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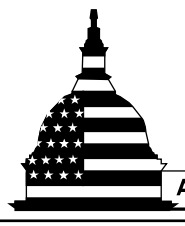
GAO

Report to Congressional Requesters

June 2012

MEDICAID

States' Plans to Pursue New and Revised Options for Home- and Community-Based Services



G A O

Accountability * Integrity * Reliability

GAO-12-649

June 2012

MEDICAID

States' Plans to Pursue New and Revised Options for Home- and Community-Based Services

GAO Highlights

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Highlights of GAO-12-649, a report to congressional requesters

Why GAO Did This Study

The 1999 Supreme Court decision in *Olmstead v. L.C.* held that states must serve individuals with disabilities in community-based settings under certain circumstances. Under the joint federal and state Medicaid program, states are required to cover nursing facility care for eligible individuals, while the provision of most HCBS is optional. In 2010, PPACA created two new options and revised two existing options for states to cover HCBS for Medicaid beneficiaries.

GAO was asked to assess the implementation status of the four Medicaid HCBS options in PPACA. GAO assessed (1) how the four options are structured to increase the availability of services, (2) what is known about states' plans to use the options, and (3) factors affecting states' decisions regarding implementing the options.

To determine the structure of the options, GAO reviewed federal statutes and regulations and interviewed officials at CMS. To determine what is known about states' plans, GAO obtained copies of states' grant applications and state plan amendments. To understand factors affecting states' decisions, GAO conducted interviews with officials in 10 states. The states were selected to reflect a range of state Medicaid spending for HCBS as a percentage of total Medicaid expenditures for long-term services and supports.

GAO provided a draft of this report to HHS. HHS had no general comments on the report but provided technical comments, which GAO incorporated as appropriate.

View GAO-12-649. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

The four Medicaid options for home- and community-based services (HCBS) included in the Patient Protection and Affordable Care Act (PPACA) provide states with new incentives and flexibilities to help increase the availability of services for Medicaid beneficiaries. Two of the options were newly created by PPACA, and the other two were existing options amended by the law. Three of the options provide states with financial incentives in the form of enhancements to the Medicaid matching rate that determines the federal share of the program's costs.

Medicaid Options for HCBS in PPACA

Option	New or existing?	Financial incentives?
Community First Choice Covers personal care and other services for eligible individuals.	New	Yes
Balancing Incentive Program Provides incentives for eligible states to rebalance their long- term services and supports systems towards more home- and community-based care.	New	Yes
Money Follows the Person Supports the transitioning of eligible individuals who want to move from institutional settings back to the community.	Existing	Yes
1915(i) state plan option Covers a range of HCBS for eligible individuals.	Existing	No

Source: GAO analysis.

As of April 2012, 13 states had applied for and received Money Follows the Person grants, in addition to the 30 states and the District of Columbia that had received grants prior to PPACA, and states were beginning to apply for the other three options. The 13 new Money Follows the Person states were awarded $621 million and were in various stages of implementation. One state had applied for Community First Choice. Two states had received approval to participate in the Balancing Incentive Program, and the Centers for Medicare & Medicaid Services (CMS) was reviewing two additional state applications. Three states had received approval to offer the revised1915(i) state plan option since PPACA's enactment.

The 10 states GAO contacted reported considering several factors in deciding whether to pursue the PPACA options, including potential effects on state budgets, staff availability, and interaction with existing state Medicaid efforts. States were attracted by the increased federal funding available under some of the options, but were concerned about their ability to contribute their share of funding. Limited staff resources and competing priorities were also concerns. Finally, broader Medicaid reform efforts, such as transitions to statewide managed care, and the potential interaction with existing HCBS options factored into states' considerations. The Department of Health and Human Services (HHS) and CMS have initiatives under way to assist states with their HCBS efforts. The complexities of the Medicaid HCBS options available and the changing factors affecting states' planning underscore the importance of ongoing federal technical assistance to help states navigate various HCBS options as they seek to ensure appropriate availability of HCBS.

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Abbreviations

ADL	activities of daily living
CMS	Centers for Medicare & Medicaid Services
FMAP	federal medical assistance percentage
FPL	federal poverty level
HCBS	home- and community-based services
HHS	Department of Health and Human Services
IADL	instrumental activities of daily living
LTSS	long-term services and supports
MSTAT	Medicaid State Technical Assistance Teams
PPACA	Patient Protection and Affordable Care Act
SSI	Supplemental Security Income

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United States Government Accountability Office
Washington, DC 20548

June 13, 2012

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable John D. Rockefeller IV
Chairman
Subcommittee on Health Care
Committee on Finance
United States Senate

For many individuals with physical, developmental, or cognitive disabilities, receiving care in the community through home- and community-based services, such as adult day care, home health, or personal care, is preferable to receiving care in a nursing home or other institutional setting. Increasing the availability of home- and community-based services is also important to states' ability to comply with the Supreme Court's 1999 decision in *Olmstead v. L.C.*, known as the *Olmstead* decision, in which the Court held that unjustified institutionalization of a person based on disability violates Title II of the Americans with Disabilities Act.[1]

Medicaid—the joint federal-state financing program for health care services for certain low-income individuals—is the nation's primary payer

[1]*Olmstead v. L.C.*, 527 U.S. 581 (1999). In particular, the Court held that states must provide community-based services for persons with disabilities who are otherwise entitled to institutional services when such services are appropriate, the individual does not oppose such treatment, and the community-based services can be reasonably accommodated, taking into account the resources available to a state and the needs of others with disabilities.

of long-term services and supports,[2] including home- and community-based services. While states are required to cover institutional care as part of Medicaid, coverage for most home- and community-based services is optional. State spending on home- and community-based services as a percentage of total spending on long-term services and supports varies widely, from less than 20 percent in one state to over 70 percent in others.[3] The Medicaid program provides states with several tools to make home- and community-based services available to eligible elderly individuals and nonelderly individuals with disabilities, and the Patient Protection and Affordable Care Act (PPACA) further expanded these opportunities. PPACA created two new options and revised two existing options for Medicaid home- and community-based services: Community First Choice, the Balancing Incentive Program, Money Follows the Person, and the 1915(i) state plan option, respectively.

The availability of home- and community-based services can enable individuals with disabilities to remain in their homes, maintain their independence, and participate in community life to the fullest extent possible. You asked about how the four Medicaid home- and community-based services options in PPACA could potentially affect access to services and the status of their implementation. Our review examined the following questions:

1. How are the four Medicaid home- and community-based services options in PPACA structured to increase the availability of services?

2. What is known about states' plans to use the PPACA Medicaid home- and community-based services options?

3. What factors affect states' decisions regarding implementing Medicaid home- and community-based services options under PPACA?

[2]For this report, we use the term long-term services and supports rather than long-term care. Long-term services and supports is a term that is commonly used by researchers and policymakers to describe the types of assistance that are provided to persons with disability and frail, elderly individuals. The Patient Protection and Affordable Care Act uses the term long-term services and supports and defines the term to include certain institutionally based and noninstitutionally based long-term services and supports. Pub. L. No. 111-148, §10202(f)(1), 124 Stat. 119, 926-27 (Mar. 23, 2010).

[3]Centers for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act Section 10202: State Balancing Incentive Payments Program Initial Announcement* (Baltimore, Md.: September 2011).

To determine how the four Medicaid home- and community-based services options in PPACA are structured to increase the availability of services, we reviewed relevant federal statutes and regulations, examined guidance and other documents issued by the Centers for Medicare & Medicaid Services (CMS), and interviewed CMS officials responsible for overseeing Medicaid programs covering home- and community-based services.

To determine what is known about states' plans to use the PPACA Medicaid home- and community-based services options, we interviewed program officials at CMS responsible for each of the four options and obtained copies of proposed and approved state applications for the Balancing Incentive Program, state plan amendments for Community First Choice and the 1915(i) state plan option, and state operational protocols for Money Follows the Person that states had submitted for these options to CMS.

To understand the factors affecting states' decisions on implementing the Medicaid home- and community-based services options in PPACA, we conducted interviews with state Medicaid and other state agency officials in 10 states: Florida, Maine, Michigan, Mississippi, Montana, Nevada, New Jersey, New Mexico, Oklahoma, and Oregon. The states were judgmentally selected by stratifying all states and the District of Columbia on their percentage of Medicaid long-term services and supports spending on home- and community-based services and then identifying 10 states that reflected the range of state spending on home- and community-based services. We conducted the state interviews between November 2011 and February 2012. To supplement the state interviews, we also conducted interviews with officials from several state associations and health policy organizations that track Medicaid home- and community-based services issues, including the National Association of States United for Aging and Disabilities, National Academy for State Health Policy, National Association of Medicaid Directors, National Association of State Directors of Developmental Disabilities Services, and the National Association of State Mental Health Program Directors.

We conducted this performance audit from October 2011 to May 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Long-term services and supports (LTSS) include many types of health and health-related services for individuals of all ages who have limited ability to care for themselves because of physical, cognitive, or mental disabilities or conditions. Individuals needing LTSS have varying degrees of difficulty performing activities of daily living (ADL), such as bathing, dressing, toileting, and eating, without assistance. They may also have difficulties with instrumental activities of daily living (IADL), such as preparing meals, housekeeping, using the telephone, and managing money. Assistance for such needs takes many forms and takes place in varied settings, including care provided in institutional settings, such as nursing homes; services provided in community-based settings, such as adult foster care; and in-home care.[4] Home- and community-based services (HCBS) cover a wide range of services and supports to help individuals remain in their homes or live in a community setting, such as personal care services to provide assistance with ADLs or IADLs, assistive devices, respite care for care givers, and case management services to coordinate services and supports that may be provided from multiple sources.

Medicaid Financing and Eligibility

While a variety of sources are used to pay for LTSS, Medicaid is the largest. States and the federal government share responsibility for Medicaid costs. In general, state Medicaid spending for medical assistance is matched by the federal government, at a rate that is based in part on each state's per capita income according to a formula established by law. The federal share of Medicaid expenditures, known as the federal medical assistance percentage (FMAP), typically ranges from 50 to 83 percent. Although Medicaid is jointly financed by the states and the federal government, it is directly administered by the states, with

[4]On May 3, 2012, CMS published a notice of proposed rulemaking that proposed defining the qualities of a home- and community-based setting in which the provision of home- and community-based services is eligible for federal reimbursement. Under the proposed rule, in order to be an eligible site for the delivery of HCBS, a setting must (1) be integrated in, and facilitate an individual's full access to, the greater community; (2) be selected by the individual among all available alternatives and identified in the individual's person-centered service plan; (3) protect the individual's right to privacy, dignity, and respect, and freedom from coercion and restraint; (4) allow for individual initiative, autonomy, and independence in making major life decisions; and (5) allow for the individuals to choose their services and supports and who provides them. Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, 77 Fed. Reg. 26362, 26400 (May 3, 2012).

oversight from CMS, within the Department of Health and Human Services (HHS).

