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

Descriptive Overview and Summary of Balancing Incentive Program Participating States at Baseline

August 2015

Office of the Assistant Secretary for Planning and Evaluation

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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.

DESCRIPTIVE OVERVIEW AND SUMMARY OF BALANCING INCENTIVE PROGRAM PARTICIPATING STATES AT BASELINE

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ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

AAA	Area Agency on Aging
ACA	Affordable Care Act
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
AIDS	Acquired Immune Deficiency Syndrome
CDS	Core Dataset
CFCM	Conflict-Free Case Management
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CSA	Core Standardized Assessment
DSH	Disproportionate Share Hospital
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentage
FY	Fiscal Year
HCBS	Home and Community-Based Services
HIV	Human Immunodeficiency Virus
I&R	Information and Referral
I/DD	Intellectual or Developmental Disabilities
IADL	Instrumental Activity of Daily Living
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ILC	Independent Living Center
LTSS	Long-Term Services and Supports
MFP	Money Follows the Person
NWD	No Wrong Door
PACE	Program of All-Inclusive Care for the Elderly

SEP	Single Entry Point
SMI	Serious Mental Illness
TTY	telecommunications device for the deaf

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), such as personal care assistance. Despite the preferences of people with disabilities to live in the community, it is only in very recent years that Medicaid spending on institutional settings, such as nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and psychiatric hospitals has been reduced to around 50% of LTSS expenditures. This picture of national spending on LTSS, however, masks wide variation across states and subpopulations of individuals who use LTSS. For example, the share of HCBS as a percentage of total Medicaid LTSS spending by state ranged from 27% in New Jersey to 78% in Oregon in Fiscal Year 2012.

The 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 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. All participating states are required to achieve three infrastructure goals: creation of a no wrong door (NWD)/single entry point system of application for LTSS, implementation of a core standardized assessment (CSA), and establishment of a conflict-free case management (CFCM) system.

To assess the status of the Balancing Incentive Program participating states at the beginning of the program or baseline, RTI International and our partners at the National Academy of State Health Policy and the National Association of State Directors of Developmental Disability Services reviewed states' Balancing Incentive Program applications and work plans, available data on state LTSS expenditures, and other sources of data. This report presents findings from that work. We describe the baseline status of the 21 states participating in the Balancing Incentive Program, including patterns of LTSS expenditures and progress toward the required infrastructure goals. Based on these data, we developed a "challenge score" for each state, which summarized the amount of work required to be completed relative to the amount of time available to the state. In addition, we describe the challenges each state faced and the strengths and resources they brought to the task. These strengths and challenges are affected by the additional, non-mandatory goals that states set for themselves, and the

resources that states may have as a result of participating in other HCBS options and initiatives. The findings presented here offer a context for evaluation of states' progress toward the required goals.

Findings from this baseline review indicate the following:

- There is significant variation among states in how close they are to achieving each of the goals. Some states are closer than others, but each faces some challenges.

- States generally are closer to achieving expenditure goals than they are to achieving the infrastructure goals. Two states had achieved the required expenditure goals at the time of their application but were still eligible because the statute specified 2009 as the year in which the degree of rebalancing was to be measured.

- States vary in how close they are to the required expenditure goal for different target populations. Overall, people with intellectual or developmental disabilities (I/DD) are being served in the community, but other populations have a longer way to go to achieve expenditure balance. Despite these differences in baseline status, most states are focusing their Balancing Incentive Program efforts across populations, rather than on a single population group.

- At baseline, no state had achieved any one or more of the three required infrastructure reforms. States were closer to achieving a CSA and a NWD entry approach than they were to achieving CFCM.

- States identified numerous strengths and challenges in their applications. Frequently mentioned strengths included making progress toward implementing the infrastructure goals, and the active use of other rebalancing options.

- Frequently mentioned challenges concerned lack of adequate services, inadequate information systems, concerns with case management, and other issues related to general state policy.

- All of the Balancing Incentive Program states are operating multiple Medicaid initiatives to improve the balance of LTSS provision. All Balancing Incentive Program states are participating in the Money Follows the Person program and are operating at least one 1915(c) waiver. Several states are participating in other waiver initiatives as well.

- Engagement in multiple initiatives offers the opportunity to leverage resources, as well as the ability to address goals beyond those required under the Balancing Incentive Program. Many of the additional goals identified by states, although meaningful in their own right, also can play a role in moving states closer to achieving the mandatory Balancing Incentive Program goals. Several states are

working to expand waiver programs and eliminate waiting lists, as well as to expand other programs to better serve new populations. Higher payment rates also may increase the share of LTSS dollars that are spent on HCBS. Improved quality measurement is an important goal, with no direct tie to the required goals.

- Very few states chose to target their efforts to specific populations of users. One state (Maryland) planned to focus its efforts on the population with the lowest share of LTSS dollars being spent on HCBS: elders and people with physical disabilities. Other states (Indiana, Kentucky) that plan to focus on specific populations are placing emphasis on people with I/DD, who already are receiving much of their LTSS in the community. Massachusetts is unusual in its choice to focus efforts on people with behavioral health needs.

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

1. INTRODUCTION

Long-term services and supports (LTSS) are used by people with disabilities or chronic health conditions who need help with activities of daily living (ADLs) (e.g., bathing, dressing, eating) or instrumental activities of daily living (IADLs) (e.g., preparing meals, managing money). People with disabilities strongly prefer home and community-based services (HCBS) to institutional care (Kaiser Family Foundation, 2007; Mattimore et al., 1997). Moreover, people with disabilities living in the community have substantial unmet needs for personal care and other HCBS. These unmet needs may lead to higher rates of adverse events, including discomfort, weight loss, dehydration, falls, burns, skin problems, missed meals, inability to follow special diets, missed doctor visits, and having to wear dirty clothes, factors that affect quality of life for persons with disabilities (LaPlante et al., 2004). A key element in the preference by people with disabilities for HCBS is the belief that quality of care for these services is superior to that of nursing home care. For example, older people associate the ability to stay in their own homes through HCBS with retention of independence and control over care decisions (AARP, 2003).

Historically, Medicaid LTSS financing and delivery has favored institutional care over HCBS such as personal care assistance (Eiken et al., 2014; Wiener & Anderson, 2009; Wiener, Anderson, & Khatutsky, 2008). Despite the preferences of people with disabilities to live in the community, spending on institutional services, in settings such as nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), and psychiatric hospitals continue to account for about half of all Medicaid LTSS expenditures (Eiken et al., 2014; Wiener, 2013). This picture of national spending on LTSS, however, masks wide variation across states and subpopulations of individuals who use LTSS. The share of HCBS as a percentage of total Medicaid LTSS spending by state ranged from 27% in New Jersey to 78% in Oregon in fiscal year (FY) 2012. Among LTSS subpopulations, national spending on HCBS made up 39% of the share of total Medicaid LTSS spending for older individuals and individuals with physical disabilities. In contrast, national spending on HCBS made up 70% of the share of total Medicaid LTSS spending for individuals with developmental disabilities in FY 2012 (Eiken et al., 2014).

Federal Medicaid and other policies are supporting more opportunities for states to provide HCBS. Congress has enacted several Medicaid options to encourage states to shift Medicaid LTSS spending toward HCBS, including State Plan personal care services, Section 1915(c) HCBS waivers, the Real Choice Systems Change Grants for Community Living program, Money Follows the Person (MFP), and the Section 1915(i) Medicaid State Plan option. The Affordable Care Act (ACA) of 2010 created additional State Plan options for expanding Medicaid HCBS, including health homes, the Section 1915(k) Community First Choice program, and the Balancing Incentive Program (Townley & Takach, 2012; Wiener, 2010).

The Balancing Incentive Program is unique in its focus on states with a lower percentage of HCBS as a proportion of total Medicaid LTSS. The program seeks to encourage these states to increase the amount of LTSS that are provided through HCBS, rather than in institutional settings, by offering an incentive of a temporarily higher federal match for Medicaid HCBS. In exchange, participating states are required to increase the share of LTSS dollars spent for HCBS, and to develop three key aspects of LTSS infrastructure to support their efforts to shift services to HCBS. These infrastructure components include the use of a no wrong door/single entry point (NWD/SEP) approach for individuals needing help with and possibly applying for LTSS; the establishment of a core standardized assessment (CSA) tool for determining eligibility for services; and development of conflict-free case management (CFCM) for planning and monitoring services.

The evaluation of the Balancing Incentive Program addresses the key question of whether, when combined with other Medicaid state options, a modest increase in the Federal Medical Assistance Percentage (FMAP) combined with other requirements, can motivate significant change in the Medicaid LTSS system among states that have lagged in the development of HCBS. This report is part of an evaluation of the effectiveness of the Balancing Incentive Program sponsored by the Office of the Assistant Secretary for Planning and Evaluation/U.S. Department of Health and Human Services in cooperation with the Centers for Medicare and Medicaid Services (CMS). An outcomes evaluation will assess how well states have achieved the desired goals, and a process evaluation will examine how the Balancing Incentive Program has operated within the context of other Medicaid options for rebalancing state LTSS systems.

