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Medicaid Home- and Community-Based Services Programs Enacted by the ACA:

Expanding Opportunities One Step at a Time

BACKGROUND PAPER NO. 86

CAROL V. O'SHAUGHNESSY, MA, *Principal Policy Analyst*

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OVERVIEW — *The Patient Protection and Affordable Care Act of 2010 (ACA) enacted the most significant opportunities for optional state expansion of Medicaid-financed home- and community-based services (HCBS) since 1981, when Congress enacted the section 1915(c) waiver program. Three of the ACA provisions, the Balancing Incentive Program (BIP), the Community First Choice (CFC) state plan option, and the health home state plan option, offer states enhanced federal Medicaid matching funds as long as they meet federal requirements. The ACA also expanded two HCBS programs established under the Deficit Reduction Act of 2005 (DRA) by extending the Money Follows the Person (MFP) Rebalancing program through 2016 and expanding the scope of services and eligibility under the section 1915(i) HCBS state plan option. Although state interest in implementing these programs has been fairly robust, some states have been concerned about their ability to contribute their share of matching funds and pressures on limited state staff to implement the programs. This background paper reviews the HCBS programs under the ACA, factors affecting state uptake, and future considerations for policymakers.*

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones, MA
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau, MA
Director, Publications and Online Communications

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Many in the long-term services and supports (LTSS) community have long championed wider access to home- and community-based services (HCBS) for people with LTSS needs under Medicaid. (For a description of HCBS, see box.) Advocates have pointed out that HCBS benefits are not on a level playing field with nursing home care which is a mandatory Medicaid state plan benefit for eligible beneficiaries. Under Medicaid law, people eligible under a state's Medicaid plan are entitled to nursing home care; that is, if a person meets the state's income and asset tests and level of care requirements for nursing home admission, he or she is entitled to the benefit.

For many years the entitlement to, and financing for, nursing home care has influenced state Medicaid policy and care options available to people with LTSS needs, as well as state LTSS spending. Institutional spending far outweighed HCBS spending for decades, but the proportion of Medicaid LTSS spending for institutional care and HCBS nationally approached a 50-50 ratio by 2011.[1] The increase in HCBS spending over the decades has been primarily due to use of the Medicaid section 1915(c) waiver program, enacted in 1981, which offers states the option to modify their spending patterns by allowing them to offer a wide range of HCBS for people who would otherwise qualify for Medicaid-financed institutional care. Prior to enactment of the waiver program, states were required to offer home health services to people who were eligible for care in a skilled nursing facility, and they had the option to offer personal care services that were prescribed by a physician.[2] The waiver program significantly expanded the scope of HCBS for many groups of beneficiaries who meet state-defined

The term HCBS refers to a wide range of supportive and health-related home and community services provided to individuals of all ages who have disabilities and need assistance to help them reside in their own homes and communities. Individuals may require assistance due to a functional, cognitive, mental, behavioral, or intellectual disability. Individuals with disabilities in need of assistance may include children, adolescents, working age adults, or the elderly. HCBS may refer to care management, homemaker/home health aide, personal care/attendant care, adult day health, habilitation, respite care, and/or family caregiver support, as well as other services for those needing assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or supervision due to a disability. ADLs include bathing, dressing, toileting, eating, and transferring from a bed to a chair; IADLs include shopping, preparing meals, transportation, and managing money.

institutional level of care criteria, including people age 65 or older; younger people with physical, cognitive or intellectual disabilities; people with HIV/AIDS; and medically fragile and/or technology-dependent children, among others.

Perhaps more importantly, section 1915(c) gives states authority to "waive" certain Medicaid requirements that would otherwise apply to state plan services, and thereby allows the state to maintain control of their HCBS budgets. Specifically, states may receive approval to waive requirements that services be offered to beneficiaries on a statewide basis and be available in the same amount, duration, and scope to all those eligible for Medicaid regardless of their eligibility category. (See box, next page, on selected differences between state plan services and section 1915(c) waiver services.) Therefore states can offer waiver services in selected geographic areas and to certain groups of beneficiaries as requested by the state and approved by the Centers for Medicare & Medicaid Services (CMS). In addition, states may use a more liberal financial eligibility standard to determine an individual's eligibility than is used for other state plan services. The HCBS waiver program has been extremely popular with states because they can tailor service programs to meet LTSS needs of various populations and provide services to individuals who would not otherwise meet the state's financial eligibility standards, while controlling participation and financing for services. Virtually all states have implemented multiple waiver programs; there are more than 300 programs nationwide, which provide opportunities for many people with LTSS needs to receive services in settings of their choice. About 1.4 million people nationwide received waiver services in 2009.[3]

Even so, the flexibility afforded to states under the waiver programs has resulted in constraints on the number of people who can receive care, as well as uneven access across and within states. Because states can limit the number of waiver slots, people who need HCBS may be placed on waiting lists. In 2012, 524,000 individuals were reported to be on waiting lists for waiver programs in all but nine states, with an average wait time for services across LTSS populations of 27 months.[4] Many advocates continue to push for more Medicaid HCBS coverage options and improvements in state LTSS infrastructures. The ACA addressed some of these concerns by creating new Medicaid state plan options for HCBS or amending optional authorities established by prior law. While these programs represent the most

significant expansions of Medicaid HCBS options since 1981, when the section 1915(c) waiver program was enacted, they are optional and states may decide whether to implement.

ACA MEDICAID HCBS OPTIONS

The ACA authorizes two time-limited grant programs that offer states an enhanced federal medical assistance percentage (FMAP) rate for qualified services to promote HCBS; it authorizes for the first time the Balancing Incentive Program (BIP), and extends the Money Follows the Person (MFP) Rebalancing program that was originally enacted by the Deficit Reduction Act of 2005 (DRA). The law also authorizes states to use their state plan authority to implement three permanent HCBS programs; it (i) created the section 1915(k)

Medicaid HCBS Provided Under a State Plan or a Section 1915(c) Waiver: Selected Key Differences

State Medicaid agencies provide HCBS in a number of ways. The two most common methods are through state plan services and HCBS waivers. HCBS state plan services include home health services and transportation to and from providers that states are required to provide for beneficiaries entitled to, and eligible for, nursing facility care. Optional state plan services include personal care and other services through programs included in the ACA. In addition to state plan services, states have the option to provide a wide array of HCBS under the section 1915(c) waiver authority, including homemaker/home health aide, personal care, adult day health, habilitation, respite care, and other services requested by the state and approved by CMS.

