approved as of September 30, 2015.
d. Ohio implemented a waiver for an integrated care delivery system as part of its demonstration for dually eligible individuals.
e. Texas' 1115 waiver was amended to authorize managed LTSS statewide, and to add additional HCBS to capitation.
f. Illinois has an 1115 waiver pending that would consolidate 9 distinct 1915(c) waivers.

Two other State Plan options were used less often. Section 1915(i) allows states to provide HCBS as a State Plan option. Section 1915(k), also called the Community First Choice option, provides enhanced FMAP for states that are providing community-based attendant services and supports to people who need assistance to live in the community and who meet an institutional level of care. Three states had a 1915(i) State Plan option in place at the start of the Balancing Incentive Program, and one of those expanded it after beginning participation in the Balancing Incentive Program. Another four states implemented a new 1915(i) State Plan option during the course of the Balancing Incentive Program. 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 their Balancing Incentive Program participation. Four states (Maryland, Connecticut, New York, and Texas) adopted the Section 1915(k) option after beginning participation in the Balancing Incentive Program.

Health Homes, a third type of relevant 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. Five states had adopted Health Homes before beginning the Balancing Incentive Program, and two of those expanded their Health Homes programs during this time. Five other states began Health Home State Plan programs after beginning the Balancing Incentive Program.

Section 1115 Research and Demonstration Waivers offer states the opportunity to test 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 LTSS; 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 covered LTSS, including HCBS. One of those states (Texas) expanded its Section 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 an 1115 demonstration application in 2014, but implementation was pending at the end of the Balancing Incentive Program.

## ***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.

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

| EXHIBIT 3. Strategies Used to Expand HCBS as a Share of Total LTSS Expenditures | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Balancing 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 to Serve More People, New Populations** | **Reduce HCBS Waitlists** | **Increase HCBS Waiver Slots** | **Other Strategies** | **Total Strategies Used by State** |
| Arkansas[a] | X | | | | | | | X | 2 |
| Connecticut | X | X | X | X | X | | X | | 6 |
| Georgia | X | X | X | | | | X | X | 5 |
| Illinois | X | X | X | X | X | X | X | | 7 |
| Indiana* | | | X | | | | X | | 2 |
| Iowa | X | | X | | X | | X | | 4 |
| 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 | X | X | | 6 |
| Missouri | | | | | X | | X | | 2 |
| Nevada | | | | X | X | | | | 2 |
| New Hampshire[b] | X | | | | | | | X | 2 |
| New Jersey | X | X | X | X | X | | | X | 6 |
| New York | | X | | | | | | X | 2 |
| Ohio | | X | X | | X | | X | | 4 |
| Pennsylvania | | | | | | | X | | 1 |
| Texas | X | X | X | | X | X | X | | 6 |
| **Total** | **11** | **11** | **12** | **5** | **11** | **4** | **14** | **5** | **73** |

* Participation in the program ended early.

a. In addition to the accomplishments indicated in this table, Arkansas was engaged in planning for a Section 1915(i) State Plan option; Health Homes for participants in I/DD, physical disabilities, and aging waivers, and for individuals with SMI; and a Community First Choice SPA. All three initiatives were on hold at the time of this report. Rate increases for waiver and State Plan personal assistance services have been implemented.

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

States used several methods to increase the number of people receiving HCBS. Twelve 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, and 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 shifted people from institutions to the community, thereby increasing the number of Medicaid beneficiaries receiving HCBS. Five states used this approach. Other approaches included expanding current HCBS programs by serving new populations (11 states), reducing waiting lists (four states), and increasing the number of waiver slots (14 states).

## *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 was required to meet three structural reform goals--establishment of a NWD/SEP system, creation and implementation of a CSA, and implementation of a process to ensure CFCM. In addition, some states set additional goals for themselves beyond those required of all participating states.

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

One of the structural requirements was the establishment of a NWD/SEP system to make it easier for beneficiaries to access the service system. The NWD/SEP staff are key to the process of guiding individuals through assessment and eligibility determination. A single NWD/SEP eligibility coordinator or a case management system should guide the individual through the entire assessment and eligibility determination process. To fulfill this requirement, the NWD/SEP staff coordinate completion of the functional assessment, completion of the financial eligibility assessment, final eligibility determinations, enrollment in services, and setup of supports for individuals with LTSS needs (Mission Analytics, 2013). As established by CMS, the required NWD/SEP system has five key components:

1. Standardized informational materials for consumers.

2. Training staff on eligibility determination and enrollment processes.

3. Implementing a clear and consistent process to guide individuals through assessment and eligibility determination.

4. Establishing a NWD/SEP website.

5. Establishing a NWD/SEP 1-800 telephone number through which consumers may ask a representative any questions they have about available HCBS.

