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TO ADOPT OR NOT TO ADOPT:
FACTORS IMPACTING STATES' PURSUIT AND IMPLEMENTATION OF ACA'S
HOME AND COMMUNITY-BASED PROGRAMS

A Dissertation Presented
by
LISA KALIMON BEAUREGARD

Submitted to the Office of Graduate Studies,
University of Massachusetts Boston,
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2019

Public Policy Program

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IMPLEMENTATION OF ACA'S HOME AND COMMUNITY-BASED PROGRAMS

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By

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ABSTRACT

TO ADOPT OR NOT TO ADOPT: FACTORS IMPACTING STATES' PURSUIT AND IMPLEMENTATION OF ACA'S HOME AND COMMUNITY-BASED PROGRAMS

May 2019

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The Patient Protection and Affordable Care Act (ACA) sought to improve the United States' long-term services and supports (LTSS) system by expanding home and community-based services (HCBS). The ACA contained several optional Medicaid HCBS opportunities for states, including the Balancing Incentive Program, the 1915(k) Community First Choice personal care benefit, and the revised 1915(i) state plan benefit. This research examined these HCBS provisions to explain what factors determine whether states participate in the ACA's new HCBS programs and, after adoption, what factors facilitate or impede implementation of

these programs. To answer these questions, this study used a mixed methods research design. The quantitative portion of this research relied on several modeling approaches to identify the factors that affected states' decisions to adopt these policies. The qualitative research used case studies of three states to examine the state-level decision-making processes around adoption and then subsequent implementation of these policies.

This research has implications for federal officials interested in spurring states to achieve greater rebalancing of Medicaid LTSS toward home and community-based care, and state officials interested in pursuing new HCBS policy opportunities. In the quantitative results, more liberal political ideology, more 1915(c) waivers, and lower Medicaid LTSS spending on HCBS were key factors that increased the likelihood of state adoption of the ACA HCBS programs. The qualitative findings identified the important role that leaders within the state Medicaid agency or disability services agencies played in the policy adoption decisions. Consistent with the quantitative results, these leaders recognized that the three ACA policies would complement or substitute for existing HCBS policies and fill gaps in HCBS offerings. When implementing these policies, additional financial resources, frequent communication with the Centers for Medicare and Medicaid Services, and leveraging existing HCBS programs and infrastructure facilitated the implementation process. Barriers to implementation included aggressive timelines, insufficient staff, and limited engagement with external stakeholders.

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I would also not have been able to complete this dissertation without the unwavering support of my family. My parents instilled in me a commitment to education and helped me finish this degree by watching my children so I could focus on writing. Lastly, I would like to thank my husband and children. My husband, Dan, has been supportive of me during the last eight years while I completed my coursework and worked on this dissertation. He proofread chapter drafts and took on added responsibilities so I could complete my studies. My children provided the motivation for me to complete this research.

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LIST OF ABBREVIATIONS

ACA: Affordable Care Act

ADA: Americans for Democratic Action

ADLs: Activities of daily living

ADRC: Aging and Disability Resource Center

ARRA: American Recovery and Reinvestment Act of 2009

BIC: Bayesian information criteria

BIP: Balancing Incentive Program

CFC: Community First Choice

CMS: Centers for Medicare and Medicaid Services

CON: Certificate of need

DHMH: Department of Health and Mental Hygiene (Maryland)

DRA: Deficit Reduction Act

FTE: Full-time equivalent

FMAP: Federal Medical Assistance Percentage

FPL: Federal Poverty Level

GAO: Government Accountability Office

GDP: Gross Domestic Product

HCBS: Home and Community-Based Services

HHA: Home health agency

IADLs: Instrumental activities of daily living

ID/DD: Intellectually disabled/developmentally disabled

LTC: Long-term care

LTSS: long-term services and supports

MFP: Money Follows the Person

NASUAD: National Association of State Units on Aging and Disability

NF: Nursing facility

OBRA: Omnibus Budget Reconciliation Act of 1981

OR: Odds ratio

PRTF: Psychiatric Rehabilitation Treatment Facility

SAMSA: Substance Abuse and Mental Health Services Administration]

SCHIP: State Children's Health Insurance Program

SD: Standard deviation

SSI: Supplemental Security Income

SPA: State plan amendment

VA: Department of Veterans Affairs

VIF: variance inflation factor

CHAPTER 1

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) sought to improve the United States' long-term care (LTC) system by expanding home and community-based services (HCBS). The ACA contained several optional Medicaid HCBS opportunities for states, including the Balancing Incentive Program (BIP), the 1915(k) Community First Choice (CFC) personal care benefit, and the revised 1915(i) state plan benefit. This research will examine these HCBS provisions to explain: what factors determine whether states participate in the ACA's new HCBS opportunities and, after adoption, what factors facilitate or impede implementation of these programs. Among academics, policymakers, and the general public, most discussions about the ACA focus on states' decisions to adopt the Medicaid expansion and exchanges (Frakt & Carroll, 2012; Jacobs & Callaghan, 2013; Olson, 2015; National Conference of State Legislatures, 2017). Comparatively less attention has been paid to states' adoption decisions regarding the ACA's long-term services and supports (LTSS) provisions (for exceptions, see Government Accountability Office (GAO), 2012; Scully et al., 2013; Dorn et al., 2016). The factors shaping a state's position on the LTSS provisions may differ from the factors that influence a state's stance on these other aspects of the ACA. Several states challenging the individual mandate and Medicaid insurance expansion, such as

Louisiana, Mississippi, and Texas, have pursued the expanded Medicaid HCBS options. Therefore, an interesting puzzle exists as to the reasons various state opt in or out of these new HCBS policy opportunities.

Background: Long-Term Services and Supports in the United States

In the United States, an estimated 12 million individuals require long-term services and supports (Kaye, Harrington, & LaPlante, 2010; Commission on Long-Term Care, 2013). These individuals need help with at least one activity of daily living (ADL), such as bathing, dressing, eating, or toileting, or instrumental activity of daily living (IADL), such as shopping, meal preparation, transportation, or money management. Approximately one-quarter of Americans in need of LTSS (3.2 million) require assistance with two or more ADLs (Kaye et al., 2010) and, as such, exhibit significant functional impairment.

As the population ages, the number of people needing LTSS will grow precipitously as the likelihood of needing LTSS increases with age (United States Congressional Budget Office, 2013). Among the population turning 65, an estimated 52% will require LTSS at some point during their life (Favreault & Dey, 2015). While 18% of population aged 65 years and older have difficulty performing at least one ADL or IADL, more than half of the population aged 85 years and older (54%) has these difficulties (United States Congressional Budget Office, 2013). Although most individuals needing LTSS reside in the community (half of whom are under 65), an estimated 1.6 to 1.8 million reside in nursing homes, and are overwhelmingly elderly (Kaye et al., 2010). Moreover, the number of people in need of LTSS is expected to more than double in the coming decades. By 2050, an estimated 27

million individuals will need LTSS as a result of the aging of the Baby Boom generation (Office of the Assistant Secretary for Planning and Evaluation, 2003).

The majority of long-term care in the United States is provided by unpaid caregivers such as family or friends. In 2013, the economic value of unpaid caregivers was an estimated \$470 billion (Reinhard, Feinberg, Choula, & Houser, 2015). In addition to unpaid care, the United States spent \$310 billion on paid LTSS in 2013 (The Henry J. Kaiser Family Foundation, 2015). Paid supports include nursing facility care, adult day health care, home health aide services, personal care, and homemaker services, among others. The cost of LTSS can be high and poses a financial challenge to individuals needing assistance. The average annual nursing home cost in 2016 was \$82,128; assisted living, \$43,500; and home health aide, \$46,332 (Genworth Financial Inc., 2016). Most individuals are ill prepared to pay for LTSS. Only 11% of adults 65 and older have private long-term care insurance policies (Johnson, 2016), and nearly half of older adult households have \$10,000 or less in non-housing financial assets (Commission on Long-Term Care, 2013).

Due to the high costs of care, many Americans quickly spend down their income and assets and rely on Medicaid, the joint federal-state health insurance program, to pay for LTSS. Medicaid covers LTSS for low-income individuals or individuals who have exhausted their financial resources by spending down to Medicaid eligibility. The program is the primary payer of LTSS in the United States and represents approximately two-thirds of LTSS spending. Other payers of LTSS include other government programs, out-of-pocket spending, and private long-term care insurance (The Henry J. Kaiser Family Foundation, 2015). While Medicare pays for nursing facility care and home health aide services following

an acute hospitalization, the health insurance program for older adults does not pay for long-term care. In fiscal year 2013, Medicaid spent \$146 billion on LTSS, which accounts for 34% of overall Medicaid spending (Eiken, Sredl, Burwell, & Saucier, 2015a). Most Medicaid spending for LTSS is for older adults and persons with physical disabilities (\$88.9 billion). This is followed by people with developmental disabilities (\$43 billion), people with serious mental illness or serious emotional distress (\$9.2 billion), and other populations (\$4.9 billion).

Medicaid Long-Term Services and Supports Rebalancing

Medicaid spending on LTSS includes both institutional services and HCBS. State Medicaid programs are required to cover nursing facility care, but HCBS are almost exclusively optional benefits -- often with limited enrollment slots. Since nursing facility care is mandatory but HCBS typically is not, Medicaid has historically been biased towards institutional care with the majority of Medicaid LTSS spending going towards institutional care rather than HCBS. Over the past several decades, however, federal and state officials have been focused on rebalancing Medicaid LTSS spending away from institutional to home and community-based alternatives.

Several rationales exist for HCBS programs, including a preference-based argument, a cost-based argument, and a rights-based argument. Medicaid LTSS rebalancing has been driven, in part, by the preferences and well-being of individuals receiving services and perceived cost savings associated with expanding HCBS. It has also been accelerated after 1999 by the U.S. Supreme Court decision in *Olmstead v. LC* (527 U.S. 581), which

established individuals with disabilities' right to live in the most integrated setting possible under the Americans with Disabilities Act.

The federal government first sought to spur state rebalancing efforts during the early 1980s by providing states with greater flexibility over Medicaid HCBS. These efforts were motivated, in part, by the desires of most elders and persons with disabilities to live in the community rather than an institutional setting. In an AARP survey of individuals aged 45 years and older, approximately 85% said they would like to remain in their local community and stay in their current residence for as long as possible (Keenan, 2010). In addition, research suggests that individuals with intellectual and developmental disabilities (ID/DD) have a higher quality of life when living in the community compared to an institutional setting (Larson & Lakin, 1989; Kim, Larson, & Lakin, 2001; Chowdhury & Benson, 2011).

Efforts to rebalance LTSS were also driven by the belief among policymakers that HCBS are more cost effective than institutional care. Policymakers frequently make the case for HCBS by portraying home care services as a mechanism to lower the costs of LTSS (Wiener & Stevenson, 1998). Nursing facilities can cost tens of thousands of dollars per year per resident while the cost of providing services at home can be significantly less. Although policymakers often cite the cost-effectiveness of HCBS, the literature is inconclusive. Early research suggested that HCBS programs do not result in aggregate cost savings (Weissert, Matthews Cready, & Pawelak, 1988; Grabowski, 2006). With the 'woodwork effect', even though the cost per person decreases when services are provided in the home, the total budgetary cost can increase because more people are served (Doty, 2000). Home care services are more appealing than nursing facility care; as a result, the demand for services is

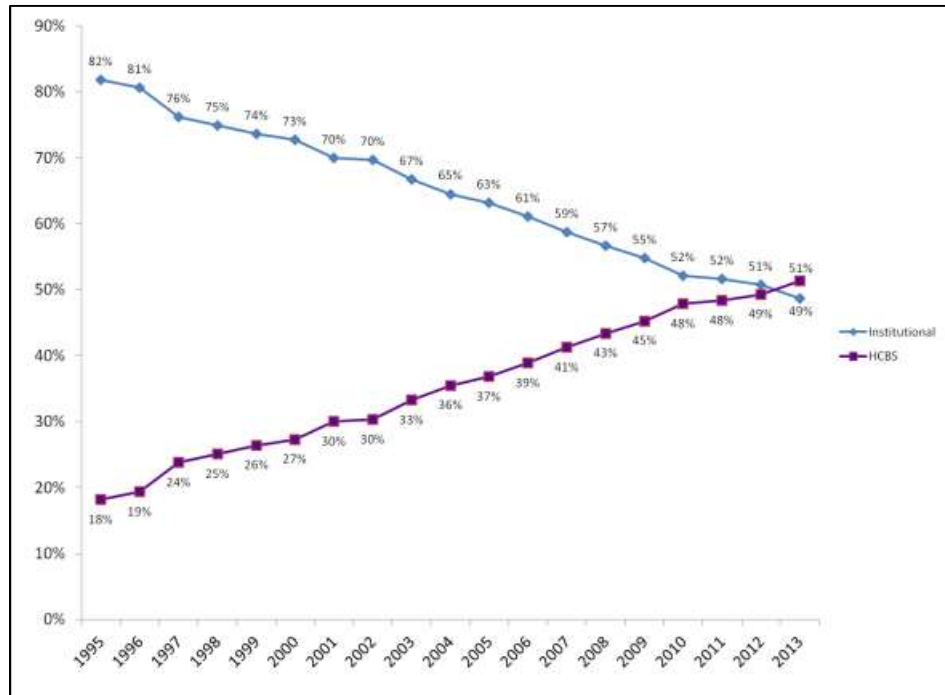
higher. Other research suggests that HCBS can be cost-effective under specific circumstances. A 1994 General Accounting Office (GAO) report found states that utilized program eligibility criteria and limits on service plans successfully constrained costs (GAO, 1994). Findings such as this buttress state policymakers' perceptions of HCBS as a mechanism to delay or prevent institutionalization and therefore save the state money.

