

medicaid  
and the uninsured

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**How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options**

**Executive Summary**

With the passage of the Affordable Care Act (ACA) in 2010, states are afforded a number of new and expanded opportunities, including enhanced federal financing, to improve access to and delivery of Medicaid long-term services and supports (LTSS). This policy brief provides an overview of six key Medicaid LTSS options created or enhanced by the ACA and state adoption of these options to date. To date, nearly every state (47 states and DC) has taken steps forward with at least one of the six options (Table 1). Many states are pursuing or plan to pursue multiple new LTSS options. The most popular state options have been the Money Follows the Person (MFP) demonstration grants (45 states and DC) and financial alignment models for dual eligible beneficiaries (26 states).

**1. Increased federal funding and expanded eligibility for the Money Follows the Person demonstration.** A total of 46 states, including the District of Columbia, are receiving federal grant money to transition Medicaid beneficiaries out of institutions and back to their homes or community-based settings through the MFP demonstration. Enacted in 2006 as part of the Deficit Reduction Act (DRA) and extended under the ACA, MFP offers states enhanced federal Medicaid matching funds for qualified services for twelve months for each Medicaid beneficiary who transitions to a community setting. As of March 2013, 37 states were operating MFP demonstrations, and another eight states (AL, CO, FL, ME, MN, MT, SD, and WV) were in the process of becoming operational; one state's program was inactive.

**2. New state demonstrations to align financing and integrate care for dually eligible beneficiaries.** The ACA created the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation, with new demonstration authority to test new payment and service delivery models that fully integrate care for dual eligible beneficiaries, and the CMS Medicare-Medicaid Coordination Office, which is charged with improving the integration of Medicare and Medicaid benefits for this population. In the spring of 2012, 26 states submitted proposals to CMS seeking to test a capitated and/or managed fee-for-service (FFS) financial alignment model for dual eligible beneficiaries. CMS is presently reviewing the states' proposals and working with selected states to develop memoranda of understanding (MOUs) to implement the demonstrations. As of March 2013, proposals from 20 states were pending approval, two states had withdrawn proposals (NM and TN), and five states had MOUs approved (CA, to implement a capitated model in October 2013; MA, to implement a capitated model in July 2013; WA, to implement a managed FFS model in July 2013 (WA's capitated proposal remains pending); OH, to implement a capitated model in September 2013; and IL, to implement a capitated model in October 2013).

**3. New option to provide health home services.** The ACA provides states with a new state plan option to provide health home services, such as care coordination and case management, for Medicaid beneficiaries with chronic conditions with a temporary 90 percent enhanced federal medical assistance percentage (FMAP). As of March 2013, CMS had approved health home state plan amendments (SPAs) in eight states (IA, ID, MO, NC, NY, OH, OR, and RI). CMS is reviewing health home SPAs officially submitted by four states (AL, ME, NY, and WI) and draft proposals from three states (IL, OK, and WV). In addition, CMS has approved funding requests from 16 states and the District of Columbia for planning activities to develop a health home SPA.

**4. New Balancing Incentive Program (BIP) with enhanced federal funding.** The Balancing Incentive Program provides financial incentives to states that implement certain structural reforms to increase access to community-based LTSS as an alternative to institutional care. States that spent 25 to 50 percent of their LTSS dollars on community-based LTSS in Fiscal Year (FY) 2009 are eligible to receive a two percent increase in their FMAPs, while states that spent less than 25 percent can receive a five percent increase. The ACA makes available up to \$3 billion in federal matching funds during the balancing incentive period that runs through September 2015. As of March 2013, CMS had approved BIP applications for ten states (CT, GA, IA, IN, MD, MO, MS, NH, NY, and TX). Additional states plan to implement BIP in FY 2013 (AL, AR, IL, NJ, and RI).

**5. Expansion of the § 1915(i) home and community-based services (HCBS) state plan option.** The DRA gave states new authority, through § 1915(i) of the Social Security Act (SSA), to provide HCBS as an optional Medicaid state plan benefit; previously, HCBS could be offered only through waiver or demonstration projects. The ACA builds on this DRA authority by making several changes to § 1915(i), effective October 1, 2010. Specifically, the ACA expands financial eligibility for § 1915(i) services, creates a new optional Medicaid eligibility group that allows people not otherwise eligible to access full Medicaid benefits in addition to state plan HCBS, allows states to target § 1915(i) services to specific populations (based on diagnosis, age, disability or coverage group), and expands the services states may cover under this option. As of March 2013, nine states reported having the HCBS option in place (CA, CO, CT, IA, ID, LA, NV, OR, and WI). Washington had previously implemented this option but reported eliminating it in FY 2012. In addition, two states (DE and MD) reported plans to implement the option in FY 2013, and two states (IN and MN) reported plans to implement in FY 2014.

**6. New § 1915(k) Community First Choice (CFC) state plan option with enhanced federal funding.** The ACA establishes a new Medicaid optional state plan benefit under § 1915(k) of the SSA, CFC, to allow states to provide statewide home and community-based attendant supports and services to individuals who would otherwise require an institutional level of care. States taking up the option will receive a permanent six percent increase in their FMAP for CFC services. The new option is designed to assist individuals with activities of daily living, instrumental activities of daily living, and health-related tasks and with acquiring, maintaining, and enhancing their own skills to accomplish these tasks. CFC services required include “self-direction” opportunities; backup systems; and at state option, other services and supports linked to an assessed need or goal in the person-centered service plan, such as help with utility deposits and first month’s rent to support transitions to community living. As of March 2013, California was the only state to receive CMS approval for a CFC option SPA. Two states (AZ and LA) submitted SPAs that are pending approval. An additional six states reported definite plans to implement the CFC option (AR, MD, MN, MT, NY, and OR) in FY 2013 or FY 2014.