For each of these components, states reported the percentage completed and whether they had experienced any delays in completion as compared to the proposed timetable each state submitted with its application (***Exhibit 4***). The number of states experiencing delays indicates which components were most difficult to address.

Although all states were expected to complete these tasks before the end of the Balancing Incentive Program, not all states were able to do so. Six of the 20 states were unable to complete all of the activities related to establishing a NWD/SEP by the end of the project period. Of these six, two were states that ended their participation in Balancing Incentive Program early. The other four states ranged in completeness from an average across tasks of 27% in Nevada, which was unable to complete any of the tasks, to Ohio, which had an average of 99% completion but was experiencing delays with establishing its NWD/SEP website. Regardless of whether they ultimately completed all tasks, most states reported experiencing some delays. Only three of the states that completed all tasks had no delays, and others had delays on as many as four of the five tasks.

Establishing a 1-800 telephone number associated with their NWD/SEP appeared to be the easiest task for states to complete. Most states (17) had successfully completed this task, with an average completion rate of 93%, and only five states reported delays in accomplishing that task. Illinois, for example, had requested an extension from CMS to allow time for a vendor to be selected and branding to be developed specific to the 1-800 telephone number. Arkansas, Missouri, New Jersey, and Ohio, the other four states with delays, successfully established their 1-800 numbers.

Most (16 of 20) of the states reported that they had completed the task of developing standardized informational materials that their NWD/SEP s could provide to individuals, and the same number of states reported completing a process to guide individuals through the state’s assessment and eligibility determination.

The most challenging tasks were training staff on the eligibility and determination and enrollment processes, and establishing a NWD/SEP website. Only 15 states had trained staff and 14 states had established a NWD/SEP website.

| EXHIBIT 4. Status of NWD/SEP Requirements as of September 30, 2015 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Balancing Incentive 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** | | **Overall** | |
| | **Percent Complete** | **Delays** | **Percent Complete** | **Delays** | **Percent Complete** | **Delays** | **Percent Complete** | **Delays** | **Percent Complete** | **Delays** | **Average Percent Complete** | **Number of Delays** |
| Arkansas | 100 | No | 100 | No | 100 | No | 100 | Yes | 100 | Yes | 100 | 2 |
| Connecticut | 100 | No | 100 | No | 100 | No | 100 | No | 100 | No | 100 | 0 |
| Georgia | 100 | No | 100 | No | 100 | No | 100 | No | 100 | No | 100 | 0 |
| Illinois | 75 | Yes | 55 | No | 100 | No | 60 | Yes | 95 | Yes | 77 | 3 |
| Indiana* | 75 | Yes | 25 | Yes | 10 | Yes | 80 | Yes | 100 | No | 58 | 4 |
| Iowa | 100 | No | 100 | Yes | 100 | Yes | 100 | Yes | 100 | No | 100 | 3 |
| Kentucky | 100 | Yes | 100 | Yes | 100 | No | 100 | Yes | 100 | No | 100 | 3 |
| Louisiana* | 100 | No | 0 | No | 0 | No | 75 | No | 100 | No | 55 | 0 |
| Maine | 100 | Yes | 100 | No | 100 | No | 100 | No | 100 | No | 100 | 1 |
| Maryland | 100 | No | 100 | No | 100 | No | 100 | No | 100 | No | 100 | 0 |
| Massachusetts | 100 | Yes | 100 | Yes | 100 | No | 100 | No | 100 | No | 100 | 2 |
| Mississippi | 100 | Yes | 100 | Yes | 100 | Yes | 100 | No | 100 | No | 100 | 3 |
| Missouri | 100 | Yes | 100 | Yes | 100 | Yes | 100 | No | 100 | Yes | 100 | 4 |
| New Hampshire | 100 | Yes | 100 | Yes | 100 | Yes | 100 | Yes | 100 | No | 100 | 4 |
| New Jersey | 100 | Yes | 100 | No | 100 | Yes | 100 | No | 100 | Yes | 100 | 3 |
| New York | 100 | Yes | 100 | Yes | 100 | No | 100 | Yes | 100 | No | 100 | 3 |
| Nevada | 40 | Yes | 20 | Yes | 35 | Yes | 30 | Yes | 10 | No | 27 | 4 |
| Ohio | 100 | No | 100 | No | 100 | Yes | 95 | Yes | 100 | Yes | 99 | 3 |
| Pennsylvania | 50 | Yes | 25 | Yes | 30 | Yes | 50 | Yes | 50 | No | 41 | 4 |
| Texas | 100 | No | 100 | Yes | 100 | No | 100 | No | 100 | No | 100 | 1 |
| **Total States** | | | | | | | | | | | | |
| 100% complete | 16 | | 15 | | 16 | | 14 | | 17 | | 14 | |
| Average percentage completed | 92 | | 81 | | 84 | | 90 | | 93 | | 88 | |
| **Total States Experiencing Delays** | | **12** | | **11** | | **9** | | **10** | | **5** | | **16** |
| * Participation in the program ended early. | | | | | | | | | | | | |