Further state-level rebalancing has been spurned by the U.S. Supreme Court's 1999 *Olmstead* decision and subsequent legal challenges enforcing this decision. The *Olmstead* case was brought by two women with mental illness and developmental disabilities who were institutionalized in the state of Georgia but wanted to live in the community. In the *Olmstead* decision, the U.S. Supreme Court determined that, under the Americans with Disabilities Act, government entities must provide community services when appropriate and when living in the community can be reasonably accommodated. In the years after *Olmstead*, the federal and state governments have worked to achieve compliance with the decision, thereby accelerating progress towards rebalancing over the last 15 years.

Due to these changes in policy, Medicaid spending has increasingly shifted toward HCBS, which has grown while spending on institutional care has decreased over time. As shown in Figure 1.1, in 1995, 82% of Medicaid LTSS spending was for institutional care compared to 18% for HCBS. Federal fiscal year 2013 marked the first time Medicaid HCBS spending (51%) exceeded spending on institutional services (49%) (Eiken et al. 2015a). In addition, the number of individuals receiving Medicaid HCBS has increased significantly. In 2012, 3.2 million people received Medicaid HCBS services compared to 2.3 million in 2002 (Ng, Harrington, Musumeci, & Reaves, 2015). During this period the utilization of nursing

facility care declined. Between 2000 and 2013, the number of nursing facility residents in the United States decreased from 1.4 million to 1.3 million, and the nursing facility bed occupancy rate decreased from 82.4% to 80.8% (National Center for Health Statistics, 2016).

**Figure 1.1: % of Medicaid LTSS Spending on Institutional Services and HCBS
(1995-2013)**



Source: Eiken et al., 2015.

Long-Term Services and Supports before the Affordable Care Act

Prior to the Affordable Care Act, states primarily provided Medicaid-funded HCBS through three mechanisms: home health state plan services, personal care state plan services, and 1915(c) HCBS waivers. Home health state plan services include nursing and home health aide services, and medical equipment. All states are required to provide these services through their Medicaid state plan. In 2012, 764,487 individuals received Medicaid home

health services at a total cost of \$5.2 billion (Ng et al., 2015; Eiken et al., 2015a). The Medicaid personal care state plan benefit is optional for states. Personal care services provide assistance with tasks necessary to live independently such as ADLs and IADLs. In 2012, 32 states provided personal care services to 944,507 beneficiaries at a total cost of \$10.9 billion (Ng et al., 2015; Eiken et al., 2015a).

Before 1981, the only Medicaid HCBS benefits states could provide were home health and personal care services. The Omnibus Budget Reconciliation Act of 1981 (OBRA) added Section 1915 to the Social Security Act allowing states to waive Medicaid requirements for comparability and statewideness which require states to provide Medicaid state plan services to all eligible individuals throughout the state. With this waiver, states could provide HCBS to specific populations such as the elderly or developmentally disabled, and choose to provide services to certain regions within the state. With Section 1915(c), in particular, states now had the option of providing home and community-based services to individuals who meet the eligibility requirements for institutional care.

The introduction of 1915(c) waivers offered states significant flexibility in designing programs to target specific populations; such as the elderly, developmentally disabled, and individuals with physical disabilities; limit services to certain geographic regions within the state; and provide a broad range of services necessary for community living. As part of the 1915(c) waiver, state must demonstrate cost neutrality, meaning that in the aggregate the costs of providing HCBS to 1915(c) waiver participants must be less than the cost of providing institutional services for these individuals. As with personal care services, 1915(c) waivers are optional for states.

Initially states were slow to adopt waivers but over the last two decades waivers have grown significantly. The number of 1915(c) waiver programs that states operate increased from six in 1982 to 257 in 2007 to 290 in 2012 (Thompson & Burke, 2008; Ng et al., 2015). Waivers are the largest Medicaid HCBS program in terms of both participants and HCBS expenditures. The total number of 1915(c) waiver participants in 2012 was 1,497,528 in 47 states plus the District of Columbia (Ng et al., 2015). Much of the LTSS rebalancing that has occurred over the past decade has been driven by expansion of HCBS waivers. In 2001, waiver spending was \$14.3 billion; in 2011, spending nearly tripled to \$39.5 billion (Ng et al., 2015, Eiken et al., 2015). In addition to 1915(c) waivers, several states have chosen to provide HCBS under 1115 research and demonstration waivers. Section 1115 of the Social Security Act permits the federal government to grant waivers to states to develop and evaluate new ways to deliver health care services. Arizona, Rhode Island, and Vermont have pursued 1115 waivers to redesign their Medicaid programs and HCBS offerings.

The Affordable Care Act and Long-Term Services and Supports

The ACA legislation sought to further promote rebalancing within Medicaid LTSS. The Balancing Incentive Program, the Community First Choice personal care benefit, and the 1915(i) HCBS state plan benefit provide states with additional opportunities to expand HCBS. None of these programs are mandatory, and state Medicaid officials have the option of adopting these programs as part of their Medicaid offerings. These three options seek to encourage state participation by providing states with financial incentives, additional flexibility, and the ability to provide services to a broader population needing LTSS. As of 2015, the number of states participating in the three federal initiatives ranges from eight for

the CFC personal care benefit, 19 for the 1915(i) HCBS benefit, and 21 for the Balancing Incentive Program (The Henry J. Kaiser Family Foundation, 2015).

The goal of BIP was to further rebalance LTSS spending and improve access and quality of Medicaid HCBS across states. Through this program, states received an enhanced Federal Medical Assistance Percentage (FMAP)¹ in exchange for rebalancing LTSS spending and adopting structural changes to their LTSS system. BIP was a time limited program through federal fiscal year 2015 and was open to states with less than fifty percent (50%) Medicaid LTSS spending on non-institutional care. States with less than 50% LTSS spending on HCBS had to achieve the 50% benchmark by September 30, 2015 and states with less than 25% LTSS spending had to achieve the 25% benchmark in the same period. In return, states initially at less than 50% HCBS spending received an additional 2% FMAP on non-institutional Medicaid spending and states at less than 25% HCBS spending received an additional 5% FMAP on non-institutional Medicaid spending through September 30, 2015, after which they no longer received the enhanced FMAP. Participating states were also required to implement three structural changes. These structural changes were to implement a No Wrong Door/Single Entry Point to access community-based LTSS, ensure a system of conflict-free case management, and collect core data elements when conducting functional assessments for services. If states did not demonstrate progress on implementing these three structural changes and in achieving the relevant rebalancing threshold, the Centers for

¹ FMAP is the percentage to determine the federal financial contribution for state Medicaid spending. Depending on the state, the federal government covers between 50% and 75% of Medicaid spending. Each state's percentage is based on the income level of the state.

Medicare and Medicaid Services (CMS) could suspend or terminate their participation in BIP, including the enhanced FMAP.

The second ACA HCBS initiative is the Community First Choice 1915(k) state plan option which allows states to provide home and community-based attendant services and supports through the Medicaid state plan. Through the CFC benefit, states must provide more extensive services with a greater emphasis on participant self-direction than existing Medicaid HCBS (Government Accountability Office, 2012). A key benefit for states in adopting the CFC benefit is an additional six percent (6%) FMAP for these expenditures. CFC's comprehensive services include assistance with ADLs, IADLs, health-related tasks, and back-up systems. To receive these services, an individual must be at an institutional level of care and have an income at or less than 150 percent of the federal poverty level. Individuals with a higher income level are eligible for CFC if they are receiving waiver services. Unlike 1915(c) waivers, states cannot target specific age groups, types of disabilities or geographic regions under the Community First Choice state plan benefit. States can deliver services through agency providers or through a self-directed model in which the recipient is responsible for hiring, training, supervising, and firing his or her worker.

The ACA revises the already existing 1915(i) state plan benefit to make it more attractive for states. The Deficit Reduction Act (DRA) of 2005 enacted the Medicaid 1915(i) HCBS state plan benefit. The 1915(i) option differs from 1915(c) waivers in that individuals receiving these services do not need to be clinically eligible for institutional care, and states do not have to achieve cost neutrality. However, under the DRA, states could not target services to specific populations, could only serve individuals with income at or below 150

percent of the federal poverty level, and could offer fewer services than available through 1915(c) waivers (Centers for Medicare & Medicaid Services, 2014). Due, in part, to these requirements, only a handful of states adopted the 1915(i) state plan benefit prior to the ACA. The ACA revised the 1915(i) state plan benefit so states have the flexibility of targeting specific populations, determining a wide array of available services, and establishing more lenient financial eligibility criteria (GAO, 2012). Thus, the 1915(i) offers an expansion of HCBS by allowing states to provide services to individuals with less stringent functional and financial eligibility standards than 1915(c) waivers.

Statement of the Problem

Over the last several decades significant rebalancing away from institutional care to HCBS alternatives has occurred in Medicaid-funded LTSS. As discussed earlier, this rebalancing was driven by the desires of elders and persons with disabilities to remain in their own homes; the belief that HCBS is less costly than institutional care, and the *Olmstead* decision. However, Medicaid LTSS rebalancing remains uneven at the state level, with some states achieving significantly more rebalancing than others. The substantial cross-state variation in LTSS rebalancing is partly attributable to the optional nature of most Medicaid HCBS programs. With limited federal mandates around the provision of HCBS, the majority of HCBS decision-making occurs at the state level. This devolution contributes to disparities in access to HCBS which can have serious implications for individuals.

Previous research and government publications have noted considerable cross-state differences in HCBS offerings (Coleman, 1996; GAO, 2002; Harrington, Ng, Kaye, & Newcomer, 2009a; Woodcock, Stockwell, Tripp, & Milligan, 2011; Houser, Fox-Gage, and

Ujvari, 2012; Ng et al., 2015). A 2013 report from the U.S. Senate Committee on Health, Education, Labor, and Pensions bemoaned cross-state disparities in HCBS (United States Senate, Health Education, Labor, and Pensions Committee, 2013). The report titled *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act* urged the federal government to require states to provide HCBS through Medicaid and set rebalancing benchmarks with financial incentives for states that meet these targets and penalties for states that fail to achieve them. However, since then little has been done to decrease differences in HCBS offerings.

Why Variation Exists in Medicaid Home and Community-Based Services

Variation in state HCBS policy is due, in part, to the flexibility states have in determining Medicaid eligibility, the optional nature of most HCBS programs, and the ability of states to determine the services offered as well as the amount, duration, and scope of those services. Since Medicaid is a joint federal-state program, the financial and functionality eligibility criteria for Medicaid LTSS vary by state. The federal government sets minimum requirements for financial eligibility but states often have the option to increase eligibility up to a certain point. At a minimum, states generally must provide Medicaid to Supplemental Security Income (SSI) recipients. In 2015, the monthly SSI income eligibility amount for an individual was \$733 and \$1,100 for a couple. Recipients must also have assets of less than \$2,000 for an individual and \$3,000 for a couple to be eligible.