For the most part, individuals who qualify for and receive Medicaid coverage of LTSS are age 65 or older, disabled, or blind. Such individuals typically qualify for Medicaid coverage of LTSS on the basis of their eligibility for the federal Supplemental Security Income (SSI) program, a means-tested income assistance program that provides cash benefits to individuals who meet certain disability criteria and have low levels of income and assets.[5,6] States may also require individuals to meet state-defined level-of-care criteria for Medicaid coverage of certain LTSS. These criteria, which generally include some measures of an individual's functional limits, help states manage overall service utilization and therefore costs.

Medicaid Spending for HCBS Relative to Institutional Care

For decades, the majority of Medicaid LTSS expenditures have been for care provided in institutional settings, but Medicaid spending for HCBS has been steadily increasing as states invest more resources in alternatives to institutional care. Under Medicaid, coverage of certain institutional services is mandatory, while coverage of nearly all HCBS is optional for states. Since the Medicaid program was first established in 1965, states have been required to cover nursing facility care for all Medicaid beneficiaries age 21 and older. States may also offer other types of institutional care under their Medicaid programs, including care provided in intermediate-care facilities for individuals with intellectual disabilities and care provided for individuals age 65 or older and certain individuals under age 22 in institutions for mental diseases.[7] Medicaid

[5]In 2012, an individual qualifying for SSI cannot have countable income of more than $698 per month or countable assets of more than $2,000.

[6]States also have options to determine income eligibility through non-SSI pathways. For example, states may cover aged, blind, and disabled individuals with higher incomes who "spend down" their anticipated income to a specified level by incurring medical expenses and aged, blind, and disabled individuals who are institutionalized and who have incomes less than 300 percent of the SSI benefit rate.

[7]Rosa's Law, enacted in October 2010, amended provisions of federal law to substitute the term "an intellectual disability" for "mental retardation," and "individuals with intellectual disabilities" for "the mentally retarded" or "individuals who are mentally retarded." Intermediate Care Facilities for Persons with Intellectual Disabilities is the new title for the program formerly known as Intermediate Care Facilities for the Mentally Retarded. Pub. L. No. 111-256, §4,124 Stat. 2643, 2645 (Oct. 5, 2010).

initially provided limited coverage for care provided in community settings or in the home, but numerous changes to federal Medicaid law since the program's inception have expanded states' options for covering HCBS. States have taken advantage of the new options, and since 1995, Medicaid spending for HCBS has steadily increased by 1 to 3 percentage points each year. In fiscal year 2009, total Medicaid expenditures for LTSS were $127.1 billion. Of this amount, about $55.9 billion was for HCBS, which was about 44 percent of all Medicaid LTSS spending that year, up from 18 percent in 1995.[8]

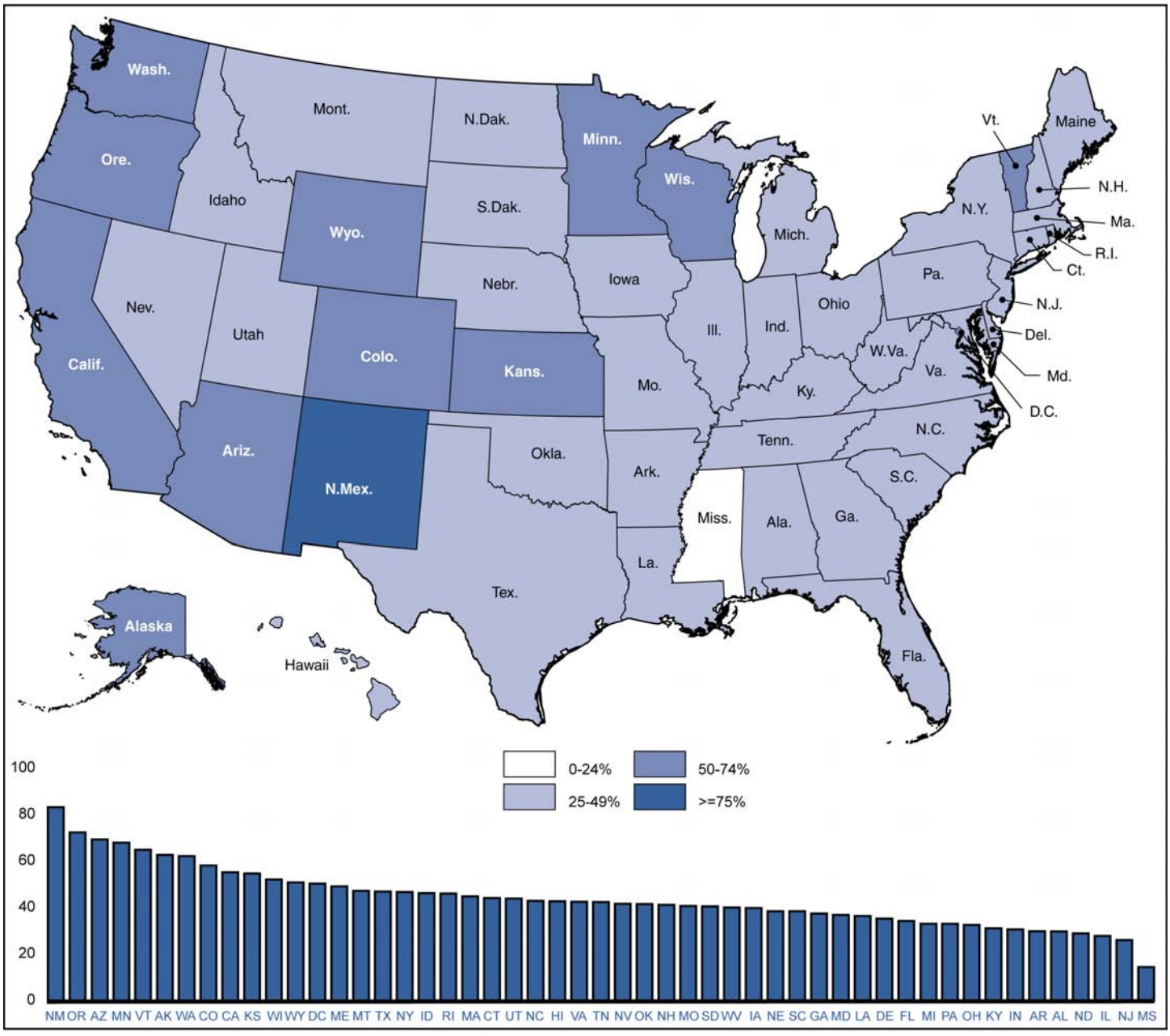
Olmstead Decision

The *Olmstead v. L.C.* case was brought by two residents of a state psychiatric hospital with developmental disabilities and mental illness whose physicians agreed that a community-based setting would be appropriate for their needs. The Supreme Court held that it was discriminatory for the plaintiffs to remain institutionalized when (1) a qualified state professional had approved community placement, (2) the plaintiffs were not opposed to such placement, and (3) the state could reasonably accommodate the placement, taking into account its resources and the needs of other state residents with mental disabilities.

States' ability to leverage federal Medicaid funding for the provision of HCBS can help them achieve compliance with the *Olmstead* decision, which outlined the scope and nature of states' obligations to provide HCBS for individuals with disabilities; however, state spending on HCBS as a percentage of total LTSS spending varies widely. States have considerable flexibility in designing their Medicaid programs. Within broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of covered services; and sets provider payment rates. In 2009, state spending on HCBS as a percentage of total LTSS spending ranged from 14.4 percent in Mississippi to 83.2 percent in New Mexico. (See fig. 1.)

[8]Steve Eiken, Kate Sredl, Brian Burwell, and Lisa Gold, *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update* (Cambridge, Mass.: Thomson Reuters, October 2011).

Figure 1: Variation in State Spending on HCBS as a Percentage of LTSS Spending, Fiscal Year 2009



Source: GAO analysis of CMS data.

Note: Data developed by CMS included estimates of states' expenditures for managed care LTSS based on data provided by states and other sources.

Medicaid Coverage of HCBS

States have covered HCBS through a wide and complex range of options within Medicaid, including through state plan benefits and through waivers. A state Medicaid plan defines how the state will operate its Medicaid program, including which populations and services are covered. States are required by federal Medicaid law to cover certain mandatory benefits in their state Medicaid plan. For example, all states are required to offer the Home Health benefit to all individuals entitled to nursing facility coverage under the state's Medicaid plan. Services that may be covered under this benefit include nursing, home health aides, medical equipment, and therapeutic services. States may also elect to cover other HCBS through optional benefits. For example, states have the option to offer the Personal Care benefit, which covers assistance with ADLs and IADLs, furnished either at home or in another location. According to a recent study, 33 states and the District of Columbia offered the Personal Care benefit in 2008.[9] Changes a state wishes to make to its state Medicaid plan, including adding an optional state plan benefit, must be submitted to CMS for review and approval in the form of a proposed state plan amendment. With certain exceptions, services provided through state plan benefits (both mandatory and optional) must (1) be sufficient in amount, duration, and scope to reasonably achieve their purposes; (2) be comparable in availability among different groups of enrollees; (3) be offered statewide; and (4) allow beneficiaries freedom of choice among health care providers or managed care entities participating in Medicaid.