State plan services are subject to certain federal requirements: (i) they must be provided to beneficiaries throughout the state (*statewideness* requirement); and (ii) they must be available in the same amount, duration and scope to the various categorically eligible groups under a state plan (*comparability* requirement). States may not limit the number of people served and may not establish waiting lists for state plan services. CMS approval for state plan services is not limited to a specific time frame.

Section 1915(c) permits the Secretary of the U.S. Department of Health and Human Services (HHS) to waive certain Medicaid requirements that ordinarily apply to state plan services. Specifically, with HHS approval, (i) states may provide HCBS in only a portion of the state (waiving the statewideness requirement); and (ii) may offer services in different amounts, duration, and scope to beneficiaries enrolled in a waiver program than other beneficiaries eligible under state plans (waiving the comparability requirement). States are also allowed to use a more liberal financial eligibility standard than is used for eligibility for state plan services. States may limit the number of waiver slots, which has the effect of creating waiting lists for waiver programs. Also, waiver programs must meet a "cost neutrality" test; that is, the cost of HCBS waiver services cannot exceed the cost of institutional services for covered individuals absent the waiver. CMS approval for HCBS waiver services is tied to specific time frames.

Community First Choice (CFC) state plan option that offers states an enhanced FMAP rate for attendant care services; (ii) amended the section 1915(i) HCBS state plan option (originally enacted by the DRA) to expand eligibility and scope of services permitted and allow targeting of specific population groups; and (iii) created the health home state plan option that offers states a time-limited, enhanced FMAP rate for funds for care management and coordination of services for beneficiaries with chronic conditions. (See Appendix for selected characteristics of the section 1915(c) waiver program, the ACA state plan options, and the federal grant programs.)

Each of these programs has different requirements regarding services to be provided and eligibility groups served. The programs may be used in combination with one another to expand and leverage a state's HCBS programs for unserved or underserved groups, or may stand alone.

Balancing Incentive Program (BIP)

Some states have made progress in balancing their spending for HCBS and institutional care, but many have not. The BIP offers an opportunity to states whose Medicaid LTSS spending is considered unbalanced (that is, less than 50 percent of all Medicaid LTSS spending is devoted to HCBS) by providing $3 billion to temporarily increase federal funding. The increased funding is intended to help states expand access to HCBS for Medicaid beneficiaries and make structural changes in their LTSS infrastructures. States must use BIP funds to increase non-institutional services or access to services.

Enhanced FMAP — BIP offers states an enhanced FMAP rate for HCBS that the state provides under various Medicaid authorities. The level of the enhanced FMAP is tied to a state's level of Medicaid HCBS spending in fiscal year (FY) 2009.

- States that spent less than 25 percent of their FY 2009 Medicaid LTSS expenditures for HCBS qualify for a 5 percentage point increase in their regular FMAP rate. These states must reach a benchmark of 25 percent of LTSS spending on HCBS by September 30, 2015.
- States that spent less than 50 percent, but more than 25 percent, of their total FY 2009 Medicaid LTSS expenditures for HCBS qualify for a 2 percentage point increase in their FMAP rate. These states must reach a benchmark of 50 percent of LTSS spending on HCBS by September 30, 2015.[5]

According to CMS data, only 12 states and the District of Columbia spent 50 percent or more of their total LTSS Medicaid funds on HCBS in FY 2009 and therefore are ineligible for the BIP enhanced FMAP rate. Thirty-eight states spent less than 50 percent of spending on HCBS, including one state that spent less than 25 percent.[6] Of the 38 states eligible for the enhanced matching rate, 16 have CMS-approved BIP applications as of October 2013.[7]

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Medicaid HCBS programs that are eligible for an enhanced FMAP rate include: section 1915(c) waivers, home health state plan services, personal care state plan services, section 1915(i) HCBS state plan services, rehabilitative services for mental health and substance abuse, section 1915(k) CFC state plan services, services under the Program for All-Inclusive Care for the Elderly (PACE) program, health home state plan services, and HCBS under managed care arrangements, among others.[8]

Structural reforms — Approved BIP states must also make structural reforms to their LTSS infrastructures by (i) developing a statewide system for a "no wrong door" or "single entry point system" that provides consumers with information on service availability and how to apply for services, referral to services and supports available in the community, and financial and functional eligibility determinations; (ii) establishing conflict-free case management processes that ensure the independence of those performing assessments of individuals in need of care from those who develop and approve individual care plans; and (iii) developing a uniform standardized assessment instrument to determine a beneficiary's need for services and an individual service plan for use throughout the state. (States may develop different instruments tailored for different beneficiary populations.)

CMS has stipulated that states with an approved BIP application must have a work plan for implementation of the structural changes within 6 months from the date of their application submission, and the changes must be in effect by September 30, 2015.[9] CMS has produced a manual to guide states in making the structural changes, and it has established a technical assistance center to help states implement BIP programs.[10]

Funding under the BIP program became available October 1, 2011, and is available until September 30, 2015, or until the full $3 billion has been expended. Eligible states have until August 1, 2014, to apply

for funds.[11] As of September 2013, about $2 billion in BIP funding had been committed to state grantees.[12]

Money Follows the Person (MFP) Rebalancing Demonstration Program

The ACA extends the MFP program, originally created by the DRA in 2005, through FY 2016.[13] Its purpose is to provide time-limited federal demonstration funds to state grantees so that they can help Medicaid beneficiaries living in institutions transition to their own homes or other qualified residential settings of their choice. States receive grants to develop transition programs for beneficiaries and to develop initiatives that will improve their HCBS infrastructures. The MFP demonstration is now in its seventh year of operation. Since the original awards were made in 2007, CMS has released three additional MFP solicitations to allow more grantees to enter the program. Currently 44 states and the District of Columbia participate. CMS has awarded an ongoing evaluation contract to Mathematica Policy Research, which has produced more than 20 reports on the program.[14]