### *Core Standardized Assessment*

A second required component of the Balancing Incentive Program is the use of a CSA to ensure that similar key information is collected for all populations receiving LTSS. In addition to a required core set of domains and items used for all populations, states may use additional items for specific populations, so that the assessment may vary by populations; however, the assessment for any given population must be consistent across the state--it may not vary by region or program. Successful development of a CSA includes the following three criteria:

- **Criterion 1**: Develop a Level I screen assessment. This assessment is used to assess a person's financial and functional status, and determine likely eligibility for services when that person first makes inquiry about 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/SEP s in the use of the CSA.

Sixteen of the states reported that they had met all of these criteria by September 30, 2015. States were most likely to have completed development of the Level I Screen Assessment; 19 of the 20 states had completed that activity. Ten states had experienced delays in completing the task when compared to the state's timetable submitted in its application, but nine of those ten had completed it despite the delays (***Exhibit 5***).

Most states also had completed the remaining stages of CSA development. Eighteen states reported completely incorporating the required core domains and topics into their assessments. Eleven states reported delays in completing this task. Nine of the 11 states that had been delayed had since completed that task. Two states had made limited progress toward the goal, completing only 30% or less of the required work; one of those states (Indiana) ended participation early in the Balancing Incentive Program. Maine, one of the states that had incorporated all required domains and topics into its assessments, did not, in fact, need to update its assessment tools at all during the course of the Balancing Incentive Program, as its existing assessment tools already included the required CDS domains and items.

States also had made less progress toward accomplishing the necessary training of staff in the use of the CSA. Seventeen states had completed that task, and 11 states had encountered delays. Seven of the states that had experienced delays had, however, since completed that task. Of the four states that had failed to complete staff

training, two did not report the level of completion of that criterion. One of those two was Indiana, which ended its participation early.

Overall, 16 states completed all of the required tasks associated with development of the CSA. These states faced varying numbers of delays, from none to three. Two states had 77% of the goals completed (with one delay each), and one had 80% complete (with two delays). The overall rate of completion could not be computed for one state because of missing data.

**EXHIBIT 5. Status of CSA Requirements as of September 30, 2015**

| Balancing Incentive Program State | Develop Level I Screen Assessment | | Incorporate Additional Domains and Topics into Assessments | | Train Staff at NWD/SEPs to Coordinate CSA | | Overall | |
|---|---|---|---|---|---|---|---|---|
| | Percent Complete | Delays | Percent Complete | Delays | Percent Complete | Delays | Average Percent Complete | Number of Delays |
| Arkansas | 100 | No | 100 | No | 100 | No | 100 | 0 |
| Connecticut | 100 | No | 100 | No | 100 | No | 100 | 0 |
| Georgia | 100 | Yes | 100 | Yes | 100 | Yes | 100 | 3 |
| Illinois | 100 | No | 100 | No | 30 | Yes | 77 | 1 |
| Indiana* | 75 | Yes | 25 | Yes | [a] | Yes | - | 3 |
| Iowa | 100 | Yes | 100 | Yes | 100 | Yes | 100 | 3 |
| Kentucky | 100 | Yes | 100 | No | 100 | No | 100 | 1 |
| Louisiana* | 100 | No | 100 | Yes | 100 | No | 100 | 1 |
| Maine | 100 | No | 100[b] | No | 100 | No | 100 | 0 |
| Maryland | 100 | Yes | 100 | Yes | 100 | Yes | 100 | 3 |
| Massachusetts | 100 | No | 100 | No | 100 | No | 100 | 0 |
| Mississippi | 100 | Yes | 100 | Yes | 100 | Yes | 100 | 3 |
| Missouri | 100 | Yes | 100 | No | 100 | Yes | 100 | 2 |
| New Hampshire | 100 | Yes | 100 | Yes | 100 | No | 100 | 2 |
| New Jersey | 100 | Yes | 100 | Yes | 100 | Yes | 100 | 3 |
| New York | 100 | No | 100 | No | 100 | Yes | 100 | 1 |
| Nevada | 100 | No | 100 | Yes | 40 | Yes | 80 | 2 |
| Ohio | 100 | Yes | 100 | Yes | 100 | Yes | 100 | 3 |
| Pennsylvania | 100 | No | 30 | Yes | 100 | No | 77 | 1 |
| Texas | 100 | No | 100 | No | 100 | No | 100 | 0 |
| **Total States** | | | | | | | | |
| 100% completed | 19 | | 18 | | 17 | | 16 | |
| Average percentage completed | 99 | | 93 | | 93 | | 97c | |
| **Total States Experiencing Delays** | | **10** | | **11** | | **11** | | **15** |