States have also covered HCBS for Medicaid beneficiaries through waivers. Waivers can allow states to provide services not otherwise covered by Medicaid to designated populations who may or may not otherwise be eligible for Medicaid services. If approved, a waiver may allow a state to limit the availability of services geographically, target services to specific populations or conditions, control the number of individuals served, and cap overall expenditures—actions that are generally not otherwise allowed under the federal Medicaid law, but which may enable states to control costs. States must submit their waiver requests to CMS for approval. The 1915(c) waiver, authorized under section 1915(c) of the Social Security Act, is the primary means by which states provide HCBS for Medicaid beneficiaries and accounts for the

[9]Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home- and Community-Based Services Programs: Data Update* (Washington, D.C.: December 2011). Two of the states with the Personal Care option—Rhode Island and Delaware—did not report any individuals in their program.

large majority of state Medicaid HCBS expenditures.[10] Under 1915(c) waivers, states may cover a broad range of services to participants, as long as these services are required to prevent institutionalization; thus to be eligible, individuals must meet the state's level-of-care criteria for institutional care. Included among the services that may be provided are homemaker/home health aide, personal care, adult day health, and other services as approved by the Secretary of HHS. States can have multiple 1915(c) waivers that target different populations, for example, one for individuals with developmental disabilities and another for individuals with physical disabilities. In fiscal year 2010, 47 states and the District of Columbia operated 318 1915(c) waiver programs, expending over $35 billion, according to a study using CMS data.[11]

Medicaid HCBS Options Created or Amended by PPACA

PPACA created two new Medicaid options for states to cover HCBS—Community First Choice and the Balancing Incentive Program—and amended two existing Medicaid HCBS options—the 1915(i) state plan option and Money Follows the Person.

- Community First Choice is a new optional state plan benefit created by PPACA to finance home- and community-based attendant and other services for Medicaid beneficiaries.[12] Community First Choice became effective October 1, 2011.
- The Balancing Incentive Program is a new time-limited program established by PPACA to help increase access to HCBS for beneficiaries.[13] The Balancing Incentive Program became effective October 1, 2011, and expires September 30, 2015.

[10]In addition, some states use section 1115 waivers, either in addition to or in place of 1915(c) waivers, to provide HCBS to targeted populations. Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to grant states waivers of certain federal Medicaid requirements and to provide federal matching funds for expenditures that are not otherwise allowable for the purpose of demonstrating alternative approaches to service delivery. Relative to 1915(c) waivers, section 1115 waivers offer states more flexibility, including in the design of the benefit package and the delivery of services.

[11]Eiken, Burwell, Gold, and Sredl, *Medicaid 1915(c) Waiver Expenditures: 2011 Update.*

[12]Pub. L. No. 111-148, §2401, 124 Stat. at 297 (Mar. 23, 2010).

[13]Pub. L. No. 111-148, §10202, 124 Stat. at 923 (Mar. 23, 2010).

- The 1915(i) state plan option was established by the Deficit Reduction Act of 2005 as a new optional state plan benefit under section 1915(i) of the Social Security Act.[14] The 1915(i) state plan option provides states with a way to offer beneficiaries a comprehensive package of HCBS under a state plan option. One important distinction from 1915(c) waivers is that individuals qualifying for services under the 1915(i) state plan option do not need to meet the state's institutional level of care criteria to receive HCBS. However, a state that offers services under the 1915(i) state plan option must establish needs-based criteria for determining eligibility for services under the option that are less stringent than the state's criteria for determining eligibility for institutional care. Five states—Colorado, Iowa, Nevada, Washington, and Wisconsin—had offered 1915(i) prior to the changes to the option made by PPACA.[15] These revisions included expansions to the scope of covered services and eligibility requirements, among other changes, and became effective October 1, 2010.[16]

- Money Follows the Person was established by the Deficit Reduction Act of 2005 as a demonstration grant program to support states' transition of eligible individuals who want to move from institutional settings back to the community.[17] Each state's Money Follows the Person program consists of a transition program, to identify Medicaid beneficiaries living in institutions who wish to live in the community and help them do so, and a rebalancing program for states to make systemwide changes to support Medicaid beneficiaries with disabilities living and receiving services in the community. A total of $1.75 billion in federal funds was appropriated for Money Follows the Person for fiscal years 2007 through 2011, and CMS awarded Money Follows the Person grants to 30 states and the District of Columbia in

[14]Pub. L. No. 109-171, § 6086, 120 Stat. 4,121 (Feb. 8, 2006).

[15]Washington received approval to implement its 1915(i) state plan option beginning January 1, 2010. The state later removed the option from its state Medicaid plan, effective October 1, 2011.

[16]Pub. L. No. 111-148, § 2402, 124 Stat. at 301 (Mar. 23, 2010).

[17]Pub. L. No. 109-171, § 6071, 120 Stat. at 1020 (Feb. 8, 2006).

2007.[18] PPACA extended the program through 2016 and provided additional funding to continue the demonstration. The changes made by PPACA, which included an expansion of the eligibility requirements, became effective April 22, 2010.[19]

Four PPACA Options Provide States with New Incentives and Flexibilities for Offering HCBS

The four PPACA options include new incentives and flexibilities to help states increase the availability of HCBS for Medicaid beneficiaries. Three of the options—Community First Choice, Balancing Incentive Program, and Money Follows the Person—provide states with financial incentives in the form of enhanced federal matching funds for HCBS. All four options allow states flexibility in designing their coverage of services and implementing HCBS. For example, the revised 1915(i) state plan option allows states to design benefit packages to meet the needs of particular groups. In addition, three of the options have maintenance of effort or eligibility requirements that require states to sustain or increase HCBS expenditures or maintain existing eligibility standards, methodologies, or procedures as a condition of receiving enhanced federal funding, which should help to ensure that the options increase the availability of services. These options also include evaluation components or data reporting requirements that may help discern the extent to which the options have increased the availability of HCBS for beneficiaries. For a summary of specific features of the four options, see appendix I.

Community First Choice provides incentives for states to finance attendant and other services. Community First Choice provides states with a 6 percentage point increase in their FMAP for home- and community-based attendant and other services provided to beneficiaries. Under the benefit, states must cover services to help individuals accomplish ADLs and IADLs and health-related tasks and services to support the acquisition or maintenance of skills necessary for individuals

[18]The original Money Follows the Person grantees were Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin.

[19]Pub. L. No. 111-148, §2403, 124 Stat. at 304 (Mar. 23, 2010).

to accomplish ADLs and IADLs.[20] Beyond personal care services, states must also cover back-up systems, such as personal emergency response systems, pagers, or other mobile electronic devices, to ensure continuity of services in the event that providers of services and supports are not available. States must also cover voluntary training for individuals on how to select, manage, and dismiss their personal attendants. Community First Choice also allows states the flexibility of covering transition costs, such as rent and utility deposits, and other expenditures that allow for greater independence, such as nonmedical transportation services.

PPACA included several requirements for Community First Choice. Structured as a state plan benefit, Community First Choice does not allow states to set ceilings on the number of people who can receive services and requires services to be offered statewide. Further, unlike other HCBS options that states may use to cover personal care services, such as 1915(c) waivers and the 1915(i) state plan option, which allow states significant flexibility to restrict the type of services available, Community First Choice requires states to provide a specified set of HCBS. CMS described Community First Choice as a "robust" service package. Also, states offering Community First Choice must adhere to maintenance of effort requirements. Specifically, for the first full fiscal year the option is implemented, participating states must maintain or exceed the preceding year's level of expenditures for personal care services. Additionally, data reporting requirements included in the law may shed some light on the extent to which states are covering additional individuals as a result of the option. States that offer Community First Choice must report the number of individuals who received services under the option the preceding fiscal year and whether they had been previously served under the state plan or waivers, such as the personal care benefit, 1915(c) waivers, and 1915(i) state plan benefit. PPACA also requires the Secretary of HHS to conduct an evaluation of Community First Choice to determine (1) the effectiveness of the provision of services in allowing individuals to lead independent lives, (2) the impact of the services on individuals' physical

[20]On May 3, 2012, CMS published a proposed rule defining the qualities of a home- and community-based setting in which the provision of HCBS under the Community First Choice option will be eligible for federal reimbursement. Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, 77 Fed. Reg. 26362, 26400 (May 3, 2012).

and emotional health, and (3) the cost of services provided under the option compared with the cost of institutional care.[21]

Balancing Incentive Program incentivizes certain states to rebalance their LTSS systems toward home- and community-based care. The Balancing Incentive Program offers a targeted increase in FMAP to states in which less than 50 percent of LTSS expenditures are for HCBS and that undertake certain structural reforms to their Medicaid programs to increase access to HCBS.[22] Under the program, states that spent under 25 percent of the LTSS expenditures on HCBS in fiscal year 2009 qualify for a 5 percentage point increase in their FMAP for state HCBS expenditures, and states that spent between 25 and 50 percent are eligible for a 2 percentage point increase.[23] Participating states are required to make three structural changes to their LTSS programs to help increase access to HCBS. They must establish (1) a "no wrong door/ single-entry point system" to enable consumers to access all long-term services and supports; (2) conflict-free case management services in which the persons responsible for assessing the need for services and developing plans of care are not related to or financially responsible for the individual, or are not a provider of services for the individual; and (3) a standardized assessment instrument to determine eligibility for HCBS. States receiving a 5 percentage point increase in FMAP must achieve a rebalancing benchmark of 25 percent of total Medicaid LTSS expenditures for HCBS by the program's end, September 30, 2015; and similarly, states receiving a 2 percentage point increase in FMAP must achieve a rebalancing benchmark of 50 percent by then. PPACA set a limit of $3 billion in enhanced FMAP payments for the Balancing Incentive Program; funds from enhanced FMAP must be used to provide new or

[21]HHS is required to submit an interim report to Congress on the evaluations' findings by December 31, 2013, and a final report by December 31, 2015.

[22]CMS identified 38 states as eligible for the Balancing Incentive Program based on available data. States are permitted to provide CMS with additional information on their Medicaid expenditures for LTSS and HCBS for fiscal year 2009 for the purposes of determining Balancing Incentive Program eligibility.

[23]The increased federal match rate under the Balancing Incentive Program is applicable to expenditures for HCBS provided under several different Medicaid authorities, including the home health care services and personal care services state plan benefits, 1915(c), 1915(i), and Community First Choice. According to CMS, the enhanced FMAP available under the Balancing Incentive Program can be added to the enhanced FMAP available under Community First Choice but not Money Follows the Person.

expanded offerings of HCBS. States participating in the Balancing Incentive Program must meet maintenance of eligibility requirements that prohibit the state from applying methodologies or procedures for determining eligibility for HCBS that are more restrictive than the eligibility methodologies or procedures in effect on December 31, 2010. In addition, states must collect data on services, quality, and outcomes and inform CMS on a quarterly basis how they are collecting these data. Outcome measures to be collected include measures of beneficiary and family caregiver experience with providers and satisfaction with services; and measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

PPACA revisions to 1915(i) state plan option provide increased flexibility to offer new services to targeted populations. While several features of the 1915(i) state plan option remain the same—including its availability to individuals not needing an institutional level of care and its lack of an enhanced matching rate—PPACA made several changes to the option that provide states with increased flexibility in designing their benefit packages.[24] First, PPACA expanded the range of services previously available under the 1915(i) benefit. Formerly, states that offered the 1915(i) could cover only those services explicitly identified in the statute, which among other services included homemaker/health aide, case management, personal care, and respite care. PPACA revised the option to allow states to offer services not specifically identified in the law if approved by CMS, as they are able to do under 1915(c) waivers. Second, as a result of the changes in PPACA, states are able to offer HCBS to specific, targeted populations. States may offer 1915(i) service packages that differ in type, amount, duration, or scope to specific population groups, either through one service package or through multiple 1915(i) service packages.[25] For example, a state could have one 1915(i) benefit

[24]In addition, on May 3, 2012, CMS published a proposed rule for the 1915(i) state plan option. Among the proposals included was the establishment of the qualities of a home- and community-based setting in which the provision of HCBS under the 1915(i) state plan option will be eligible for federal reimbursement. Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, 77 Fed. Reg. 26362 (May 3, 2012).