Since its inception, MFP grants have helped over 33,000 Medicaid beneficiaries transition from institutions to homes or other qualified community residences with appropriate supportive services.[15] In addition to the assistance of transition coordinators who help beneficiaries move from institutions, services frequently provided to participants are home-based services, such as home health aide, personal care, companion and homemaker services, and care in group- or shared-living arrangements or residential settings that provide 24-hour health and social services.[16]

The DRA provided $1.75 billion for the program from FY 2007 to FY 2011, and the ACA provides $2.25 billion for FY 2012 through FY 2016, bringing the total federal investment to $4 billion. The ACA stipulated that the demonstration will end in 2016; states are allowed to use any MFP funds remaining after FY 2016 until FY 2020.

MFP enhanced match — States with approved MFP programs receive an enhanced FMAP rate for MFP expenditures, which can be used to support the administration of the demonstration and implementation of broader infrastructure investments. These investments include initiatives such as: creating systems for performance improvement and quality assurance, developing housing initiatives, supporting staff

for key transition activities, improving the direct care workforce, and building "no wrong door" access to care systems.

The enhanced FMAP that each state receives is equal to its regular FMAP rate plus the number of percentage points that is 50 percent of the regular state share. Therefore, if a state's regular share is 50 percent (and the regular FMAP rate is 50 percent), the enhanced demonstration FMAP rate equals 50 percent plus one-half of 50 percent, for a total of 75 percent. If a state's regular share is 30 percent (and the regular FMAP rate is 70 percent), the enhanced demonstration FMAP rate equals 70 percent plus one-half of 30 percent, or 85 percent. In no case can the enhanced FMAP rate exceed 90 percent.

The link to an institutional level of care standard has been part of the waiver programs since 1981 and has been considered a barrier to HCBS for many people.

Section 1915(i) HCBS State Plan Option

The ACA modified the section 1915(i) HCBS state plan option that had been established by the DRA in 2005. This provision was a significant step forward in Medicaid LTSS policy because it established a pathway to HCBS without a beneficiary having to meet institutional level of care criteria, as is required under section 1915(c) waiver programs. The link to an institutional level of care standard has been part of the waiver programs since 1981 and has been considered a barrier to HCBS for many people who have care needs that are substantial but would not qualify as needing an institutional level of care. Rather, under section 1915(i) individuals must meet "needs-based" criteria that the law stipulates must be less restrictive than the state's institutional level of care criteria.[17] According to the CMS-proposed section 1915(i) regulations "[o]ne particular result of this distinction is that, through the section 1915(i) benefit, States have the ability to provide a full array of HCBS to adults with mental health and substance use disorders."[18] (Individuals with mental health and substance abuse disorders may not necessarily require the level of care required by an institution and therefore would be ineligible for section 1915(c) waiver programs.) The proposed rules also indicate that the benefit "creates an opportunity to provide HCBS to other individuals with significant needs who do not qualify for an institutional LOC [level of care], such as some individuals with Autism Spectrum Disorder, diabetes, acquired immune deficiency syndrome, or Alzheimer's disease. In many cases, without the provision of HCBS, these conditions may deteriorate to the point where the individuals become eligible for more costly facility-based care."[19]

Although the DRA provision broke the link to institutional level of care criteria, it contained a number of provisions that limited state implementation. For example, states were limited in the types of services that they could provide, in contrast to the section 1915(c) waiver programs that allow states to provide a wide range of state-defined services. Also, the DRA provision did not allow states to apply the more liberal financial eligibility standard allowed under the section 1915(c) waiver program that allows states to provide HCBS to people who have incomes up to 300 percent of the federal Supplemental Security Income (SSI) benefit level ($25,588 in 2013 for a one-person household), a provision unique to the section 1915(c) waiver program.[20] States likely did not view the DRA HCBS state plan option as an improvement to the HCBS options that were already available under the waiver program, and only a handful of states took up the program.[21] Some changes made by the ACA may engender more interest by states, such as:

Allowable services — The ACA expands the scope of allowable services, and states may now provide one or more services that are allowed under the section 1915(c) waiver (see Appendix).

Targeted benefits — The law allows states to provide a specific set of HCBS benefits to targeted population groups. For example, a state could target a benefit package to children under the age of 21 with an intellectual disability, a developmental disability, autism, or a behavioral health condition. According to the proposed CMS regulations, states may now establish more than one section 1915(i) benefit program, each fashioned for a specific population; may provide one set of benefits that targets multiple populations; and may offer different services to each of the defined target groups within the benefit.[22]

Option to provide HCBS to individuals eligible for waiver programs and to use more liberal income eligibility levels — In general, the ACA makes section 1915(i) services available to people whose income does not exceed 150 percent of the federal poverty level (FPL) ($17,235 in 2013 for a one-person household) who meet the state's needs-based criteria that are less than its institutional level of care criteria. But the ACA added new provisions allowing states to apply the more liberal income eligibility criteria that are used to determine eligibility for section 1915(c) waivers, that is, income up to 300 percent of the SSI federal benefit level. This more liberal income standard is available only to those individuals who are eligible, or who would be eligible, under an existing section 1915(c), (d), or (e) waiver or section 1115

waiver and who will receive section 1915(i) services.[23] (Individuals who would be eligible under section 1915(c) would be required to meet the state's institutional level of care criteria.)