Evaluating the effectiveness of the Balancing Incentive Program requires assessing the effects of this program against each participating state's baseline status. This report describes the baseline status of each state participating in the Balancing Incentive Program. Baseline information includes the expenditures and infrastructure of each state, as well as the context in which the Balancing Incentive Program is being implemented in each state. Contextual factors include other state activities that support rebalancing efforts, strengths and challenges with which each state was working, and additional goals desired by the state.

Data and Methods

This report provides information about the baseline status for each of the states participating in the Balancing Incentive Program. We address the baseline status as it relates to the balance of LTSS expenditures, and each of the required infrastructure components. ***Exhibit 1*** shows the specific research questions we addressed, and the data sources used for each.

EXHIBIT 1. Research Questions and Data Sources	
Research Questions	**Data Sources**
Research Question 1: To what extent did the states have to increase their HCBS spending from their baseline in order to meet the Balancing Incentive Program's required HCBS spending benchmarks?	• Truven Health Analytics report on Medicaid expenditures (Eiken et al., 2010) • Balancing Incentive Program Technical Assistance website
Research Question 2: How far were states from having the required infrastructure in place at baseline?	• State proposals and work plans for the Balancing Incentive Program • AARP LTSS Scorecard (http://www.longtermscorecard.org/2014-scorecard#.U8fgtfldUnU) • State Balancing Incentive Program websites, other state websites • Mission Analytics' profiles of state programs (http://www.balancingincentiveprogram.org/state-activities) • CMS website for the Balancing Incentive Program (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html)
Research Question 3: How much time (given when they applied for the Balancing Incentive Program) did states have to meet both sets of requirements, and how much enhanced federal Medicaid funds could they claim?	• State proposals and work plans for the Balancing Incentive Program • Mission Analytics' profiles of state programs
Research Question 4: Which states faced the greatest challenges and which faced the least to achieve the congressionally mandated goals--in terms of both expenditures and infrastructure reforms?	• Truven Health Analytics report on Medicaid expenditures • Kaiser Commission on Medicaid and the Uninsured HCBS Programs Data Update • Mission Analytics' profiles of state programs • State proposals and work plans for the Balancing Incentive Program
Research Question 5: What State Plan or waiver HCBS benefit options or enhanced matching grant opportunities had states taken up as of or after 2009 but before being approved for Balancing Incentive Program participation?	• State proposals • State Balancing Incentive Program websites, other state websites • Mission Analytics' profiles of state programs • CMS's Medicaid State Plan Amendment Database • National Association of States United for Aging and Disabilities' State Medicaid Integration Tracker • Mathematica Policy Research descriptions of Balancing Incentive Program state initiatives interacting with MFP • Urban Institute evaluation of the Health Homes State Plan option

EXHIBIT 1 (*continued*)	
Research Questions	**Data Sources**
Research Question 6: What strengths and challenges did the states identify in their LTSS systems, and what challenges did they expect to have to address?	• State proposals and work plans for the Balancing Incentive Program • State Balancing Incentive Program websites, other state websites • Mission Analytics' profiles of state programs
Research Question 7: What non-mandatory goals did states set for themselves?	• State proposals and work plans for the Balancing Incentive Program • State Balancing Incentive Program websites, other state websites • Mission Analytics' profiles of state programs
Research Question 8: Did states choose to focus on particular target populations of HCBS users for their expenditure increases?	• State proposals and work plans for the Balancing Incentive Program • State Balancing Incentive Program websites, other state websites • Mission Analytics' profiles of state programs

Because states began participating in the Balancing Incentive Program at various points, baseline is defined in various ways. For expenditures, baseline for all states is defined as 2009. This reflects the legislative requirement that eligibility for the Balancing Incentive Program required that less than 50% of state Medicaid LTSS expenditures were for HCBS in 2009. Therefore, although states began participating in the Balancing Incentive Program at different times, 2009 is treated as the baseline year for assessing progress toward rebalancing of expenditures. The amount of enhanced FMAP available to states also was determined on the basis of HCBS expenditures in 2009.

Expenditure data were compiled using CMS's Balancing Incentive Program Technical Assistance website (Mission Analytics, 2011) and Truven Health Analytics' reports on Medicaid LTSS expenditures for FY 2009 and FY 2012 (Eiken et al., 2010; Eiken et al., 2014). These sources primarily use data from CMS-64 Quarterly Expense Reports: audited state claims detailing aggregate spending. CMS-64 reports are submitted to CMS to determine federal matching reimbursement for each state. CMS-64 expenditure data are from the CMS Medicaid and Children's Health Insurance Program (CHIP) Budget and Expenditure System.

Expenditures are reported by service category, allowing the data to be identified as HCBS or institutional LTSS expenditures. LTSS expenditures include spending for nursing homes, ICFs/IID, mental health facilities, mental health disproportionate share hospital (DSH) payments, personal care, home health, Program of All-Inclusive Care for the Elderly (PACE), services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929. Of these LTSS expenditures, those that are for personal care, home health, PACE, and services authorized under HCBS waivers/Sections 1115/1915(j) and Section 1929 are categorized as HCBS. All other expenditures are for institutional LTSS. Although data from CMS-64 reports are considered reliable, there are some limitations. Before FY 2010, rehabilitative services, private duty nursing, managed LTSS, and HCBS under Section 1915(i) could not be

identified from CMS-64 data. These services, therefore, are omitted in data from years prior to 2010.[1]

Expenditure data in ***Exhibit 2a*** are presented as they appear in the source documents described above. Data in ***Exhibit 2b*** were calculated by the RTI team to show trends in HCBS expenditures from 2004 to 2009, using data from those source documents. Calculations excluded managed LTSS expenditures, because these data are not available for 2004. ***Exhibit 2c*** shows the proportion of LTSS data spent on HCBS for different populations. State-level data are presented as they appear in the data sources. Data reported as aggregates across states were calculated by RTI International, using the source data.

The baseline period for issues other than expenditures is defined on a state-specific basis. In addition to requiring that states increase spending for HCBS, the Balancing Incentive Program requires that states develop three key infrastructure components: NWD/SEP, CSA, and CFCM. Although expenditure data share a common baseline year of 2009, the baseline for these infrastructure components refers to the situation existing in the state at the time of application. Depending on the state, this baseline period ranged from 2012 to 2014. Information for these aspects of the state situation (***Exhibits 4-7***) is drawn from a variety of sources, including the Balancing Incentive Program Technical Assistance website, State Balancing Incentive Program Applications, State Structural Change Work Plans, State Balancing Incentive Program Award Letters, State Department of Health websites, and other grey literature. The Balancing Incentive Program Technical Assistance web page, developed by Mission Analytics Group (a CMS contractor), provides resources for states including application materials and an implementation manual. The implementation manual describes the criteria for achieving the required structural changes, data collection and reporting requirements, and how to fund the structural changes. State Balancing Incentive Program applications include a preliminary work plan, an application narrative, and a detailed budget specifying the available federal financial participation (FFP) and how the State Plans expands non-institutional LTSS to achieve its rebalancing targets. The application narrative, composing the bulk of the application, is a discussion of the state's objectives in undertaking the Balancing Incentive Program, current system strengths and challenges, a funding plan, other balancing initiatives, and other relevant subjects. State structural change work plans are submitted to CMS following approval of the application. These provide further detail on the status of each infrastructure component, major objectives, and interim tasks, due dates, deliverables; task leads also are identified. State award letters, state Department of Health websites, and other grey literature were used for supplemental information, particularly on program start dates.

[1] For a detailed discussion of CMS-64 limitations, see Eiken et al. (2014).

2. FINDINGS

Research Question 1: To what extent did the states have to increase their HCBS spending from their baseline in order to meet the Balancing Incentive Program's required HCBS spending benchmarks?

As described previously, states were eligible for the Balancing Incentive Program if, in FY 2009, they spent less than 50% of LTSS dollars on HCBS. Within that requirement, there was significant variation in the amount that states needed to increase their spending to reach the desired benchmarks. ***Exhibit 2a*** provides information on the baseline expenditures that includes the total amount a state spent on LTSS in FY 2009, and the percentage of those expenditures that were for HCBS at that time.

On average, states participating in the Balancing Incentive Program spent 39.2% of their LTSS expenditures on HCBS in FY 2009. This ranged from 14.4% of LTSS spending for HCBS in Mississippi to 49.1% in Maine. Depending on the share of LTSS spent on HCBS in FY 2009, states qualify for different amounts of enhanced federal match and have different requirements for participation. States that spent between 25% and 50% of their LTSS spending on HCBS in 2009 receive an additional 2 percentage points on their federal match for HCBS and are required to reach 50% of LTSS spending toward HCBS by September 30, 2015. States that spent less than 25% of their LTSS expenditures on HCBS in 2009 receive an additional 5 percentage points on their federal match for HCBS and are required to reach 25% of LTSS spending toward HCBS by September 30, 2015. ***Exhibit 2a*** indicates that almost all of the states participating in the Balancing Incentive Program are in the first category (i.e., spent between 25% and 50% of LTSS on HCBS in 2009); only one state (Mississippi) spent less than 25% on HCBS and qualified for the higher match rate. Eight states (Connecticut, Maine, Massachusetts, Missouri, Nevada, New Hampshire, New York, and Texas) were spending at least 40% of LTSS dollars on HCBS in 2009.