* Participation in the program ended early.
a. No report of percentage complete.
b. Maine did not update its assessment tool because its existing assessment tools included the required core domains and items.
c. Average includes only those 19 states for which complete data were available.

### *Conflict-Free Case Management*

The third key required infrastructure improvement in the Balancing Incentive Program is the establishment of CFCM, which is designed to remove potential conflict of interest regarding conducting assessments and developing care plans and the provision of services. In some states, care providers both develop the care plan and provide the services, which may create incentives for the provider to overstate the level of need and

to include the services they provide in the care plan. Requirements for CFCM are not unique to the Balancing Incentive Program. Similar, but not identical, requirements are included as part of the Community First Choice (Section 1915(k)) provisions of the ACA and in the Medicaid Program Final Rule on State Plan Home and Community-Based Services (CMS, 2014). While states participating in the Balancing Incentive Program have made progress on this requirement, they must undertake continued evaluation of their structures to ensure regulatory compliance.

Nearly all states (19 of 20) met the requirement concerning CFCM; the only state that failed to do so was Indiana, which ended its participation in the Balancing Incentive Program early. Six states, including Indiana, reported delays in developing a protocol for removing conflict of interest (***Exhibit 6***). 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 faced some delays when working with its behavioral health programs. Some other states described challenges ensuring CFCM in rural areas, where the same organization may provide both care planning and services, and there are few options to for other organizations to take on those roles.

**EXHIBIT 6. Status of CFCM as of September 30, 2015**

| | **Establish Protocol for Removing Conflict of Interest** | |
|---|---|---|
| | **Percent Complete** | **Delays** |
| Connecticut | 100 | No |
| Georgia | 100 | Yes |
| Illinois | 100 | No |
| Indiana* | 50 | Yes |
| Iowa | 100 | Yes |
| Kentucky | 100 | No |
| Louisiana* | 100 | No |
| Maine | 100 | No |
| Maryland | 100 | Yes |
| Massachusetts | 100 | No |
| Mississippi | 100 | Yes |
| Missouri | 100 | No |
| New Hampshire | 100 | No |
| New Jersey | 100 | No |
| New York | 100 | Yes |
| Nevada | 100 | No |
| Ohio | 100 | No |
| Pennsylvania | 100 | No |
| Texas | 100 | No |
| **Total States** | | |
| 100% complete | 19 | |
| Average percentage completed | 98 | |
| **Total States Experiencing Delays** | | **6** |

* Participation in the program ended early.

## *State Discretionary Goals*

**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 | X | X[c] | X | X[d] | | X[e] |
| Georgia | X | | X | X | | | X |
| Illinois | X | | X | | X[f] | X | X |
| Indiana* | X | | X | | X | | |
| Iowa | X | X | | X | | | |
| Kentucky | X | | | | | | |
| Louisiana* | X | | X | | | | |
| Maine | X | | | | | | O[g] |
| Maryland | X | X | X[h] | X | | | O |
| Massachusetts | O | | | X | X | | X[i] |
| Mississippi | | X | | O | | X[j] | |
| Missouri | | | | | | X | O |
| Nevada | O | | | | | | |
| New Hampshire | | | | | | X[k] | |
| New Jersey | | | | | X | | |
| New York[l] | | O | O | O | O | | O |
| Ohio | X | | X | | | | X[m] |
| Pennsylvania | X | | | | X | | |
| Texas[n] | X | O | O[o] | X | O | | X[p], O[q] |
| **Total Number of States** | **14** | **7** | **10** | **8** | **8** | **4** | **11[r]** |
| Work is underway | 12 | 5 | 8 | 6 | 6 | 4 | 7 |
| No activity yet/ status unknown | 2 | 2 | 2 | 2 | 2 | 0 | 5 |

**NOTE**: X = work on goals began before September 30, 2015. O = no evidence exists to show that work had begun on these goals as of September 30, 2015. Blank cells indicate that the state did not have any such goal.