**Table 1. Summary of States' Activities, by ACA Provision, March 2013<sup>1</sup>**

States	Money Follows the Person Demonstration	Financial Alignment Demonstrations for Dual Eligible Beneficiaries	Health Home State Plan Option	Balancing Incentive Program	Home and Community-Based Services State Plan Option	Community First Choice State Plan Option
AK	-	-	-	-	-	-
AL	X <sup>A</sup>	-	X <sup>H,J</sup>	X <sup>L</sup>	-	-
AR	X	-	X <sup>J</sup>	X <sup>L</sup>	-	X <sup>S</sup>
AZ	-	X	X <sup>J</sup>	-	-	X <sup>R</sup>
CA	X	X <sup>C</sup>	X <sup>J</sup>	-	X <sup>M</sup>	X <sup>O</sup>
CO	X <sup>A</sup>	X	-	-	X <sup>M</sup>	-
CT	X	X	-	X <sup>K</sup>	X <sup>N</sup>	-
DC	X	-	X <sup>J</sup>	-	-	-
DE	X	-	-	-	X <sup>O</sup>	-
FL	X <sup>A</sup>	-	-	-	-	-
GA	X	-	-	X <sup>K</sup>	-	-
HI	X	X <sup>F</sup>	-	-	-	-
IA	X	X	X <sup>G</sup>	X <sup>K</sup>	X <sup>M</sup>	-
ID	X	X	X <sup>G,J</sup>	-	X <sup>N</sup>	-
IL	X	X <sup>C</sup>	X <sup>I</sup>	X <sup>L</sup>	-	-
IN	X	-	-	X <sup>K</sup>	X <sup>P</sup>	-
KS	X	-	X <sup>J</sup>	-	-	-
KY	X	-	-	-	-	-
LA	X	-	-	-	X <sup>N</sup>	X <sup>R</sup>
MA	X	X <sup>C</sup>	-	-	-	-
MD	X	-	-	X <sup>K</sup>	X <sup>O</sup>	X <sup>T</sup>
ME	X <sup>A</sup>	-	X <sup>H,J</sup>	-	-	-
MI	X	X	-	-	-	-
MN	X <sup>A</sup>	X <sup>E</sup>	X <sup>J</sup>	-	X <sup>P</sup>	X <sup>S</sup>
MO	X	X	X <sup>G</sup>	X <sup>K</sup>	-	-
MS	X	-	X <sup>J</sup>	X <sup>K</sup>	-	-
MT	X <sup>A</sup>	-	-	-	-	X <sup>S</sup>
NC	X	X	X <sup>G,J</sup>	-	-	-
ND	X	-	-	-	-	-
NE	X	-	-	-	-	-
NH	X	-	-	X <sup>K</sup>	-	-
NJ	X	-	X <sup>J</sup>	X <sup>L</sup>	-	-
NM	-	X <sup>D</sup>	X <sup>J</sup>	-	-	-
NV	X	-	X <sup>J</sup>	-	X <sup>M</sup>	-
NY	X	X	X <sup>G,H</sup>	X <sup>K</sup>	-	X <sup>S</sup>
OH	X	X <sup>C</sup>	X <sup>G</sup>	-	-	-
OK	X	X	X <sup>I</sup>	-	-	-
OR	X <sup>B</sup>	X <sup>E</sup>	X <sup>G</sup>	-	X <sup>M</sup>	X <sup>S</sup>
PA	X	-	-	-	-	-
RI	X	X	X <sup>G</sup>	X <sup>L</sup>	-	-
SC	X	X	-	-	-	-
SD	X <sup>A</sup>	-	-	-	-	-
TN	X	X <sup>D</sup>	-	-	-	-
TX	X	X	-	X <sup>K</sup>	-	-
UT	-	-	-	-	-	-
VA	X	X	-	-	-	-
VT	X	X	-	-	-	-
WA	X	X <sup>C</sup>	X <sup>J</sup>	-	X <sup>M</sup>	-
WI	X	X	X <sup>H,J</sup>	-	X <sup>M</sup>	-
WV	X <sup>A</sup>	-	X <sup>I,J</sup>	-	-	-
WY	-	-	-	-	-	-
<b>Total</b>	<b>46</b>	<b>26</b>	<b>25</b>	<b>15</b>	<b>14</b>	<b>9</b>

NOTES: The total, by ACA provision, indicates the number of states that are participating, previously participated, or have plans to participate in Fiscal Year (FY) 2013 or FY 2014 as of March 2013. For a detailed description of each state's status, by provision, please see the expanded notes.

**Expanded Notes for Table 1. Summary of States' Activities,  
by ACA Provision, March 2013<sup>1</sup>**

***Money Follows the Person (MFP) Demonstration.***

Thirty-seven states have operating MFP programs.

<sup>A</sup> Eight states (AL, CO, FL, ME, MN, MT, SD, and WV) are currently in the planning stage or are not yet operational.

<sup>B</sup> Oregon's MFP program is currently inactive.

***Financial Alignment Demonstrations for Dual Eligible Beneficiaries.***

Twenty states have proposals pending with the Centers for Medicare & Medicaid Services (CMS).

<sup>C</sup> Five states (CA, IL, MA, OH, and WA) have approved memoranda of understanding with CMS to implement demonstrations. WA's managed fee-for-service proposal is approved, and its capitated proposal remains pending with CMS.

<sup>D</sup> Two states (NM and TN) withdrew their proposals.

<sup>E</sup> Two states (MN and OR) will not pursue financial alignment but may pursue other administrative or programmatic alignment.

<sup>F</sup> Hawaii does not anticipate implementation by 2014, as required by current CMS guidance, but its proposal is still pending with CMS.

***Health Home State Plan Option.***

<sup>G</sup> Eight states (IA, ID, MO, NC, NY, OH, OR, and RI) have an approved State Plan Amendment (SPA).

<sup>H</sup> Four states (AL, ME, NY, and WI) officially submitted a SPA to the CMS.

<sup>I</sup> Three states have draft SPAs currently under review by CMS (IL, OK, and WV).

<sup>J</sup> Planning grant requests were approved for 16 states (AL, AR, AZ, CA, ID, KS, ME, MN, MS, NC, NJ, NM, NV, WA, WI, and WV) and DC.

***Balancing Incentive Program.***

<sup>K</sup> Ten states have approved applications (CT, GA, IA, IN, MD, MO, MS, NH, NY, and TX).

<sup>L</sup> Five states reported plans to implement in Fiscal Year (FY) 2013 (AL, AR, IL, NJ, and RI).

***Section 1915(i) Home and Community-Based Services State Plan Option.***

<sup>M</sup> Seven states implemented the option prior to FY 2012 (CA, CO, IA, NV, OR, WA (eliminated option in FY 2012), and WI).

<sup>N</sup> Three states implemented the option in FY 2012 (CT, ID, and LA).

<sup>O</sup> Two states (DE and MD) reported plans to implement the option in FY 2013.

<sup>P</sup> Two states (IN and MN) reported plans to implement in FY 2014.

***Section 1915(k) Community First Choice State Plan Option.***

<sup>Q</sup> One state's SPA was approved (CA).

<sup>R</sup> Two states submitted SPAs that are pending with CMS (AZ and LA).

<sup>S</sup> Five states plan to implement the option in FY 2013 (AR, MN, MT, NY, and OR).

<sup>T</sup> One state plans to implement in FY 2014 (MD).

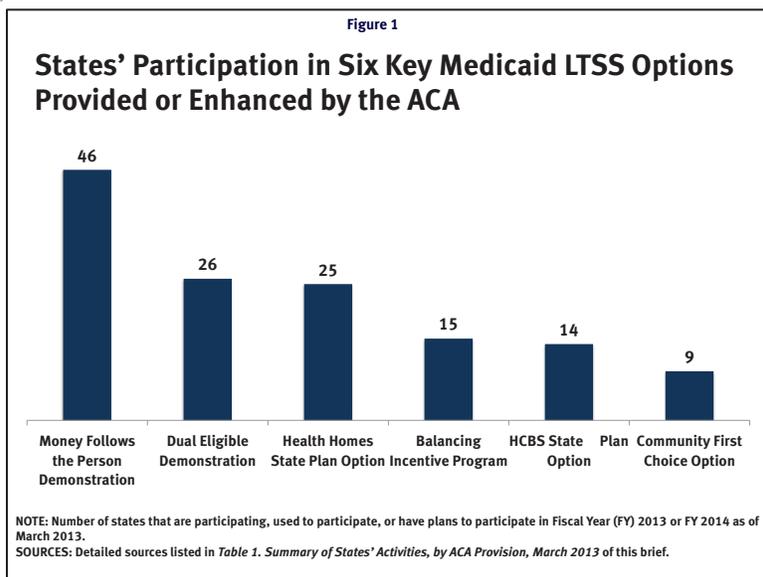
## Introduction

Medicaid is the nation's primary payer for long-term services and supports (LTSS) covering a continuum of benefits ranging from home and community-based services (HCBS), which allow persons to live independently in their own homes or in the community, to care provided in institutions, such as nursing facilities or intermediate care facilities for individuals with intellectual or developmental disabilities (I/DD). Many Medicaid populations require LTSS, including the elderly and individuals with mental illness, I/DD, physical disabilities, traumatic brain injuries, and other conditions such as Alzheimer's disease.