The rate of spending on HCBS among states participating in the Balancing Incentive Program was considerably less than the average among non-participating states: 39.2% and 50.2%, respectively. States not participating in the Balancing Incentive Program can be split into two distinct groups: those that are eligible (i.e., spent less than 50% of LTSS on HCBS) but are not participating in the program, and those that are ineligible (i.e., spent more than 50% of LTSS dollars on HCBS). Eligible but non-participating states had a slightly lower share of LTSS on HCBS than did the participating states (38.6% and 39.2%, respectively). States that were ineligible spent a much greater share of their LTSS dollars on HCBS, 59.5%.

EXHIBIT 2a. Baseline Medicaid LTSS Expenditures and the Percentage for HCBS, by States Participating in the Balancing Incentive Program					
Balancing Incentive Program State	**Total LTSS Expenditures, 2009**	**HCBS Expenditures as a Share of Total LTSS Expenditures, 2009**	**Year of Application**	**Total LTSS Expenditures, Application Year**	**HCBS Expenditures as a Share of Total LTSS Expenditures, Application Year**
Arkansas	$1,225,282,115	29.8%	2012	$1,789,069,353	44.7%
Connecticut	$3,434,199,696	44.1%	2012	$3,018,565,429	43.4%
Georgia	$1,998,697,427	37.4%	2012	$2,344,252,399	45.5%
Illinois	$3,301,552,848	27.8%	2013	n	---
Indiana	$2,418,817,416	30.6%	2012	$2,687,270,415	31.9%
Iowa	$1,337,917,609	39.8%	2012	$1,571,210,580	43.4%
Kentucky	$1,475,855,855	31.1%	2013	---	—
Louisiana	$2,107,979,885	36.4%	2013	---	—
Maine	$826,858,695	49.1%	2013	---	—
Maryland	$2,133,345,188	36.8%	2012	$2,695,649,057	53.6%
Massachusetts	$3,960,407,165	44.8%	2014	—	—
Mississippi	$1,245,025,098	14.4%	2012	$1,510,137,743	27.4%
Missouri	$2,136,106,574	40.7%	2012	$2,737,357,315	43.6%
Nebraska	$711,179,651	38.4%	2014	---	---
Nevada	$377,768,818	41.6%	2014	---	---
New Hampshire	$606,861,367	41.2%	2011	$714,695,840	44.7%
New Jersey	$4,416,214,965	26.0%	2012	$4,045,075,863	27.4%
New York	$21,829,503,089	46.7%	2013	---	---
Ohio	$5,554,989,397	32.5%	2013	---	---
Pennsylvania	$6,774,658,581	33.0%	2014	---	---
Texas	$6,342,463,677	46.9%	2012	$7,585,627,683	50.4%
TOTAL Balancing Incentive Program States (N = 21)	$74,215,685,116	39.2%	Not applicable	$30,698,911,677	Not applicable
TOTAL, States Not Participating in the Balancing Incentive Program	$51,363,774,888	50.2%	Not applicable	Not applicable	Not applicable
Eligible, non-participating states (N = 17)	$22,893,761,878	38.6%	Not applicable	Not applicable	Not applicable
Ineligible states (N = 13)	$28,470,013,010	59.5%	Not applicable	Not applicable	Not applicable

SOURCE: Eiken et al., 2014, and CMS Balancing Incentive Program Website, Mission Analytics Group, 2011.
NOTES: Expenditure data are not yet available for FY 2013 and FY 2014. LTSS expenditures include those for nursing facilities, ICFs/IID, mental health facilities, mental health DSH payments, personal care, home health, PACE, services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929. Of those, personal care, home health, PACE, services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929 are categorized as HCBS. Managed LTSS expenditures are accounted for in this table.
--- = not available.

Because not all states began their Balancing Incentive Program participation at the same time, ***Exhibit 2a*** also provides the baseline expenditures for each state in the year of its Balancing Incentive Program application. This information provides insight into the extent to which each state had to reorient its LTSS expenditures in order to increase its HCBS spending as a share of total LTSS spending and meet the required HCBS spending benchmarks by September 30, 2015. Similar to the 2009 expenditure data, ***Exhibit 2a*** also includes both the total amount a state spent on LTSS at the time of its Balancing Incentive Program application as well as the percentage of those expenditures that were for HCBS. Expenditure data are not yet available for states with application dates in FY 2013 or FY 2014.

These data indicate that all participating states were already increasing their HCBS spending as a share of total LTSS spending at the time of application. Two states

(Maryland, Texas) had actually reached the Balancing Incentive Program goal of at least 50% of their LTSS expenditures for HCBS by the time of application. For example, Texas spent 46.9% of its LTSS expenditures for HCBS in FY 2009, but by the time it submitted its Balancing Incentive Program application, its HCBS expenditures had increased to 50.4% of total LTSS expenditures. However, because the legislation establishing the Balancing Incentive Program specified that eligibility for participation was to be determined by a state's FY 2009 LTSS expenditures, these states were still eligible to participate.

EXHIBIT 2b. Changes in LTSS Spending Patterns in States Participating in the Balancing Incentive Program, 2004-2009

Balancing Incentive Program State	Percentage Change in Total LTSS Expenditures, 2004-2009	Percentage Change in Total HCBS Expenditures, 2004-2009	Percentage Point Change in HCBS Expenditures as Proportion of Total LTSS Expenditures, 2004-2009
Arkansas	29.7%	69.7%	7.0
Connecticut	60.9%	99.8%	8.6
Georgia	-0.1%	60.6%	14.1
Illinois	-0.5%	13.1%	3.3
Indiana	16.0%	57.6%	8.1
Iowa	37.6%	80.5%	9.5
Kentucky	29.8%	48.3%	3.9
Louisiana	47.2%	162.9%	16.0
Maine	23.8%	48.3%	8.1
Maryland	24.4%	39.7%	4.0
Massachusetts	24.7%	70.3%	12.4
Mississippi	22.9%	-22.8%	-8.5
Missouri	14.9%	49.0%	9.3
Nebraska	8.0%	34.8%	7.6
Nevada	39.7%	117.8%	14.9
New Hampshire	19.8%	45.4%	7.3
New Jersey	27.2%	25.7%	-0.3
New York	21.4%	33.8%	4.2
Ohio	7.7%	74.6%	12.4
Pennsylvania	4.8%	63.6%	11.9
Texas	25.2%	45.6%	6.1
TOTAL in Balancing Incentive Program states	19.6%	47.8%	7.3
TOTAL, states not participating in the Balancing Incentive Program	21.6%	55.9%	10.7%
Eligible, non-participating states	22.0%	59.1%	8.9%
Ineligible states	21.3%	54.0%	12.3%

SOURCE: Eiken et al., 2010
NOTES: LTSS expenditures include those for nursing facilities, ICFs/IID, mental health facilities, mental health DSH payments, personal care, home health, PACE, services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929. Of those, personal care, home health, PACE, services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929 are categorized as HCBS. Managed LTSS expenditures are not included, because comparable data were unavailable for 2004.

Although FY 2009 was the common base year for expenditures, states had been making efforts toward rebalancing LTSS expenditures before then. ***Exhibit 2b*** provides information on the percentage change in LTSS spending and, more specifically, HCBS spending for the 5-year period preceding the 2009 baseline. In addition to the rate of growth, we show the change in percentage points of LTSS that this represents. Across all Balancing Incentive Program states, total LTSS expenditures grew 19.6% from 2004 to 2009, whereas total HCBS expenditures grew more than twice as fast--47.8% over

the 5 years--indicating that rebalancing was taking place during this time. On average, this represented an increase of 7.3 percentage points in the share of LTSS spent on HCBS. Despite this progress, growth in expenditures for HCBS was slower among the participating states than among non-participating states, whether eligible or ineligible.

There was considerable variation in the rates of change in total LTSS spending in the Balancing Incentive Program states. Almost every Balancing Incentive Program state increased its total LTSS spending over the 2004-2009 time period, with varying rates of growth. Total LTSS expenditures increased only 4.8% in Pennsylvania over this 5-year period, but increased 60.9% in Connecticut over this same time period. Two states experienced slight decreases in total LTSS expenditures from 2004 to 2009 (0.1% decrease in Georgia, and 0.5% decrease in Illinois).

Among those states that increased their HCBS spending over the 2004-2009 time period, the range in the percentage increase was greater than among overall LTSS spending. The percentage increase in state spending on HCBS from 2004 to 2009 ranged from 13.1% in Illinois to 162.9% in Louisiana. Of note, total LTSS spending decreased in both Illinois and Georgia over the 5-year period, but HCBS spending increased over the same period. Expenditure data from Mississippi indicated the opposite result, with a 22.9% increase in total LTSS spending from 2004 to 2009, but a 22.8% decrease in total HCBS spending over that same time period. These declines are difficult to explain.[2]

The average increase in HCBS spending (47.8% over 5 years) represents a change of 7.3 percentage points during this time period (***Exhibit 2b***). In New Jersey, however, although total HCBS spending increased over the 5-year period by 25.7%, the share of HCBS spending out of the total LTSS spending decreased slightly, by 0.3 percentage points.