States may opt to increase income eligibility for seniors and persons with disabilities up to 100% of the Federal Poverty Level (FPL); twenty-one states have taken advantage of this option (O'Malley Watts, Cornachlone, & Musumeci, 2016). States can also elect to

broaden eligibility for Medicaid through the medically needy program for individuals whose income is otherwise too high to qualify for Medicaid but who have high medical expenses; thirty-three states have done so (O'Malley Watts et al., 2016). In addition, most states permit individuals who need an institutional level of care to qualify for Medicaid at even higher income levels, up to 300% of the SSI amount, under the special income rule. Most, but not all states, apply the special income rule to individuals receiving Medicaid LTSS in the community as well.

In addition to determining financial eligibility criteria, states set functionality eligibility criteria for Medicaid LTSS. Several of the Medicaid HCBS options require that an individual be at a nursing facility level of care to be eligible for services. The definition of nursing facility level of care varies across states, with some states utilizing clinical criteria, other states utilizing functional criteria, and the remaining using both (Hendrickson & Kyzr-Sheeley, 2008).

States also have discretion in determining the Medicaid HCBS benefits available. While all states must cover nursing facility services, states have greater flexibility with respect to HCBS. Under the 1965 legislation enacting the Medicaid program, nursing facility care was a mandatory benefit and home health services an optional benefit. In 1970, home health services became a mandatory Medicaid benefit states had to offer to individuals eligible for nursing facility care (O'Keeffe et al., 2010). Since then the additional opportunities provided to states to offer HCBS have been optional.

States have considerable flexibility in determining the particular services offered within many of the Medicaid HCBS options available to them. Some states decide to offer a

wide range of services while other states are more restrictive. States can also determine the amount, scope, and duration of services. The 1915(c) waiver authority specifically provides states with a wide degree of latitude in determining benefits. States, for example, can provide services that are not typically covered by Medicaid, such as transitional assistance or environmental adaptations, as long as CMS approves the provision of those services within the state's waiver application (O'Keeffe et al., 2010). States can also establish cost limits or service/hourly limits and limit the number of beneficiaries served even if they otherwise qualify for benefits. Growing use of 1915(c) waivers and the flexibility states have in designing their waiver programs have contributed to substantial differences in HCBS offerings across states.

Quantifying State Variation in Home and Community-Based Services

State variation in LTSS is evident when examining the demand for LTSS among the general population, the setting of services – institutional verse community, the amount spent, the number of individuals served, the LTSS populations served, and the number of providers per state. States differ with respect to the number and percentage of the population requiring LTSS. In 2017, the proportion of the population with a disability ranged from 9.6% in Utah to 20.2% in West Virginia (Bureau of the Census, 2018). Utah also had the smallest percentage of its population aged 65 years and older (10.8%) in 2017 while Florida had the highest percentage (20.1%) (Bureau of the Census, 2018).

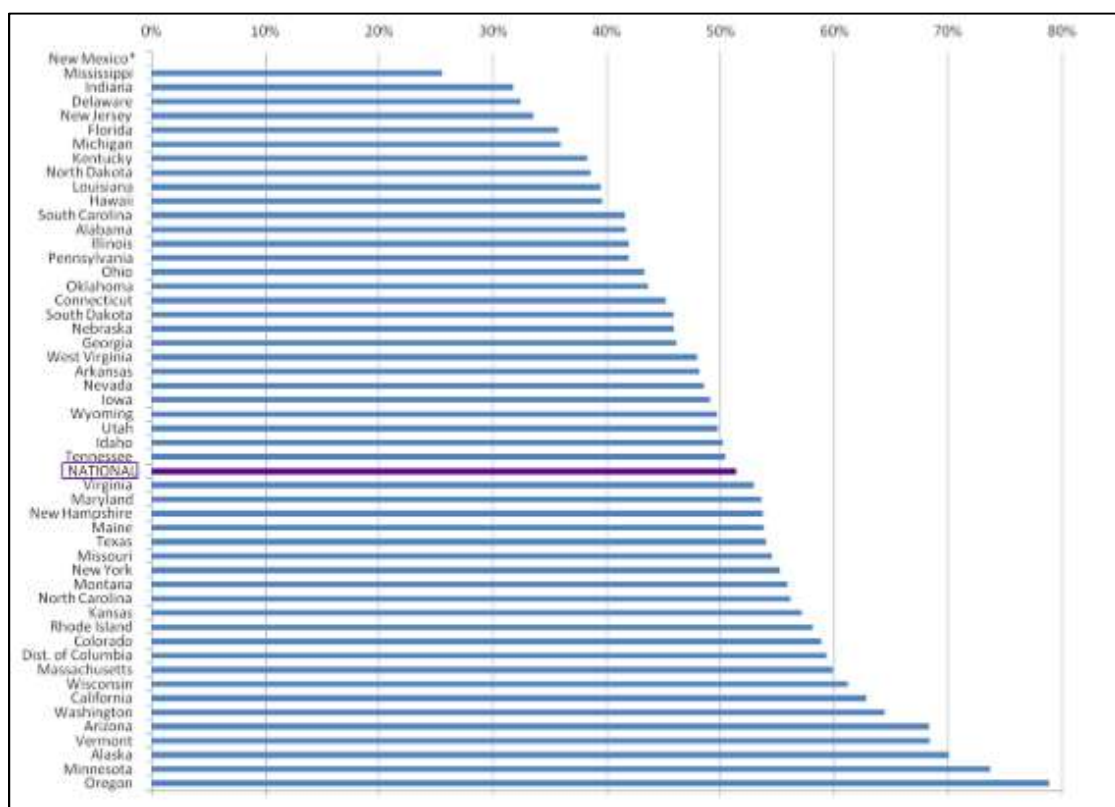
Whether an individual in need of LTSS receives institutional or non-institutional care depends, in part, on where they reside. Recipients of Medicaid LTSS may rely exclusively on institutional care or HCBS, or some combination of the two. Among individuals who

received Medicaid LTSS in 2011, 29.4% received only institutional services, 66.0% received only HCBS, and 4.7% received both HCBS and institutional services (Eiken, Sredl, Saucier, & Burwell, 2015b).² Across states, the percentage of Medicaid LTSS recipients relying exclusively on HCBS ranged from 39.9% in Indiana to 82.4.2% in Idaho (Eiken et al., 2015b). These finding suggest that some states make Medicaid HCBS more available to those requiring LTSS than other states.

State variation rebalancing LTSS is evident when examining the percentage of total LTSS spending on HCBS, HCBS spending per capita, and HCBS spending per recipient. In 2013, the percentage of Medicaid LTSS spending on non-institutional care compared to institutional care nationally was 51.3% but ranged from just over 25% to nearly 80% across states (Eiken et al., 2015a). As shown in Figure 1.2, more than half of all states spent less than 50% of Medicaid LTSS on HCBS with ten states spending less than 40%. At the other end of the spectrum, three states- Oregon, Minnesota, and Alaska- spent more than 70% of Medicaid LTSS expenditures on HCBS (Eiken et al., 2015a).

² Nine states (Alabama, Arizona, Hawaii, Kansas, Maine, New Mexico, Tennessee, Texas and Wisconsin) are excluded from this analysis due to missing data or data anomalies.

Figure 1.2: % of Medicaid LTSS Spending on HCBS by State (2013)



Source: Eiken et al., 2015.

Overall, average Medicaid HCBS spending per resident was \$238.22 nationally in fiscal year 2013, ranging from \$83.23 (Utah) to \$731.76 (District of Columbia) across the states (Eiken et al., 2015a). Average spending per recipient varies by service type, however. As discussed above, the three main Medicaid HCBS programs are home health aide, personal care, and 1915(c) HCBS waivers. For Medicaid home health services, average spending per recipient was \$761.69 in 2012 which translates into approximately 38 hours of home health aide services per year at the median home health aide rate of \$20 per hour (Kaiser State Health Facts, 2016). Across the states, spending per recipient for home health services ranged

from \$19.02 (Oregon) to \$2,122.45 (Arizona). Nationally, the average amount spent per recipient on personal care services in 2012 was \$888.36, ranging from \$100 to \$3,098.41 in Delaware and New York, respectively. For 1915(c) waivers, the national average amount spent per recipient was \$2,723.16 but states varied from \$1,160.49 (Mississippi) to \$7,557.43 (Tennessee). 1915(c) waiver per capita expenditures also vary by eligibility category. On waivers for people with ID/DD, states spent on average \$93.76 per capita compared to \$34.03 on waivers for older people and/or people with physical disabilities and \$0.47 on waivers for people with serious mental illness.

The number of HCBS recipients also varies significantly across states. In 2012, the number of home health recipients per 1,000 residents ranged from .25 in New Mexico to 8.76 in Connecticut. Among states that offer personal care services, the number of recipients per 1,000 residents varied from less than one one-hundredth of a percentage point in Delaware and Rhode Island to 11.04 in California (Kaiser State Health Facts, 2016). 1915(c) waivers are the largest HCBS program. In 2012, Delaware had just 3,222 1915(c) waiver participants compared to three states (California, Illinois and New York) with over 100,000 participants. On a per capita basis, Tennessee had the fewest waiver participants per 1,000 residents (1.23) while Hawaii had the most (18.64) (Kaiser State Health Facts, 2016). With 1915(c) waivers, states have the option of limiting enrollment slots and implementing a waiting list. In 2014, 582,066 individuals were on a waiting list for 1915(c) waiver services in the United States. The magnitude of individuals on a waiting list varies across states. The number of individuals on a wait list for waiver services in 2014 ranged from zero in several states to 163,146 in Texas (Ng et al., 2015).

Disparities in HCBS offerings exist across populations needing LTSS. In general, states have achieved greater rebalancing for the ID/DD population than others needing LTSS. In FY13, 72.3% of Medicaid LTSS spending nationally for the ID/DD population was for HCBS with state spending percentages ranging from 16.5% (Mississippi) to 100% in several states (Oregon, Maryland, and Michigan) (Eiken et al., 2015a). All but two states spent more than 50% of LTSS spending on HCBS for the ID/DD population. For older adults, persons with disabilities, and people with serious mental illness and emotional disturbance, less rebalancing has been achieved. Among older adults and persons with disabilities, the percentage of spending on HCBS was 40.2% nationally with state spending percentages ranging from 12.6% (Kentucky) to 66.8% (Minnesota) in FY13 (Eiken et al., 2015a). That significantly less rebalancing has occurred for the aged and physically disabled is noteworthy given that fact that the majority of older adults express a strong desire to remain in their own homes and communities as they age (Farber, Shinkle, Lynott, Fox-Grange, & Harrell, 2011). In general, states offer few HCBS alternatives to individuals with serious mental health issues. Nationally, the proportion of Medicaid LTSS spending devoted to HCBS for this population was just 36.2% nationally, with the percentage ranging from 0% in multiple states to 100% in Hawaii (Eiken et al., 2015a).

Differences also exist in the supply of HCBS across states. The supply of HCBS can determine, in part, whether individuals receive services in their home or community. The number of direct care workers varies across states. The number of home health and personal care aides per 100 individuals age 18 and older with ADL disabilities ranges from 10 (Alabama, Mississippi, and Kentucky) to 41 (New York) while the median is 19 (AARP

Foundation, 2017). State variation also exists among adult day health providers and assisted living residences. The number of adult day health providers in the United States is approximately 4,800 and varies from approximately 10 in Alaska, Delaware, and West Virginia to 1,100 in California (United States Centers for Disease Control and Prevention, 2014). The median number of assisted living and residential care units per 1,000 residents age 75 and older is 52 and ranges from 20 in Louisiana and 121 in Oregon (AARP Foundation, 2017). In addition, some states have substantial adult foster care programs which are minimal in other states. Adult foster care varies by states but generally provides assistance with ADLs or IADLs in a home like environment to a limited number of individuals.

Impact of State Variation in Home and Community-Based Services

The statistics cited above suggest that an individual's ability to receive home care services may depend more on his or her state of residence than his or her needs. Indeed, the GAO found that elders with the same needs in different states would likely receive vastly different service plans based on their state of residence. (GAO, 2002). In addition, studies have found that the number of individuals in nursing facilities with low care needs varies significantly across states (Thomas & Mor, 2013; Thomas, Keohane & Mor, 2014). These findings suggest that a state's HCBS offerings may determine whether an individual requiring LTSS can have his or her needs met in the community as opposed to an institutional setting. By allowing states to determine service offerings, benefit amounts, and number of enrollment slots, an individual in one state may encounter a dearth of Medicaid HCBS offerings or face a lengthy waiting list while an individual with the same needs in

another state receives HCBS services to meet all of his or her needs. Individuals with the greatest needs are also more likely to live in a state that does not offer substantial HCBS options because states with comparatively higher need for LTSS often devote fewer resources to HCBS programs (Kaye & Harrington, 2015). The institutional bias and flexibility in Medicaid clearly contributes to geographic disparities in access to HCBS.