Spending on LTSS represents a third of total Medicaid spending<sup>2</sup> and therefore is an important focus for policymakers. Over the past two decades, spending on Medicaid HCBS has been growing relative to institutional care spending as more states continue to reorient their long-term care programs by increasing access to HCBS. While the majority of Medicaid LTSS dollars still goes toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 20 percent in 1995 to 45 percent in 2010.<sup>3</sup>

This change has been driven by a number of factors. Many Medicaid beneficiaries who need LTSS prefer to access those services in a community-based setting rather than in institutions. In addition, HCBS are often less expensive than comparable institutional care. Long-term care rebalancing also has been motivated by the states' obligations under the Americans with Disabilities Act and the Supreme Court's 1999 decision in *Olmstead v. L.C.*, which held that people with disabilities have the right to live at home or in the community if they are able and do not oppose doing so, rather than to be institutionalized.<sup>4</sup>

The Affordable Care Act (ACA) offers states a number of new and expanded opportunities, including enhanced federal financing, to improve access to and delivery of Medicaid LTSS. This policy brief presents an overview of six key Medicaid LTSS options provided by the ACA and state take up of these options (Figure 1 and Table 1). As of March 2013, nearly every state had taken steps forward with at least one of the six options (for more information about the options, see Table 2 below).



**Table 2: Overview of Six Key Medicaid LTSS Options Provided by the ACA**

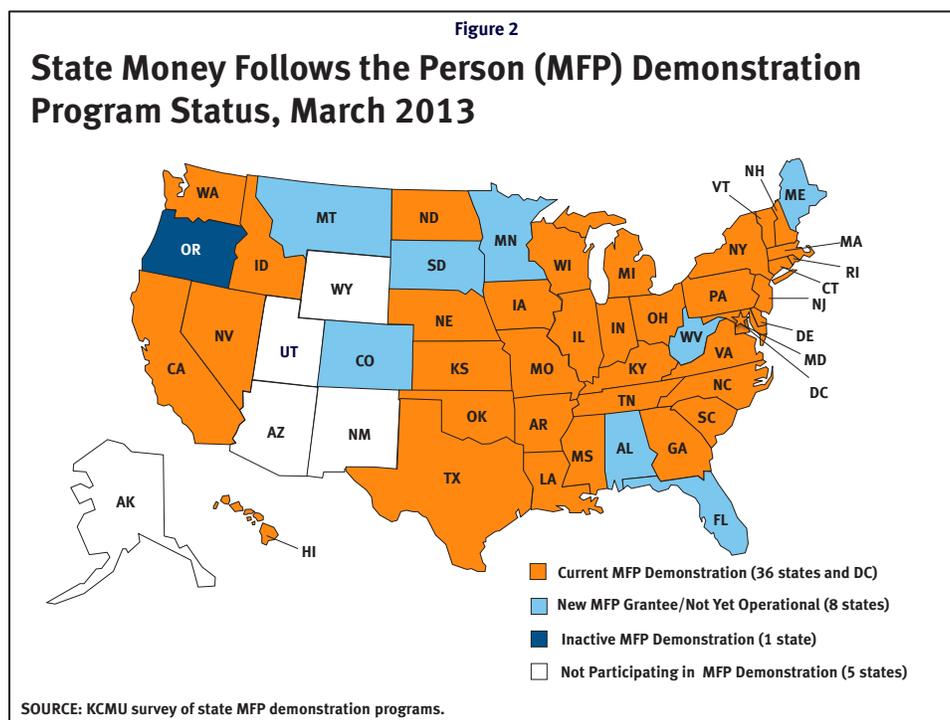
Program Name	Summary	Enhanced Federal Funding Available?	Application Process	Open to all states?	Time-limited?	Self-directed services permitted?
<b>Money Follows the Person Demonstration (MFP)</b>	Offers home and community-based, demonstration, and supplemental services for Medicaid beneficiaries who would otherwise require institutional care and who transition to a house, apartment, or group home with less than four non-related residents. Medicaid beneficiaries who reside in an institution for more than 90 consecutive days are eligible to participate.	Yes; enhanced federal medical assistance percentage (FMAP) for one year for services for each beneficiary.	Demonstration grant program	Yes	Yes; The Affordable Care Act (ACA) extended MFP through September 2016 with an additional \$2.25 billion.	Yes
<b>Financial Alignment Demonstrations for Dual Eligible Beneficiaries</b>	Tests capitated and managed fee-for-service models that integrate Medicare and Medicaid benefits and align financing for dual eligible beneficiaries.	No; but design contracts of up to \$1 million were awarded to 15 states in 2011, and states with approved memoranda of understanding (MOUs) may apply for implementation grant funding.	Demonstration program pursuant to § 1115A waiver authority	Yes; application period is currently closed.	Yes; three year demonstrations to begin in 2013 or 2014.	Yes
<b>Health Home State Plan Option</b>	Provides care management and coordination services for beneficiaries with chronic conditions.	Yes; temporary 90% enhanced FMAP for first two years; also planning funds of up to \$500,000 available.	State Plan Amendment (SPA)	Yes	No; effective January 2011.	Yes
<b>Balancing Incentive Program</b>	Financial incentive program for states that implement structural reforms to increase access to home and community-based services (HCBS) as an alternative to institutional care. Required elements include: (1) a “no wrong door”/single entry point system for all long-term services and supports (LTSS); (2) conflict-free case management services; and (3) a core standardized assessment instrument for determining eligibility.	Yes; states spending < 25% of total Medicaid LTSS expenditures on HCBS in FY 2009 will receive a 5% FMAP increase and will be expected to reach a 25% expenditure target during the balancing period; states spending 25%-50% for HCBS will receive a 2% FMAP increase and will be required to reach a 50% expenditure target.	SPA or waiver	No; only states whose HCBS expenditures were less than 50% of total Medicaid LTSS expenditures in FY 2009 can participate.	Yes; October 2011 through September 2015 with \$3 billion allocated to the program.	Yes
<b>Home and Community-Based Services (HCBS) State Plan Option (§ 1915(i))</b>	Offers HCBS to beneficiaries who meet needs-based criteria that are less stringent than the state's institutional level of care criteria. Services must be statewide and waiting lists are not permitted. ACA amendments allow state plan HCBS to be targeted to particular groups of beneficiaries, expand financial eligibility for state plan HCBS, establish a new coverage group for individuals not otherwise eligible for full Medicaid benefits who receive state plan HCBS, and expand the HCBS that states may cover under this option.	No	SPA	Yes	No; effective October 2010, as amended by ACA.	Yes
<b>Community First Choice State Plan Option (§ 1915(k))</b>	Offers home and community-based attendant services and supports to beneficiaries who require an institutional level of care. Services must be provided statewide with no enrollment caps.	Yes; 6% enhanced FMAP for services provided under the option.	SPA	Yes	No; effective October 2011.	Yes; required.

SOURCE: The Patient Protection and Affordable Care Act. Pub.L. 111–148, 124 Stat. 119, H.R. 3590, enacted March 23, 2010. Available at: <http://www.govtrack.us/congress/bills/111/hr3590>.