Although the percentage of Medicaid LTSS spent on HCBS has been increasing, various population groups have had different experiences. A key concern to be addressed by the Balancing Incentive Program evaluation is how the initiative affects different population groups. ***Exhibit 2c*** presents the share of all LTSS spent on HCBS in total, and for two key population groups: a combined group of elders and people with physical disabilities, and people with intellectual or developmental disabilities (I/DD).

Among states taking part in the Balancing Incentive Program, the share of spending on HCBS was much greater for people with I/DD (60.7%) than it was among elders and people with physical disabilities (31.2%). There was a sizeable range among states in the share of LTSS spent on HCBS for the different populations. Among elders and adults with physical disabilities, the share of spending on HCBS ranged from 14.9% of LTSS spending in Maryland to 49.6% of LTSS spending on HCBS in Texas. The

[2] As noted earlier, the expenditure data reported here do not include managed care expenditures. It is possible that the observed decline in LTSS spending reflects a shift of spending to managed care. However, during the period in which we examined trends in LTSS spending, none of the states that reported declines in LTSS or, more specifically, in HCBS spending, had expansions of managed LTSS to account for such declines.

range among individuals with I/DD was 13.3% of LTSS spending for HCBS in Mississippi to 98.1% of LTSS spending for HCBS in New Hampshire. With the exception of Mississippi and Texas, all Balancing Incentive Program states had a larger share of their LTSS spending going toward HCBS for individuals with I/DD than they did for older adults and individuals with physical disabilities. This pattern of spending is consistent with historic practices in Medicaid through which the different population groups have been served.

EXHIBIT 2c. HCBS as Proportion of Total LTSS Spending, Overall and by Population Group, States Participating in the Balancing Incentive Program, 2009

Balancing Incentive Program State	HCBS Expenditures as Share of Total LTSS, All Populations (%)	Older People and People with Physical Disabilities (%)	People with I/DD (%)
Arkansas	29.8	29.0	47.6
Connecticut	44.1	24.4	67.4
Georgia	37.4	28.5	78.5
Illinois	27.8	23.3	42.3
Indiana	30.6	16.4	61.7
Iowa	39.8	29.3	50.4
Kentucky	31.1	19.4	70.8
Louisiana	36.4	32.4	46.7
Maine	49.1	24.5	85.0
Maryland	36.8	14.9	93.1
Massachusetts	44.8	35.1	90.1
Mississippi	14.4	15.8	13.3
Missouri	40.7	33.7	73.6
Nebraska	38.4	24.9	71.7
Nevada	41.6	34.1	81.7
New Hampshire	41.2	17.7	98.1
New Jersey	26.0	20.8	47.0
New York	46.7	40.9	59.5
Ohio	32.5	24.2	58.4
Pennsylvania	33.0	17.6	70.5
Texas	46.9	49.6	43.6
TOTAL, Balancing Incentive Program States	39.2	31.2	60.7
TOTAL, States Not Participating in the Balancing Incentive Program	50.2	42.6	74.6
Eligible, non-participating states	38.6	26.9	68.8
Ineligible states	59.5	53.7	79.4

SOURCE: Truven Health Analytics: Medicaid Long-Term Care Expenditures FY 2012.
NOTES: LTSS expenditures include those for nursing facilities, ICFs/IID, mental health facilities, mental health DSH payments, personal care, home health, PACE, services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929. Of those, personal care, home health, PACE, services authorized under HCBS waivers, and HCBS authorized under Sections 1115/1915(j) and Section 1929 are categorized as HCBS. Managed LTSS expenditures are accounted for in this table. Significant data are missing for Rhode Island and Hawaii. Rhode Island is excluded from calculations of totals for both population groups; Hawaii is excluded from calculations of totals for the Older/Physically Disabled population. Data on HCBS expenditures in 2009 are unavailable for serious mental illness (SMI)/severe emotional disturbance populations.

As is to be expected, states participating in the Balancing Incentive Program spent a smaller percentage of their LTSS expenditures on HCBS, overall and for both of the

population groups, than did non-participating states. Among states that are ineligible to participate (i.e., excluding states that are eligible but non-participating), for older people and adults with physical disabilities, 53.7% of LTSS dollars were spent on HCBS, compared with only 31.2% among states participating in the Balancing Incentive Program. For spending on people with I/DD, the gap is slightly narrower, although still sizeable: 79.4% of LTSS spending was for HCBS among the ineligible states, compared with 60.7% in the states participating in the Balancing Incentive Program.

The results are mixed when comparing those states that are participating in the Balancing Incentive Program with those that are eligible but not participating. Participating states were spending a somewhat greater share of LTSS on HCBS for older people and adults with physical disabilities than were eligible, non-participating states (31.2% and 26.9%, respectively). However, participating states were spending a smaller share of LTSS on HCBS for people with I/DD than was the case among eligible non-participating states (60.7% and 68.8%, respectively). The difference between these two sets of states in the share of total LTSS spending on HCBS was minimal (39.2% among participating states; 38.6% among eligible, non-participating states).

Research Question 2: How far were states from having the required infrastructure in place at baseline?

The Balancing Incentive Program legislation requires states to meet three LTSS infrastructure requirements. These infrastructure components--a NWD/SEP; a core, standardized assessment tool and process; and CFCM--are aspects of the LTSS system that states may have had in place or been developing prior to the Balancing Incentive Program. Each of these components was defined as part of CMS's Balancing Incentive Program application materials. Further clarification and specification of the criteria used to define whether each component was in place was provided by the Balancing Incentive Program Technical Assistance Contractor (Kako et al., 2013).[3]

The RTI team carefully reviewed each state's Balancing Incentive Program application to determine the extent to which the required criteria were met. Additional information from states' Balancing Incentive Program work plans was used to supplement and clarify the information in the applications. No state met all of the criteria for each of the three infrastructure components, and very few states fully met the requirements of a single infrastructure component at the time of application. States varied in the amount of progress they had made toward any one component. ***Exhibit 3*** summarizes our findings, illustrating the extent to which these infrastructure components existed within Balancing Incentive Program states at baseline.

[3] See *Appendix A* of this report for detail about the criteria used.

EXHIBIT 3. Balancing Incentive Program State LTSS Infrastructure at Baseline			
Balancing Incentive Program State	**NWD/SEP**	**CSA Tools and Processes**	**CFCM**
Arkansas	†	†	•
Connecticut	†	•	•
Georgia	•	•	•
Illinois	•	†	•
Indiana	†	•	•
Iowa	•[1]		
Kentucky	†	•	•
Louisiana	•		•
Maine	•	•	†
Maryland	†	†	•
Massachusetts	•	•	†
Mississippi	•	•	•
Missouri	•	•	•
Nebraska	•	•	•
Nevada	†	†	•
New Hampshire	•	†	•
New Jersey	†	†	•
New York	•	†	•
Ohio	•	†	•
Pennsylvania	•		•
Texas	•[1]	†	•
Total states with all criteria for infrastructure achieved	0	0	0
Total states started on most criteria for infrastructure	7	9	2
Total states not yet started on most criteria for infrastructure	14	9	18
NOTES: 1. Equal number of criteria are in place/in progress as have not yet been begun. • = Most criteria are not yet begun. † = Most criteria are in progress or have been fully achieved. Blank cells indicate that the state has not yet begun work on any of the criteria.			

At the time of their application for the Balancing Incentive Program, most states had not met all of the requirements for an NWD/SEP. The Balancing Incentive Program technical assistance materials identified 12 distinct criteria for achievement of the NWD/SEP component of the infrastructure reform. No state met all 12 of those criteria. One-third (seven) of the Balancing Incentive Program states had begun work or met a majority of those criteria at the time of application. Twelve states had made little progress, defined as having begun work on fewer than half (six) of the required criteria. The remaining two states had made progress toward six of the criteria, but had not yet begun work on the remaining NWD/SEP six criteria.

Slightly more states were closer to meeting all of the criteria for a CSA at the time of their Balancing Incentive Program application. Three distinct criteria were defined for successful achievement of a CSA. Nine states had made progress toward achievement of those at the time of application, defined as having made progress in a majority (two

or more) of criteria. The remaining 12 states had made less progress. Two states had not yet begun work on any of the three criteria for a CSA.

Overall, the states were the furthest from meeting the criteria for CFCM at the time of their Balancing Incentive Program application. Successful completion of a CFCM component was defined by nine distinct criteria. Two states had begun work on a majority (five or more) of those criteria. The remaining states had made less progress at the time of application. One state had not yet begun work on any of the CFCM criteria.