Option to establish a new eligibility pathway for full Medicaid benefits to individuals receiving section 1915(i) services — The Act created an optional eligibility pathway that would make individuals eligible for section 1915(i) benefits, and not otherwise eligible for Medicaid, to receive full Medicaid benefits. According to the proposed regulations, for example, "an individual age 65 or older, who has chronic needs but not at an institutional level of care and has too much income and/or resources to qualify for Medical Assistance under a State's Medicaid plan, could be eligible for section 1915(i) services if he/she meets the needs-based criteria for the section 1915(i) benefit, has income up to 150 percent of the FPL and will receive section 1915(i) services. Under this group, States may also elect to cover individuals with income up to 300 percent of the SSI/FBR [federal benefit level] who would be eligible under an existing section 1915(c), (d), (e) waiver or section 1115 waiver and who will receive section 1915(i) services…. Individuals eligible for Medicaid under this group would eligible for full Medicaid benefits."[24]

Other characteristics of section 1915(i) — In some ways, the section 1915(i) benefit contains the flexibility of the section 1915(c) waiver program. Because states may choose to provide a wide range of services for certain targeted groups of individuals with LTSS needs, the benefit has the ability to serve people that waiver programs cannot. It also allows states to target the benefit and to offer benefits differing in type, amount, duration, or scope to specific populations. However, states must provide HCBS state plan services statewide, and they may not limit participation; in contrast, waiver programs are not required to be statewide and states may limit participation.[25] The statewideness requirement may affect a state's decision to elect the section 1915(i) option; unless they target populations and services packages carefully, states may not be prepared to finance services for an unknown number of eligible applicants throughout the state. Also, one researcher has pointed out that states which already have waiting lists for section 1915(c) waiver programs (for individuals who must meet the state's institutional level of care requirements) may be reluctant to establish a state program for people who have less intensive needs.[26]

Unlike other ACA HCBS options, states do not receive an enhanced FMAP rate under section 1915(i). As of October 2013, 13 states have elected this option, 9 of which have done so since enactment of the ACA.[27] There are a total of 15 approved section 1915(i) programs among 13 states.

Section 1915(k) Community First Choice (CFC) State Plan Option

The ACA added a new Medicaid state plan option, Community First Choice, allowing states to provide HCBS attendant services and supports to beneficiaries of all ages. Individuals who may receive HCBS under this option must be Medicaid eligible under an existing eligibility pathway that includes access to nursing facility services; or, if a beneficiary is eligible under an eligibility group that does not provide access to nursing facility services, the beneficiary must have income that is below 150 percent of the FPL. In both cases, the beneficiary must meet the state-defined level of care criteria required for institutional care.[28]

Unlike the section 1915(c) waiver program that allows states to choose from a wide array of services for groups of beneficiaries, the CFC program requires states to offer a specific set of services and allows them to offer others. Required CFC services are assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, and/or cueing; acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks; backup systems or mechanisms to ensure continuity of services and supports, such as personal emergency response systems; and voluntary training on how to select, manage, and dismiss attendants. States have the option to pay for expenses associated with helping a beneficiary transition from an institution and other services that increase his or her independence or substitute for human assistance.[29]

The CFC program stresses the notion that a person-centered planning process be used to develop a beneficiary's plan of care. Also, states may choose to implement services through an agency-provider model of care, where services and supports are provided by an entity chosen by the state Medicaid agency, or through a self-directed

model of care where beneficiaries recruit and hire their attendant care providers whom they supervise, manage, and pay.

Unlike the section 1915(c) waiver program, services must be provided on a statewide basis, and states are not allowed to limit or target participation. The final CMS regulations state that CFC services and supports must be provided in the most integrated setting appropriate to the individual's needs, without regard to the individual's age, type, or nature of disability, or the form of home and community-based attendant services that the individual requires to have an independent life.[30]

Under the ACA, states are to receive a 6 percentage point increase in their FMAP rate for CFC services. As of September 2013, two states have approved state plan amendments for CFC, California and Oregon, and several additional states are planning to implement.[31]

Health Home State Plan Option

The health home state plan option, though focused on covering beneficiaries with chronic conditions, is frequently grouped with the ACA HCBS options. Many beneficiaries with chronic conditions are at risk for needing HCBS. The option offers an opportunity for states to integrate and coordinate primary, acute, and behavioral health care (both mental health and substance use) and LTSS for beneficiaries of all ages who have chronic illnesses. Health homes are expected to integrate and coordinate primary and behavioral health care services and to provide linkages to HCBS for beneficiaries covered under the benefit.

Those eligible are Medicaid beneficiaries who have two or more chronic conditions; have one chronic condition and are at risk for a second; or have one serious and persistent mental health condition. Chronic conditions listed in the statute include a mental health condition, substance abuse disorder, asthma, diabetes, heart disease, or being overweight by having a body mass index (BMI) over 25. States may elect to provide health home services to those who have any of these conditions and may elect to target services to populations with higher numbers or greater severity of conditions. States may elect to include populations with conditions other than those stipulated in the statute, such as those with HIV/AIDS. The statute waives the Medicaid comparability requirement and thus allows states to offer

health home services in a different amount, duration, and scope than services to other populations not included under the health home benefit.[32]

Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services. An enhanced FMAP rate of 90 percent is available for health home services for the first eight quarters from the effective date of the state's plan amendment; thereafter, services are matched at the state's regular FMAP rate.

Health home services may be provided by a designated provider, a team of health care professionals operating with such a provider, or a health team that provides health home services. Providers that may qualify as a designated provider include physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state and approved by the Secretary of HHS. This list, therefore, is not an exhaustive list. States may include additional providers in this category, including other agencies that offer behavioral health services. Each designated provider must have systems in place to provide health home services and to satisfy certain health home qualification standards.

The team of health care professionals would include physicians as well as other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state and approved by the Secretary of HHS. (This, too, is not an exhaustive list.) These teams may operate in free-standing or virtual settings, or may be based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the state and approved by the Secretary.