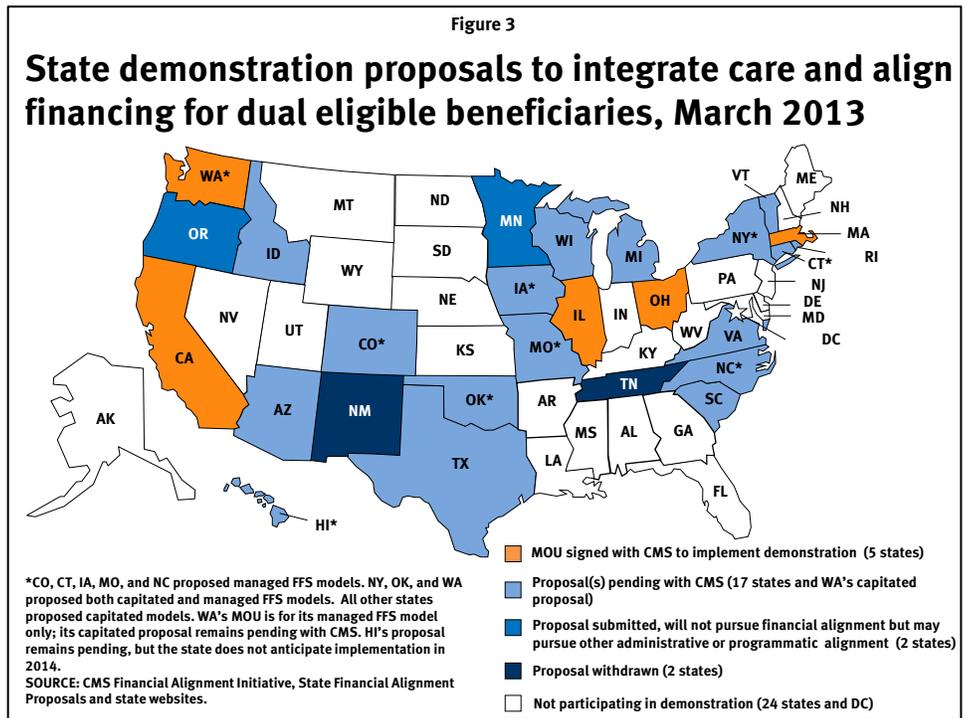
## Key Findings: State Adoption of Six Key Medicaid LTSS Options

**1. Increased federal funding and expanded eligibility for the Money Follows the Person (MFP) demonstration.** The MFP demonstration is a federal grant program designed to help states reduce reliance on institutional care and increase options for the elderly and persons with disabilities to receive care in the community. Enacted in 2006 as part of the Deficit Reduction Act (DRA) and extended under the ACA,<sup>5</sup> MFP offers states enhanced federal matching funds for twelve months for each Medicaid beneficiary who transitions from an institution to a home or community-based setting. Enhanced funding is available during the transition year for HCBS offered through the state's existing Medicaid state plan and waivers, additional or enhanced HCBS that states choose to offer through the demonstration, and one-time supplemental services to facilitate transitions that are not typically reimbursable through Medicaid. States must use their enhanced federal funds from MFP to rebalance their LTSS systems.

The ACA extends MFP for five more years, until 2016, allocates an additional \$2.25 billion to the program, and expands MFP eligibility to include people residing in an institution for more than 90 consecutive days (previously the length of stay criterion was six months to two years). As of March 2013, a total of 46 states, including the District of Columbia, have received federal MFP grant money: 37 states were operating MFP demonstrations, another eight states' demonstrations were in the process of becoming operational, and one state's program was inactive (Figure 2). Nationwide, over 25,000 individuals have transitioned to the community since the MFP demonstration program began.<sup>6</sup> Most of these individuals have been seniors and individuals with physical disabilities who transitioned back to their own homes or to an apartment. States have also transitioned individuals with developmental disabilities and mental illness whose needs tend to be greater and more complex. The biggest challenge to transition continues to be finding safe, affordable, and accessible housing for MFP participants, along with the need for more community-based service providers.



**2. Integrating care and aligning financing for dual eligible beneficiaries.** There are an estimated nine million seniors and younger people with disabilities who are dually eligible for Medicare and Medicaid. Many of these beneficiaries have complex medical and long-term care needs and account for a disproportionate share of spending in the two programs. For example, dual eligible beneficiaries represent 20 percent of the Medicare population and 31 percent of Medicare program costs and 15 percent of the Medicaid population and 39 percent of Medicaid program costs.<sup>7</sup>



The cost of caring for dual eligible beneficiaries and the lack of coordination between the separate Medicare and Medicaid programs have led to an increased focus on improving care quality and decreasing costs for this population. The ACA created the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI), with new demonstration authority to test new payment and service delivery models that fully integrate care for dual eligible beneficiaries, and the CMS Medicare-Medicaid Coordination Office (MMCO), which is charged with improving the integration of Medicare and Medicaid benefits for this population. The financial alignment demonstrations are governed by the Department of Health and Human Services (HHS) Secretary's § 1115A demonstration authority, which requires her to evaluate each model that is tested.<sup>8</sup> The law also authorizes the Secretary to expand the duration and scope of models after the initial testing period, including on a nationwide basis, that are expected to reduce program spending without reducing the quality of care or improve patient care without increasing spending.

In April 2011, CMMI, in conjunction with MMCO, awarded design contracts of up to \$1 million each to 15 states (CA, CO, CT, MA, MI, MN, NC, NY, OK, OR, SC, TN, VT, WA, and WI) to develop service delivery and payment models that integrate care for dually eligible beneficiaries. CMS subsequently proposed two models to integrate Medicare and Medicaid benefits and align financing for dual eligible beneficiaries, one capitated model and one managed fee-for-service

(FFS) model; the opportunity to test these models was offered to all states. In the spring of 2012, 26 states, including the 15 that received design contracts, submitted proposals to CMS seeking to test one or both of these models. CMS is presently reviewing the states' proposals and working with selected states to develop memoranda of understanding (MOUs) to implement the demonstrations.<sup>9</sup>