***Research Question 3*: How much time (given when they applied for the Balancing Incentive Program) did states have to meet both sets of requirements, and how much enhanced federal Medicaid funds could they claim?**

Although eligibility for the Balancing Incentive Program was determined by baseline expenditures in FY 2009, states could apply for and begin Balancing Incentive Program participation at different points in time. All states are required to meet their goals by the program end, September 30, 2015. This means that states had varying amounts of time in which to achieve the goals of the Balancing Incentive Program. The rate of enhanced FMAP--2% or 5%--available to states from the Balancing Incentive Program was determined based on the level of HCBS expenditures in the baseline year. ***Exhibit 4*** presents the resources, both time and dollars, available to states to achieve Balancing Incentive Program goals. States that began participation in the Balancing Incentive Program at earlier dates may have greater success in meeting their state-specific and legislatively established goals because they have more time in which to do so. On the other hand, states that begin participating in Balancing Incentive Program later may already have achieved some of the desired goals through other HCBS initiatives at the time of application.

The majority of states participating in the Balancing Incentive Program began their programs in 2012 or 2013. Eight states started their programs at some point in 2012 and eight more states started their programs in 2013. The remaining five states began their Balancing Incentive Programs in 2014. New Hampshire and Maryland were the earliest states to begin their programs, starting on April 1, 2012, and, therefore, had the greatest amount of time to meet their requirements. Nebraska, on the other hand, has the least amount of time to meet its requirements given that it was the last Balancing Incentive Program state to begin its program, on October 1, 2014.

The estimated amount of enhanced FMAP available to the Balancing Incentive Program states varied greatly, ranging from just over $3 million (Nevada) to almost $600 million (New York). All states except Mississippi qualified for the 2% enhanced FMAP; Mississippi's starting HCBS expenditures qualified the state to receive a 5% enhanced FMAP for its Balancing Incentive Program–related services. States included the anticipated total FMAP enhancement in their application by estimating the amount and cost of the additional Balancing Incentive Program services the state would provide

throughout the duration of its program. States that had started their Balancing Incentive Program later than other states generally had lower estimated available federal funding because of their shorter implementation period. For example, Nevada and Nebraska, which were the two latest states to begin their participation, had the two smallest amounts of available federal match. Other factors that also could lead to differences in the (estimated) federal funding granted to the different states include eligible population size and the extent to which the state needed to reorient its LTSS system to meet the expenditure and infrastructure requirements. States with smaller eligible populations would tend to have smaller budgets overall and therefore smaller total dollars in FMAP, for the same rate of match. The rate of enhanced FMAP match varied by the extent to which states needed to rebalance their LTSS system.

EXHIBIT 4. Resources (time and FFP) Available to Balancing Incentive Program States

Balancing Incentive Program State	Start Date of Participation	Enhanced FMAP--Total Dollars[1]
Arkansas	January 1, 2013	$67,424,092
Connecticut	January 1, 2013	$72,780,505
Georgia	July 1, 2012	$68,832,854
Illinois	July 1, 2013	$90,311,013
Indiana	September 1, 2012	$90,223,500
Iowa	July 1, 2012	$61,769,421
Kentucky	January 1, 2014	$25,579,577
Louisiana	August 1, 2013	$82,248,147
Maine	July 1, 2013	$21,246,061
Maryland	April 1, 2012	$106,338,569
Massachusetts	July 1, 2014	$110,668,102
Mississippi	July 1, 2012	$68,490,726
Missouri	July 1, 2012	$100,887,328
Nebraska	October 1, 2014	$8,122,707
Nevada	April 1, 2014	$3,361,490
New Hampshire	April 1, 2012	$26,458,827
New Jersey	April 1, 2013	$108,490,368
New York	April 1, 2013	$598,665,500
Ohio	July 1, 2013	$169,076,032
Pennsylvania	July 1, 2014	$96,785,656
Texas	October 1, 2012	$277,769,869

NOTES:

1. Enhanced FMAP is 2% for all states except Mississippi, for which it is 5%. The amounts shown here are states' estimates as reported in their applications for the Balancing Incentive Program, based on projected LTSS expenditures during the time that they are participating in the Balancing Incentive Program.

Research Question 4: Which states faced the greatest challenges and which faced the least to achieve the congressionally mandated goals--in terms of both expenditures and infrastructure reforms?

In determining which states faced the greatest and least challenges in meeting the Balancing Incentive Program's LTSS expenditure and infrastructure requirements, we took into account the findings from the three previous research questions. That is, the

degree of challenge for each state was based on a combination of the baseline status of expenditures and system infrastructure, indicating how much change is required in the state, and the amount of time available to accomplish that change.

EXHIBIT 5. State Scores on How Far States Must Go to Meet Balancing Incentive Program Requirements

Balancing Incentive Program State	Balancing Incentive Program Expenditure Requirement	NWD/SEP	CSA Tool	CFCM	Total Score	Challenge Score
Arkansas	1	3	3	2	9	11.0
Connecticut	3	3	2	2	10	16.5
Georgia	2	2	2	2	8	9.75
Illinois	1	2	3	2	8	6.75
Indiana	1	3	2	2	8	9.25
Iowa	2	2	1	1	6	6.5
Kentucky	1	3	2	2	8	5.25
Louisiana	2	2	1	2	7	5.2
Maine	3	2	2	3	10	13.5
Maryland	2	3	3	2	10	21.0
Massachusetts	3	2	2	3	10	7.5
Mississippi	2	2	2	2	8	9.75
Missouri	3	2	2	2	9	13.0
Nebraska	2	2	2	2	8	3.0
Nevada	3	3	3	2	11	18.0
New Hampshire	3	2	3	2	10	21.0
New Jersey	1	3	3	2	9	10.0
New York	3	2	3	2	10	15.0
Ohio	1	2	3	2	8	6.75
Pennsylvania	2	2	1	2	7	3.0
Texas	3	2	3	2	10	18.0

NOTES: For states with baseline expenditures on HCBS representing more than 25% of total LTSS, Balancing Incentive Program expenditure requirement was scored as 1 when less than 33% of LTSS expenditures were for HCBS; 2 when 33%-40% of LTSS expenditures were for HCBS; and 3 when greater than 40% of LTSS expenditures were for HCBS. For those states in which less than 25% of LTSS was spent on HCBS at baseline, the score was 1 if less than 8% of LTSS expenditures were for HCBS; 2 if HCBS accounted for 8%-16% of total LTSS; and 3 if HCBS accounted for more than 16% of total LTSS expenditures. Only Mississippi fell into this latter category.

NWD/SEP, CSA Tool, and CFCM were each scored as 1 if the state had not yet begun work on the required criteria; 2 if the state had not yet begun or not yet achieved most of the required criteria; and 3 if the state had begun or achieved most of the required criteria. The required criteria for each of these are listed in ***Appendix A***.

The challenge score was calculated as the number of months from start date to project end (September 30, 2015) divided by the total distance from accomplishment (12-total score).

Based on the data from these first three research questions, we developed a summary challenge score for each state (***Exhibit 5***). The purpose of the challenge score was to quantitatively assess how far each state was from achieving the Balancing Incentive Program requirements, taking into account the amount of time they had to make those changes. The challenge score was calculated on a combination of the following:

- Balancing Incentive Program expenditure requirement: (1) furthest from accomplishing (less than 33% of LTSS is for HCBS); (2) mid-range from

accomplishing (33%-40% of LTSS is for HCBS); and (3) closest to accomplishing (greater than 40% of LTSS is for HCBS).[4]

- NWD/SEP: (1) state has not started yet; (2) most criteria are not under way/not achieved; and (3) most criteria are under way/achieved.

- Uniform assessment tools and processes: (1) state has not started yet; (2) most criteria are not under way/not achieved; and (3) most criteria are under way/achieved.

- CFCM: (1) state has not started yet; (2) most criteria are not under way/not achieved; and (3) most criteria are under way/achieved.

We added together the four individual scores to create a summary score for each state. A lower score indicated that the state had further to go, and a higher score indicated that the state was closer to achieving the Balancing Incentive Program expenditure and LTSS infrastructure requirements. We created a final "challenge score," which was defined as the number of months between the start date in the state and the Balancing Incentive Program end (September 30, 2015) divided by the "distance" each state needed to go to achieve the required spending and infrastructure components; distance was defined as 12 (the possible score) minus the total score. For example, Arkansas had a total score of 9, meaning it needed to increase by 3 points to achieve the desired goals. Beginning in January 2013, it had 33 months in which to achieve these goals. Its challenge score is shown as 11 (i.e., 33 divided by 3). Lower challenge scores indicate greater challenge for the state (i.e., less time in which to achieve the required goals).

Pennsylvania and Nebraska appear to have the greatest challenge, both because they had made less previous progress toward the Balancing Incentive Program goals than had many other states, and because they were among the last states to begin program participation. States facing much less challenge included New Hampshire, Nevada, and Connecticut. New Hampshire was one of the earliest states to take advantage of the Balancing Incentive Program. Nevada was a relative latecomer to the program; however, it was relatively advanced in terms of expenditures, NWD/SEP, and CSA development.

[4] States with less than 25% of LTSS expenditures going for HCBS in the base year were only required to achieve 25% HCBS spending rate by the end of the program. For this situation, we defined furthest from accomplishing as less than 8% of LTSS spent on HCBS; mid-range of accomplishment as 8%-16%; and closest to accomplishing as greater than 16% of LTSS spent on HCBS. Only Mississippi fell into this group.

Research Question 5: What State Plan or waiver HCBS benefit options or enhanced matching grant opportunities had states taken up as of or after 2009 but before being approved for Balancing Incentive Program participation?