CMS has stated that it expects the health home delivery model "will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual."[33]

States are not required to provide health home benefits on a statewide basis and may target particular geographic regions. As of September 2013, 12 states have received CMS approval to implement health homes, with several states having elected to provide multiple health home models.[34]

A 2012 report of the first year of six health home programs in four states (Missouri, New York, Oregon, and Rhode Island) found that states are focusing on beneficiaries with serious mental illness (SMI), substance abuse, and chronic physical conditions. New York and Oregon have chosen to combine all three populations in single, broadly focused program. Missouri and Rhode Island each have separate programs primarily for beneficiaries with SMI or with chronic physical conditions. The report found that integration of physical health, mental health, and nonclinical support services, while important to program success, is a challenge even in states with more experience with integration, perhaps because it represents a culture change for providers. Providers were concerned about who would incur costs and who would benefit from the return on investments; the inadequacy of data systems to meet provider needs; and the pace and effects of practice transformation. In all four states, the availability of the enhanced FMAP rate was cited as an important part of state motivation for implementation.[35] Evaluations by the Urban Institute and NORC are ongoing.

The ACA HCBS options are the most significant expansion of Medicaid HCBS in 30 years.

FACTORS AFFECTING STATE IMPLEMENTATION

The ACA HCBS options are the most significant expansion of Medicaid HCBS in 30 years, and a number of states are implementing one or more of them. The most popular option has been the MFP program and most states have had several years of experience with its implementation. For the remaining programs, some states have received CMS approval to implement, are in the planning stages, or in some cases are not moving forward. The ACA has provided states a number of rather flexible options for expanding their HCBS platforms, increasing the number of beneficiaries who can receive HCBS, and balancing their spending patterns for LTSS. Many states seem particularly interested in those options that offer enhanced FMAP. The ACA also offers new and expanded ways for states to meet goals of reducing or eliminating unnecessary institutionalization that are included in a state's Olmstead plan[36] or under the terms of a state's

Olmstead agreement with the Department of Justice.[37] Though the added flexibility and enhanced funding may be attractive to states, widespread implementation will take time and some states may face a number of barriers.

State Budget and Staffing Constraints

A number of reports indicate that some states are still feeling the effects of the recession and are experiencing a slow or uneven recovery that continues to affect staff capacity.[38] Thus, some states may have limited ability to implement the ACA options due to possible increases in service expenditures as a result of increased utilization. Staff shortages could impinge on a state's current ability to develop a strategy to incorporate the programs into its existing infrastructure and negotiate state plan amendments necessary for CMS approval. Also, some states may have limited state funds that would be needed to take advantage of the enhanced FMAP rates. A 2012 report by the U.S. Government Accountability Office (GAO) regarding ACA HCBS implementation found that states were concerned about their ability to contribute their regular matching share for expanded services, or to continue services once the period for enhanced FMAP rates ends. In addition, some states expressed caution about their ability to implement the new options that must be offered on a statewide basis, such as the section 1915(k) CFC and the section 1915(i) HCBS state plan options, uncertain of their ability to sustain their share of matching funds. Another barrier cited by GAO was states' inability to dedicate staff to manage the new options, such as infrastructure development, quality assurance, and financial tracking systems.[39] A 2013 report by the Kaiser Commission on Medicaid and the Uninsured also indicated that some states' HCBS programs are "waiting in line" for access to limited state information technology personnel who have responsibilities to implement other ACA provisions.[40]

Complexity in the Mix of HCBS Authorities

The various HCBS options generally have different service packages, eligibility requirements, and financing arrangements, which makes implementation complex. For example, while some of the HCBS options require a beneficiary to meet the same functional eligibility standard used for entry into an institution, the HCBS state plan option does not. The health home provision is targeted to people with

specific chronic conditions, but other options target people with functional needs who need the level of care provided in an institution. The section 1915(k) CFC state plan option requires a specific set of services, but other options do not. Some of the programs offer the incentive for enhanced FMAP rates, but others do not. States must choose among the various options and decide what strategies are best for integration into their preexisting HCBS infrastructure, and which additional groups of individuals to serve and services to provide. In addition, assigning beneficiaries who have similar and often overlapping functional needs into predetermined eligibility categories may be complex and difficult for case managers, who must determine what state HCBS option would best meet beneficiary needs.

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States must carefully assess the effect of each of these options, not only on service delivery and populations previously unserved or underserved, but also on their ability to continue financing the programs over future years. The section 1915(k) CFC and section 1915(i) HCBS state plan options must be provided statewide with no enrollment caps. Some of the programs have certain safeguards allowing states to control utilization and spending. For example, the section 1915(i) HCBS option allows states to target specific population groups and to constrict functional eligibility criteria if the projected number of beneficiaries exceeds estimates; the health home benefit allows states to target specific geographic areas. However, unless states have solid data on the potential number of people who may qualify, they could face financial shortfalls to continue the programs in future years. Also, those states in the process of initiating Medicaid managed LTSS systems will need to assess how the new options would be integrated into such systems, and they may want to assess the effect of managed care before taking up the new options.

Coordinating with ACA Provisions

Other factors that may affect HCBS implementation include the pressure states may be under to implement broader ACA changes to Medicaid eligibility and enrollment as well as state-administered health insurance exchanges, if they have chosen these options.[41] State exchange implementation has explicit deadlines. Once these deadlines are met, perhaps states will be able to dedicate staff to implement the ACA HCBS options. However, implementation of the broader Medicaid expansions will continue to roll out over a number

of years and will require dedicated state staff, potentially affecting states' capacity to further develop their HCBS programs.

Enhanced FMAP Sunset

Three of the ACA provisions carry an opportunity for time-limited enhanced FMAP rates for qualified services. States are not under any deadlines to implement any of the HCBS provisions. However, if they decide to implement BIP, its enhanced FMAP is available only until September 30, 2015, or until the full amount of funds available has been expended. Grant funds for the MFP program will end in 2016, even though unused funds may continue to be used until 2020. The health home state plan option has an enhanced FMAP for a two-year period. At the end of these periods, states may be faced with decisions of whether and how to continue the programs without the benefit of additional federal funds. Advocates for the programs are likely to propose continuation of the enhanced matching amounts to maintain the progress made in serving LTSS populations previously unserved or underserved. And when enhanced FMAP periods end, federal policymakers may be faced with decisions as to whether continuation of the enhancements is warranted.