Limited HCBS programs or enrollment slots can contribute to unmet needs. Unmet needs are defined as unavailable or insufficient help for an individual with disabilities who requires assistance (Williams, Lyons, & Rowland, 1997). Measuring unmet needs is challenging. Several studies have sought to estimate unmet needs using survey data. Depending on how LTSS needs are defined, the number of individuals needing LTSS with unmet needs can vary substantially (Williams et al., 1997). Estimates of the community dwelling elder population with unmet needs range from 2.6% to 34.6% (Williams et al., 1997; Gibson & Verma, 2006; Freedman & Spillman, 2014). Low-income older adults eligible for both Medicare and Medicaid are particularly susceptible to experiencing unmet needs. For this population, known as “the dually eligible” or “duals”, Medicare provides coverage for preventive, acute, and post-acute care while Medicaid wraps around Medicare benefits, covering LTSS and Medicare cost-sharing, premiums, and deductibles. An estimated 58% of community-based duals have an unmet need for LTSS (Komisar, Feder, & Kasper, 2005). Since Medicare is a federally administered universal health insurance program, it is better able to meet duals health care than the state run means-tested Medicaid program is able to meet their LTSS needs.

Several factors contribute to unmet needs, including the availability of informal caregivers, the degree of functional impairment, and the availability of paid LTSS (Williams et al. 1997; Komisar et al., 2005). Unpaid caregivers provide the majority of long-term care in the United States. When an unpaid caregiver becomes ill, functionally declines, or can no longer provide care for whatever reason, the recipient may not have all of his or her needs met. In addition, societal changes are contributing to fewer potential informal caregivers as the number of Baby Boomers increases (Freemant & Spillman, 2014). With smaller families and more women in the workforce, there are fewer caregivers to provide care for a growing aging population.

Unmet needs are also shaped by the extent of functional impairment. The more functionally impaired an individual is the more likely she or he is to have unmet needs (Williams et al., 1997; Komisar et al. 2005). Over 80% of individuals with three or more ADLs live in the community as opposed to a nursing facility or supportive care setting (Freedman & Spillman, 2014). Meeting all of an individual's needs in the community may be particularly difficult for those who require extensive assistance.

The availability of formal LTSS can reduce the likelihood of individuals having unmet needs. Studies suggest that the public provision of LTSS, through programs such as Medicaid and the Older Americans Act, can play a role in reducing unmet needs (Komisar et al., 2005; Kemper, Weaver, Farley Sort, Shea, & Kang, 2008). States that provide more generous home and community-based services tend to have a lower percentage of individuals with unmet needs (Komisar et al., 2005; Kemper et al., 2008). This is because, in part, individuals who rely on paid supports are less likely to have unmet needs than people who

only rely on unpaid assistance (Komisar et al., 2005). However, among elders living in the community receiving assistance, 78.8% rely on unpaid care only while 18.8% receive both paid and unpaid care (Freedman & Spillman, 2014). Paid services can fill crucial gaps to ensure that all needs are being met.

Unmet LTSS needs can have serious consequences for individuals and their caregivers. Studies suggest that between 23% and 42% of community dwelling older adults experience adverse consequences from unmet needs (Freeman & Spillman, 2014; Allen et al., 2014). These may include not being able to get around the house or go outside, going without showering or bathing, wetting or soiling clothes, and mistakes in taking medications (Freeman & Spillman, 2014; Allen, Piette, & Mor, 2014). Among community-dwelling Medicare recipients, approximately 23%, or 2 million individuals needing help with self-care reported a negative consequence from an unmet need (Allen et al., 2014). The most common consequences were wetting or soiling oneself followed by going without showering/bathing and going without getting dressed (Allen et al., 2014).

The long-term ramifications for the individual, their caregiver, and the health care community can be sobering: individuals with unmet needs are at greater risk of falling, hospitalization, and institutionalization (Gibson & Verma, 2006; Summer, 2003). To meet their LTSS needs, most individuals must rely on the support and assistance of family and friends. The heavy reliance on unpaid caregivers for the provision of long-term services and supports can contribute to physical strain, emotional stress, and financial hardship for caregivers, all of which can contribute to adverse outcomes for care recipients. Cross-state

variation in publically provided HCBS may thus have negative impacts not just for care recipients but unpaid caregivers as well.

Research Questions and Purpose

State differences in Medicaid HCBS policy have serious implications for individuals dependent on Medicaid-funded LTSS. In addition, inequities in access to HCBS are recognized as a policy problem (United States Senate, Health Education, Labor, and Pensions Committee, 2013). State variation in HCBS programs and inequities in state policies matters for several reasons. Foremost, the *Olmstead* decision affirmed the rights of individuals with disabilities to live in the most integrated setting possible if they wished to do so. Differences in HCBS programs can prevent some individuals from living in the community because of their state of residence. In some states, individuals clinically eligible for institutional care must wait for over 10 years for Medicaid waiver services. A second reason variation in state HCBS options is important is that greater variation exists in states' provision of HCBS as compared to institutional care because of the bias in Medicaid policy. States are required to cover institutional care, such as care in nursing facilities or intermediate care facilities, but the overwhelming majority of HCBS programs are optional. While variations exist in states' coverage of institutional care, including eligibility criteria and provider rates, greater variation is evident in HCBS because states are not required to cover most HCBS programs through Medicaid. In addition, states can implement waiting lists for many HCBS programs which are not permitted in institutional settings such as nursing facilities. Lastly, state variation in Medicaid HCBS is paradoxical given that there is general agreement that providing services to individuals in their own homes and communities is preferable to an

institutional setting. Rebalancing LTSS is typically not a partisan issue and members of both political parties are in favor of individuals living in their own homes and community.

Since Medicaid is a joint federal-state program and the federal government grants significant flexibility to the states, differences in state LTSS and HCBS programs and policies will always exist. Kaye (2014) identifies several goals of a model LTSS system including promoting living in the community as opposed to institutions and treating people needing LTSS equitably. The three new HCBS options in the ACA focus on the first goal of promoting community living but may impair the second goal of ensuring equity since all three programs are optional for states. If states that pursue these options had robust HCBS systems prior to the ACA, the gaps in HCBS offerings across states may increase. Therefore, identifying the factors that contribute to state adoption of these policies is important to understand the effects of these policies on state variation in HCBS. If the federal government wants to reduce state variation in Medicaid HCBS, it may need to consider eliminating the institutional bias in Medicaid and requiring states to coverage HCBS for certain populations, such as individuals requiring an institutional level of care.

Since most HCBS policymaking occurs within states, understanding the factors that impact states' adoption and successful implementation of HCBS policies can help develop future policies to expand access to HCBS while reducing inter-state disparities. The first research question of this study is thus: what factors influenced state adoption of the ACA's HCBS programs? This question focuses on the determinants of state LTSS policy and has implications for the ability of federal policymakers to influence state policy. Those states electing to participate in the ACA's HCBS initiatives represent a diverse collection of

states—liberal and conservative; small and large; and states with both low and high percentages of non-institutional LTSS spending (The Henry J. Kaiser Family Foundation, 2015). Numerous factors may contribute to state LTSS decision-making, such as existing LTSS policies, governing capacity, provider capacity, political ideology, economic considerations, or interest group pressure. This research will endeavor to understand the key factors critical to state decision-making with respect to the ACA’s HCBS programs.

Existing research has identified many factors that contribute to variation in state policy adoption. The policy adoption literature recognizes that public policies can be shaped by internal factors, such as political and economic conditions, as well external factors, including the actions of other states (Berry & Berry, 1990). Studies focusing specifically on the adoption of the ACA’s Medicaid expansion and exchanges have found that partisanship, economic considerations, prior policies, and administrative capacity played a role in state decision-making (Jacobs & Callaghan, 2013; Jones, Bradley, & Oberlander, 2014). However, since the states adopting the ACA’s HCBS programs do not align with the states adopting the expansion and exchanges, the factors influencing state decision-making may be different in this policy area. The comparative HCBS state policy literature has identified demographic characteristics, provider supply, per capita income, and partisanship as important in explaining state variation in the public provision of HCBS (Miller, Ramsland, Goldstein, & Harrington, 2001; Kitchener, Carrillo, & Harrington, 2004; Miller et al., 2005; Miller & Kirk, 2016). Studies that examine state adoption of 1915(c) HCBS waiver programs have found the need for services, the presence of a Democratic governor, provider supply, the state FMAP

rate, legislative support, and advocacy efforts are important in state adoption decisions (Nelson, 2007; Merryman, Miller, Shockley, Eskow, & Chasson, 2015).

This study advances the literature on HCBS programs in several ways. Existing research on state HCBS variation largely examines predictors of spending levels, number of recipients, or the adoption of 1915(c) waivers. The majority of the studies on state variation in HCBS focus on spending level or participants and not directly on states' decisions to adopt HCBS programs (Kane, Kane, Ladd, & Veazie, 1998; Miller et al. 2001; Miller, Rubin, Elder, Kitchener, & Harrington, 2006). The reasons states adopt HCBS programs may differ from determinants of state spending levels and number recipients after adoption. In addition to studies focused on state spending levels and participants, several studies examine the adoption of 1915(c) waivers (Nelson, 2007; Miller, Elder, Kitchener, Kang, & Harrington, 2008; Merryman et al. 2015). The HCBS options in the ACA differ from 1915(c) waivers in several ways, and the factors influencing states' adoption of these programs could vary from the factors influencing adoption of 1915(c) waivers. Waivers are unique in that they provide states with significant flexibility in waiving specific Medicaid program criteria. With waivers, states have the ability to limit the number of enrollees and establish waiting lists as a mechanism to control costs. In contrast, state plan services, like CFC and the 1915(i), must be available in all areas of the state, and states cannot limit enrollment. BIP differs from waiver and state plan programs in that BIP was time limited and required states to meet specific spending and rebalancing benchmarks. In addition, two of the ACA's HCBS options, BIP and CFC, provide states with enhanced financial incentives which 1915(c) waivers do not. Therefore, this study advances the HCBS policy adoption literature by examining the

adoption decisions of non-waiver programs including state plan services and time-limited Medicaid programs.

The ACA arguably included the most substantial increase in HCBS options for states since the authorization of 1915(c) waivers in the early 1980s. Since these policies have the potential to greatly expand HCBS, understanding state decision-making processes around these options is important. To this author's knowledge, only three studies have examined states' decisions to adopt the ACA's HCBS policies that are the focus of this study (General Accountability Office, 2012; Scully et al., 2013; Dorn et al., 2016). This current study expands upon these existing studies in several ways. First, this study covers a longer time period. The previous studies were conducted soon after the ACA options became available, when many states were uncertain whether they were going to pursue them. This study examines the five years after these options became available so that states have had time to examine these options and decide which, if any, to pursue. In addition, this study relies on both quantitative and qualitative methods while existing studies involved interviews and surveys with national and state officials. By utilizing event history modeling, this study can contribute to an understanding of the timing of why states adopted HCBS policies when they did and the role of both internal and external factors in the decision-making process. This study's comparative case studies examine in-depth the decision-making processes in several states and include interviews with both national and state-level officials as well as HCBS stakeholders.

The current study also examines the implementation process for these programs, in contrast to existing studies that only focused on the adoption decision. Understanding the

implementation process of HCBS programs is critical because challenges or setbacks in implementation can inhibit the attainment of policy goals. The second research question of this study is thus: what factors facilitated or impeded implementation of the ACA's HCBS programs? This research question examines state policymaking after states had elected to participate and CMS had approved Medicaid program changes stemming from participation in one or more of the ACA's HCBS programs. Implementing state HCBS policy is typically the responsibility of bureaucrats within the state Medicaid office. This research will seek to uncover the factors that shape state administration of the new HCBS policies. Numerous factors, including agency staff and financial resources; level of support among political actors, bureaucrats, providers and advocacy organizations; and the degree of flexibility and clarity of the policy, may determine whether a state successfully implements a policy.