[25]States that elect to offer HCBS to specific targeted populations under 1915(i) may do so for a period of 5 years and may renew the election for additional 5-year terms.

package specifically for individuals with chronic mental illness and another for children with autism. Third, PPACA expanded income eligibility for the option by allowing states to offer the benefit to individuals with incomes up to 300 percent of the SSI benefit rate if they are also eligible for HCBS under certain waivers, which may require the individual to meet the state's institutional level of care criteria.[26,27] The law also allows states to expand Medicaid eligibility to individuals with income up to 150 percent of the federal poverty level who are eligible to receive HCBS under the 1915(i) state plan option. Although PPACA provided new flexibility to states under the 1915(i) option, the law also eliminated the ability states had previously under 1915(i) to limit the number of individuals who could receive services and to offer services in selected geographic areas. States that offer 1915(i) are required to report the number of individuals projected to be served under the option.[28]

PPACA extension of Money Follows the Person included additional funding and some new flexibility. PPACA extended the Money Follows the Person demonstration program, which was scheduled to expire in 2011, for 5 years through fiscal year 2016. PPACA appropriated $450 million for the program annually for each of fiscal years 2012 through 2016, for a total of $2.25 billion. Most features of the demonstration program were unchanged by PPACA, including the program's enhanced FMAP of up to 90 percent for certain services for

[26]In 2012, the maximum federal SSI annual payment amounts were $8,386.75 for an individual and $12,578.71 for a couple.

[27]PPACA also continued to allow states to offer the 1915(i) state plan option to individuals with incomes up to 150 percent of the federal poverty level. Such individuals must meet the state's needs-based criteria for the option, but are not required to demonstrate a need for institutional care. In 2012, the federal poverty level for individuals in the 48 contiguous states and the District of Columbia was an annual income of $11,170 for an individual and $15,130 for a couple.

[28]In it its proposed rule for the 1915(i) state plan option, CMS proposed that states annually report both the projected number of individuals to be served and the actual number served in the previous year. States would also be required to develop and implement an HCBS quality improvement strategy that must be provided to CMS upon request. Further, for a state that chooses to target the 1915(i) option to specific populations, CMS would evaluate the state's performance at the time of renewal every 5 years, based upon the state's HCBS quality outcomes and requirements contained in its state plan amendment.

12 months for each Medicaid beneficiary transitioned.[29] One change PPACA did make was to relax one of the eligibility requirements for Money Follows the Person. Under the original program, an individual had to reside for not less than 6 months but no more than 2 years in an inpatient facility, such as a nursing facility, to be eligible to receive services. PPACA shortened the minimum number of days from 6 months to 90 consecutive days.[30] Some of the initial Money Follows the Person grantees reported that the 6-month institutional residency requirement was a barrier to recruitment because many candidates interested in transitioning had not been institutionalized long enough to qualify and individuals who do meet the requirement often have complex medical or mental health needs that make it more difficult to serve them in the community. Some states have transition programs that have less stringent institutional residency requirements. The reduction in the institutional residency requirement in Money Follows the Person may potentially increase the number of individuals who can be transitioned through the program. PPACA made no changes to a maintenance of effort requirement included in the original demonstration. Under the program, a state's expenditures for HCBS in each year of the demonstration must not be less than such expenditures for fiscal year 2005, or for the fiscal year preceding the first year of the demonstration, whichever is greater.

PPACA also extended the national evaluation of Money Follows the Person, which was designed to assess whether the demonstration had met its goals to increase the number of institutionalized Medicaid beneficiaries who can be transitioned to the community and to rebalance states' LTSS systems. The Deficit Reduction Act of 2005 allowed up to $1.1 million of the funds appropriated for Money Follows the Person each fiscal year to be used for the evaluation through 2011; PPACA extended the program's evaluation and the funding for it through 2016. See appendix II for more information on the national evaluation of the program and the results to date.

[29]The enhanced FMAP available under Money Follows the Person is equal to taking the published FMAP for a state, subtracting it from 100 percent, dividing the total in half, and adding that percentage to the published FMAP. The maximum enhanced FMAP available under the demonstration is 90 percent.

[30]PPACA also stipulated that any days that an individual was in an institution for the sole purpose of receiving short-term rehabilitative services that are reimbursed under Medicare would not count toward the 90-day minimum residence requirement.

Since PPACA's Enactment, 13 States Applied for and Received New Money Follows the Person Grants, and States Have Begun to Apply for the Other Three Options

Thirteen of the 20 states that had not previously received Money Follows the Person grants applied for and received new grants made available as a result of funds appropriated in PPACA. In addition, states were beginning to apply and applications had been approved for the other three PPACA HCBS options.

Since PPACA's Enactment, 13 New States Applied for and Received Grants for Money Follows the Person

In February 2011, CMS awarded Money Follows the Person grants to 13 of the 20 states that had not previously received Money Follows the Person grants under the original program.[31] A total of $621 million was awarded to these 13 states and will be available to these states through fiscal year 2016. The amounts awarded varied from a low of approximately $6.5 million for Idaho to a high of approximately $187 million for Minnesota.

By April 2012, most of the 13 states were making some progress implementing their Money Follows the Person programs, as evidenced by CMS's approval to allow the states to begin enrolling and transitioning individuals to their homes or the community. When applying for Money Follows the Person grants, states must submit operational protocols to CMS that detail how the states plan to implement their programs. Once CMS has approved a state's operational protocol, the state can begin enrolling and transitioning individuals from institutions to the community. As of April 2012, CMS had approved operational protocols for 11 of the 13 states.[32] Some states received approval of their operational protocols not long after their grants were awarded in February 2011 and thus could

[31]The states that had received grants under the original Money Follows the Person program are continuing their programs, with the exception of South Carolina and Oregon. South Carolina, although an original grantee, had not implemented its program as of April 2012. Additionally, Oregon temporarily suspended transitioning individuals in October 2011. As of April 2012, Oregon had not reinstituted its program.

[32]Florida's and Minnesota's operational protocols had not been approved as of April 2012.

begin transitioning individuals at that time, while others received approval much later. See table 1 for information on the amounts awarded to the 13 states and the dates on which these states could begin transitioning individuals.

Table 1: Amounts Awarded and Date Approved to Begin Transitioning Individuals for Money Follows the Person Programs in States Awarded Grants in 2011

State	Amount awarded	Date approved to begin transitioning individuals
Colorado	$22,189,486	11/23/2011
Florida	$35,748,853	Not applicable[a]
Idaho	$6,456,560	3/25/2011
Maine	$7,151,735	2/24/2012
Massachusetts	$110,000,000	7/12/2011
Minnesota	$187,412,620	Not applicable[a]
Mississippi	$37,076,814	4/28/2011
Nevada	$7,276,402	4/29/2011
New Mexico	$23,724,360	4/4/2011
Rhode Island	$24,570,450	7/26/2011
Tennessee	$119,624,597	10/1/2011
Vermont	$17,963,059	4/4/2011
West Virginia	$22,220,423	10/3/2011
Total	**$621,415,359**	

Source: CMS.

[a]Florida's and Minnesota's operational protocols had not been approved as of April 2012.

The 11 states with approved operational protocols planned to transition approximately 8,800 individuals from institutions to their homes or communities between 2011 and 2016. Individual states projected transitioning from 122 individuals (Maine) to 2,225 individuals (Tennessee) during the course of the demonstration. The 11 states planned to target a variety of populations to transition, including individuals age 65 or older and individuals with physical disabilities, developmental or intellectual disabilities, or mental illness. About half of the individuals the states planned to transition are age 65 or older, but most states planned to target three or more populations. For example, Maine planned to transition older adults; adults with physical disabilities; and persons with any complex combination of medical, behavioral, and cognitive impairment. (See table 2.)

Table 2: Projected Number and Percentage of Transitions by Target Population for the Money Follows the Person Programs in States Awarded Grants in 2011

	Projected number and percentage of transitions by targeted population (2011–2016)					
State	**Individuals age 65 or older[a]**	**Individuals with physical disabilities**	**Individuals with developmental or intellectual disabilities**	**Individuals with mental illness[b]**	**Other[c]**	**Total**
Colorado	158	210	72	45	5	**490**
Florida	--	--	--	--	--	**--**
Idaho	180	115	30			**325**
Maine	75	27			20	**122**
Massachusetts	1,358	510	142	182		**2192**
Minnesota	--	--	--	--	--	**--**
Mississippi	72	142	138	243		**595**
Nevada	256	256	12			**524**
New Mexico	295	287		70	18	**670**
Rhode Island	576	64				**640**
Tennessee	1,195	980	50			**2225**
Vermont	324	51				**375**
West Virginia	195	340		65		**600**
Total (percentage)	**4,684 (53.5)**	**2,982 (34.0)**	**444 (5.1)**	**605 (6.9)**	**43 (0.5)**	**8,758 (100)**

Source: CMS and state operational protocols.

Note: Dashes indicate that the state did not have an approved operational protocol, as of April 2012.

[a]Includes data for states that characterized the target population as "elderly," "older adults," "nursing home elders," or "elderly over age 65."

[b]Includes data for states that characterized the target population as individuals with severe mental illness.

[c]Other target populations include individuals with a dual diagnosis and individuals with a qualifying brain injury.

These 11 states with approved operational protocols planned to provide a broad range of Money Follows the Person demonstration services—program-specific services provided only to Money Follows the Person participants and not to other Medicaid beneficiaries—to help individuals

transition to home- and community-based settings.[33] For example, Nevada planned to offer transition navigation, community transition services, environmental accessibility adaptation, housing coordination, and personal emergency response systems. Idaho planned to provide community transition services and transition management services. (See appendix III for information on the demonstration and supplemental Money Follows the Person services that states planned to provide.)