* Participation in the program ended early.

a. Planning for 1915(i) is on hold.
b. Offering substance abuse treatment services.
c. Slots added to 1915(c) Mental Health Waiver.
d. Connecticut's Department of Developmental Services conversion of intermediate care facilities for individuals with intellectual disabilities to Community Living Arrangements.
e. Developed HCBS waiver case management system.
f. Using MFP for people with mental health disabilities.
g. Developing Olmstead Request for Proposal, establishing a Shared Living Demonstration, conducting the Personal Support Specialist Rate Study.
h. Adding personal care services for people in group homes for people with mental health disabilities.
i. Enhancing services for elders and individuals with autism.
j. Mississippi is still evaluating the quality measures that will be reported from LTSS.
k. New Hampshire intends to use the Subset of Medicaid Adult Health Quality Measures as stated in the Balancing Incentive Program manual.
l. New York has spent most of its enhanced FMAPs for "enhancement of community services offered under waivers/managed care." It is unclear exactly what has been done and how it meets these goals.
m. Expanding the Program of All-inclusive Care for the Elderly.
n. Texas reports having used enhanced FMAP for "service expansion," but does not provide detail about which services have been expanded, waiver or State Plan.
o. Texas reported plans to establish recovery support centers. That status of those efforts was unclear.
p. 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.
q. Status of planned efforts to increase data sharing between Texas Department of State Health Services and homeless program is unclear.
r. Two states had begun work on some discretionary goals, but not on others. They are counted only once in the total.

In addition to the required goals, states had the opportunity to set additional goals of their own choosing at the time of their application. The available state-provided administrative reports vary in the detail provided about activities related to these goals, but suggest several types of activities in which states were engaged and ways in which

the enhanced funds from the Balancing Incentive Program were 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 were strategies for helping to increase the share of LTSS expenditures for HCBS (***Exhibit 7***).

*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 adding 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*

Two states (Illinois and Texas) indicated a focus on improving services for people with intellectual or developmental disabilities (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 in the community. Texas also was planning for a pilot test of managed LTSS for people with I/DD, but that program was not implemented as of September 2015.

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.

## ***Research Question 5*: Did the 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?**

Although states were 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 could be targeted to specific populations. At the time of their application, all states had indicated plans to focus efforts to increase the share of spending for HCBS on two or more populations, and most states (13) had plans to address at least four distinct populations (Wiener et al., 2015). The four populations

commonly addressed 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 or substance use disorders (SMI/SUD). Six states had planned at baseline to focus on other populations as well, including people with HIV/AIDS and people with traumatic brain injury (TBI), as well as others (***Exhibit 8***).

During the course of the Balancing Incentive Program, several states implemented programs or activities that targeted a subpopulation they had not identified in their original application. Other states did not report activities targeted to populations that they had identified at baseline as a focus of activities. Arkansas, for example, had planned to focus activities on all of the four key populations, but ultimately addressed only people with physical disabilities and those age 65 or older. A few states also focused efforts on other populations, including individuals with HIV/AIDS, people with TBIs, dual eligible individuals, and children. States addressing these other populations were as likely to adopt new waivers or State Plan options as to increase provider rates.

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. Approaches to increasing access, such as increasing the number of people served under existing waivers or adopting new HCBS waivers or State Plan options, were the most commonly used method for all populations.

Twelve of the states used more than one of these strategies overall, and nine states used more than one strategy for a given population. For the four most commonly targeted populations, states were more likely to focus efforts on increasing access than on increasing payment. Increased access was generally accomplished by increasing the number of waiver slots of existing waivers or by adopting new waivers or State Plan options.