The diverse literature on policy implementation has identified many factors that may impact implementation, finding that successful implementation can depend on the specific features of the policy; staffing and financial resources; the number of actors and their attitudes towards the policy; and timing (O'Toole, 1986). A major debate within the literature has been whether top-down approaches, which emphasize the importance of centralized decisions and clarity, or bottom-up approaches, which stress the role of local discretion, contribute to successful implementation. Although studies on policy implementation have evolved over the last several decades, there is little consensus on what factors lead to successful implementation.

The literature on the implementation of HCBS policies and programs is relatively limited. Several studies have explored the implementation of caregiver support services,

waivers, and HCBS for veterans (Friss Feinberg & Newman, 2004; Friss-Feinberg & Newman, 2006; Miller, 2014; Thomas & Allen, 2016). In addition, Karon et al. (2015) conducted case studies of the implementation of the Balancing Incentive Program in two states. Miller (2014) finds that insufficient staff and agency leadership, division of responsibilities, and lack of sufficient information technology systems posed challenges in the implementation of Rhode Island's Global Waiver. In a study of the implementation of Veteran-Direct HCBS, Thomas and Allen (2016) find that frequent and clear communication between the local Veterans Administration and aging and disability network agencies was key for successful implementation while delays in funding and reimbursement posed challenges for participating agencies.

This study contributes to the implementation literature in several ways. Foremost, the existing literature on HCBS policy implementation includes few cross-state comparisons. Studies either look in depth at the implementation of a single program in one state (Miller, 2014) or broadly across many states (Friss Feinberg & Newman, 2004; Friss-Feinberg & Newman, 2006; Thomas & Allen, 2016). This research relies on structured comparative case studies to understand the challenges or successes implementing the same programs in two very different states. In addition, this study also examines the simultaneous implementation of multiple HCBS programs whereas most HCBS implementation studies explore the implementation of a single policy; two of the states in this study, Maryland and Texas, adopted and implemented all three of the ACA's HCBS policies. The process of implementing multiple HCBS programs concurrently may facilitate or impede the implementation processes. As discussed above with the policy adoption literature, this study

also examines implementation of state plan services. The federal requirements for state plan services, including statewideness and prohibitions on waiting lists, may have important implications for the implementation process.

The present study builds upon the existing state policy adoption and implementation literature by positing and refining a conceptual framework in which state-level bureaucrats are the central decision-makers shaping HCBS policy changes. To test the conceptual framework, both quantitative and qualitative methods are utilized. The quantitative component of the study informs understanding of states' decisions to adopt these HCBS policies while the qualitative component informs understanding of state policy implementation in addition to adoption. The quantitative portion of this research involves multivariate regression models using event history analysis. The qualitative portion is composed of case studies of states that have made different adoption decisions. While numerous studies have researched state variation in LTSS policy, spending, participants, and adoption, the existing literature is predominantly, although not exclusively, quantitative (Harrington, Carrillo, Wellin, Miller, & LeBlanc, 2000; Pandley 2002; Miller et al., 2005; Miller et al., 2006; Miller, 2014). Therefore, this research supplements quantitative research with case studies of several states. In addition, most studies of policy implementation examine the implementation process separate from the adoption decision. Decisions made in adopting the program may critically impact the implementation process. Therefore, by studying both processes together, this study seeks to combine aspects of both the policy adoption and implementation literatures.

This study also has implications for policymakers interested in changing long-term services and supports systems. The ACA's LTSS initiatives indicate that federal policymakers want to encourage states to provide more HCBS alternatives to institutional care despite substantial progress in this area over the last twenty years. Federal policymakers sought to promote Medicaid rebalancing by providing states additional HCBS options and financial incentives for pursuing these options. Future federal efforts to influence state HCBS policy can be informed by factors known to influence state decisions to adopt Medicaid program changes in this area. By understanding the state decision-making process, federal policymakers can better tailor initiatives to achieve desired results. State decisions to adopt policy changes are only one step in the policymaking process, however. If states encounter challenges implementing changes to their HCBS systems and subsequently abandon those efforts, then limited progress will be achieved rebalancing LTSS. If federal policymakers understand the factors that contribute to successful state Medicaid LTSS policy implementation, they can better design policies to promote successful administration of federal rebalancing efforts. By not considering LTSS policy development and implementation at the state-level, new optional Medicaid HCBS offerings, like those in the ACA, may reinforce rather than narrow disparities among states, a recognized policy problem.

The remaining sections of this dissertation are laid out as follows. The second chapter is a review of the policy adoption and implementation literature. Then Chapter 3 introduces this study's conceptual framework, hypotheses, and propositions. Chapter 4 describes the study's data and methods. Chapter 5 presents the quantitative findings while Chapters 6 and

7 present the qualitative findings related to adoption and implementation respectively.

Chapter 8 is the discussion of the findings, and Chapter 9 is the conclusion.

CHAPTER 2

LITERATURE REVIEW: STATE POLICY ADOPTION AND IMPLEMENTATION

The literature on state policy adoption identifies multiple factors that may influence the adoption of new Medicaid home and community-based services (HCBS) offerings. These factors can be conceptualized in two broad categories: factors internal to a state and factors external to a state (Berry & Berry, 2007). Internal factors that shape state policy adoption include political ideology, governing capacity, interest groups, economic considerations, and existing policies while external factors relate to other states and the federal government. Once a state decides to adopt a specific policy, implementation is not a forgone conclusion. Existing literature suggests that effective policy implementation can depend on a multitude of factors, including who is involved in the process as well as the specific features of the policy.

This chapter begins with a discussion of the policy adoption literature focusing first on political factors including political culture and partisanship. The following section examines the impact of governing capacity – specifically, legislative professionalism, gubernatorial power, bureaucratic expertise, and divided government. The next section discusses the role of interest groups in policy adoption. Then I examine the impact of demographic and economic factors on state policy adoption followed by the role of institutional arrangements and previous policy decisions. The policy adoption literature overview concludes by examining the impact of factors external to the state, including the federal government and other states. After the policy adoption

discussion, I focus on the policy implementation literature. This section discusses how the policy implementation literature has progressed over the last fifty years, including major areas of debate and criticism. The chapter concludes with discussion of the HCBS policy implementation literature.

Policy Adoption

The policy adoption literature recognizes that many factors affect states' adoption of new policies. Within the literature, researchers initially examined internal and external factors separately. Internal factors were broadly grouped into two schools of thought – political or cultural factors and socio-economic factors. External factors were largely examined in the context of the diffusion literature which explored how policies adopted in one region spread to other areas. The 1990s saw the integration of internal factors, including political and economic variables, with diffusion models (Berry & Berry, 1990). Berry and Berry (1990) pioneered utilizing event history modeling³ to simultaneously test the impact of both internal factors and regional diffusion on policy innovation in the same model. Since then many studies across diverse disciplines have relied on event history modeling to understand states' adoption of specific policies.

Political Culture and Partisanship

The policy adoption literature suggests that political factors, including culture and partisanship, may account for different policy trajectories across states. Daniel Elazar was a proponent of the importance of cultural differences in explaining cross-state political variation. According to Elazar, political culture is “the particular pattern of orientation to political action in which each political system is embedded” (Elazar, 1966: 78). Elazar argued that U.S. states

³ Event history analysis is a statistically method for analyzing longitudinal data related to the timing of events.

differ in political culture, thereby contributing to differences in policy goals, political parties, and citizen involvement in governance. Elazar's research identified three political subcultures across the United States: moralistic, individualistic, and traditionalistic (Elazar, 1984).

Each political subculture perceives political participation, bureaucracy, government intervention, and the initiation of new programs differently (Elazar, 1984; Sharkansky, 1969). Moralistic culture sees the role of government as advancing the public interest and improving societal conditions. In contrast, in an individualistic political culture, the government's role is limited to ensuring order so markets can function. Unlike a moralistic culture, where new policies are enacted for the greater good; in an individualistic society, policies are determined by demand. The traditionalistic culture sees the role of government as very limited and focused primarily on ensuring safety and order. Consequently, policies in traditionalistic cultures are enacted to maintain the status quo (Elazar, 1984).

Due to historic migration patterns, the three political cultures described by Elazar dominant specific regions of the country. Moralistic culture is most often found in northern New England, the northern Midwest, and Pacific Northwest; individualist culture predominates in southern New England, the mid-Atlantic, and eastern Midwest; and traditional culture is most common in the South and Southwest. As a result of different political cultures, states may have diverse perspectives on the role of government in providing for their citizens and enacting social programs.

Empirical research supports Elazar's argument that culture accounts for variations in state public policies (Johnson, 1976; Fitzpatrick and Hero, 1988; Morgan & Watson, 1991). Johnson (1976) found that Elazar's three identified political cultures were correlated with a variety of state characteristics and government activities when controlling for state socioeconomic

characteristics, with moralistic states most likely to pursue innovative activities and traditional states least likely to pursue such activities. Fitzpatrick and Hero (1988) also identified relationships between political culture, policy innovation, and economic inequality, with moralistic states characterized by the greatest policy innovation and the least inequality. Morgan and Watson (1991) updated states' classification in Elazar's typology with more recent data. They found that moralistic states have more innovative and liberal policies while traditional states have the fewest. Overall, empirical evidence supports Elazar's assertion that moralistic states are more innovative and focused on reducing income inequality while individualistic and traditional states are less so.

Variation in state policy has also been explained by partisan factors including inter-party competition and the ideological leanings of state political parties. Early literature on state variation in public policy examined the role of partisan competition. Key (1949) and Lockard (1959) found that the degree of party competition within states can determine whether a state pursues more expansive policies. Key (1949) concluded that southern states with limited party competition were more likely to pursue policies that maintain the status quo whereas states with competitive party factions were more likely to pursue liberal policies. According to Key, political parties in states with greater competition have to appeal to the have-nots by enacting liberal social policies. Lockard (1959) examined the six New England states and found policy differences between one-party and two-party states in this region with respect to tax systems, spending for the disadvantaged, protection against employment discrimination, and legislative apportionment. In particular, Lockard (1959) found two-party states characterized by more equitable systems and greater protections for the disadvantaged compared to one-party states.

Subsequent empirical research found limited support for Key and Lockard's arguments. These studies concluded that socio-economic factors, including per capita income and industrialization, were more important influences on social welfare policies than inter-party competition (Dawson & Robinson, 1963; Fry & Winters, 1970; Hofferbert, 1966; Winters, 1976). Dawson and Robinson (1963), for example, found that while strong inter-party competition is correlated with more liberal social welfare policies, when controlling for socio-economic factors this influence diminishes. Winters (1976) found that interparty competition had no impact on the level of redistribution across states while economic variables were important predictors.

Greater support exists for the role of partisan control of state government as an influence on state-level policy development. Traditionally, Democrats tend to be more supportive of social welfare spending while Republicans tend to be more fiscally conservative and less supportive of funding programs in this area (Grogan, 1994). Therefore, states' provision of social services may be shaped by ideological differences of the two main political parties and which political party occupies the governor's office and controls the state legislature. Early research found that socioeconomic factors, rather than partisanship, played a larger role in explaining differences in social welfare spending. According to Dye, "differences in the policy choices of states ... turn out to be largely the product of differing socioeconomic levels rather than the direct impact of political variables"(Dye, 1966: 46). Similarly, Winters (1976) concludes that which political party is in control does not impact the level of redistribution or changes in redistribution policy. Other studies have found that the political party in control does have an impact but the effect is the opposite of what might be expected, with Democratic control associated with less political liberalism. Erikson, Wright, and McIver (1989) find that once in office legislators moderate their

policy stances, with Democrats moving to the right and Republicans moving to the left.

Likewise, Barrilleux (1997) also confirms that Democratic control is associated with less liberalism in policy outputs. These findings challenge conventional wisdom that Democrats are associated with liberal social welfare policies.

Within health care and Medicaid policy specifically, however, most research has found that Democratic leadership and liberal political ideology are associated with greater spending and more generous eligibility policies (Kousser, 2002; Grogan & Rigby, 2009; Lukens 2014; Jacobs & Callahan, 2013). Kousser (2002) finds Republican control of the state legislature is associated with less spending per capita on optional Medicaid groups. Focusing on the State Children's Health Insurance Program (SCHIP), Grogan and Rigby (2009) find that unified Democratic Party control and the percentage of Democratic legislators are correlated with increased generosity within this program. However, they also find that a Democratic governor does not contribute to more liberal SCHIP eligibility policies, signifying the importance of the legislature in determining eligibility policies. In examining determinants of Medicaid generosity for low-income children and adults, Lukens (2014) finds that unified Democratic control of state government is associated with more generous Medicaid eligibility policies. Similarly, Jacobs and Callaghan (2013) conclude that Democratic control is associated with greater and faster adoption of the ACA's health care expansion.