While many states' operational protocols were approved in 2011, some had not planned to transition, or did not start transitioning, individuals to the community until 2012. During the original Money Follows the Person demonstration, it took longer than states had planned to build the necessary infrastructure for their programs, including establishing channels of coordination across state agencies, garnering community and provider support, and building data reporting and quality assurance systems. Additionally, transitioning individuals out of institutions was more complex than many states had anticipated, in part due to the scarcity of appropriate housing options and the complex needs of the population. According to CMS officials, 4 of the 13 states that had been awarded grants in 2011 had completed 215 transitions as of March 2012.[34]

In February 2012, CMS announced that it would award additional Money Follows the Person grants, open to the seven states that had not previously received a grant.[35] The agency issued two solicitations—one

[33]Under Money Follows the Person, each state is allowed to provide up to three categories of services: qualified HCBS, demonstration HCBS, and supplemental HCBS. Qualified HCBS are defined as services that the state covers, including through the state plan or through HCBS waivers, for all Medicaid beneficiaries, regardless of whether they participate in the Money Follows the Person program. Demonstration HCBS are services specific to Money Follows the Person, provided only to participants in the demonstration and not to other Medicaid beneficiaries, and are covered only during a participant's 12-month transition period. An example of demonstration HCBS are extra hours of personal care assistance beyond what is allowed under the state's plan. Qualified and demonstration services are reimbursed at the Money Follows the Person enhanced FMAP for the state. Supplemental HCBS services are services essential for successful transition to the community, are expected to be required only during the transition period or to be a one-time cost to the program, and are typically not Medicaid-covered services. Examples of supplemental HCBS include security deposits and household set-up costs. Supplemental HCBS are reimbursed at the state's regular FMAP.

[34]The four states are Idaho, Massachusetts, Mississippi, and Tennessee.

[35]The seven states are Alaska, Alabama, Arizona, Montana, South Dakota, Utah, and Wyoming.

for a planning grant, to help states prepare their grant application (including a draft operational protocol), and the other for the actual demonstration.[36] CMS officials reported that three states (Alabama, Montana, and South Dakota) of these seven had applied and been awarded planning grants.

CMS provides states with technical assistance for Money Follows the Person through an online technical assistance website.[37] The agency also provided guidance to states on the extension of the demonstration in a June 2010 State Medicaid Directors' Letter.[38]

States Have Begun to Apply for the Other Three PPACA Options

As of April 2012, states have begun to apply for the newly established Community First Choice, the Balancing Incentive Program and the revised 1915(i) option, and applications have been approved for the Balancing Incentive Program and 1915(i) options.

Community First Choice

As of April 2012—6 months after the option first became effective and before CMS had issued final program guidance—one state, California, has applied for Community First Choice. According to California's application, the state plans to provide services required under the statute related to assistance with ADLs, IADLs, and health-related tasks. California's application indicated that the state had proposed to transition eligible individuals from the state plan personal care benefit to the Community First Choice program. CMS officials told us that, at least initially, California planned to maintain its state plan personal care services program, which would allow individuals to receive personal care services if they decide not to receive such services under the Community First Choice option. As of April 2012, California's proposed state plan amendment had not been approved by CMS and thus could change as a result of the review process.

Besides California, other states have expressed interest in Community First Choice. According to CMS officials, as of April 2012, five additional states have requested technical assistance from CMS regarding the

[36]The solicitation for the actual Money Follows the Person program grants closes August 8, 2012.

[37]The Money Follows the Person technical assistance website is http://www.mfp-tac.com/.

[38]CMS, Letter to state Medicaid directors, SMDL #10-012, June 2010.

Community First Choice option. States have asked CMS questions pertaining to program eligibility, data collection, and quality improvement requirements, among others. Additionally, some states have had questions about replacing their state plan personal care services benefit with Community First Choice. For example, Maryland is interested in consolidating personal care services available under three existing state Medicaid programs—the state plan personal care benefit and two waiver programs—under Community First Choice.

CMS officials said that states may have been waiting for the final rule before applying for Community First Choice. CMS issued a proposed rule for Community First Choice in February 2011.[39] Although the Community First Choice option became effective on October 1, 2011, CMS only recently published a final rule implementing the program on May 7, 2012.[40] Since Community First Choice is a permanent Medicaid option for states, there is no deadline for states to apply for it.

Balancing Incentive Program

As of April 2012—6 months after the program first became effective and 16 months before the application deadline—two states had applied for and received CMS approval to participate in the Balancing Incentive Program. One of the states approved, New Hampshire, was awarded the full amount of enhanced matching funds it requested from CMS for the program—$26.5 million. The requested amount was based on total projected community-based LTSS expenditures of $1.32 billion from January 1, 2012, through September 30, 2015. In fiscal year 2009, New Hampshire spent 41.2 percent of its LTSS expenditures on HCBS, and the state expects to get to 50 percent by September 30, 2015. The state plans to use the Balancing Incentive Program funds to support the design and implementation of LTSS enhancements, help develop a community infrastructure across the state, and strengthen the community-based network of services across the continuum of care and populations in New Hampshire. Another state, Maryland, was awarded $106.34 million in enhanced matching funds for its Balancing Incentive Program, based on the state's total projected HCBS expenditures. Maryland plans to use the Balancing Incentive Program funds to further expand community capacity. Specifically, the state plans to use the funds to improve provider payment rates for personal care providers. As of April 2012, two additional states—

[39]Community First Choice Option, 76 Fed. Reg.10736 (Feb. 25, 2011).

[40]Medicaid Program; Community First Choice Option, 77 Fed. Reg. 26828 (May 7, 2012).

Georgia and Missouri—had also applied for grants under the program. Other states have expressed interest in the Balancing Incentive Program. According to CMS, a dozen additional states have requested technical assistance, in particular regarding CMS's expectations for the required LTSS structural changes. The Balancing Incentive Program became effective October 1, 2011, and states have until August 1, 2014, to apply or until the $3 billion in authorized funds have been expended, whichever is earlier. CMS has provided several types of guidance to states about the Balancing Incentive Program, including a letter to state Medicaid directors, an implementation manual, and a technical assistance website.[41]

1915(i) State Plan Option

As of April 2012—18 months after PPACA's changes to the option became effective—three states had submitted state plan amendments and received CMS approval to offer the revised 1915(i) state plan option. Under the approved amendments, the three states—Idaho, Oregon, and Louisiana—plan to target children with developmental disabilities or individuals with mental illness.

Idaho's 1915(i) program became effective in July 2011, and the state plans to add HCBS services for children with developmental disabilities. To be eligible, a child must require assistance due to substantial limitations in three or more major life care activities and have a need for interdisciplinary services because of a delay in developing age-appropriate skills. The state plans to serve approximately 3,200 individuals during the first year of its program.

Oregon's 1915(i) program will become effective in June 2012, and the state plans to provide home- and community-based habilitation services, as well as home- and community-based psychosocial rehabilitation services for individuals with chronic mental illness. Eligibility is limited to individuals who need assistance for at least 1 hour per day to perform two personal care services and who are not eligible for such services under the state's 1915(c) waiver.[42] Oregon plans to serve approximately 3,000

[41](1) CMS, Letter to state Medicaid directors, SMDL #11-010, September 2011; (2) Mission Analytics Group, *The Balancing Incentive Program: Implementation Manual,* prepared at the request of CMS (San Francisco, Calif., October 2011); and (3) the Balancing Incentive Program technical assistance website is http://www.balancingincentiveprogram.org/.

[42]Eligibility for services under Oregon's 1915(c) waiver is limited to aged and physically disabled individuals who meet a nursing home level of care.

individuals during the first year of its program (June 1, 2012, through May 31, 2013).

Louisiana's 1915(i) program became effective on March 1, 2012, and the state plans to provide psychosocial services to adults with mental illness, including adults with acute stabilization needs, serious mental illness, and major mental disorders. The state plans to limit the option to adults who exhibit at least a moderate level of risk of harm to self and others and moderate levels of need based on a standardized assessment tool. The state plans to provide such services under the 1915(i) option to a much higher number of individuals than either Idaho or Oregon—55,000 during the first year of its program.

In addition to the states with approved 1915(i) state plan amendments, four states—California, Connecticut, Florida, and North Carolina—currently have 1915(i) applications under review with CMS, according to officials. Proposals in California and Florida—which had not been approved by CMS, as of May 2012, and thus could change as a result of the review process—showed varying plans for targeted groups and services proposed, as the following examples illustrate.

- Florida proposed to provide various types of family therapy services to redirect troubled youth away from residential placements and into treatment options that will allow them to live at home. The state plans to serve 597 children in the first year.

- California has submitted two 1915(i) state plan amendments. The first proposes to target infants and toddlers with developmental delays and would provide a 1-day session with families to prepare the children for school or other appropriate facilities, which is currently funded with state-only funds. California anticipates serving 3,800 in the first year. The second proposes to target developmentally disabled individuals with a need for habilitation services. Services to be provided would include community living arrangement services, respite care, and day services. The state anticipates serving 42,000 in the first year.

The changes made by PPACA to section 1915(i) became effective October 1, 2010. CMS provided guidance to states about the changes in

an August 2010 letter to state Medicaid directors.[43] CMS published a proposed rule for the 1915(i) state plan option on May 3, 2012.[44]

States Are Factoring Potential Effect on State Budgets, Staff Availability, and Interaction with Existing Reform Efforts into Their Decisions

Medicaid officials in the states we selected for our study reported being attracted to the enhanced federal matching funds available under three of the PPACA options, but also expressed concern about the potential effect on budgets given continuing fiscal challenges at the state level. Further, Medicaid officials cited limited staff availability to research or implement these options. Officials were also considering broader Medicaid reforms occurring in the state and the potential interaction with existing HCBS.

States Are Attracted by Increased Funding but Concerned about Their Ability to Contribute State Share

Officials from the 10 states we contacted for our study reported they are considering the new HCBS options with an eye to how they might affect their state's budget. States, in general, continue to experience fiscal challenges, and the state officials we talked with noted that while they are attracted by the enhanced federal matching funds that come with Community First Choice and the Balancing Incentive Program especially, there were limits as to how much the state can contribute. Officials from 8 of the 10 states we selected reported that state budget considerations were either a general concern when evaluating any potential new HCBS option or a specific concern regarding Community First Choice or the Balancing Incentive Program. A state official in Mississippi noted that her first consideration of a new Medicaid option is how much the federal government is providing in funding and for how long. She said that she needs to determine what the cost will be to the state now, and if applicable, what the cost to the state would be once the enhanced federal matching rate ends. Regarding the Balancing Incentive Program, Nevada officials similarly reported that while the state is eligible for the 2 percent enhanced federal match, it does not have the money to build the

[43]CMS, Letter to state Medicaid directors, SMDL #10-015, August 2010.