In addition to the Balancing Incentive Program, states use a number of Medicaid initiatives to improve the balance of how LTSS is provided. Understanding which options states are using provides an important context for understanding the resources available to them, and the relative role of the Balancing Incentive Program. ***Exhibit 6*** shows the HCBS initiatives that states were actively using at the time that they began Balancing Incentive Program participation. This exhibit shows Balancing Incentive Program state participation in each of six different HCBS options: State Plan Personal Care, State Plan Option 1915(i), MFP, Health Homes, 1915(i) waivers, and 1115 Research and Demonstration Waiver (CMS, 2014; CMS, n.d.; CMS, 2015). Although State Plan Option 1915(k) (Community First Choice) became available during this time period, none of the Balancing Incentive Program states were participating in it at baseline.

EXHIBIT 6. HCBS Options in Use Prior to Balancing Incentive Program Participation

Balancing Incentive Program State	State Plan Personal Care	State Plan Option 1915(i)	MFP	Health Homes	1915(c) Waivers	1115 Research and Demonstration Waiver	Number of Programs in Operation
Arkansas	Y		Y		Y	Y	4
Connecticut		Y	Y		Y		3
Georgia			Y		Y		2
Illinois			Y		Y		2
Indiana			Y		Y	Y	3
Iowa		Y	Y		Y	Y[1]	4
Kentucky			Y		Y	Y[2]	3
Louisiana	Y	Y	Y		Y	Y	5
Maine	Y		Y	Y	Y	Y	5
Maryland	Y		Y		Y		3
Massachusetts	Y		Y		Y	Y	4
Mississippi			Y		Y	Y	3
Missouri	Y		Y	Y	Y	Y	5
Nebraska	Y		Y		Y		3
Nevada	Y	Y	Y		Y	Y	5
New Hampshire	Y		Y		Y		3
New Jersey	Y		Y		Y	Y	4
New York	Y		Y	Y	Y	Y	5
Ohio			Y	Y	Y		3
Pennsylvania			Y		Y		2
Texas	Y		Y		Y	Y[3]	4
Number of Balancing Incentive Program States Using the Option	12	4	21	4	21	13	na

NOTES:
1. State's 1115 waiver was for family planning only.
2. This waiver was in effect in 2009, but expired in 2012, before the Balancing Incentive Program began in the state.
3. This managed LTSS waiver began 7 months prior to the Balancing Incentive Program start date. It replaced a previous 1915(b)/(c) waiver.

All of the states (21) were participating in the MFP program. The grant money from MFP helps states support individuals to transition from institutions back into the

community. Forty-four states nationwide are participating in this program. In addition, all Balancing Incentive Program states had one or more 1915(c) waivers in operation prior to their participation in the Balancing Incentive Program. These waivers allow states to offer a broad array of services to people who need an institutional level of care.

More than half of Balancing Incentive Program states (14) provided State Plan Personal Care services. These states have taken the option of providing personal care services under the Medicaid State Plan, in addition to or in place of HCBS waivers and Medicaid home health care.

More than half of the states (11) had Section 1115 Research and Demonstration Waivers that include HCBS. These waivers are intended to support "experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs." States can test policy approaches for issues like expanding eligibility for Medicaid or CHIP, providing new services, or using innovative delivery systems. These demonstrations, which must be budget neutral to the Federal Government, are approved for 5 years, with the option to renew for another 3 years.

Only a few states participated in the Health Homes (four) and State Plan Option 1915(i) (three) programs. Health Homes are an optional Medicaid State Plan benefit that states may use to coordinate care for those with chronic conditions. Health Homes are designed to support the integration and coordination of all primary, acute, behavioral health, and LTSS. Medicaid State Plan Option 1915(i) allows states to offer HCBS under the Medicaid State Plan. To do so, states must target a specific population(s), establish needs-based criteria separate from Medicaid criteria, establish a separate Medicaid eligibility group, and define what is included under the HCBS benefit.

Overall, states' participation in these options ranges from two to five options per state, with an average of three. These findings suggest that states are making significant efforts to support the provision of HCBS, and have opportunity to leverage funds from these multiple programs to achieve the desired goals.

***Research Question 6*: What strengths and challenges did the states identify in their LTSS systems, and what challenges did they expect to have to address?**

In their applications for the Balancing Incentive Program, states identified the strengths of their existing LTSS systems, as well as the challenges they expected to address. ***Exhibit 7a*** and ***Exhibit 7b*** summarize states' perception of their strengths and challenges that were specifically listed in applications, so the absence of a strength or challenge for a given state in the table means only that the state did not mention it in its application.

EXHIBIT 7a. Strengths Identified by Balancing Incentive Program States at Time of Application																						
Strengths	**AR**	**CT**	**GA**	**IL**	**IN**	**IA**	**KY**	**LA**	**ME**	**MD**	**MA**	**MS**	**MO**	**NE**	**NV**	**NH**	**NJ**	**NY**	**OH**	**PA**	**TX**	**TOTAL**
Progress toward CFCM	X	X	X				X	X	X	X	X			X		X	X				X	12
Progress toward NWD/SEP		X				X		X	X	X			X		X				X			8
Progress toward universal assessment	X			X				X		X		X				X		X	X		X	9
Coordination between programs (I&R, partnerships across AAAs, ILCs, etc.)		X		X																		2
Easy access to information on available HCBS services									X			X		X								3
Engaged stakeholders	X									X				X								3
Information systems under development or in use		X	X	X	X																	4
Other active rebalancing programs (closing institutions, MFP, waivers)	X			X			X												X	X	X	6
Progress toward new eligibility systems			X	X			X	X						X		X			X			7
Strong ADRC	X		X	X	X					X	X				X	X	X				X	10
Strong care planning/ care management												X	X									2
System transformation efforts complement Balancing Incentive Program	X									X							X		X	X		5
Toll-free number	X	X						X									X				X	5
Website	X	X						X			X						X					5
OTHER				X	X	X	X							X				X		X	X	8

EXHIBIT 7b. Challenges Identified by Balancing Incentive Program States at Time of Application																						
Challenges	**AR**	**CT**	**GA**	**IL**	**IN**	**IA**	**KY**	**LA**	**ME**	**MD**	**MA**	**MS**	**MO**	**NE**	**NV**	**NH**	**NJ**	**NY**	**OH**	**PA**	**TX**	**TOTAL**
Barriers to access of HCBS such as capped enrollment, wait lists	X					X		X		X		X		X								6
Bias toward/incentivizing of institutional services	X	X						X											X			4
Challenges around NWD/SEP			X		X	X							X				X		X	X	X	8
Competing health reform initiatives		X					X			X						X		X				5
Consumers experience difficulty in obtaining information about options, navigating the system.	X		X			X							X				X	X	X			7
Eligibility and enrollment system need upgrade	X				X					X									X	X		5
Fragmentation of LTSS system	X			X					X			X			X			X	X		X	8
Housing and transportation challenges for target population		X			X				X	X	X				X			X		X	X	9
Inadequate support for self-direction and person-centered planning		X								X		X						X				4
Lack of coordination between programs/ agencies			X	X	X				X	X								X	X		X	8
Lack of resources for systems change		X		X	X	X	X	X	X	X	X			X	X			X			X	13
Lack of sufficient HCBS services and supply, workforce		X				X			X	X	X					X		X				7
Lack of adequate, universal assessment tools		X		X		X	X	X		X			X						X			8
Outdated I&R systems; lack of coordinated information systems		X	X				X	X		X			X								X	7
Potential conflicts of interest in case management	X		X							X				X				X				5
No or weak case management	X													X								2
Uneven distribution of resources or services, by geography or population								X		X	X							X	X			5
ADRC lacking or inadequate for future demands			X										X	X			X				X	5
Lack of coordinated information systems			X																		X	2
Inadequate behavioral health/mental health supports			X			X		X		X	X										X	6
State budgetary constraints				X					X						X						X	4
Rural geography with associated transportation, communication, and resource challenges									X						X			X			X	4

EXHIBIT 7b (*continued*)																						
Challenges	**AR**	**CT**	**GA**	**IL**	**IN**	**IA**	**KY**	**LA**	**ME**	**MD**	**MA**	**MS**	**MO**	**NE**	**NV**	**NH**	**NJ**	**NY**	**OH**	**PA**	**TX**	**TOTAL**
Need for staff training to support new initiatives and approaches to LTSS								X		X									X			3
IT systems upgrades							X	X											X		X	4
OTHER		X		X	X		X	X		X	X				X	X	X	X	X		X	13

The most common strength (***Exhibit 7a***), with more than half of states mentioning (12), was having made some progress toward CFCM. Nearly half (nine) of states said they had made progress toward a universal assessment, while slightly fewer mentioned progress toward new eligibility systems (seven) and a NWD/SEP system (eight). Six states said they have other active rebalancing programs, such as closing institutions, MFP, and waivers. Three of those same states, and two others, reported that progress on general system transformation efforts complemented their work toward Balancing Incentive Program goals.