LOOKING TO THE FUTURE

The Medicaid program touches many people with LTSS needs, through its mandatory coverage of state plan services such as physician, hospital, and nursing facility services. It also touches many people living in the community who would otherwise need institutional care through section 1915(c) waivers and other state plan services. However, for many years, advocates of LTSS expansion have indicated that HCBS should be on a level playing field with nursing home care, which is a mandatory Medicaid benefit for those who qualify. HCBS in its many forms, whether as a waiver or an optional state plan service, is not mandatory, the ACA expansions notwithstanding. Except for home health services, other HCBS are still a coverage choice that states must make. Beneficiaries who qualify for ACA state plan options, such as section 1915(i) HCBS or section 1915(k) CFC services, would be entitled to these services for the period that a state covers the state plan option and as long as individual continues to meet a state's eligibility requirements for the covered service. The ACA opens the door to new service opportunities for

unserved or underserved populations, and states have unique opportunities to enhance their HCBS programs by leveraging the various state options. Even so, states retain the authority whether and how to take up the options, control eligibility, and, within certain federal stipulations, define the scope of services. While championing the new opportunities, some advocates and practitioners may view these provisions as stepping stones toward a broader-based HCBS entitlement yet to come.

Beyond the issue of optional versus mandatory services, a number of analysts have pointed to the complexity of integrating the various HCBS options, from the myriad section 1915(c) waiver programs to the various state plan service options. As one analyst has pointed out, LTSS public policy has "developed through a collection of disparate program authorities…often designed in isolation from one another but implemented within LTSS delivery systems in conjunction with other programs having both complimentary and conflicting policies."[42] A policy option that has surfaced in the past is the possible integration of the various HCBS optional programs and the development of a standardized approach to serve people with multiple and overlapping LTSS needs that would eliminate fragmented programs and pathways to care. However, to date, how to operationalize service pathways that are more consumer friendly has not received a full discussion among policymakers and practitioners. The issue of integration and simplification was raised again by the congressional-mandated Commission on Long-Term Care when it recommended in its 2013 report that Congress "reduce Medicaid waiver complexity by streamlining the HCBS provisions of the Medicaid statute."[43] While integration may be more desirable than a stepping-stone approach to changing HCBS policy, some states may want to retain the flexibility inherent in the status quo.

With the aging of the population and greater demand for HCBS by people of all ages, some analysts and practitioners worry that state Medicaid programs will not be able to sustain their current commitments or develop new programs to meet growing needs. Moreover, those with moderate incomes and assets who do not meet stringent Medicaid eligibility criteria but are unable to meet their own LTSS needs will likely continue to rely on family caregivers. How to more adequately address the issues around LTSS financing and access will continue to be an issue for policymakers in coming years.

With the aging of the population and greater demand for HCBS by people of all ages, some worry that state Medicaid programs will not be able to sustain their current commitments or develop new programs to meet growing needs.

ENDNOTES

1. Steve Eiken *et al.*, "Medicaid Expenditures for Long Term Services and Supports in 2011," CMS and Truven Health Analytics, June 2013, www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Downloads/LTSS-Expenditure-Narr-2011.pdf.

2. Janet O'Keeffe *et al.*, "Understanding Medicaid Home and Community Services: A Primer, 2010 Edition," prepared for HHS, Office of the Assistant Secretary for Planning and Evaluation, October 29, 2010, http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm.

3. Terrence Ng *et al.*, "Medicaid Home and Community-Based Service Programs: 2009 Update," Kaiser Commission on Medicaid and the Uninsured, executive summary, December 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7720-06.pdf.

4. Pamela Doty, presenting on behalf of Terence Ng, "HCBS Waiver Wait Lists: National Estimates 2012," slides from presentation at the NAUSAD HCBS Waiver Conference, September 10, 2013, www.nasuad.org/documentation/HCBS_2013/Presentations/9.11%2010.00-11.15%20Roosevelt.pdf.

5. Centers for Medicare & Medicaid Services (CMS), "Patient Protection and Affordable Care Act, Section 10202, State Balancing Incentive Payments Program, Initial Announcement," www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/BIP-Application.pdf.

6. CMS, "Patient Protection and Affordable Care Act, Section 10202, State Balancing Incentive Payments Program, Initial Announcement," Attachment C.

7. CMS, "Balancing Incentive Program," www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html.

8. Balancing Incentive Program, "Which services are eligible for enhanced FMAP?" www.balancingincentiveprogram.org/resources/which-services-are-eligible-enhanced-fmap.

9. Cindy Mann, CMS, State Medicaid Director Letter #11-010, ACA#20, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/11-010.pdf.

10. Mission Analytics Group, "The Balancing Incentive Implementation Manual," prepared for CMS, February 2013, www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/BIP-Manual-.pdf; and Balancing Incentive Program, The Technical Assistance Center, www.balancingincentiveprogram.org/.

11. Balancing Incentive Program, www.balancingincentiveprogram.org/taxonomy/term/65.

12. CMS, "Balancing Incentive Program Intensive," slides from a presentation at the NASUAD HCBS Conference, September 9, 2013, www.nasuad.org/documentation/HCBS_2013/Presentations/2013_HCBS_Conference_BIP_Intensive_v4.pdf.

13. Carol V. O'Shaughnessy, "Money Follows the Person (MFP) Rebalancing Program: A Work in Progress," National Health Policy Forum, Background Paper No. 85, May 10, 2013, www.nhpf.org/library/details.cfm/2927.

14. Mathematica Policy Research, "Money Follows the Person: Expanding Options for Long-Term Care," www.mathematica-mpr.com/health/moneyfollowsperson.asp.

15. Susan R. Williams *et al*., "Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2012, Final Report," Mathematica Policy Research, July 30, 2013, www.mathematica-mpr.com/publications/pdfs/health/mfp_july-dec2012_progress.pdf.