[44]Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice, 77 Fed. Reg. 26362 (May 3, 2012).

infrastructure, quality assurance system, and financial tracking system called for by the program.

Although the enhanced federal matching rate in Community First Choice was attractive to several states, they also noted potential financial risk caused by the inability to limit the program's enrollment or utilization. Officials in half of the states we interviewed noted concerns about a potential inability to control expenditures in Community First Choice given the requirement that the option be offered statewide and the prohibition on state enrollment and utilization caps. Mississippi officials reported that their main problem with pursuing the option is the inability to limit potential state expenditures. Officials from the National Association of State Directors of Developmental Disabilities Services reported that the fact that there is no way for states to cap Community First Choice deters states from taking up the option. States wonder how to keep such a program within their budgets if they cannot limit either enrollment or utilization. In contrast, more than half of the state officials we interviewed found the 1915(i) state plan option attractive because of the ability to limit the provision of services to specific populations, thus providing the state with the opportunity to limit state financial exposure.

In considering the options that would provide the most federal funding possible, officials from a few states told us that when they initially looked at Community First Choice it was to replace existing state options that do not qualify for enhanced federal matching rates. Oregon officials noted that if they chose to use Community First Choice, which provides a 6 percent enhanced federal matching rate, it would be as a replacement for one of the state's existing 1915(c) waivers. Expenditures under 1915(c) waivers qualify for the standard federal matching rate. However, the state officials did not think that the Community First Choice option would allow them to cover all the services in their 1915(c) waiver, which would then require the state to cover these services with state-only funds or drop them altogether. Officials from Nevada similarly reported that they initially considered using Community First Choice as a replacement for the state's existing self-directed personal care state plan option.[45] While the

[45]Under section 1915(j) of the Social Security Act, states are given the choice of covering self-directed personal care services. The self-directed program must allow beneficiaries to express choice and control over the budget, planning, and purchase of their services. Other requirements include an assessment of the beneficiary's needs, the availability of a support system to counsel beneficiaries, a written service plan, an individualized budget, and appropriate quality assurance and risk management.

state has not ruled out taking up Community First Choice, the officials thought that the administrative requirements included in Community First Choice, specifically the requirements for backup systems and the establishment of a Development and Implementation Council to engage stakeholders,[46] as well as the additional reporting requirements, meant that Community First Choice would not be a cost-effective replacement for its existing self-directed personal care option.

Limited Staff Resources and Competing Priorities Pose Barriers to States' Pursuing New Options

According to state officials, staffing shortages in a number of states have made it difficult for states to review all the new HCBS options in depth or put together the teams needed to assemble applications and implement the options. Officials from New Mexico told us that they previously had a hiring freeze and have a current staff vacancy rate of about 9 percent. They said their current staff of 190 runs a $4 billion Medicaid program, which already included a personal care option, a Money Follows the Person program, and a managed care program for LTSS. The officials said that if they decided to pursue, for instance, the Community First Choice option, they would have to use these same staff to implement and oversee the program, including writing the state plan amendment, obtaining public input, and shepherding the amendment through the CMS approval process. According to the New Mexico officials, the current staff already has too much work. Officials in Maine told us that the state recently offered retirement incentives to staff as a cost-saving measure. Under the retirement incentive policy, positions that are open because of the incentive cannot be filled for 2 years. The state is also under a hiring freeze. Officials from the National Association of Medicaid Directors reported that state Medicaid programs are running with a fraction of their prior staff. Given this, officials from the association said states may not even have enough staff to put together an application.

State officials also reported that the time involved in making other changes to their state Medicaid programs as a result of PPACA has prevented their staff from doing in-depth research on the new HCBS options. Officials from two states specifically said they had not had

[46]PPACA requires that states using Community First Choice consult and collaborate with a Development and Implementation Council during development and implementation. The Development and Implementation Council, which will provide stakeholder input, must include a majority of members with disabilities, elderly individuals, and their representatives.

enough time to research the opportunities in full as a result of their other work. Nevada officials, for instance, noted that staff is working on developing the Health Home state plan option in PPACA, which allows states to provide for care coordination for persons with chronic conditions or serious mental illness, and is making other PPACA-required changes to its Medicaid program.[47] The officials reported prioritizing all the state requirements in PPACA and said the Balancing Incentive Program keeps dropping down the list. Similarly, officials in Montana said the HCBS options were a lot to consider at the same time states are facing many other changes as a result of PPACA, including accommodating a large number of new individuals expected to become eligible for Medicaid.[48] National Association of Medicaid Directors officials reported that PPACA contained both state mandates and options and that therefore states needed to triage where they invest staff resources. They also noted that they would expect states to invest resources in mandated changes rather than the optional changes, such as the new HCBS options.

Planned Changes to State Medicaid Programs and Potential Interaction of Options with Existing HCBS Programs Factor into States' Decisions

Officials in several of the states we interviewed reported putting off decisions about the HCBS options in PPACA until they completed major reforms to their Medicaid programs. Four of the 10 states we contacted reported being in the midst of or planning for broad Medicaid reforms. This situation is consistent with national trends. One national survey of states found that 11 were planning to implement a managed care system for long-term services and supports in either 2012 or 2013.[49] New Jersey, for example, was in the midst of planning for the transition of its Medicaid program, including LTSS, to managed care. Under the proposal submitted to CMS, managed care organizations would take over responsibility for care, including HCBS and nursing home care, for individuals who are enrolled in one of several of the state's HCBS waivers, who require a nursing home-level of care, or who reside in a

[47]PPACA created an optional Medicaid state plan option for states to establish Health Homes to coordinate care for individuals with chronic conditions or serious mental illness. PPACA's Health Home state plan option provides states with an enhanced federal matching rate of 90 percent for the first eight quarters that the state plan option is in place.

[48]PPACA mandated that states expand Medicaid eligibility to all individuals with income under 133 percent of the federal poverty level beginning in 2014.

[49]M. Cheek, M. Roherty, L. Finnan, et al, *On the Verge: The Transformation of Long-Term Services and Supports* (Washington, D.C.: AARP Public Policy Institute, February 2012).

nursing home. The managed care organizations would be required to develop and implement an annual person-centered plan of care and individual service agreement for each individual requiring LTSS and would have authority to place an individual in the most cost-effective setting, whether a home- or community-based setting or a nursing home.[50] The managed care organization, however, would also be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. At the time we spoke with New Jersey officials, the state was awaiting CMS's decision on the proposal. Given the planned transition of LTSS to managed care, the New Jersey officials did not think applying for the 1915(i) option at this time made sense, and their decision on whether to apply for Community First Choice would depend on how their managed care system looked if approved by CMS. Similarly, Florida was also moving to statewide Medicaid managed care. Officials in the state told us that they had not explored the Balancing Incentive Program or Community First Choice because the state Medicaid agency's primary focus has been on the transition to statewide managed care and the time and resources they have devoted to the transition have prevented them from exploring the new HCBS options.

States also factored in how easily the new HCBS options would fit in with their existing HCBS programs, according to state officials. States that decided to take up some of the new HCBS options reported doing so because they complemented existing HCBS options. Four of the five states we interviewed that received the Money Follows the Person grant following the initial post-PPACA solicitation told us the state had an existing transition program to move individuals from institutions into the community.[51] Each of these states told us that Money Follows the Person

[50]Under New Jersey's proposal, the plan of care would analyze and describe the medical, social, behavioral, and long-term services that the member would receive. In developing the plan of care and the individual service agreement, the managed care organization would consider appropriate options for the individual related to his or her medical, behavioral health, psychosocial, and case-specific needs at a specific point in time, as well as goals for longer-term strategic planning.

[51]Among the original 30 grantees, those with an existing transition infrastructure to build upon at the start of the program generally made the most progress through the end of 2010. See C. Irvin, D. Lipson, A. Wenzlow, S. Simon, A. Bohl, M. Hodges, and J. Schurrer, *Money Follows the Person 2010 Annual Evaluation Report*, Final report submitted to the Centers for Medicare & Medicaid Services, Mathematica Policy Research, Inc. (Cambridge, Mass.: Oct. 7, 2011).

would be a supplement to their existing programs and would provide the state with additional federal funds.[52] Officials from Nevada, for example, told us that while the state had an existing state-funded community transition program, they thought the Money Follows the Person program would give the state the opportunity to target more difficult populations that could still benefit from community placement. The state plans to use the Money Follows the Person rebalancing fund to integrate the state's various HCBS case management systems and expand outreach. Similarly, New Jersey state officials told us they planned to apply for the Balancing Incentive Program because it fit in well with the state's existing efforts to rebalance LTSS funding toward HCBS. The state officials told us that, in part, the state's move to a managed care model reflects an effort to increase the availability of HCBS in the state. Because the managed care organizations assume financial risk, the state officials believed the organizations would have an incentive to increase HCBS placements, which are generally less costly than institutional placements.

State officials said one reason states were interested in taking up the 1915(i) state plan option is that it offers the opportunity to provide services to people who could not necessarily be served under other HCBS options. Officials in both Oregon and Montana said they were looking at the 1915(i) state plan option to provide a set of services for adults with serious mental illness or children with serious emotional disorders who cannot be targeted under a 1915(c) waiver either because of its cost neutrality requirement or because the individuals do not meet an institutional level of care.[53]

[52]Three of the five states that received Money Follows the Person grants post-PPACA told us that PPACA's reduction of the residency requirement for persons in institutions from 180 days to 90 days made Money Follows the Person more attractive to the state. The other two states said it was not a factor in their decision to apply for the post-PPACA Money Follows the Person grants.

[53]Under 1915(c) waivers, states must show that the average Medicaid expenditures for services provided under a waiver are equal to or less than the average for the same population to be served in an institution. Medicaid does not provide federal payment for services provided to individuals older than 21 years and younger than 65 years in an institution for mental disease. Therefore, for individuals currently receiving services in institutions for mental disease, it is impossible to show that Medicaid expenditures for services provided to such individuals in the community would be less than the Medicaid expenditures for services for such individuals in an institution for mental disease.