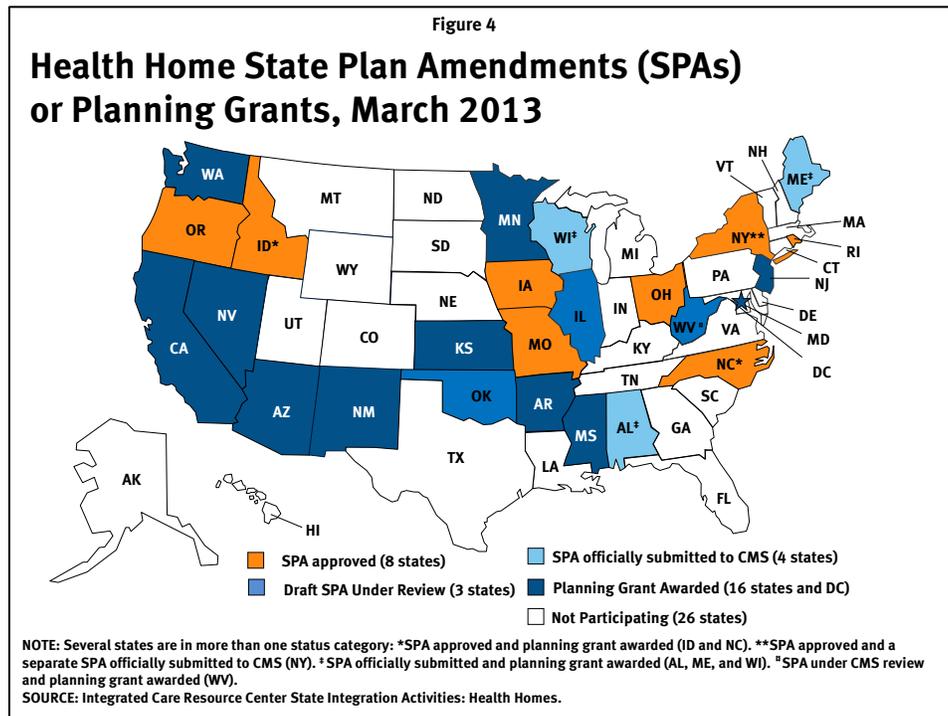
Of the 26 states that submitted proposals, two states have withdrawn their proposals (NM and TN), and 24 states' proposals remain active with CMS (Figure 3). Active proposals from 20 states are still pending approval (AZ, CO, CT, HI, IA, ID, MI, MN, MO, NC, NY, OK, OR, RI, SC, TX, WA's capitated proposal, WI, VA, VT); two of these states have decided that they will not pursue financial alignment (MN and OR) but still seek to implement other administrative or programmatic alignment; another state (HI) does not anticipate being able to implement a demonstration by 2014, although its proposal remains pending. To date, five states' proposals have been approved for implementation: California<sup>10</sup> will implement a capitated model with enrollment effective in October 2013, Massachusetts<sup>11</sup> will implement a capitated model with enrollment effective in July 2013, Washington<sup>12</sup> will implement its managed FFS model with enrollment effective in July 2013, Ohio<sup>13</sup> will implement a capitated model with enrollment effective in September 2013, and Illinois<sup>14</sup> will implement a capitated model with enrollment effective October 2013; MOUs with other states are expected to follow. (Notably, Washington's managed FFS demonstration is based on the new health homes Medicaid state plan option, described below.) Current CMS guidance requires that approved models must be implemented in 2013 or 2014, and the demonstrations will last for three years.

**3. New state plan option to provide health home services for individuals with chronic conditions.** Health homes are a person-centered service delivery model that provides care management and coordination services for enrollees with chronic physical or mental health conditions. The health homes model expands on the traditional medical home models developed in many state Medicaid programs by enhancing the coordination and integration of physical and behavioral health care and acute and long-term care services and by offering referrals to community-based social services and supports. The aim of health homes is to improve health care quality and clinical outcomes as well as the patient care experience while also reducing per capita costs through more cost effective care.<sup>15</sup>

The ACA adds new authority for states to provide health home services as an optional Medicaid state plan benefit.<sup>16</sup> To encourage state take-up of this option, the ACA authorizes a temporary 90 percent enhanced federal medical assistance percentage (FMAP) rate<sup>17</sup> for the first two years that a state's Medicaid health home state plan amendment (SPA) is in effect. The state plan option includes a range of "health home" services:

- Comprehensive care management;
- Care coordination and health promotion;
- Transition care from inpatient to other care settings;
- Individual and family support;
- Referral to community and social support services; and
- Use of health information technology to link services.

To qualify for the enhanced federal funding, states must develop a model that is focused on beneficiaries with at least two chronic conditions; one chronic condition and the risk of developing another; or at least one serious and persistent mental health condition. These may include: a mental health diagnosis, substance abuse disorder, asthma, diabetes, heart disease, and being overweight.



States pursuing the option can utilize one of three distinct types of health home provider arrangements:

- Designated providers – A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state, and that meets qualification standards set by the HHS Secretary.
- Team of health care professionals that links to a designated provider – The team may include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state. The team can be freestanding, virtual, or based in any setting determined appropriate by the state and approved by the HHS Secretary.
- Health team – A community-based interdisciplinary, interprofessional team of health care providers that supports primary care practices and is established by a state or Indian tribe pursuant to a grant or contract to support patient-centered medical homes offered by the Secretary of HHS under the ACA. The team may include medical specialists, nurses,

pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physicians' assistants.

The new health home state plan option became effective January 1, 2011. As of March 2013, CMS had approved health home SPAs from eight states (ID, IA, MO, NY, NC, OH, OR, and RI). Four states (AL, ME, NY (phase II), and WI) have officially submitted SPAs that are pending with CMS, and CMS also is reviewing draft SPAs submitted by three states (IL, OK, and WV) (Figure 4).<sup>18</sup> In addition, CMS has authorized states to spend up to \$500,000 of Medicaid funding for planning related to the development of a health home SPA; state spending for this purpose will be matched at the state's regular FMAP. As of March 2013, CMS had approved health home planning requests from DC and 16 states (AL, AR, AZ, CA, ID, KS, ME, MN, MS, NC, NJ, NM, NV, WA, WI, and WV).<sup>19</sup>

**4. New Balancing Incentive Program (BIP) with enhanced federal funding.** While developing and expanding home and community-based alternatives to institutional care is a priority for many state Medicaid programs, states vary with regard to the percentage of their LTSS dollars that go toward providing HCBS. To reduce this disparity, the ACA created BIP, which provides financial incentives to states that implement certain structural reforms to increase access to community-based LTSS as an alternative to institutional care.<sup>20</sup> Under BIP, states that devoted less than 50 percent of their total Medicaid LTSS spending to HCBS programs in Fiscal Year (FY) 2009 are eligible for an enhanced FMAP for all Medicaid HCBS including: the mandatory home health state plan benefit, the optional personal care state plan benefit, home and community-based waiver services, self-directed personal assistance services, and Program of All-Inclusive Care for the Elderly services.

Eligibility for BIP is determined by the state's share of total LTSS dollars spent on non-institutional LTSS in FY 2009. States that spent between 25 to 50 percent of their Medicaid LTSS dollars on community-based LTSS are eligible to receive a two percentage point increase in their FMAP, if they adopt a target of 50 percent of total LTSS spending on HCBS by the end of the balancing incentive period in September 2015. States that spent less than 25 percent can receive a five percentage point increase, if they adopt a target of 25 percent of total LTSS spending on HCBS. States that participate in BIP must use the enhanced federal funds to expand or enhance HCBS and may not adopt more restrictive eligibility standards than were in place as of December 31, 2010.<sup>21</sup>

To qualify for BIP, a state must commit to making the following three structural changes in its Medicaid LTSS delivery system:

- A “no wrong door”/single entry point system for all LTSS;
- Conflict-free case management services; and
- A core standardized assessment instrument to determine eligibility for non-institutionally-based LTSS.<sup>22</sup>

CMS's implementation guidance for BIP states that the “no wrong door”/single entry point system should be a statewide system that provides information about the availability of

community-based LTSS, determines financial and functional eligibility, and enrolls eligible individuals into appropriate services. Conflict-free case management services are defined as those that develop a service plan, arrange for services and supports, support the beneficiary in self-directing the provision of services and supports, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes. The core standardized assessment instrument is designed to determine eligibility for non-institutionally-based LTSS in a uniform manner throughout the state and to determine a beneficiary's needs for training, support services, medical care, transportation, and other services in accordance with an individual's service plan. Within six months of their application date, states must submit a final work plan that describes activities for implementing these structural changes. CMS intends to share any finalized universal assessment core elements from BIP with states to use as examples of elements to incorporate into functional needs assessments required for the Community First Choice (CFC) state plan option and other HCBS programs.<sup>23</sup>