16. Carol V. Irvin *et al*., "Money Follows the Person 2011: Annual Evaluation Report, Final Report," Mathematica Policy Research, October 31, 2012, www.mathematica-mpr.com/publications/PDFs/health/MFP_annual_report_2011.pdf.

17. The needs-based criteria may apply to individuals with incomes up to 150 percent of the federal poverty level who are otherwise eligible for Medicaid. The ACA extended eligibility to also include people who would otherwise be eligible for HCBS services under a section 1915(c), (d), or (e) waiver or under a section 1115 demonstration project, at state option.

18. CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule," *Federal Register*, 77, no. 86, (May 3, 2012), www.gpo.gov/fdsys/pkg/FR-2012-05-03/html/2012-10385.htm.

19. CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule."

20. For a discussion of financial eligibility standards for HCBS beneficiaries, see O'Keeffe *et al*., "Understanding Medicaid Home and Community Services: A Primer, 2010 Edition."

21. Diane Justice, "Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services," National Academy for State Health Policy, October 2010, www.nashp.org/publication/implementing-affordable-care-act-new-options-medicaid-home-and-community-based-services.

22. CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule."

23. CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule."

24. CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule."

25. See discussion in CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule."

26. Justice, "Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services."

27. E-mail communication with CMS staff, October 29, 2013.

28. CMS, "Medicaid Program; Community First Choice Option, Final Rule," *Federal Register*, 77, no. 88, May 7, 2012, www.medicarefind.com/searchdetails/ManualData/Attachments/2012-10294.pdf.

29. CMS, "Medicaid Program; Community First Choice Option, Final Rule."

30. CMS, "Medicaid Program; Community First Choice Option, Final Rule."

31. Suzie Bosstick, "CMS Health Reform Updates and Trends in LTSS," slides from the presentation at the National Health Policy Forum on September 27, 2013, www.nhpf.org/uploads/Handouts/Bosstick-slides_09-27-13.pdf.

32. Cindy Mann, CMS, "Health Homes for Enrollees with Chronic Conditions," State Medicaid Director Letter #10-024, ACA#12, November 16, 2010, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

33. CMS, "Health Homes for Enrollees with Chronic Conditions."

34. Bosstick, "CMS Health Reform Updates and Trends in LTSS."

35. Brenda C. Spillman, Barbara A. Ormond, and Elizabeth Richardson, "Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Final Annual Report – Base Year," prepared for the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services by the Urban Institute, December 6, 2012, http://aspe.hhs.gov/daltcp/reports/2012/HHOption.pdf.

36. On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (i) such services are appropriate; (ii) the affected persons do not oppose community-based treatment; and (iii) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity. See U.S. Department of Justice, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*," www.ada.gov/olmstead/q&a_olmstead.pdf.

37. For a listing of state *Olmstead* decrees, see Department of Justice, ADA Home Page, "Olmstead Cases by Circuit Court of Appeals," www.ada.gov/olmstead/olmstead_cases_list.htm#eleven.

38. Diane Scully *et al.*, "At the Crossroads: Providing Long-Term Services and Supports at a Time of High Demand and Fiscal Constraint," AARP Public Policy Institute, In Brief, IB 208, July 2013, www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/crossroads-ltss-in-brief-AARP-ppi-health.pdf.

39. U.S. Government Accountability Office, "Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services," GAO-12-649, June 2012, www.gao.gov/assets/600/591560.pdf.

40. MaryBeth Musumeci *et al*., "Key Issues in State Implementation of the New and Expanded Home and Community-Based Services Options Available Under the Affordable Care Act," September 2013, http://kff.org/medicaid/issue-brief/key-issues-in-state-implementation-of-the-new-and-expanded-home-and-community-based-services-options-available-under-the-affordable-care-act/.

41. Musumeci *et al*. "Key Issues in State Implementation of the New and Expanded Home and Community-Based Services Options Available Under the Affordable Care Act."

42. Justice, "Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services."

43. U.S. Senate, Commission on Long-Term Care, *Report to Congress*, September 18, 2013, www.ltccommission.senate.gov/Commission%20on%20Long-Term%20Care%20-%20Final%20Report%20-%209-18-13.pdf.

APPENDIX: Selected Characteristics of Six Medicaid Home- and Community-Based Service (HCBS) Programs Administered by the Centers for Medicare & Medicaid Services (CMS)

PROGRAM	SERVICES	POPULATIONS SERVED	STATEWIDENESS REQUIREMENT	ENHANCED FMAP [Federal Medical Assistance Percentages] PROVIDED
Section 1915(c) HCBS Waiver Program [Enacted 1981/Omnibus Budget Reconciliation Act (OBRA)]	States may provide case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care, and other services requested by the state and approved by CMS. Beneficiaries with chronic mental illness may also be offered day treatment or other partial hospitalization services, psycho-social rehabilitation and clinic services. States may limit the amount, duration, and scope of services offered. Cost neutrality is required; that is, the cost of HCBS waiver services cannot exceed the cost of institutional services for covered individuals absent the waiver.	Individuals of all ages who meet state-defined level of care criteria required for entry into an institution. States may target services by population group. States are allowed to limit the number of people served and may establish waiting lists for waiver programs.	States may limit the geographic areas where services are to be provided.	None.
Money Follows the Person (MFP) Rebalancing Demonstration Grant Program [Enacted 2005/amended in 2010/Patient Protection and Affordable Care Act (ACA)]	States may provide help to beneficiaries who wish to transition from an institution to home- and community-based settings. Services include help from transition coordinators and HCBS, such as home health aide, personal care, companion and homemaker services, and care in group (or shared) living arrangements, or residential settings that provide 24-hour health and social services.	Beneficiaries who reside (and have resided for a period of not less than 90 consecutive days) in an inpatient facility; are receiving Medicaid benefits for inpatient services; meet state-defined level of care criteria required for entry into an institution; and could be served in a HCBS setting.	States specify where MFP will operate, under the terms of a CMS-approved grant.	Enhanced FMAP is equal to the state's standard federal match plus the number of percentage points that is 50 percent of the regular state matching share. Up to $4 billion provided for the MFP demonstration which will end in 2016; states may use any MFP funds remaining after 2016 until 2020.