While the selected states were more likely to find the new HCBS options attractive if they complemented existing options or offered the opportunity to serve new populations, state officials also noted the complexity of layering new HCBS options on top of their state's existing HCBS system. Nevada officials told us that each waiver and each program the state operates is its own silo, with each requiring its own reporting structure, provider enrollment system, and quality assurance system. As such, the Nevada officials told us that they were already reporting to CMS on four 1915(c) waivers, the personal care state plan option, and a 1915(i) state plan option. Each of those, according to the Nevada officials, came with its own set of requirements. Mississippi officials said that, when looking at how the four PPACA HCBS options relate to each other, as well as to existing HCBS options, it becomes hard not only for state staff, but also for providers and beneficiaries, to work out the differences in all the different programs. They said they would like CMS to send out guidance about how states could use these different options together, instead of issuing guidance on each option separately.

CMS officials told us they have recently undertaken a number of initiatives to help states coordinate and align the different Medicaid HCBS options. While the CMS officials noted a number of efforts to align the options, they also noted a natural trade-off between giving states maximum flexibility and simplifying the number of different HCBS options available to states. In February 2011, CMS established Medicaid State Technical Assistance Teams (MSTAT), which consist of CMS staff with knowledge of Medicaid financing, eligibility, coverage, waivers, and state-specific issues.[54] The teams work with individual states to assist in any area a state has identified or to help states identify specific program areas that may yield efficiencies. According to CMS, as of April 2012, 27 states have used MSTATs, and a majority of those have included at least some discussion of the various HCBS options. In addition to the MSTATs, CMS officials told us they offer technical assistance to states in several areas. For example, there is a specific technical assistance provider that can help states build quality measurement into their systems that can work across the different options. CMS staff also has presented information during all-state conference calls and at an annual HCBS conference to help states learn about the different options and how they can work

[54]The goal of the teams is to partner with states to ensure that states have the information allowing them to take full advantage of existing Medicaid opportunities and are structuring new program innovations to maximize resources.

together. CMS recently formed a work group consisting of representatives from the National Association of Medicaid Directors, the National Association of States United for Aging and Disabilities, and the National Association of State Directors of Developmental Disabilities Services, as well as officials from 10 states, including 14 HCBS waiver administrators, to focus in part on developing quality in a systems approach as opposed to within individual 1915(c) waivers. In addition, in April 2012, HHS announced the establishment of a new agency—the Administration for Community Living—which will combine the efforts of several HHS agencies for the purpose of enhancing and strengthening HHS's efforts to support seniors and people with disabilities and ensuring consistency and coordination in community living policy across the federal government.[55]

Concluding Observations

In the 13 years since the *Olmstead* decision, states have continued to make progress rebalancing their LTSS systems toward more HCBS, increasing opportunities for individuals who need LTSS to live more independent lives in the community. The four Medicaid HCBS options established or revised by PPACA add to the array of options states have to consider in designing their coverage of services for beneficiaries. Some states that are further along in rebalancing their provision of LTSS may have less need to utilize these new options. Other states have further to go in determining whether and how to incorporate these options into their existing programs and have many factors to weigh, including their state budgets and the coverage and flexibility the options provide to reach their rebalancing goals. The complexities of the Medicaid HCBS options available and the changing factors affecting states' planning underscore the importance of ongoing federal technical assistance to help states navigate various HCBS options as they seek to ensure appropriate availability of HCBS.

Agency Comments

We provided a draft of this report to HHS for review. HHS had no general comments on the report but provided technical comments, which we incorporated as appropriate.

[55]The Administration for Community Living will include the efforts of HHS's Administration on Aging, Office of Disability, and Administration on Developmental Disabilities.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

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Director, Health Care

Appendix I: Medicaid Options for Home- and Community-Based Services in the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) created two new options—Community First Choice and the Balancing Incentive Program—and amended two existing options—1915(i) state plan option and Money Follows the Person—for states to cover home- and community-based services (HCBS) for Medicaid beneficiaries. Table 3 summarizes components of the four options.

Table 3: Summary of Selected Components of Medicaid HCBS Options Authorized or Amended in the Patient Protection and Affordable Care Act (PPACA)

	Community First Choice	Balancing Incentive Program	1915(i)[a]	Money Follows the Person
Summary of PPACA provision	Created new state plan option to provide home- and community-based attendant services and other services.	Created time-limited program providing enhanced federal matching funds for states that have spent less than 50 percent of long-term services and supports (LTSS) dollars on home- and community-based services (HCBS). A state must undertake three structural changes to its LTSS system to increase access to HCBS: (1) establish a "no wrong door/single-entry point" system to enable consumers to access LTSS, (2) implement conflict-free case management services,[b] and (3) develop a core standardized assessment instrument.	Revised existing 1915(i) state plan option by (1) expanding scope of covered services; (2) allowing states to offer different packages of services to different populations; (3) expanding income eligibility for certain populations; and (4) eliminating states' ability to cap enrollment and limit services to certain geographic areas. Also granted states the option of extending Medicaid eligibility to those that qualify for services under the state's 1915(i) option.	Extended existing demonstration program through 2016 and appropriated additional funding. Also reduced minimum stay requirement for individuals to be eligible from 6 months to 90 days in an inpatient facility.
Status of option as of May 2012	Option became effective Oct. 1, 2011. Proposed rule issued Feb. 25, 2011; final rule issued May 7, 2012.	Option became effective Oct. 1, 2011. Application available Sept. 2011; application closes Aug. 2014.	Revised option became effective Oct. 1, 2010. State Medicaid Directors' letter explaining changes issued Aug. 2010. Proposed rule issued May 3, 2012.	Revised option became effective April 22, 2010. Grant awards were made in February 2011. Solicitation for another round of grants issued Feb. 2012; application closes Aug. 2012.
Duration	Permanent	Expires Sept. 30, 2015.	Permanent[c]	Expires Sept. 30, 2016.[d]
Funding limit	None	$3 billion through Sept. 30, 2015.	None	$2.25 billion for fiscal years 2012-2016.

	Community First Choice	Balancing Incentive Program	1915(i)[a]	Money Follows the Person
Enhanced federal medical assistance percentage (FMAP)[e]	6 percentage point increase in FMAP. Applied to expenditures related to option.	5 percentage point increase in FMAP for states that have spent less than 25 percent of LTSS expenditures for HCBS. 2 percentage point increase in FMAP for states that have spent between 25 and 50 percent of LTSS expenditures for HCBS. Applied to expenditures for personal care, home health, and other HCBS authorized under certain state plan benefits and waivers. Funds from enhanced FMAP must be used to provide new or expanded offerings of HCBS.	None	A percentage point increase equal to (100 - current FMAP)/2, up to a maximum FMAP of 90 percent. Applied to HCBS expenditures for up to 12 months after an individual has transitioned from an institution to the community.
Individual eligibility	Individuals eligible for Medicaid, who in the absence of HCBS would require an institutional level of care, and who have income that does not exceed 150 percent of the federal poverty level (FPL), or if greater, are eligible for nursing facility services under the state plan.	Not applicable.[f]	Individuals eligible for Medicaid whose income does not exceed 150 percent of the FPL, without regard to their need for an institutional level of care, but who also meet the state's need-based criteria for the option, which must be less stringent than the state's criteria for institutional care. States may also elect to serve individuals eligible for certain waiver programs with incomes up to 300 percent of the Supplemental Security Income (SSI) benefit rate.[g]	Individuals who have resided in an inpatient facility for at least 90 days; are receiving Medicaid benefits for inpatient services provided at the facility; and who reside in a qualified residence beginning on the initial date of participation in the demonstration.
State eligibility	All states are eligible to apply.	States that spent less than 50 percent of their Medicaid LTSS expenditures for HCBS in 2009 are eligible. Data published by the Centers for Medicare & Medicaid Services (CMS) indicate that 38 states are eligible.	All states are eligible to apply.	States that did not previously receive a Money Follows the Person grant are eligible.

	Community First Choice	Balancing Incentive Program	1915(i)[a]	Money Follows the Person
Covered services or services eligible for enhanced FMAP	Covered services include personal care attendant services to help individuals accomplish ADLs, IADLs; back-up systems to ensure continuity of services or supports in the event that providers are not available; training for individuals on how to select, manage, and dismiss their attendants. States can also choose to cover transition costs, such as rent and utility deposits.	Certain HCBS covered under the state plan and waivers are eligible for the enhanced FMAP.	Covered services include case management, homemaker/home health aide, personal care services, adult day health services habilitation, and respite care. In addition, for persons with chronic mental illness: day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services. Further, PPACA allowed states to request approval from CMS to provide services not expressly identified in the law.	Covered services include (1) qualified services—any HCBS available to beneficiaries under state plan or waiver authority; (2) demonstration services—program-specific services provided only to Money Follows the Person participants and not to other Medicaid beneficiaries; and (3) supplemental services—services essential for successful transition to the community, typically not covered by Medicaid. Enhanced FMAP available for qualified and demonstration services provided to Money Follows the Person-eligible individuals.
Maintenance of effort or eligibility	For the first full 12-month period that the option is in effect, state must maintain or exceed expenditures for personal care services for the preceding 12-month period.	Standards, methodologies, and procedures for determining eligibility for HCBS may not be more restrictive than those in effect Dec. 31, 2010.	Not applicable.	State expenditures for HCBS in each year of a Money Follows the Person demonstration project must not be less than the greater of such expenditures for fiscal year 2005 or for the fiscal year preceding the first year of the demonstration project.

	Community First Choice	Balancing Incentive Program	1915(i)[a]	Money Follows the Person
Evaluation component or data reporting requirements	The Secretary of Health and Human Services (HHS) must conduct an evaluation to determine (1) the effectiveness of the provision of services in allowing individuals to lead independent lives, (2) the impact of the services on individuals' physical and emotional health, and (3) the cost of services provided under the option compared with the cost of institutional care. HHS is required to submit an interim report to Congress on its findings by Dec. 31, 2013, and a final report by Dec. 31, 2015.	States are required to inform CMS of their processes for collecting data on services, quality, and outcomes.	The proposed rule would require states to submit annually a projection of the number of individuals to be enrolled in the benefit and the actual number enrolled in the benefit in the previous year. The proposed rule also requires states to have a quality improvement strategy that can be provided to CMS upon request. For states that target populations, CMS proposes to require states to submit, with their renewal application every 5 years, HCBS quality outcomes and performance requirements detailed in the state plan amendment.	National evaluation of the demonstration extended through 2016.