Several states mentioned achievements toward improving consumer access to information, including providing a toll-free number (five), website (five), or more general statements of providing easy access to information about HCBS (three). Other states (four) mentioned progress toward improving systems for sharing information across agencies and organizations, activities that may support the NWD/SEP requirement. Two states listed the benefit of coordination between programs, such as partnerships across Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs). Three states suggested that engaged stakeholders were a strength of their current LTSS system.

More than a third of states (eight) listed "other" strengths:

- Two states described efforts to increasing housing opportunities.
- A small number of states identified the benefit of having oversight of HCBS activities within a single agency (three).
- Engaged state legislature and bipartisan support for system redesign to improve access.
- Consumers are offered a broad range of services to address medical/functional needs.
- There is an online, integrated application process for people seeking help with health and human services, including Medicaid.
- Managed care expansion is improving access to services for the Supplemental Security Income population.
- Self-service portals and the community partner program help people apply for public benefits.

In addition to these strengths, states described challenges they will need to address with the Balancing Incentives Program. These challenges can be grouped into four categories: general policy or state challenges, limited or lack of services, outdated or inadequate information systems, and issues with case management. Many states reported general policy or state challenges, such as lack of resources for systems change (13), challenges around developing an NWD/SEP system (eight), fragmentation

of the LTSS system (eight), and lack of coordination among programs or agencies (eight). Fewer states reported issues like competing health reform initiatives (five), Aging and Disability Resource Centers (ADRCs) lacking or inadequate for future demands (five), bias toward institutional services (four), state budgetary constraints (four), rural geography of the state (four), and a need for staff training to support new initiatives and approaches to LTSS (three).

In regard to a lack of adequate services, half of states (nine) reported housing and transportation challenges for the target population, and a third of states (seven) reported lack of sufficient HCBS services and workforce. Slightly fewer states mentioned barriers to accessing HCBS, such as capped enrollment or wait lists (six), inadequate behavioral health or mental health supports (six), and uneven distribution of resources or services by geography or population (five).

Five challenges reported by states can be categorized as issues with outdated or inadequate information systems. Seven states reported that consumers experience difficulty in obtaining information about options or navigating the system, and another seven reported outdated information and referral (I&R) systems or a lack of coordinated information systems. Almost a quarter of states reported that eligibility and enrollment systems need upgrades (five). Fewer mentioned needed general information technology system upgrades (four) and a general lack of a coordinated information system (two).

Four challenges that states mentioned could fall in the category of issues with case management. The leading challenge in this category was a lack of an adequate or universal assessment tool (eight). Five states reported that potential conflicts of interest exist in their case management system, and four reported inadequate support for self-direction and person-centered planning. Two states suggested that they generally have no or a weak case management system.

A large number of states (13) reported challenges that were not specified above and are grouped as “Other” in ***Exhibit 7b***. A sample of these challenges is listed here:

- For those with complex needs, assessments are not holistic; not all options are presented.
- A huge demand on community infrastructure has resulted from *Olmstead* lawsuits.
- Providers have shown confusion about Medicaid expansion and rebalancing initiatives.
- The state is currently using paper-based reporting.
- Many consumers need help with medication administration, but the state does not allow nurses to delegate the task to others (e.g., health aides, direct care workers).

- Current infrastructure continues to lack capacity to address predicted growth in older population.

- Stakeholder engagement is limited.

- Providers use different clinical records systems, creating challenges for discharge planning and continuity of services.

States reported between three and 15 of the above challenges, with an average of seven challenges per state.

Research Question 7: What non-mandatory goals did states set for themselves?

In addition to the required Balancing Incentive Program goals of rebalancing expenditures and implementing required structural changes, states established a wide range of non-mandatory goals for use of enhanced FMAP. Data come from state Balancing Incentive Program applications and from a report on states' planned use of enhanced FMAP (Mission Analytics Group/Balancing Incentive Program Technical Assistance Center, 2014). States' non-mandatory goals are presented below in ***Exhibit 8***.

EXHIBIT 8. Non-Mandatory 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				X
Connecticut	X	X					X
Georgia	X		X	X			X
Illinois	X		X		X	X	X
Indiana	X		X		X		
Iowa	X			X			
Kentucky	X						
Louisiana	X		X				
Maine	X						
Maryland	X	X		X			X
Massachusetts	X			X	X		
Mississippi		X		X		X	
Missouri						X	X
Nebraska						X	
Nevada	X						
New Hampshire						X	
New Jersey					X		
New York		X	X	X	X		X
Ohio	X		X				X
Pennsylvania							
Texas	X	X		X	X		X
Total Number of States	13	6	7	7	6	5	9

Although the Balancing Incentive Program requires increasing HCBS expenditures as a percentage of total LTSS spending, there are many ways in which that could be done: increasing payment rates for HCBS, decreasing spending rates for institutional LTSS, increasing the amount of service provided to HCBS recipients, among others. The most common non-mandatory goal described by states was to expand access to HCBS, either by expanding 1915(c) waiver slots, expanding State Plan HCBS, or both. A total of 16 states planned to expand HCBS, including 13 states that planned to expand waiver slots. Six states planned to serve more individuals or new populations by expanding State Plan HCBS, either by implementing the Community First Choice Option (Arkansas, Connecticut, Maryland, New York, and Texas) or by implementing 1915(i) for a new population (Mississippi).

Expansion of behavioral health services was another common, non-mandatory goal. This was reported by seven states. In addition, Arkansas planned to fund a behavioral health system transformation, and Ohio planned to streamline access to crisis interventions for individuals with SMI. Another priority for states was raising reimbursement rates for HCBS providers, with seven states planning rate increases.

Six states planned to support transitions from institutions (nursing facilities and intermediate care facilities) to community settings, and five states planned to use enhanced FMAP to improve quality measurement.

Nine states had other goals for improving community services and increasing their capacity to meet individuals' needs in the community. Examples include the following:

- Arkansas planned to implement health home services to coordinate care for individuals who use behavioral health services and LTSS.

- Connecticut planned to design, implement, and evaluate three demonstrations of new services under MFP.

- Illinois planned to implement an Employment First initiative to expand employment opportunities for individuals with disabilities, and expand ombudsman services to the entire LTSS system.

- New York planned to implement grants to promote LTSS service delivery innovation by providers.

- New York and Ohio planned to expand PACE sites within the state.

Research Question 8: Did states choose to focus on particular target populations of HCBS users for their expenditure increases?

Although the statute establishes a spending goal that includes all HCBS, participating Balancing Incentive Program states may choose to focus their rebalancing

efforts on specific populations of LTSS users, including older people, younger adults with physical disabilities, adults or children with I/DD, people with SMI/substance abuse, people with HIV/AIDS, people with traumatic brain injuries, and other populations (***Exhibit 9***). Additionally, populations that are not the focal point of specific Balancing Incentive Program efforts may nonetheless benefit as a result of infrastructure development that is cross-cutting.

The populations most targeted for Balancing Incentive Program rebalancing efforts are adults or children with I/DD (18), followed closely by elders and younger adults with physical disabilities (17 states for each of those populations). Most states (20) identified multiple populations as targets for their Balancing Incentive Program activities, with 13 of 21 states targeting four or more groups. Four states have chosen to focus their efforts on populations in the "other" category, particularly on children with various types of health needs. One state is focusing efforts on people described as "medically complex."

EXHIBIT 9. Populations Targeted by Balancing Incentive Program States

Balancing Incentive Program State	Elders (age 65+)	Adults Younger than 65 with Physical Disabilities	Adults or Children with I/DD	People with SMI/ Substance Abuse	People with HIV/AIDS	People with Traumatic Brain Injuries	Other
Arkansas	X	X	X	X			
Connecticut	X	X	X	X			
Georgia	X	X	X	X			X
Illinois	X	X	X	X	X	X	X
Indiana			X	X			
Iowa			X	X			
Kentucky			X			X	
Louisiana	X	X	X	X			
Maine	X	X	X				
Maryland	X	X					X
Massachusetts				X			
Mississippi	X	X	X	X		X	
Missouri	X	X	X	X	X		
Nebraska	X	X				X	
Nevada	X	X	X				
New Hampshire	X	X	X	X			
New Jersey	X	X	X	X			
New York	X	X	X	X			
Ohio	X	X	X	X			X
Pennsylvania	X	X	X	X			
Texas	X	X	X	X		X	
Total Number of States	17	17	18	16	2	5	4

3. DISCUSSION

The Balancing Incentive Program established by the ACA is designed to help states provide a greater share of LTSS through HCBS, while at the same time improving the LTSS infrastructure to create a more consumer-friendly, consistent, and equitable system. This report presents the baseline status of the 21 states participating in the Balancing Incentive Program, to describe the challenges each faced and the strengths and resources they brought to the task. The findings presented here offer a context for the evaluation of states' progress toward the required goals. Findings from this baseline review indicate the following:

States vary in how close they are to the required expenditure goal, overall and for different target populations. Overall, Balancing Incentive Program states spent 39.2% of their Medicaid LTSS expenditures for HCBS in 2009; Mississippi, at 14.4%, had the lowest percentage of any of the participating states. Medicaid LTSS expenditures on HCBS for people with I/DD were, on average, already above 50% of all LTSS expenditures for people with I/DD, whereas the percentage of HCBS spending of LTSS expenditures for older people and younger adults with adult-onset disabilities were generally much lower. The Balancing Incentive Program legislation requirement that states attain at least 50% spending on HCBS is an overall goal; states are not required to meet the goal for subpopulations. Most participating states are focusing their Balancing Incentive Program efforts on increasing HCBS across populations, rather than on a single population group.