Research focused specifically on state long-term care and HCBS policies indicates that Democratic leadership and liberal political ideology contributes to more robust long-term care and HCBS policies. Lockhart, Giles-Sims, and Klopfenstein (2008) find that Democratic control is associated with greater generosity of state Medicaid nursing facility policies. Nattinger and Kaskie (2017) find that more liberal legislatures result in the adoption of greater protections for

assisted living residents. Studies focused on state Medicaid HCBS policies are consistent with these results. Harrington et al. (2000) find having a Democratic governor is associated with greater HCBS waiver spending. Kitchener et al. (2007) conclude that liberal states are more likely to offer a personal care benefit and have more personal care participants per capita. Similarly, according to Miller et al. (2008), having a Democratic governor is associated with greater state adoption of 1915(c) waivers for individuals with HIV/AIDS and more spending on each waiver participant. Miller and Kirk (2016) find that a Democratic governor is associated with greater investments for HCBS in states with an initially low investment.

Governmental Structure and Capacity

In addition to political factors, a state's governing capacity may influence the pursuit of new public policies. In particular, states with more professional legislatures, governors with stronger institutional authority, and a larger, more highly skilled bureaucracy may be in a better position to innovate (Miller, 2005; Miller et al., 2012). Some states have professional legislatures that resemble the U.S. Congress while other states have citizen legislatures where being a legislator is not a full-time profession. Generally, professional legislatures are characterized by higher pay, full-time membership, and greater staff and other resources compared to citizen legislatures (Squire, 1993). In the second half of the 20th century, state legislatures grew more professional with a higher percentage of state legislators working full-time as legislators (Jones, 1994). By having more staff and technical resources, states with professional legislatures are better positioned to adopt new policies, are more likely to adopt policies earlier, and are more likely to enact generous social welfare policies when compared to states with less professional legislatures (Walker, 1969; Hayes, 1996; Rom, 2014). State legislatures with full-time members and staff are better equipped to understand the intricacies and nuances of the complex programs

such as Medicaid. In addition, more professional legislatures may attract legislators with higher education who are more open to policy innovation. Higher legislative salaries can also increase legislative diversity because individuals with lower income have greater ability to serve.

In the empirical literature, the impact of legislative professionalism on policy innovation is mixed. Evidence suggests that the influence of legislative professionalism may depend on the policy under consideration. Both Carter and LaPlant (1997) and Karch (2006) find that legislative professionalism is associated with less innovation in some policy areas and more innovation in other policy areas. Within long-term care policy, Miller and Wang (2009a) conclude that legislative professionalism increases the likelihood of states adopting case-mix adjusted nursing facility reimbursement policies in the period prior to the Balanced Budget Act of 1997 but decreases the likelihood after the Balanced Budget Act implementation. Kelly, Liebig, and Edwards (2008) observe that greater legislative professionalism does not impact the volume of nursing home deficiencies but is associated with a lower percentage of severe deficiencies. Nattinger and Kaskie (2017) find that more professional legislatures result in less rigorous protection policies for assisted living residents.

Within state government, the adoption of new policies may also be influenced by the institutional powers of the governor. Across states, governors' powers vary with respect to the line-item veto, appointment power, and term limits. Governors in states with greater powers may have more autonomy to pursue new, innovative, or controversial public policies. As with legislative professionalism, the empirical evidence on the importance of gubernatorial power on public policy outputs is mixed. Several studies have found that governors with strong institutional powers are not more likely to shape public policy compared to governors with weak powers (Dye, 1969; Ferguson, 2003). In contrast, Barrilleux and Berkman (2003) conclude that

governors with stronger institutional budgetary power are better able to influence state policy. Similarly, Barrilleux (1999) finds that states with stronger governors tend to pursue more liberal public policies. Bowling and Ferguson (2001) find that the impact of governors with more formal powers depends on the policy in question. States with strong governors are more likely to pass legislation in the policy areas of crime and education but the powers of the governor have no impact on legislative achievements in several other policy areas (Bowling & Ferguson, 2001). In an analysis of comparative state health policy research, Miller (2005) found that in most studies gubernatorial power, reputation, and longevity were not significant predictors of variation in state health policy.

The third key governmental actor is state level bureaucrats. Within state government, bureaucrats typically have the detailed knowledge and expertise about intricate policy issues. Bureaucrats are able to utilize this specialized knowledge developed through administration to influence public policy (Niskanen, 1971). States vary with respect to both the size and professionalization of their bureaucracy. Literature on Medicaid decision-making suggests that state-level bureaucrats are key actors in determining specific Medicaid service offerings and program design (Schneider & Jacoby, 1996; Schneider, Jacoby, & Cogburn, 1997; Miller, 2006). As part of the Medicaid program, states must establish a single Medicaid agency within state government for the operation and oversight of the program. State officials within this agency are highly knowledgeable about the complexities of Medicaid policies, rules, and regulations. State bureaucrats play an especially important role in determining optional Medicaid services. According to Schneider et al. (1997), “decisions regarding optional services are left almost entirely to state Medicaid administrators. Program officials take the lead in proposing and formulating Medicaid optional service provisions for their respective states” (Schneider et al.,

1997: 241). While legislators and governors are concerned with overall Medicaid spending, both are less concerned with the details of program operation than program administrators. The details of operating Medicaid and proposing policy changes are thus left to bureaucrats within the state Medicaid offices.

These state bureaucrats within the Medicaid office are influenced by many of the same factors identified in the policy adoption literature. Literature suggests state political leaders, interest groups, structural factors, and state environmental conditions may influence bureaucrat behavior (Schneider & Jacoby, 1996). The governor can control the state bureaucracy through several mechanisms, such as appointing agency leadership and proposing budgets, while the legislative branch can exert influence over the bureaucracy by determining agency budgets and through legislative statutory control and oversight (Hammond & Knott, 1996; Huber, Shipan, & Pfahler, 2001). The relationship between state bureaucrats and interest groups can vary depending on the degree of interdependence between them. While the traditional depiction is of interest groups exerting influence over decision-makers, the relationship can also be mutually beneficial, with interest group and bureaucrats working together to advance shared interests (Barrilleaux & Miller, 1988; Abney & Lauth, 1986). In addition, state bureaucrats may be influenced by budgetary limitations, the need for services or programs within the state, or state ideology (Schneider & Jacoby, 1996).

The empirical literature suggests that having greater administrative capacity and a more professional bureaucracy contributes to increased spending and greater policy innovation. According to Barrilleaux (1999), increased capabilities of state agencies are associated with more liberal public policies. Particularly in the area of healthcare and Medicaid policymaking, the professionalization of the bureaucracy can be important because the issues are often complex,

and officials in the bureaucracy have specialized knowledge about the policies. Miller (2005) concludes that agency resources are positively correlated with outcomes such as nursing facility oversight and Medicaid expenditures. Barrilleux and Miller (1988) find that increased administrative professionalism is correlated with more Medicaid spending. In addition, Miller, Wang, Feng and Mor (2012) find that states with greater administrative capacity are more likely to adopt innovations such as wage pass-through policies to support direct care workers. When examining the ACA's health insurance provisions, Jacobs and Callaghan (2013) find that greater administrative capacity is positively correlated with Medicaid expansion adoption.

Policy adoption may also be impacted by whether the state government is divided. Three possibilities exist: unified government when the governor's office and both legislative bodies are controlled by the same political party, divided government when the governor's office is controlled by one party and both legislative bodies by the other party; or divided legislature when the governor's office and one legislative body are controlled by one party and the other party controls the other legislative body. Unified government may make it more feasible to pass public policies because there is greater consensus and fewer roadblocks when the same party holds the governorship and legislature (Berry & Berry, 1990).

While some studies have found that unified government is less likely to adopt specific policies (Berry & Berry 1990; Bowling & Ferguson, 2001), the majority of the literature either finds no significant relationship or a positive relationship between unified government and policy development (Miller, 2005). Mayhew (1991) challenged conventional wisdom by arguing that divided government was just as likely to pass significant legislation as unified government. Contrary to Mayhew's findings, Kelly (1993), Edwards, Barrett, and Peake (1997), Binder (1999), and Coleman (1999) conclude that divided government limits innovative and significant

legislation. Bowling and Ferguson (2001) find that the impact of divided government depends on the policy in question and whether the legislature is divided. They find that a divided legislature is associated with a higher percentage of bill failures for high conflict policy areas while divided government can increase the likelihood of bill passage for low conflict policies such as health and agriculture (Bowling & Ferguson, 2001).

Interest Groups

Another strand of literature examines the role interest groups play in policy outputs and expenditures. Interest group activity theories have different perspectives regarding the openness of American governmental institutions to all interests and groups. One theory of interest group activity, pluralism, suggests that all interest groups have the opportunity to influence policy. Proponents of pluralism, including Truman (1951) and Dahl (1961, 1967), argued that American democracy is open and responsive, and that through a process of bargaining and compromise public policies are shaped by all interested parties. In the United States, according to Truman (1951), there are many points of access for any group to influence government. In addition, there always exists the ability for “potential groups” to emerge if individuals are unsatisfied with the status quo. Dahl argued that “when one looks at American political institutions ... what stands out as a salient feature is the extraordinary variety of opportunities these institutions provide for an organized minority to block, modify, or delay a policy which the minority opposed” (Dahl, 1967: 326). In his seminal study of New Haven politics, Dahl (1961) found that a single group or small number of groups did not solely influence policy. Instead decision-making within city government was characterized by bargaining and compromise among many groups and interests. Due to the openness of government and the variety of interests attempting to influence government, pluralism sees all interests as sufficiently represented in the policymaking process.

A second theory, plural elitism or interest group liberalism, suggests that some groups are better organized and have more political power than others. Lowi (1967) and Olson (1965, 1981) disagreed with Truman's argument that unorganized individuals will unite if their interests are threatened. According to Lowi, well-established groups are able to define the problem and shape policy whereas the general public is amorphous and difficult to organize (Lowi, 1967). Lowi (1979) detailed how the United States has evolved to a system of interest group liberalism in which governmental agencies delegate power and influence to interest groups within their particular policy areas. Once interest groups become imbued with this power, it becomes difficult for others to have influence. Mancur Olson (1965) identified the challenges mass-based interest groups face in achieving policy goals. With large groups, members have little incentive to contribute towards the group goals because they can reap the benefits without bearing the costs. In contrast, smaller groups with concentrated interests are easier to organize and the gains are not spread as thin. As a result, large interest groups have less influence than small niche groups. Applying this argument to the health care industry, Olson contended that health policy is mainly influenced by provider groups because individuals are not incentivized to organize together (Olson, 1981).

Empirical studies testing these explanations of interest group activity offer mixed evidence and suggest that the influence of interest groups is more nuanced than either approach suggests. Mark Smith (2010) examines the impact when business interests unify to support or oppose policy change. Contrary to conventional wisdom, Smith finds that when corporations unite they are less likely to achieve their objectives because other interests, such as labor or environmental groups, unify in opposition. Nevertheless, business can achieve its public policy goals when there is limited opposition and by shaping public opinion (Smith, 2010).

Baumgartner, Berry, Hojnacki, Kimball and Leech (2009) examine interest group activity and lobbying across nearly 100 policy areas. They find that spending on lobbying and Political Action Committees has limited impact on policy outcomes; however, interest groups with substantial business assets and connections to government are slightly more likely to achieve their preferred policy position. According to Baumgartner et al. (2009), one reason resources have a modest impact is that the status quo already reflects the interest of the wealthy and powerful. Maintaining the status quo is easier and requires less resources than achieving policy change. In testing both pluralism and elite pluralism, Gilens and Page (2014) find empirical evidence that business-oriented interest groups have an influence over policy outputs while the impact of mass-based interest groups is minimal. These findings support Olson's argument that mass-based groups have a difficult time organizing.