Source: GAO summary of relevant provisions of the Patient Protection and Affordable Care Act and CMS documents.

[a]CMS issued a proposed rule to implement the revised section 1915(i) state plan option on May 3, 2012. 77 Fed. Reg. 26362 (May 3, 2012). Our description of the revised section 1915(i) option is based on our review of the statute and proposed rule.

[b]Conflict-free case management services means that the persons or entities responsible for conducting the evaluation, assessing the individual, and developing the individual's service plan are independent of the individual and are not providers of services for the individual.

[c]Individual state plan options are effective for 5-year periods in states that target services to specific populations.

[d]Funds are appropriated through Sept. 30, 2016 but may remain available for expenditure by state grantees until Sept. 30, 2020.

[e]The federal medical assistance percentage (FMAP) is the federal share of Medicaid expenditures. The rate is based in part on each state's per capita income, according to a formula established by law, and typically ranges from 50-83 percent.

[f]Section 10202 of PPACA, which establishes the Balancing Incentive Program, provides, at state option, an election to increase eligibility for HCBS under a 1915(i) state plan amendment to individuals with incomes up to 300 percent of the SSI benefit rate. It is CMS's position that this provision is duplicative of PPACA's expanded 1915(i) option, which similarly allows states to provide HCBS under a 1915(i) state plan amendment to individuals with incomes up to 300 percent of the SSI benefit rate, provided they are eligible for HCBS under a waiver.

[g]SSI is a means-tested income assistance program that provides cash benefits to individuals who meet certain disability criteria and have low levels of income and assets.

Appendix II: Description of Money Follows the Person Evaluation Findings

In 2005, Money Follows the Person was established as a demonstration grant program to support states' transition of eligible individuals who want to move from institutional settings—such as nursing homes or intermediate care facilities for the intellectually disabled—back to their homes or the community. The Centers for Medicare & Medicaid Services (CMS) awarded Money Follows the Person grants to 30 states and the District of Columbia as part of the original round of funding in 2007.[1] The Patient Protection and Affordable Care Act extended the demonstration through 2016 and provided additional funding to support the original Money Follows the Person state grantees and to award grants to additional states. While these newer grantees are just beginning to implement their Money Follows the Person programs, the national evaluation contractor has released results from the original round of grantees.

According to CMS officials, results from the Money Follows the Person evaluation show that since the program's inception in 2007, participating states had transitioned over 20,000 individuals to the community as of December 31, 2011. Some states were initially slow to transition individuals to the community through the Money Follows the Person program because they encountered problems or delays in meeting federal planning and data reporting requirements and challenges identifying affordable and accessible housing.[2] States that had prior experience transitioning individuals to the community through existing transition programs generally were able to complete more transitions than states without such programs, in part due to availability of staff with transition experience.[3] Over time, the number of transitions per year has been steadily increasing, with cumulative transitions totaling nearly 1,500 in 2008, 5,700 in 2009, and 12,000 in 2010.

[1]South Carolina was an original grantee but has not yet started its Money Follows the Person program. Therefore, we refer to 30 original grantees hereafter.

[2]N. Denny-Brown, and D. Lipson, "Early Implementation Experiences of State MFP Programs," The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program, Reports from the Field, no. 3, Mathematica Policy Research, Inc. (Cambridge, Mass.: November 2009).

[3]See C. Irvin, D. Lipson, A. Wenzlow, S. Simon, A. Bohl, M. Hodges, and J. Schurrer, *Money Follows the Person 2010 Annual Evaluation Report*, final report submitted to the Centers for Medicare & Medicaid Services, Mathematica Policy Research, Inc. (Cambridge, Mass.: Oct. 7, 2011).

The original 30 grantees used the Money Follows the Person program to transition different kinds of institutional residents. Approximately 37 percent of individuals transitioned through June 2011 were under age 65 and had physical disabilities, 34 percent were elderly, 25 percent had intellectual disabilities, and the remainder had other characteristics or conditions that were unknown.[4] According to the national Money Follows the Person evaluation contractor, the percentage of total transitions by elderly individuals and individuals under age 65 with physical disabilities has been increasing since 2008, while the percentage of transitions by individuals with intellectual disabilities has decreased during the same time frame.[5] The evaluation contractor noted that many states had ongoing initiatives to move individuals with intellectual disabilities out of intermediate care facilities for the intellectually disabled at the start of the demonstration. Therefore, individuals with intellectual disabilities were some of the first to start transitioning. Since then, more individuals in the other target populations have begun transitioning.

The large majority of individuals who have transitioned to the community through the Money Follows the Person program remained in the community for at least 1 year after their transition. For individuals for whom, as of 2010, more than 1 year had passed since their transitions (4,746 participants), 85 percent remained in the community more than 1 year after their transition, 9 percent had been reinstitutionalized in a nursing home or other institutional setting for stays of 30 days or more, and 6 percent had died.[6] Those who did return to an institution tended to do so in the first 6 months, most likely in the first 3 months.

[4]See N. Denny-Brown, D. Lipson, M. Kehn, B. Orshan, and C. Stone Valenzano, *Money Follows the Person Demonstration: Overview of Grantee Progress*, January to June 2011, report submitted to the Centers for Medicare & Medicaid Services, Mathematica Policy Research, Inc. (Cambridge, Mass.: December 2011).

[5]See Irvin, Lipson, Wenzlow, Bohl, Hodges, and Schurrer, *2010 Annual Evaluation Report*, 10-11.

[6]See J. Schurrer, and A. Wenzlow, “A First Look at How MFP Participants Fare After Returning to the Community,” The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program, Reports from the Field, no. 7, Mathematica Policy Research, Inc. (Cambridge, Mass.: July 2011).

The annual per-person HCBS costs of Money Follow the Person participants were nearly $40,000 during the first year of community living.[7] Costs were generally the least for the elderly, about $20,000 per year, and the highest for those with intellectual disabilities, about $75,000 per year.[8] Across all populations, monthly HCBS costs were significantly higher during the first month after an individual's transition. Monthly expenditures during the first 30 days after the initial transition were, on average, more than 50 percent higher than those for the remainder of the year. Many of these costs include services specific to the transition—such as transition planning and coordination—which are only needed in the short term. The costs incurred after the first 30 days are more likely to reflect the costs associated with ongoing care needed for individuals to remain in the community for the long term. Overall, early evaluation results indicated that average annual spending on HCBS for Money Follows the Person program participants was about one-third lower than average annual Medicaid spending on institutional care for elderly individuals in nursing homes. The evaluation noted that further analyses, which take into account total health care costs, including hospitalizations and emergency room visits, would be needed before the cost-effectiveness of the program could be determined.[9]

[7]C. Irvin, A. Bohl, V. Peebles, and J. Bary, "Post-Institutional Services of MFP Participants: Use and Costs of Community Services and Supports," Reports from the Field, No. 9, Mathematica Policy Research, Inc. (Cambridge, Mass.: February 2012).

[8]See Irvin, Bohl, Peebles, and Bary, "Post-Institutional Services," 1.

[9]See Irvin, Lipson, Wenzlow, Bohl, Hodges, and Schurrer, *2010 Annual Evaluation Report*, 57.

Appendix III: Money Follows the Person Planned Demonstration and Supplemental Services in States Awarded Grants in 2011

Under the Money Follows the Person demonstration program, participating states can cover demonstration and supplemental home- and community-based services (HCBS), in addition to HCBS available to other beneficiaries under the state Medicaid plan or through waivers.[1] Demonstration HCBS are services specific to Money Follows the Person, provided only to participants in the demonstration and not to other Medicaid beneficiaries, and are covered only during a participant's 12-month transition period. Enhanced matching funds are available for demonstration HCBS. Supplemental HCBS are services essential for successful transition to the community, are expected to be required only during the transition period or to be a one-time cost to the program, and are typically not Medicaid-covered services. Supplemental HCBS are reimbursed at the state's regular Medicaid matching rate. Table 4 provides information on the 13 states awarded Money Follows the Person grants in 2011, including the names of the demonstration programs and information on the demonstration and supplemental services that the states planned to provide.

[1]HCBS available to other beneficiaries under the state Medicaid plan or through waivers are referred to as qualified HCBS under the Money Follows the Person demonstration.

Table 4: Money Follows the Person Program Names and Planned Demonstration and Supplemental Services in States Awarded Grants in 2011

State	State name of demonstration program	Demonstration services	Supplemental services
Colorado	Colorado Choice Transitions	Assistive technology, behavioral health support, enhanced nursing services, family services, home delivered meals, extended home modifications, independent living skills training, intensive case management, transition mental health counseling, on-call attendant services, transitional substance abuse counseling, extended dental/vision, specialized day rehabilitation services	
Florida[a]	--	--	
Idaho	Idaho Home Choice	Transition management, community transition services	
Maine	Homeward Bound	Transition assistance, clinical assessments, independent living assistance, household start-up, enhanced care coordination, planning services, care coordination technology extension services, peer support	
Massachusetts	Money Follows the Person	Assistive technology, case management, mobility training, transitional assistance	
Minnesota[a]	--	--	
Mississippi	Money Follows the Person	Transportation, extended pharmacy, caregiver support, crisis supports, therapy services, life skills training, peer counseling/peer supports, transition care management, household furnishings and goods, moving expenses, environmental accessibility adaptations	
Nevada	Money Follows the Person	Transition navigation, community transition services, environmental accessibility adaptation, housing coordination, personal emergency response systems	
New Mexico	Money Follows the Person	Community transition services; case management; intensive case management	Enhanced comprehensive community support services (only for adults with mental illness)
Rhode Island	Rhode to Home	Community transition services provided by transition coordinators (for individuals age 65 or older)	
Tennessee	Money Follows the Person		Transition allowance
Vermont	Money Follows the Person	One-time transition payment	

State	State name of demonstration program	Demonstration services	Supplemental services
West Virginia	Take Me Home, West Virginia	Transition navigation, community transition services, extended direct care services, Take Me Home goods and services, cognitive rehabilitation therapy, case management, personal attendant services, transportation (for individuals with traumatic brain injury)	Supportive housing (for individuals with severe mental illness)

Source: Money Follows the Person state operational protocols.

[a]State did not have an approved operational protocol, as of April 2012.

Appendix IV: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Catina Bradley, Assistant Director; Lori Achman; Sandra C. George; Jawaria Gilani; Linda McIver; and Roseanne Price made key contributions to this report.