Funding of \$3 billion is available for four years (October 2011 – September 2015) for the program. As of March 2013, CMS had approved BIP applications for ten states (CT, GA, IA, IN, MD, MO, MS, NH, NY, and TX).<sup>24</sup> Additionally, five states (AL, AR, IL, NJ, and RI) reported plans to implement in FY 2013.<sup>25</sup> States can participate in BIP through a SPA or a waiver. States considering this new program can potentially combine BIP funding with enhanced federal funds from other programs, such as their established MFP demonstration programs, to increase LTSS capacity in the community.<sup>26</sup> Notably, a state that participates in both CFC (at an enhanced FMAP of 6%) and BIP (at the typical enhanced FMAP of 2%) could receive a total enhanced FMAP of 8 percent on all services that qualify under both programs.<sup>27</sup>

**5. Expansion of the § 1915(i) HCBS state plan option.** Another option for states attempting to reduce institutional bias and rebalance LTSS expenditures is to offer HCBS as part of the state plan benefits package, as authorized by the DRA, which added § 1915(i) of the Social Security Act (SSA). Prior to § 1915(i), states could receive federal Medicaid matching funds for HCBS only through waiver or demonstration projects. The ACA builds upon the DRA authority by making several changes to § 1915(i), effective October 1, 2010. Specifically, the ACA expands financial eligibility for § 1915(i) services, establishes a new optional Medicaid coverage group for individuals who receive state plan HCBS and who are otherwise ineligible for full Medicaid benefits, allows states to target § 1915(i) services to specific populations, expands the services states may cover under this option, and requires that state plan HCBS be provided statewide with no waiting lists.<sup>28</sup> The following description provides more detail about the ACA's changes to the HCBS state plan option:

- **Financial eligibility expanded.** Under § 1915(i), states continue to have the ability to provide state plan HCBS to individuals with incomes up to 150 percent of the federal poverty level (FPL) (\$1,436 per month in 2013) who are otherwise eligible for Medicaid without regard to whether such individuals need an institutional level of care (LOC). Instead, these beneficiaries must meet needs-based eligibility criteria that are less stringent than the state's institutional LOC criteria. The ACA expands financial eligibility for § 1915(i) services by allowing states to offer state plan HCBS to individuals with income up to 300 percent of the Supplemental Security Income (SSI) federal benefit rate (FBR) (\$2,134 per month in 2013) who would be eligible for HCBS

under an existing § 1915(c), (d), or (e) waiver or § 1115 demonstration project.<sup>29</sup> These individuals do not actually have to be receiving waiver services as long as they meet the eligibility criteria for the waiver.

- **New Medicaid eligibility group with access to full Medicaid benefits and state plan HCBS.** The ACA adds a new provision to § 1915(i) that allows states to offer full Medicaid benefits, including state plan HCBS, to individuals who are not otherwise eligible for Medicaid. States electing this new coverage group may cover either or both (1) individuals with incomes up to 150 percent of the FPL, with no resource test, who meet the § 1915(i) needs-based eligibility criteria and who will receive § 1915(i) state plan HCBS; and/or (2) individuals who would be eligible for Medicaid under an existing § 1915(c), (d), or (e) waiver or § 1115 demonstration project, with incomes below 300 percent of the SSI FBR and who will receive state plan HCBS. Individuals in the latter group do not actually have to be receiving waiver or demonstration services as long as they meet the eligibility criteria for the waiver or demonstration.<sup>30</sup> States that choose to offer the new eligibility group under § 1915(i) also must offer § 1915(i) state plan HCBS to people who are otherwise eligible for Medicaid, as described above.
- **Targeted benefits and populations and expanded services.** States have new flexibility to target specific § 1915(i) services to defined populations as has been done under § 1915(c) HCBS waivers. The ACA allows states to have multiple § 1915(i) state plan provisions for specific populations based on diagnosis, disability, Medicaid eligibility group and/or age with services that vary in amount, duration and scope for each population. If a state chooses to target a specific population, the SPA will be approved for a five-year period and may be renewed for additional five-year periods. Upon CMS approval, the ACA also allows states to offer a broader range of HCBS than was previously available under § 1915(i); states now can offer the same range of HCBS as is available under § 1915(c) waivers. States continue to have the option to allow self-direction for individuals receiving state plan HCBS.
- **No waiting lists and mandatory statewideness.** Under the ACA, states continue to determine the needs-based eligibility criteria for state plan HCBS, but they are no longer permitted to limit the number of individuals served under the § 1915(i) option or to establish waiting lists. The § 1915(i) option must be offered statewide and cannot be limited to specific geographical regions of the state. However, if a state exceeds its projection of the number of individuals expected to receive § 1915(i) services, then a state can constrict its § 1915(i) needs based eligibility criteria with 60 days advance notice, provided that individuals already receiving services continue to be subject to the previous criteria until they no longer qualify. Section 1915(i) services are required to be provided in a home and community-based setting, similar to CFC services, although a standard definition for this setting has yet to be finalized.<sup>31</sup>

Nine states (CA,<sup>32</sup> CO, CT, IA, ID, LA, NV, OR, and WI) reported having the HCBS state plan option in place in FY 2012.<sup>33</sup> As of March 2013, Delaware and Maryland reported plans to implement the option in FY 2013, and two states (IN and MN) reported a planned FY 2014 implementation date.<sup>34</sup> In many cases, states taking up the HCBS state plan option reported

targeting services to persons with mental illness or I/DD. Also, because the ACA eliminates the ability of states to impose an enrollment cap on § 1915(i) services, one state that had previously implemented this option (WA) reported eliminating it in FY 2012 and transitioning enrollees into comparable HCBS waiver programs.

**6. New Community First Choice state plan option with enhanced federal funding for home and community-based attendant services and supports.** Most states (32) currently provide personal care services through the optional personal care services state plan benefit.<sup>35</sup> The ACA establishes CFC under § 1915(k) of the SSA as a new Medicaid state plan option that allows states to provide statewide home and community-based attendant services and supports to individuals who would otherwise require an institutional LOC.<sup>36</sup> States taking up the option will receive a 6 percent increase in their FMAP<sup>37</sup> for CFC services. There is no time limit or expiration on the enhanced FMAP, and CMS has indicated that the enhanced FMAP also will be available for required CFC activities such as assessments and person-centered planning.<sup>38</sup>

To be eligible for CFC services, beneficiaries must otherwise require an institutional LOC and meet financial eligibility criteria.<sup>39</sup> Specifically, states can provide CFC attendant services and supports to Medicaid-eligible:

- Individuals with incomes up to 150 percent of the FPL (\$1,436 per month in 2013) who meet institutional LOC standards; and
- Individuals with incomes above 150 percent of the FPL, up to the state plan income limit for eligibility for nursing facility services (federal maximum of 300% of the SSI FBR (\$2,130 per month in 2013)) who meet institutional LOC criteria and who qualify for Medicaid in a coverage group that offers nursing facility services; individuals in this income range who qualify for Medicaid under an HCBS waiver must be receiving at least one waiver service per month.