PROGRAM	SERVICES	POPULATIONS SERVED	STATEWIDENESS REQUIREMENT	ENHANCED FMAP [Federal Medical Assistance Percentages] PROVIDED
Balancing Incentive Program* (BIP) [Enacted 2010/ACA]	States may receive enhanced FMAP for a wide range of Medicaid HCBS to achieve greater balance in their Medicaid spending for long-term services and supports (LTSS) in the community. Services that are eligible for enhanced FMAP include: section 1915(c) waivers, 1915(i) state plan amendments, rehabilitative services for mental health and substance abuse, Community First Choice (CFC) state plan services, home health, personal care services, services provided under the Program for All-Inclusive Care for the Elderly (PACE) program, health home state plan amendments, and HCBS under managed care arrangements. States are required to make structural reforms to their LTSS infrastructures by (i) developing a statewide system for a "no wrong door" or "single entry point" system; (ii) establishing conflict-free case management processes; and (iii) developing a uniform statewide standardized assessment instrument to determine beneficiaries' need for services.	Beneficiaries of non-institutionally based LTSS.	Depends on HCBS programs to which BIP enhanced FMAP applies; for example, states may limit the geographic areas where section 1915(c) waiver services are available; states may not do so for state plan services, such as home health and personal care.	Enhanced FMAP applies to states in two different categories: • States that spent less than 25 percent of their FY 2009 Medicaid LTSS expenditures for HCBS qualify for a 5 percentage point increase in their FMAP. These states must reach a benchmark of 25 percent of Medicaid LTSS spending on HCBS by September 30, 2015. • States that spent less than 50 percent of their total FY 2009 Medicaid LTSS expenditures for HCBS qualify for a 2 percentage point increase in their FMAP. These states must reach a benchmark of 50 percent of Medicaid LTSS spending on HCBS by September 30, 2015.

PROGRAM	SERVICES	POPULATIONS SERVED	STATEWIDENESS REQUIREMENT	ENHANCED FMAP [Federal Medical Assistance Percentages] PROVIDED
Section 1915(i) HCBS State Plan Option† [Enacted 2005, the Deficit Reduction Act (DRA); amended 2010/ACA]	States may provide case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care, and other services requested by the state and approved by CMS. Beneficiaries with chronic mental illness may also be offered day treatment or other partial hospitalization services, psycho-social rehabilitation and clinic services. No requirement for cost neutrality.	Individuals must meet state-defined needs-based criteria, including risk factors, that are less stringent than criteria used for entry into an institution. Individuals are not required to meet institutional level of care criteria. States may target populations to be served based on age, disability, diagnosis, condition, or Medicaid eligibility group. Other populations at state option (see text). States are required to project the number of individuals expected to receive services. If the projection is exceeded, states are permitted to constrict their needs-based eligibility criteria. States may not limit the number of people served and may not establish waiting lists.	States are required to provide HCBS state plan services statewide.	None.

PROGRAM	SERVICES	POPULATIONS SERVED	STATEWIDENESS REQUIREMENT	ENHANCED FMAP [Federal Medical Assistance Percentages] PROVIDED
Section 1915(k) Community First Choice (CFC) State Plan Option‡ [Enacted 2010/ACA]	Community-based attendant services and supports. **Required Services:** States are required to provide assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, and/or cueing; acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks; backup systems or mechanisms to ensure continuity of services and supports, such as personal emergency response systems, and voluntary training on how to select, manage and dismiss attendants. **Permitted Services:** States may pay for expenses associated with helping a beneficiary transition from an institution, and other services that increase his/her independence or substitute for human assistance. No requirement for cost neutrality.	Beneficiaries who, absent CFC services, would otherwise meet the state-defined level of care criteria for entry into an institution. Services must be provided without regard to an individual's age, type or severity of disability, or the form of HCBS required to lead an independent life. States may not limit the number of people served and may not establish waiting lists.	States are required to provide CFC services statewide.	States receive a 6 percentage point increase in the state's FMAP for CFC services.

PROGRAM	SERVICES	POPULATIONS SERVED	STATEWIDENESS REQUIREMENT	ENHANCED FMAP [Federal Medical Assistance Percentages] PROVIDED
Health Home State Plan Option/Section 1945§ [Enacted 2010/ACA]	States may provide comprehensive care management, care coordination and health promotion, transitional care from inpatient to other settings, individual and family support, and referral to community and social support services. No requirement for cost neutrality.	Beneficiaries who have two or more chronic conditions; have one chronic condition and are at risk for a second; or have one serious and persistent mental health condition. Chronic conditions listed in the statute are a mental health condition, substance abuse disorder, asthma, diabetes, heart disease, or being overweight as evidenced by having a body mass index (BMI) over 25. Other chronic conditions may be approved by CMS. States may not establish waiting lists.	States may target by geographic area and are not required to provide health home services statewide.	Enhanced FMAP of 90 percent for a two-year period from the effective date of the state plan amendment. Up to 8 quarters of enhanced FMAP is available for each enrollee; after the first 8 quarters, states may claim their regular FMAP for health home services.

Note: Some HCBS Medicaid benefits are not presented in this table, including home health care and personal care services, and the Program of All-Inclusive Care for the Elderly (PACE).

* *For more information on BIP, see CMS, "Balancing Incentive Program,"* www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html.

† *For more information on the section 1915(i) state plan option, see proposed rules, CMS, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule," Federal Register, 77, no. 86, May 3, 2012,* www.gpo.gov/fdsys/pkg/FR-2012-05-03/html/2012-10385.htm.

‡ *CMS, "Medicaid Program; Community First Choice Option," final rule, Federal Register, 77, no 88, May 7, 2012,* www.medicarefind.com/searchdetails/ManualData/Attachments/2012-10294.pdf.

§ *For more information on health homes, see CMS, "Health Homes for Enrollees with Chronic Conditions," State Medicaid Director Letter 10-024, November 16, 2010,* http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.