**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 | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | | | | | | 0 |
| | Increase payment | | | | | | 0 |
| | Other | X | X | | | | 2 |
| Connecticut | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | X | X | X | X | | 4 |
| | Increase payment | | | | | X | 1 |
| | Other | | | | | | 0 |
| Georgia | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | X | X | X | X | | 4 |
| | Increase payment | X | X | | | X | 3 |
| | Other | | | | | | 0 |
| Illinois | Baseline plan to target | X | X | X | X | X | 5 |
| | Increase access | | | X | X | X | 3 |
| | Increase payment | | | | | | 0 |
| | Other | X | X | X | X | X | 5 |

| EXHIBIT 8 (*continued*) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Balancing Incentive Program State** | **Population** | | | | | | |
| | **Strategy** | **Age 65+** | **Physical Disabilities** | **I/DD** | **SMI/SUD** | **Other** | **Total** |
| Indiana* | Baseline plan to target | | | X | X | | 2 |
| | Increase access | | | X | X | | 2 |
| | Increase payment | | | | | | 0 |
| | Other | | | | X | | 1 |
| Iowa | Baseline plan to target | | | X | X | | 2 |
| | Increase access | | | X | X | | 2 |
| | Increase payment | X | X | X | X | X | 5 |
| | Other | | | | | | 0 |
| Kentucky | Baseline plan to target | | | X | | X | 2 |
| | Increase access | | | X | | X | 2 |
| | Increase payment | | | | | | 0 |
| | Other | | | | | | 0 |
| Louisiana* | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | X | X | X | | | 3 |
| | Increase payment | | | | | | 0 |
| | Other | | | | X | | 1 |
| Maine | Baseline plan to target | X | X | X | | | 3 |
| | Increase access | X | X | X | | | 3 |
| | Increase payment | | | | | | 0 |
| | Other | | | | | | 0 |
| Maryland | Baseline plan to target | X | X | | | | 2 |
| | Increase access | X | X | X | | | 3 |
| | Increase payment | X | X | | | | 2 |
| | Other | | | | | | 0 |
| Massachusetts | Baseline plan to target | | | | X | | 1 |
| | Increase access | | | | | | 0 |
| | Increase payment | X | X | X | X | X | 5 |
| | Other | X | | X | X | | 3 |
| Mississippi | Baseline plan to target | X | X | X | X | X | 5 |
| | Increase access | X | X | X | X | X | 5 |
| | Increase payment | | | | | | 0 |
| | Other | | | | | | 0 |
| Missouri | Baseline plan to target | X | X | X | X | X | 5 |
| | Increase access | | X | X | | | 2 |
| | Increase payment | | | | | | 0 |
| | Other | | | | | | 0 |
| Nevada | Baseline plan to target | X | X | X | | | 3 |
| | Increase access | | | | | | 0 |
| | Increase payment | | | | | | 0 |
| | Other | | | | | | 0 |
| New Hampshire | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | | | | X | | 1 |
| | Increase payment | | | | | X | 1 |
| | Other | | | | | | 0 |
| New Jersey | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | | | X | X | X | 3 |
| | Increase payment | | | X | | | 1 |
| | Other | | | | | | 0 |
| New York | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | | | | | | 0 |
| | Increase payment | | | | | | 0 |
| | Other | X | X | X | X | | 4 |
| Ohio | Baseline plan to target | X | X | X | X | X | 5 |
| | Increase access | X | X | X | | X | 4 |
| | Increase payment | | | | | | 0 |
| | Other | X | | | X | | 2 |
| Pennsylvania | Baseline plan to target | X | X | X | X | | 4 |
| | Increase access | X | X | X | | | 3 |
| | Increase payment | | | | | | 0 |
| | Other | | | | | | 0 |

| EXHIBIT 8 (*continued*) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Balancing Incentive Program State** | **Population** | | | | | | |
| | **Strategy** | **Age 65+** | **Physical Disabilities** | **I/DD** | **SMI/SUD** | **Other** | **Total** |
| Texas | Baseline plan to target | X | X | X | X | X | 5 |
| | Increase access | X | X | X | | | 3 |
| | Increase payment | X | X | X | | | 3 |
| | Other | | | | X | X | 2 |
| **Total** | Baseline plan to target | 16 | 16 | 18 | 16 | 6 | 72 |
| | Increase access | 9 | 10 | 15 | 8 | 5 | 47 |
| | Increase payment | 5 | 5 | 4 | 2 | 5 | 21 |
| | Other | 5 | 3 | 3 | 7 | 2 | 20 |

**NOTES**: "Baseline plan to target" indicates populations that the state identified in their application as a focus for their efforts. Rows for "Increase access" and "Increase payment" indicate the strategies used and populations of focus for activities that took place from implementation through September 30, 2015. "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, on the basis of available documentation, did not appear to have undertaken any of these strategies.

* Participation in the program ended early.