CFC services must be provided statewide with no enrollment caps. Services can be provided under an agency-provider model (within which individuals must maintain the ability to have a significant role in the selection and dismissal of providers of their choice), a self-directed model, or other models approved by CMS. Specific services are determined following a face-to-face assessment of an individual's needs and a person-centered planning process directed by the individual to the maximum extent possible. Required CFC services include:

- Services that assist beneficiaries with activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing;
- Services for the acquisition, maintenance, and enhancement of skills necessary for individuals to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks;
- “Self-direction” opportunities including voluntary training on how to select, manage, and dismiss direct care workers; and
- Backup systems (such as beepers or other electronic devices) to ensure continuity of services and supports.

States also may choose to cover under the CFC option other services and supports that are linked to an assessed need or goal in the person-centered service plan, including but not limited to:

- Spending for transition costs, such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, other necessities required for an individual to transition from an institutional setting to a community setting; and
- Supports that increase a beneficiary's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.<sup>40</sup>

CFC does not cover the following items:

- Room and board expenses (other than allowable transition costs);
- Special education and related services;
- Assistive technology devices (except to the extent that they qualify as backup systems or increase independence or substitute for human assistance that would otherwise be covered);<sup>41</sup>
- Medical supplies and equipment (except to the extent that they increase independence or substitute for human assistance that would otherwise be covered);<sup>42</sup>
- Home modifications (except to the extent that they increase independence or substitute for human assistance that would otherwise be covered);<sup>43</sup> and
- Vocational rehabilitation services.

In order to qualify for the enhanced federal match, states must meet several specific requirements, such as developing their CFC benefit with the input of a Development and Implementation stakeholder council that includes a majority of members with disabilities and elderly individuals and their representatives; establishing and maintaining a comprehensive quality assurance system; and collecting and reporting information for a federal evaluation. During the first year the CFC option is implemented, states must meet or exceed what they spent on Medicaid home and community-based attendant services and supports (provided under the state plan, waivers, or demonstrations) for elderly individuals and people with disabilities in the previous year.

All CFC attendant services and supports must be provided in a home and community setting. The CFC final rule, issued in May 2012, did not finalize language regarding the definition of "home and community setting," but CMS did propose revised standards including that home and community settings must exhibit specific qualities to be eligible sites for the delivery of CFC services. Until the setting definition is finalized, upon further CMS review and additional public comment, CMS will rely upon the newly proposed provisions.<sup>44</sup> When finalized, CMS intends to apply the definition uniformly across HCBS programs.<sup>45</sup>

On August 31, 2012, California was the first state to receive CMS approval of a SPA to implement the CFC option. Arizona and Louisiana have submitted SPAs for approval. Additionally, as of March 2013, six states reported definite plans to implement the CFC option (AR, MD, MN, MT, NY, and OR) in FY 2013 or FY 2014.<sup>46</sup> California will receive an estimated \$573 million in additional federal funds during the first two years of implementation.<sup>47</sup>

California’s CFC benefit offers services through an agency model, under which contracted entities will provide services and supports to beneficiaries, as well as a self-directed model, using individualized service budgets, direct cash payments, and financial management services.

## **Conclusion**

These six state Medicaid LTSS options, newly created or expanded under the ACA, give states new flexibility and enhanced federal resources to expand access to Medicaid HCBS. Nearly every state (47 states and DC) has taken steps forward on at least one of the six options, and many states are pursuing or plan to pursue multiple new LTSS options, either separately or in combination.

The new options in the ACA interact with each other in ways that will improve the overall HCBS system. For example, CMS has confirmed that states can “stack” enhanced FMAPs for services that qualify under BIP, CFC, and/or MFP to increase the provision of HCBS. In addition, the work that CMS and the states are undertaking to develop and implement these new options will help to improve and standardize access to HCBS across programs. For example, CMS will share finalized elements from the BIP universal assessment instrument with states as an example for their use in CFC and other HCBS programs that require functional needs assessments. Also, when finalized, CMS intends to apply a unified definition of home and community setting to all HCBS programs.

The new ACA options also present opportunities to improve the coordination of care for populations with chronic and complex health care needs, through the implementation of health home services and the development of financial alignment models for dual eligible beneficiaries. Some states have proposed combining these elements, for example, by designing a financial alignment demonstration based on health homes. Together, all of the new and expanded options for system transformation in the ACA hold promise for improving states’ delivery of Medicaid LTSS, and potentially containing LTSS cost growth while remaining responsive to beneficiary needs to receive more services in community-based settings.

This policy brief was prepared by Molly O’Malley Watts, Principal of Watts Health Policy Consulting, and MaryBeth Musumeci and Erica Reaves of the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured.

## Notes

<sup>1</sup> Table Sources: Vern Smith et al., “Medicaid Today; Preparing for Tomorrow: A Look at State Spending, Enrollment and Policy Trends in Medicaid: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013,” Kaiser Commission on Medicaid and the Uninsured, October 2012. Available at: <http://www.kff.org/medicaid/8380.cfm>; Integrated Care Resource Center. *State Health Home CMS Proposal Status*, November 2012. Available at:

[http://www.chcs.org/usr\\_doc/HHMap\\_v9.pdf](http://www.chcs.org/usr_doc/HHMap_v9.pdf); National Association of States United for Aging and Disabilities. (December 2012) *State Medicaid Integration Tracker*®, Available at:

[http://www.nasuad.org/medicaid\\_integration\\_tracker.html](http://www.nasuad.org/medicaid_integration_tracker.html); CMS and Mission Analytics Group and New Editions Consulting. (January 2013) *Balancing Incentive Program*. Available at:

[http://www.balancingincentiveprogram.org/sites/default/files/BIP\\_National\\_Call\\_Webinar\\_20130117\\_Final.pdf](http://www.balancingincentiveprogram.org/sites/default/files/BIP_National_Call_Webinar_20130117_Final.pdf); CMS Financial Alignment Initiative, *State Financial Alignment Proposals*. Available at

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<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured, “The Medicaid Program at a Glance,” September 2012. Available at: <http://www.kff.org/medicaid/7235.cfm>.

<sup>3</sup> Terence Ng et al., “Medicaid Home and Community-Based Services Programs: 2009 Data Update,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, December 2012. Available at: <http://www.kff.org/medicaid/7720.cfm>.

<sup>4</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999), available at <http://www.law.cornell.edu/supct/html/98-536.ZS.html>.

<sup>5</sup> ACA §2403, amending 42 U.S.C. §1396a (note).

<sup>6</sup> Molly O’Malley Watts, “Money Follows the Person: A 2012 Survey of Transitions, Services and Costs,” Kaiser Commission on Medicaid and the Uninsured, February 2013. Available at:

<http://www.kff.org/medicaid/8142.cfm>.

<sup>7</sup> Katherine Young et al., “Medicaid’s Role for Dual Eligible Beneficiaries,” Kaiser Commission on Medicaid and the Uninsured, April 2012. Available at: <http://www.kff.org/medicaid/7846.cfm>.

<sup>8</sup> For a summary of CMS’s § 1115A demonstration authority, see Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS, Appendix A* (October 2012). Available at: <http://www.kff.org/Medicaid/8369.cfm>.

<sup>9</sup> MaryBeth Musumeci, “State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, October 2012. Available at:

<http://www.kff.org/medicaid/8369.cfm>, and MaryBeth Musumeci, “Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, October 2012. Available at:

<http://www.kff.org/medicaid/8368.cfm>.