There is significant variation among states in how close they are to achieving each of the goals. Some states are closer than others, but each faces some challenges. States generally are closer to achieving expenditure goals than they are to the required infrastructure goals. Two states had achieved the required expenditure goals at the time of their application, but no state had achieved any of the required infrastructure components. States were closer to achieving a CSA and a NWD entry approach than they were to achieving CFCM. We computed a challenge score that incorporated the progress to date toward each of the expenditure and infrastructure goals, and the amount of time available to accomplish those goals. Low challenge scores are indicative of states facing greater challenges. Across the 21 participating states, challenge scores ranged from a low of 3 (Nebraska and Pennsylvania) to a high of 21 (Maryland and New Hampshire). Other states facing comparatively greater challenges than most others were Louisiana and Kentucky, whereas Texas and Connecticut were among those that faced comparatively fewer challenges.

States identified numerous strengths and challenges in their applications. Frequently mentioned strengths described progress under way toward the infrastructure goals, and the active use of other rebalancing programs. Frequently mentioned

challenges were lack of adequate services, inadequate information systems, concerns with case management, and other issues related to general state policy and challenges.

States participating in the Balancing Incentive Program are using several approaches to improve the balance of LTSS provision and achieve other state-specific goals. All of the Balancing Incentive Program states are operating multiple Medicaid initiatives that can help improve the balance of LTSS provision. All states are participating in the MFP program and are operating at least one 1915(c) waiver. Several are participating in other waiver initiatives as well. Engagement in multiple initiatives offers the opportunity to leverage resources, as well as the ability to address goals beyond those required under the Balancing Incentive Program.

States identified a variety of goals, many of which are both meaningful in their own right and also can play a role in moving closer to achievement of the mandatory Balancing Incentive Program goals. For example, several states are working to expand waiver programs and eliminate waiting lists, as well as to expand other programs to better serve new populations. Improved payment and improved quality also are important goals for several states.

Very few states chose to target their efforts to specific populations of users. Although changes to the infrastructure must be available to all HCBS users, states can accomplish the rebalancing goal through various efforts, including some that target specific populations. One state (Maryland) planned to focus its efforts on the population with the lowest share of LTSS dollars being spent on HCBS: elders and people with physical disabilities. Other states (Indiana, Kentucky) that plan to focus on specific populations are placing emphasis on people with I/DD, who already are receiving much of their LTSS in the community. Massachusetts is unusual in its choice to focus efforts on people with behavioral health needs.

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

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APPENDIX A. BALANCING INCENTIVE PROGRAM INFRASTRUCTURE REQUIREMENTS[5]

No Wrong Door/Single Entry Point (NWD/SEP)

General Structure Requirements

- Individuals accessing the system experience the same process and receive the same information about Medicaid-funded community LTSS options wherever they enter the system.

- A single eligibility coordinator, "case management system," or otherwise coordinated process guides the individual through the entire assessment and eligibility determination process, such that:
  - Individuals are assessed once for the range of community LTSS for which they may be eligible, and therefore only have to tell their story once.
  - The eligibility determination, options counseling, and enrollment processes proceed in as streamlined and timely a manner possible.
  - Individuals can easily find out eligibility status and next steps.

- State advertises the NWD/SEP system to help establish it as the "go to system" for community LTSS.

- NWD/SEP network: State has a system of NWD/SEPs that form the core of the NWD/SEP system: the NWD/SEP network. The Medicaid Agency is the Oversight Agency and may delegate the operation of the NWD/SEP system to a separate Operating Agency.

- Coordinating with existing community LTSS counseling entities and initiatives: The NWD/SEP network includes or coordinates with ILCs, AAAs, ADRCs, and/or other entities that have been functioning as entry points to community LTSS in the state.

- Full service access points: NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance. Physical locations must be accessible to older adults, individuals with disabilities, and users of public transportation.

[5] Kako, E., Sweetland, R., Melda, K., Coombs, E., Smith, M., & Agosta, J. (2013). *The Balancing Incentive Program: Implementation Manual, February 2013*. Mission Analytics Group. Report submitted to the Centers for Medicare and Medicaid Services. Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/bip-manual.pdf.

- Ensuring a consistent experience and core set of information: NWD/SEPs design and follow standardized processes for providing information, referrals, and eligibility determinations so that individuals accessing the system at different NWD/SEPs experience a similar process and are provided a consistent core set of information about community LTSS options in the state.

- Coordinated eligibility and enrollment process: The NWD/SEP coordinates both the functional and financial assessment and eligibility determination process from start to finish, helping the individual choose among services and programs for which they are qualified after eligibility determination.

Strongly Recommended

- States establish physical NWD/SEPs that are universally accessible.

- Beneficiary is assigned an eligibility coordinator who serves as a single point of contact throughout the eligibility determination and enrollment process.

- States co-locate financial and functional eligibility entities and/or staff to help coordinate and expedite determinations.

- Via the NWD/SEP system, states provide information to individuals not eligible for Medicaid-funded community LTSS, so they can access needed services covered by other programs.

Website Requirements

- A NWD/SEP system includes an informative community LTSS website. Website content is developed or overseen by the NWD/SEP.

- Operating Agency and reflects the full range of Medicaid community LTSS options available in the state. Information is current. Website is 508 compliant and accessible for individuals with disabilities.

- Website lists 1-800 number for NWD/SEP network.

Strongly Recommended

- Website includes an automated Level I screen with basic questions about functional and financial status, which results in a list of services for which an individual may be eligible. Individuals are provided instructions for “next steps” and contact information for follow up with a NWD/SEP.

- Level I screen includes results related to services outside of Medicaid for which the individual may be eligible (e.g., CHIP, low income home energy assistance program, supplemental nutrition assistance program, housing choice and other locally funded services).

- Results of Level I screen are downloadable and printable.

Recommended

- Website provides mechanism to make an appointment for a Level II assessment or to find out "more information" about community LTSS options.

- After the online Level I is complete and results are generated, individuals can choose to save data, provide contact information and agree that a NWD/SEP may contact them for follow up. The Level I data are then "pushed forward" to the NWD/SEP system database. The NWD/SEP then reaches out to the individual to schedule a Level II assessment.

1-800 Number Requirements

- Single 1-800 number routes individuals to central NWD/SEP staff or to a local NWD/SEP, where they can find out about community LTSS options in the state, request additional information, and schedule appointments at local NWD/SEPs for an assessment. The 1-800 number is accessible to non-native English speakers and those with disabilities, providing translation services and TTY.

- Website lists 1-800 number for NWD/SEP network.

Core Standardized Assessment (CSA)

Requirements

- The Level I screen/Level II assessment process is uniform across populations seeking LTSS.
  - A Level I screen is available for completion in person and over the phone.
  - Level II assessment is completed in person, with the assistance of a qualified professional.

- A Balancing Incentive Program Core Dataset (CDS) is captured statewide for all populations seeking community LTSS. The CDS is used to support the purposes of determining eligibility, identifying support needs, and informing service planning.

- The CSA contains the CDS (required domains and topics), which includes:
  - ADLs.
  - IADLs (not required for children).
  - Cognitive function and memory/learning difficulties (cognitive function, judgment and decision making, memory and learning).
  - Medical conditions.
  - Behavior difficulties (injurious to self or others, uncooperative, destructive, other serious, socially offensive).

Strongly Recommended

- Individuals can conduct a Level I self-screen online.

- The CSA data collection process is well conceived and received by respondents, as follows:

  - Sound underpinnings and infrastructure:
    - Involve stakeholders when designing the CSA.
    - Set a clear purpose for the CSA, ensuring a focus on eligibility determination.
    - Automate the assessment process.
    - Evaluate the quality and utility of data collected.
    - Ensure the CSA structure is logical and easy to understand.
    - Ensure the CSA delivers a summative view of an individual's strengths and support needs.
    - Ensure the CSA, when possible, utilizes a strengths or support-based approach, rather than a deficits-based approach.
    - Balance the need for adequate data with the burden data collection creates.
    - Test assessment tools for validity and reliability.

  - A welcoming and easy to use process:
    - Ensure individuals feel welcome and heard.
    - Implement assessments in a culturally competent way.
    - Allow information to flow in two directions.
    - Ensure family/caregiver needs are considered.

Conflict-Free Case Management (CFCM) Processes

Requirements

- Clinical or non-financial eligibility determination is separated from direct service provision.

- Case managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.

- There is robust monitoring and oversight.

- Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or state for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.

- Grievances, complaints, appeals and the resulting decisions are adequately tracked, monitored and used.

- State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised.

- State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services.

- In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

- Meaningful stakeholder engagement strategies are implemented which include beneficiaries, family members, advocates, providers, state leadership, managed care organization leadership and case management staff.

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

NOTE: All requests must be in writing.

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