Many studies have identified interest groups as an important factor in explaining state Medicaid policy. These studies recognize that within Medicaid policymaking, various populations and groups have a stake in different aspects of the program including eligibility, benefits, and provider payments (Kronebusch, 1997). The key Medicaid constituent groups include low income individuals, elders, hospitals, physicians, and nursing facilities. These populations have different interests with respect to Medicaid policy and have different relative strengths. In a study of Medicaid policy and spending, Barrilleaux & Miller (1988) conclude that "that large portions of state and national budgets are at the mercy of a relatively small and well-organized interests" (Barrilleaux & Miller, 1988: 1100). They find that a small number of provider groups within a state is associated with higher Medicaid spending. In contrast, in states with many diverse interests, those seeking to change Medicaid policy lack a unified voice and have less of an influence on policy. Camobreco (1996) examines Medicaid spending by

eligibility category and finds support for the plural elitist theory. Increased spending is associated with nursing home interest groups, hospital interest groups, and the elderly. The nursing home and hospital findings support plural elitist theories that large, well-organized business interests shape public policy.

Existing research suggests the importance of both provider groups and consumer advocacy organizations in the development of state long-term services and supports (LTSS) and HCBS policies. In regulatory policy, states with stronger assisted living industries are less likely to adopt stringent oversight protections (Nattinger & Kaskie 2017). Previous research shows that the relative power of consumer and nursing facility lobbies were important in the development of HCBS programs in five states (Kitchner & Harrington, 2004). In addition, studies of HCBS spending and participants indicate that more institutional beds are associated with less spending and use of HCBS options by states (Miller, Harrington & Goldstein, 2002; Miller et al. 2008) while Kitchener, Carrillo, and Harrington (2004) find that a larger supply of home health agencies contributes to greater HCBS participants and expenditures.

In previous research, the relative strength and organization of consumer advocacy organizations were also important in health care and LTSS policy development (Miller, 2005). Evidence suggests that the presence and strength of elder advocacy groups varies across states. Elder advocacy groups are strong in some states, such as New York and Wisconsin, while lacking in other states, including Alabama and Mississippi (Wiener & Stevenson, 1998). Less well organized and weaker HCBS consumer advocacy groups were a common factor among states that spent less per capita on HCBS waivers (Kitchner et al., 2002). A key factor in the growth of community-based alternatives for individuals with developmental disabilities has been the influential role of consumer advocacy groups such as the Arc (Braddock, 1992). In addition,

Merryman et al. (2015) find that advocacy efforts and support from family members of individuals with Autism Spectrum Disorder were important in the adoption of 1915(c) waivers for this population.

Socioeconomic Considerations

The public policies that a state pursues may be influenced by the characteristics and needs of the population within its jurisdiction. As discussed earlier, states differ with respect to the number and percentage of older adults and disabled individuals. Population differences such as these may shape the demand for state action on specific policies. Andersen's model of health services utilization identifies three factors – predisposing characteristics, enabling resources, and need – that determine an individual's health care usage (Andersen, 1995). Predisposing characteristics are the predisposition of individuals to use health care services and include demographic factors such as age and gender as well as social structure such as education, social networks, and culture. Enabling resources are factors that enable or impede an individual's use of health care; these include the availability of health care and individual resources such as health insurance and income. Need suggests an individual's need for care is an important determinant of the utilization of health care and would include disease diagnoses and perceived need (Andersen, 1995).

Andersen's approach has also been applied at a broader level to explain variation in health care and long-term care utilization across states rather than individuals (Kitchener, Carrillo, & Harrington, 2003; Kitchener, Ng, Carrillo, Miller & Harrington, 2007). Predisposing factors, such as age and disability status, may determine citizens' demand for long-term care services while enabling factors, such as the state's ability to raise revenue, the distribution of insurance, and the availability of providers, may shape a state's willingness or ability to supply

services. Studies have shown state policy development and expenditures are influenced by the characteristics of the population including age, disability status, percentage minority, and percentage urban (Miller et al., 2005; Kitchener et al., 2007). Kitchener et al. (2003) found that a higher percentage of the population aged 85 and older is associated with more Medicaid waiver participants and greater HCBS spending per capita. Miller et al. (2006) found that the percentage of the population with a disability is correlated with more waiver participants and greater per capita expenditures.

The literature also identifies several economic factors that are important in enabling social welfare spending. States in solid financial standing are often better positioned to pursue new policy opportunities than states in financial distress, both with respect to general wealth (fiscal capacity) and with respect to prevailing economic conditions (fiscal health) (Davidson, 1980; Boyd, 2003; Berry & Berry, 2007). Early literature focused on the impact of industrialization and economic growth. One of the proponents of this explanation was Wilensky (1975) who argued economic growth is the root cause of welfare state development. Since states with higher per capita income have a large taxable base and greater ability to collect taxes, this translates into more revenue to spend on various social service programs (Snyder, Rudowitz, Garfield, & Gordon, 2012). Previous research demonstrates wealthier states spend more on social services and exhibit a greater commitment to access to care (Benjamin, 1986). With respect to Medicaid specifically, studies have found states with higher per capita income have higher Medicaid spending (Buchanan, Cappelleri & Ohsfeldt, 1991; Kousser, 2002).

The literature on policy innovation also identifies economic factors as important to the adoption of new policies and programs. In explaining innovation, Mohr (1969) identifies three determinants of innovation in public agencies: the motivation to innovate, the strength of

obstacles, and the availability of resources. Mohr finds that greater resources are associated with more innovation. Having slack or excess resources can enable a state to pursue new policy opportunities (Walker, 1969). With excess capacity, agencies and organizations have the ability to pursue new programs which can bring increased status and prestige (Mohr, 1969). Both Walker (1969) and Gray (1973) finds correlations between state wealth and the adoption of new policies. In addition, when examining the adoption of optional Medicaid policies, Schneider and Jacoby (1996) and Jacobs and Callahan (2013) find that higher per capita state income increases the likelihood of pursuing these benefits.

Within long-term care, state per capita income is correlated with higher overall long-term care and nursing facility expenditures per capita (Miller et al., 2002). Several studies on Medicaid HCBS demonstrate that state per capita income is associated with more HCBS recipients per capita and higher HCBS spending per capita (Miller et al., 2001; Miller et al., 2002; Kitchener et al., 2003; Miller et al., 2005, Miller et al., 2006). When examining the percentage of LTSS spending for HCBS, states with higher income spend more on HCBS compared to nursing facilities (Miller et al., 2002). Funding concerns are often a factor in deciding to adopt specific HCBS policies. Merryman et al. (2015) find that for states that expressed an interest but did not pursue a 1915(c) waiver for individuals with Autism Spectrum Disorder, funding was the most important barrier.

A state's ability to adopt a new policy may also be shaped not only by the level of wealth but the prevailing fiscal climate. During periods of economic downturn, states often encounter declining revenues at the same time as demand for public benefits rises (Rom, 2014); specifically, higher unemployment leads to more individuals eligible for welfare and Medicaid benefits as the size of the tax base declines. In recessions, policymakers often do not implement

new policies with added costs and instead look to eliminate or limit existing programs. States typically change Medicaid eligibility requirements, decrease provider payment rates, or eliminate benefits to balance budgets during periods of economic distress (Wides, Alam, & Mertz, 2014; Snyder & Rudowitz, 2016). Unlike the federal government, most states are required to have a balanced budget which puts extra pressure on states during recessions. More than 40 states implemented Medicaid cost containment strategies in reaction to the recession in the early 2000s (Boyd, 2003). During the Great Recession, the American Reinvestment and Recovery Act of 2009 (ARRA) limited the ability of states to reduce Medicaid eligibility in an effort to reduce costs. However, after the temporary increase in federal relief through ARRA ended, many states enacted Medicaid cost containment measures. In the wake of the Great Recession, thirty-nine states reduced provider rates and eighteen cut or limited optional services such as dental and vision benefits (Smith, Gifford, Ellis, Rudowitz, & Snyder, 2011; Seefeldt & Graham, 2013). The Great Recession also contributed to reductions in LTSS spending. In fiscal year 2010, thirty-one states reported cutting aging and disability programs (Walls, Gifford, Rudd, O'Rourke, Roherty, Copeland, & Fox-Grage, 2011). Most of these cuts occurred in Older Americans Act or state-only programs and not Medicaid services. The majority of states did not make cuts to Medicaid-funded LTSS primarily because ARRA prevented states from making changes to Medicaid eligibility.

Within Medicaid policymaking, the federal fiscal contributions for Medicaid spending may mitigate the relationship between state wealth, fiscal climate, and state Medicaid generosity. In each state, a portion of Medicaid spending is reimbursed by the federal government. Typically high income states are reimbursed by the federal government for 50% of Medicaid spending while low income states are reimbursed up to 75%. Therefore, when adopting new Medicaid

benefits, the costs to the states are less in lower income states due to the higher federal match rate received by those states. However, evidence indicates that low income states spend less on Medicaid than higher income states even with the federal government covering more of the cost (General Accounting Office, 1995). Moreover, during the last few economic downturns, the federal government has increased states' Medicaid match rates. With higher federal contributions during recession, states may not need to cut benefits or change eligibility as radically as might have otherwise been required.

Existing Policies

A final internal factor that may impact policy change is existing policies which can shape or limit subsequent policymaking. In general, public policy develops and changes incrementally; as a result, past public policies shape the development of future policies (Lindblom, 1959). According to Lindblom, the development of public policies is characterized by “continually building out from the current situation, step-by-step and by small degrees” (Lindblom, 1959, 81). Since a single policy is unlikely to achieve all objectives, policymakers build on previous policies to advance goals. Based on the incremental nature of public policy, historical institutionalism perceives the diverse institutional arrangements deriving from prior policy decisions as decisive in shaping current policy decision-making and outcomes (Steinmo & Watts, 1995). These institutions may include formal constitutions, regulations, norms of behavior, and structures of the bureaucracy. Since this approach emphasizes the importance of often stable institutional structures, historical institutionalism expects path dependent processes to occur (Hall & Taylor, 1996). After starting on a particular path, deviating from that path can become costly. Due to increasing returns and institutional inertia, policies adopted early can have unintended consequences by forestalling or facilitating later policy options (Pierson, 2000). In

this respect, initial policy decisions and institutional configurations play a determinant role in subsequent policymaking.

In addition to the institutions and rules that prior policies establish, public policies can also create new constituencies and groups with an interest in that area. Once a group obtains benefits from a policy, members have an incentive to mobilize to promote future policy development. According to Schneider and Ingram (1993), public policies shape individuals' conception of citizenship and their participation in government. On the issue of Social Security and Medicare, the benefits provided to seniors helped create a powerful group with an interest in these policy areas. During the 1980s, seniors successfully mobilized to oppose detrimental changes to benefit levels in both programs (Campbell, 2003).

In addition, public policies can change mass public opinion within specific policy areas. Policy feedback can influence the public's perception of problems and potential solutions. Policies adopted can influence whether society views a problem as an individual or governmental responsibility (Mettler & Soss, 2004). Over the last eighty years, the Social Security program has contributed to the widespread opinion that providing security for older Americans is a societal responsibility. Across generations, income levels, and political parties, most Americans agree that Social Security is important and are willing to pay higher taxes to preserve the program (Walker, Reno & Bethell, 2014). In a more recent example, the ACA has changed Americans' conceptions about the role of government in health care. In a 2017 survey, 60% of Americans said the government should be responsible for ensuring health care coverage for all compared to 31% in 2000 (Bialik, 2017).

In numerous policy areas, studies indicate that previous policies influence future policy development. Scholars have adopted historical institutionalist approaches to explain variation in

welfare states and different health care systems across countries and states (Cowart, 1969; Steinmo & Watts, 1995; Chen & Weir, 2009). Cowart (1969) finds that the most important factor in a state's participation in new federal anti-poverty programs is previous participation in similar welfare programs. In a case study of the U.S and U.K, Steinmo and Watts argue the United States lacks a national health care system because the fragmented design of U.S. political institutions limits potential reform due to the comparatively greater power and influence of interest groups (Steinmo & Watts, 1995). Similarly, Chen and Weir adopt a historical institutional approach to explain why Massachusetts adopted health care reform during the 2000s while California did not (Chen & Weir, 2009). Within Medicaid policymaking specifically, several studies have found that previous policymaking is crucial in understanding the adoption of later policies. Satterthwaite (2002) finds that states with a policy legacy of managed care are more likely to adopt managed care programs for the Medicaid program. With respect to the ACA, states that had already implemented Medicaid policies expanding coverage to optional groups were more likely to adopt aspects of the ACA's health insurance provisions (Jacobs & Callaghan, 2013).