<sup>10</sup> CMS, Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) And The State of California Regarding A Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees: California Demonstration to Integrate Care for Dual Eligible Beneficiaries, March 2013, Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>.

<sup>11</sup> MaryBeth Musumeci, “Massachusetts’ Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, October 2012. Available at: <http://www.kff.org/medicaid/8291.cfm>.

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<sup>12</sup> MaryBeth Musumeci, “Washington’s Managed FFS Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, December 2012. Available at <http://www.kff.org/medicaid/8394.cfm>.

<sup>13</sup> “Massachusetts and Ohio: Capitated Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, January 2013. Available at <http://www.kff.org/medicaid/8407.cfm>.

<sup>14</sup> CMS, Memorandum of Understanding Between The Centers for Medicare & Medicaid Services (CMS) And The State of Illinois Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees: Illinois Medicare-Medicaid Alignment Initiative, February 2013, Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf>.

<sup>15</sup> Kaiser Commission on Medicaid and the Uninsured, “Medicaid’s New “Health Home” Option,” January 2011. Available at: <http://www.kff.org/medicaid/8136.cfm>.

<sup>16</sup> ACA § 2703(a), adding 42 U.S.C. § 1396w-4. CMS released guidance for states seeking to take up this new option. CMS. Health Homes for Enrollees with Chronic Conditions. November 16, 2010. Available at: <https://www.cms.gov/smdl/downloads/SMD10024.pdf>.

<sup>17</sup> Medicaid is financed by state and federal dollars. The federal share varies based on a formula in federal law that relies on states’ average per capita income compared to the national average; states with lower per capita incomes have a higher federal medical assistance percentage (FMAP). For federal fiscal year 2013, the FMAP varies across states from a floor of 50 percent (a multiplier effect of \$1 in federal funding per \$1 of state spending on Medicaid), to a high of 73.4 percent (\$2.76 in federal funding per \$1 in state spending.) See Snyder et al, “Why Does Medicaid Spending Vary Across States: A Chartbook of Factors Driving State Spending, Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, Revised November 2012. Available at: <http://www.kff.org/medicaid/8378.cfm>.

<sup>18</sup> Integrated Care Resource Center. State-By-State Health Home State Plan Amendment Matrix: Summary Overview. November 2012. Available at: [http://www.chcs.org/usr\\_doc/HHMap\\_v9.pdf](http://www.chcs.org/usr_doc/HHMap_v9.pdf).

<sup>19</sup> *Ibid.*

<sup>20</sup> ACA § 10202, codified at 42 U.S.C. § 1396d(note).

<sup>21</sup> CMS, “The Balancing Incentive Program: Implementation Manual,” October 2011. Available at: [http://hsd.aphsa.org/Home/doc/Balancing\\_Incentive\\_Program\\_Manual.pdf](http://hsd.aphsa.org/Home/doc/Balancing_Incentive_Program_Manual.pdf).

<sup>22</sup> *Ibid.*

<sup>23</sup> 77 *Fed. Reg.* 28362, 26371 (May 3, 2012); 77 *Fed. Reg.* 26828, 26855 (May 7, 2012).

<sup>24</sup> CMS, Balancing Incentive Program website, accessed on March 28, 2013, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html>.

<sup>25</sup> Vern Smith et al., “Medicaid Today; Preparing for Tomorrow: A Look at State Spending, Enrollment and Policy Trends in Medicaid: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013,” Kaiser Commission on Medicaid and the Uninsured, October 2012. Available at: <http://www.kff.org/medicaid/8380.cfm> and CMS and Mission Analytics Group and New Editions Consulting. (January 2013). Balancing Incentive Program. Available at: [http://www.balancingincentiveprogram.org/sites/default/files/BIP\\_National\\_Call\\_Webinar\\_20130117\\_Final.pdf](http://www.balancingincentiveprogram.org/sites/default/files/BIP_National_Call_Webinar_20130117_Final.pdf).

<sup>26</sup> 77 *Fed. Reg.* 26828, 26891 (May 7, 2012).

<sup>27</sup> Technical Assistance Center for the Balancing Incentive Program. Available at: <http://www.balancingincentiveprogram.org/>.

<sup>28</sup> 42 U.S.C. § 1396n(i); see also proposed regulations at 77 *Fed. Reg.* 26361-406 (May 3, 2012).

<sup>29</sup> Section 1915(i) also gives states the option for a sixty-day presumptive eligibility period to receive federal financial participation for the evaluation and assessment for people believed to be eligible for the HCBS state plan option.

<sup>30</sup> 42 CFR § § 435.219, 440.182.

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<sup>31</sup> For proposed definition see proposed 42 CFR § 441.656.

<sup>32</sup> California reported that it had requested a retroactive effective date to the submission of its SPA in FY 2011. Vern Smith et al., “Medicaid Today; Preparing for Tomorrow: A Look at State Spending, Enrollment and Policy Trends in Medicaid: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013,” Kaiser Commission on Medicaid and the Uninsured, October 2012.

Available at: <http://www.kff.org/medicaid/8380.cfm>.

<sup>33</sup> *Ibid.*

<sup>34</sup> *Ibid.*

<sup>35</sup> Terence Ng et al, “Medicaid Home and Community-Based Services Programs: 2009 Data Update,” Kaiser Family Foundation’s Commission on Medicaid and the Uninsured, December 2012. Available at: <http://www.kff.org/medicaid/7720.cfm>.

<sup>36</sup> 42 U.S.C. § 1396n(k); 42 C.F.R. § § 441.500-441.590.

<sup>37</sup> For more detail on Medicaid FMAPs, see Kaiser Commission on Medicaid and the Uninsured, Medicaid Financing: An Overview of the Federal Medicaid Matching Rate, September 2012. Available at: <http://www.kff.org/medicaid/8352.cfm>.

<sup>38</sup> 77 *Fed. Reg.* 26828, 26891 (May 7, 2012).

<sup>39</sup> 42 C.F.R. § 441.510(c).

<sup>40</sup> 42 CFR § 441.520(b).

<sup>41</sup> 42 CFR § 441.525(c).

<sup>42</sup> 42 CFR § 441.525(d).

<sup>43</sup> 42 CFR § 441.525(e).

<sup>44</sup> The revised proposed standard, 42 C.F.R. § 441.530, is included in the Home and Community-Based Services State plan option (“§ 1915(i)”) proposed rules. 77 *Fed. Reg.* 26361, 26400-01 (May 3, 2012).

Available at: <http://www.gpo.gov/fdsys/pkg/FR-2012-05-03/html/2012-10385.htm>.

<sup>45</sup> 77 *Fed. Reg.* 26362, 26378 (May 3, 2012).

<sup>46</sup> Vern Smith et al., “Medicaid Today; Preparing for Tomorrow: A Look at State Spending, Enrollment and Policy Trends in Medicaid: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013,” Kaiser Commission on Medicaid and the Uninsured, October 2012.

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[http://www.nasuad.org/medicaid\\_integration\\_tracker.html](http://www.nasuad.org/medicaid_integration_tracker.html).

<sup>47</sup> “California Receives First-In-the-Nation Approval of New Community-Based Care Option for At-Risk Seniors and Persons with Disabilities.” State of California Health and Human Services Agency, August 31, 2012. Available at: <http://www.cdss.ca.gov/agedblinddisabled/Pg2839.htm>.

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