## *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 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.

### *Money Follows the Person Program*

All states participating in the Balancing Incentive Program also were participating in the MFP program, resulting in several areas where the programs supported and built off of each other. Many states used Balancing Incentive Program funding to further the goals of their MFP programs. For example, Georgia used 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 used 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 Incentive Program funding to expand the MFP program to additional populations. Before ending participation in the Balancing Incentive Program, 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 Incentive 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. Other states described using MFP funds to help develop new assessment tools and train staff in their use. For example, Arkansas used MFP funds to pay for implementing its interRAI assessments, which it used to meet Balancing Incentive Program CSA requirements. Connecticut used MFP funds to build on its expedited system for determining eligibility for and enrollment into the program, expanding it from the MFP program to all Medicaid-funded programs. Connecticut also used MFP funds to develop the assessment items for the CSA required by the Balancing Incentive Program, and to develop an online, pre-screening assessment that individuals could use to determine their likely functional and financial eligibility for state HCBS. Connecticut tested the online pre-screen assessment with MFP participants and staff prior to implementing it statewide (Lester et al., 2013). Many states relied on 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 one or more Section 1915(c) HCBS waiver programs before the implementation of their Balancing Incentive Programs. As seen in ***Exhibit 2***, 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 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. Missouri expanded access to the Partnership for Hope Waiver, the Missouri Children with Developmental Disabilities Waiver, the Comprehensive Waiver, and the Adult Day Care Waiver. Another example of utilizing Section 1915(c) waiver programs to increase HCBS is Pennsylvania, which expanded waiver slots for seniors, adults with physical disabilities, and people with intellectual disabilities or autism.

### *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). At least five states (Arkansas,[1] Connecticut, Iowa, Mississippi, and New York) used Balancing Incentive Program funding to implement their 1915(i) State Plan programs (Mission Analytics, 2015a). In addition, some states used Balancing Incentive Program funds for their Community First Choice program. For example, 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.

### *Health Homes*

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 Incentive Program. In Iowa, the higher federal match rate of the Balancing Incentive Program was used to increase Medicaid payment rates by 2% for providers participating in Health Homes. Arkansas[2] used Balancing Incentive Program funding to support development of its Health Homes (Mission Analytics, 2015b).

### *Aging and Disability Resource Centers*

Several states reported working with Aging and Disability Resource Centers (ADRCs) to implement their NWD/SEP systems. Some states used funding from the Balancing Incentive Program to support and enhance current ADRCs. For example, Georgia's Balancing Incentive Program funding was used for structural enhancements to the state's ADRCs. Illinois reported that its Balancing Incentive Program funds were used for improving the ADRCs' branding, including additional populations and strengthening relationships with stakeholder groups. In other states, the Balancing Incentive Program benefited from the resources of the ADRCs. In New Hampshire, for example, the state used the existing ADRC website and phone number to meet the requirements to have a designated NWD/SEP website and 1-800 telephone number. Several states are using ADRCs, as well as Area Agencies on Aging, for their NWD/SEP.

### *State Innovation Model Demonstrations*

Several of the states also are participating in the State Innovation Model (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

[1] Arkansas has ended their 1915(i) State Plan program since the end of the Balancing Incentive Program.

[2] Arkansas has since ended its Health Homes program.

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), federal Medicaid funds cover 90% of the costs of the design, development, and installation or enhancement of Medicaid eligibility determination systems. Both Texas and Connecticut used these federal matching funds to cover much of the costs of the NWD/SEP information technology systems to meet 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 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).

Fifteen states had created formal advisory boards. For example, Connecticut convened a global communications workgroup to assist with the NWD/SEP advertising strategies. Ten states reported that they held meetings with stakeholder groups. Each of those states held meetings of providers and meetings of consumers and their advocates, and five also held meetings with policy makers. 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. Information about stakeholders' interaction with the state around Balancing Incentive Program activities was limited in the documentary record and may be incomplete.

