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

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.

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LIST OF EXHIBITS

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.