Six states reported that they worked with stakeholders to test or pilot proposed actions or assessments for the state LTSS system. Most (five) of those states used consumers to test proposed systems, and three also sought assistance from providers. 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 appropriately routed. Only one state (Arkansas) reported engaging stakeholders through requests for written comments.

| 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 | | X | | | 1 |
| | Policy makers | X | | | | 1 |
| | Consumers/advocates | | X | X | | 2 |
| 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 | [a] | | | | 0 |
| | Policy makers | | | | | 0 |
| | Consumers/advocates | | | | | 0 |
| Iowa | Providers | | X | | | 1 |
| | Policy makers | | X | | | 1 |
| | Consumers/advocates | | X | | | 1 |
| Kentucky | Providers | | | X | | 1 |
| | 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 |
| Maryland | Providers | X | | | | 1 |
| | Policy makers | | | | | 0 |
| | Consumers/advocates | X | | | | 1 |
| Massachusetts | Providers | | | | | 0 |
| | Policy makers | X | | | | 1 |
| | Consumers/advocates | | | X | | 1 |
| Mississippi | Providers | X | [b] | | | 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 | X | | 2 |
| | Policy makers | | X | | | 1 |
| | Consumers/advocates | | X | X | | 2 |
| 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 |
| Pennsylvania | Providers | X | | | | 1 |
| | Policy makers | | | | | 0 |
| | Consumers/advocates | | | | | 0 |
| Texas | 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** |
| **Total States** | Any stakeholders[c] | 15[d] | 10[e] | 6 | 1 | 19 |
| | Providers | 9 | 9 | 3 | 0 | 17[f] |
| | Policy makers | 8 | 5 | 0 | 0 | 13[f] |
| | Consumers/advocates | 8 | 9 | 5 | 1 | 15[f] |

* Participation in the program ended early.

a. Indiana had an advisory board, but its composition is unknown so none of the specific stakeholder groups are indicated in the table.
b. Mississippi had stakeholder meetings, but it is unclear which specific stakeholder groups were included. Therefore, no groups are indicated in the table.
c. 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.
d. The total number of states with an advisory board includes Indiana, which was known to have a stakeholder group of unspecified membership.
e. The total number of states that held meetings includes Mississippi which held stakeholder meetings, with the types of stakeholders involved being unspecified.
f. The total number of states reports those states seeking any input from a provider group. The total number may not equal the sum of states across type of input, as states may have sought multiple types of input from any provider group.

# 4. DISCUSSION

The Balancing Incentive Program established by the ACA was 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 the participating states to work toward these goals. Findings from this process evaluation indicate the following:

***States engaged in a wide range of activities to achieve the required expenditure and infrastructure goals***. States continued activities that they began before the Balancing Incentive Program and also implemented 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 combined 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 used MFP and 1915(c) waivers to help achieve the expenditure goals of the Balancing Incentive Program. States also used other Medicaid programs, such as State Plan options and 1115 demonstration programs, to help increase the use of HCBS. Enhanced matching funds generated from the Balancing Incentive Program also helped to support these other programs by such means as increasing waiver slots, reducing waiting lists, and supporting the development of Health Homes.

***States targeted activities to different populations***. Although the infrastructure changes were required to address all populations, activities to rebalance spending could be directed to specific populations. Most states addressed activities to each of the four key populations (people with I/DD, people with physical disabilities, people age 65 and older, and people with SMI/SUD), and did so in various ways. Efforts to increase access were more common than were strategies to increase payments.

***States made much progress toward infrastructure development, but did not all meet goals by September 30, 2015***. Fourteen states had completed work toward all of the required infrastructure goals by the end of FY2015. States had made the most progress toward CFCM, with 19 of the 20 states being 100% complete. The CSA was the second most commonly completed requirement; 17-19 states had completed each of the individual components of the goal, and 16 states had completed all of the components of that goal. For the NWD/SEP goal, some states struggled with training staff on eligibility determination and enrollment processes (15 of 20 states completed), implementing processes to guide individuals through assessment and eligibility determination (16 of 20 states completed), and establishing a NWD/SEP website (14 of 20 states completed).

***States also made 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 14 states. This activity, while valuable in its own right, also supported efforts to increase the share of LTSS expenditures for HCBS. Most optional state goals also helped to increase the share of LTSS expenditures for HCBS. The notable exception was a goal to improve quality measurement, identified by four states.

States made significant efforts to achieve the goals of the Balancing Incentive Program, but were not always able to achieve these goals by the end of the demonstration period. CMS granted several states extensions of time to achieve the required goals and/or to continue spending enhanced FMAP funds received. The experience of those extensions is beyond the scope of this evaluation.

The findings reported here were obtained primarily from review of states' quarterly reports. Data from those reports were somewhat limited, and it is possible that states engaged in efforts and strategies beyond those described here. Nonetheless, these findings paint a picture of states that were highly engaged in rebalancing efforts and were employing numerous strategies to achieve the required improvements in service and infrastructure. Such flexibility is necessary to accommodate each state's specific situation and build on each state's strengths. The extensions granted by CMS reflect support for that flexibility.

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