Existing policies can also facilitate or inhibit the adoption of other policies because they are, in part, alternatives or complements to the policies in question. For example, many states have adopted nursing facility certificate of need programs or a moratorium on beds in an effort to control LTSS costs and expand HCBS alternatives. Existing literature suggests that nursing facility certificate of need programs or moratoriums are associated with a greater percentage of LTSS spending on HCBS and higher HCBS spending per capita (Miller et al., 2001; Miller et al. 2002; Miller et al. 2006). In contrast, public policies that limit home health agencies are correlated with less LTSS spending that is community-based, fewer waiver participants per

capita and less waiver spending per capita (Harrington et al., 2000; Miller et al., 2001; Miller et al., 2002).

In addition to policies that limit supply, Medicaid eligibility policies may also shape policy adoption decisions. States that have generous Medicaid eligibility policies may be more likely to add optional benefits because of a greater commitment to offer benefits to residents compared to states with more restrictive eligibility requirements. Previous research has found that states with higher Medicaid eligibility criteria have higher total Medicaid, nursing facility, and HCBS expenditures (Harrington et al., 2000; Miller, 2005). In addition, states that have expanded Medicaid eligibility to optional groups such as pregnant women, working parents, and the medically needy were more likely to adopt the ACA's Medicaid expansion (Jacobs & Callahan, 2013). Alternatively, other research suggests that states with more generous Medicaid eligibility may face greater pressure to contain Medicaid costs. Miller and Wang (2009b) find that states that offered Medicaid to the medically needy were more likely to adopt nursing facility provider taxes. Similarly, Lindsey, Jacobson, and Pascal (1990) and Nelson (2007) find that states with a medically needy program are less likely to adopt a 1915(c) waiver for individuals with HIV/AIDS.

External Factors

Studies of cross-state policy differences also recognize that state policymaking does not occur in a vacuum but rather state policies are shaped by policy decisions made by other states and the federal government. Policies adopted by early innovator states may spread to other states through several different mechanisms (Balla, 2001; Shipan & Volden, 2008). Foremost, regional diffusion occurs when policymakers in one state look to the policies of neighboring states to address shared policy problems, either because they are seeking to identify the most effective

policy or a legitimate and appropriate course of action, regardless of effectiveness (Balla, 2001; Berry & Baybeck, 2005; Miller & Banaszak-Holl, 2005). According to Berry and Baybeck, “[w]hen confronted with a problem, decision-makers simplify the task of finding a solution by choosing an alternative that has proven successful elsewhere” (2005, 505). Neighboring states are a natural place for states to identify public policies due to close communication and shared values. By observing nearby states, decision-makers can glean both policy and political information (Mooney, 2001). Policy information includes the impact and effectiveness of the policy while political consequences suggest the political risks or benefits to nearby states. Empirical studies have identified a regional effect on the diffusion of policies across states (Walker, 1969; Berry & Berry, 1990)

States may also pursue policies that other states in the region have enacted to remain competitive with nearby states (Volden, 2002; Bailey & Rom, 2004; Shipan & Volden, 2008). States may adopt policies both to attract and deter specific individuals or businesses from coming to their state. Examples of policies to attract individuals or business include low tax rates and pro-business policies. To deter individuals from coming, a state may adopt limited social welfare policies because of concerns that generous welfare policies vis-à-vis its neighbors will attract welfare beneficiaries (Rom, 2014). Empirical evidence suggests that states do take into account the welfare policies of other states to avoid offering more generous benefits than nearby states (Bailey & Rom, 2002). Rom, Peterson and Scheve (1998) found that a neighboring state’s Aid to Families with Dependent Children benefit level impacted a state’s benefit level for this program. Bailey and Rom (2002) also found support for the “race to the bottom” theory across three state level redistributive programs.

The literature suggests the role of professional organizations, policy entrepreneurs, and national coalitions are important in explaining state policy adoption across a variety of issues including Health Maintenance Organization regulation, school choice policy, and same-sex marriage bans (Balla 2001; Mintrom, 1997; Haider-Markel, 2001). With the growth of state level membership organizations, state decision-makers are in closer communication not only with neighboring states but also individuals across the country. Professional organizations and national conferences bring officials from across the country together to share ideas and experiences (Walker, 1969; Balla, 2001). At these conferences, state officials can learn about the successes and challenges other states encounter in adopting policies. Policy entrepreneurs may account for the diffusion of policies and programs as well. These individuals have an interest in the adoption of specific policies. Through their expertise, coalition building, and networking they can increase the likelihood of policy adoption (Mintrom, 1997). Similar to policy entrepreneurs, national advocacy coalitions can promote the adoption of policies across states. These coalitions can mobilize state level groups and provide funding to achieve their policy goals (Haider-Markel, 2001).

Policy adoption not only occurs horizontally across states but also vertically through policies and relationships with the federal government. Federal policy can shape state policies in several ways: at the most basic level, mandates from the federal government require states to enact changes (Miller & Banaszak-Holl, 2005; Karch 2006). Governmental mandates can arise from different branches of government, including the U.S. Supreme Court, Congress, or the executive branch and bureaucracy (Allen, Pettus & Haider-Markel, 2004). Examples of federal government mandates include the Supreme Court's *Olmstead* decision requiring states to serve people with disabilities in the least restrictive setting and Congress' decision requiring states to

set a 5-year limit of welfare benefits in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Research suggests that federal mandates can have spillover effects into other policy areas. If a new mandate requires additional state spending, states make decide to reduce spending in other areas (Grogan, 1999).

Second, the federal government may use its financial resources to influence state decision-making. Financial incentives (carrots) can encourage specific actions while financial penalties (sticks) can be utilized to discourage other actions (Welch & Thompson, 1980). The federal government utilizes incentives by transferring funds to states in several ways, including grants-in-aid, block grants, and project grants (Allen et al. 2004). Financial incentives can make it easier for states to pay for the costs of a new program or policy because a portion of spending will be covered by the federal government. Both Welch and Thompson (1980) and Allen et al. (2004) find that federal incentives or penalties increase the rate of diffusion across states. This research also suggests that positive financial incentives are more effective than negative penalties at diffusing policies.

Third, states may encounter cognitive and normative pressures deriving from federal action to make policy changes (Miller & Banaszak-Holl, 2005). According to Allen et al. “the national government may send state policymakers signals concerning its preferences and the likelihood of its future action ... [t]hese signals may be taken as an endorsement by the national government of a specific policy choice, making it more likely that state policymakers will adopt that policy”(2004, 321). One reason states may respond to federal pressure without a mandate or financial incentive is that state policymakers believe the federal government will take up this policy issue in the future. Also, federal support may strengthen interest groups who then make their case at the state level (Allen et al., 2004). In addition, states may pursue policies consistent

with federal expectations because the policies reflect their own values and beliefs (Miller & Banaszak-Holl, 2005). Empirical evidence suggests that the level of clarity in the federal government's position on an issue can determine whether or not the federal government influences state policymaking (Allen et al., 2004).

Policy Implementation

A state's decision to adopt a specific policy is only one step in the policy making process. Once a policy is adopted, bureaucrats or other officials are then responsible for implementing it. Prior to the 1960s and 1970s, most public policy research focused on policy adoption while less attention was paid to implementation. The assumption was that once a policy was enacted it would be implemented without problems (Van Meter & Van Horn, 1975). The implementation challenges and failures of several prominent public policies during the 1960s contributed to a greater emphasis on the factors that impede and promote policy implementation. Since the 1960s, the policy implementation literature has progressed through several phases: initial case studies examined in detail the process implementing a single policy, while subsequent research sought to develop theoretical frameworks to identify the factors that contribute to implementation failures or successes. Although many studies have proposed frameworks for understanding implementation, a criticism of this literature is an overabundance of identified variables that may impact the implementation process and a lack of agreement on a parsimonious theoretical framework. Nevertheless, the implementation literature can still provide insights into the success and challenges states encounter when implementing new Medicaid HCBS policies.

Phases of Policy Implementation Research

During 1960s and 1970s, several case studies examined the challenges associated with policy implementation and why policies failed to achieve their goals. These studies explored a

variety of issues, including urban development, housing policy, education, the environment, and health policy (Pressman & Wildavsky, 1973; Derthick, 1972; Bailey & Mosher, 1968; Jones, 1975; Alford, 1975). Pressman and Wildavsky's (1973) examination of the failure of the federal Economic Development Authority's Oakland project is often considered the originator of this literature. The Oakland project -- the brainchild of the Economic Development Authority -- aimed to provide jobs to Oakland residents through public works projects. Pressman and Wildavsky argued that seemingly mundane and ordinary actions thwarted the implementation and doomed the project. For example, they found that involving greater numbers of individuals and agencies in the decision-making and approval processes can create impediments to implementation. Delays or challenges at one step in the process can cause setbacks or derail the project altogether. In a similar vein, Martha Derthick (1972) examined the failure of President Johnson's administration's new towns-in-town program, which intended to create housing for the poor by utilizing surplus federal land in seven U.S. cities. According to Derthick, a key reason the program failed was the federal government's attempt to direct policy on an issue (housing) that is governed locally. The federal government lacked the knowledge about local housing conditions as well as sufficient inducements to incentivize local participation in the program. Both Pressman and Wildavsky and Derthick's studies typify early implementation research, which focused in depth on a single policy utilizing case studies. Overall, these early studies presented pessimistic views of the implementation process.

During the late 1970s, a second generation of implementation studies sought to advance conceptual and theoretical models of the implementation process (Van Meter & Van Horn, 1975; Sabatier & Mazmanian, 1979; Montjoy & O'Toole, 1979). Rather than relying on single case studies, this research tried to uncover common factors that impact implementation. Van Meter

and Van Horn (1975) proposed a theoretical framework for understanding the policy implementation process. They identified two key characteristics of public policies that are important for understanding implementation: the amount of change required and the level of consensus among participants. Van Meter and Van Horn argued that implementation is more likely to be successful when change is marginal and consensus is high. They also identified six variables that can impact implementation: policy objectives; standards and objectives being clear and understood by implementers; the disposition of those implementing the policy towards it; resources; the implementing agency's capacity; and economic, social, and political conditions. According to Van Meter and Van Horn, a public policy must have clear and easily measurable objectives to evaluate whether the implementation achieves the policy goals. These objectives must be understood and supported by those implementing the policy -- otherwise implementers may not implement the policy as intended or may thwart the implementation process if the policy objectives conflict with their own goals. Policies that offer financial resources and rely on implementing agencies that have sufficiently experienced staff are more likely to achieve implementation success. Lastly, the current economic, social and political conditions can impact implementation.

Sabatier and Mazmanian (1979) also identified three components that impact implementation: the tractability of the problem; the ability of statute to structure implementation; and non-statutory factors that impact implementation. Similar to Van Meter and Van Horn, Sabatier and Mazmanian argued that some policy problems are easier to address than others, and the implementation process will be affected by the tractability of the issue. For example, many of the challenges implementing the ACA's health insurance provisions are partly attributable to the complexity of health insurance and care in the United States. According to Sabatier and

Mazamania, the policy statute can structure implementation by being clear and making financial resources available to implementing agencies. In addition, factors outside of the legislation can impact implementation such as the amount of media attention and the level of support among the general public and political officials. As is evident from the discussion, these early theoretical approaches suggest many factors that affect implementation.

During this time, a major debate within the literature arose about whether top-down or bottom-up approaches to structure the implementation process are important for implementation success. Top-down approaches stress the importance of authoritative decisions for successful policy implementation while bottom-up approaches emphasize the role of street-level bureaucrats and target populations (Matland, 1995; deLeon & deLeon, 2002). Many of these early conceptual frameworks, including Van Meter and Van Horn (1975) and Sabatier and Mazamania (1979), utilize a top-down approach and underscore the importance of policy clarity and communication from decision-makers to the implementing agency. The focus is on how closely the policy implementation process and achievement of outcomes align with the policy's goals. From a top-down perspective, Sabatier and Mazmanian (1979) argue a statute that structures the entire implementation process is a key factor for successful policy implementation. They suggest ways in which decision-makers can increase the likelihood of implementation success by selecting implementers who have a favorable perspective of the policy and by exerting control over the implementing agency. Top-down approaches emphasize factors at a centralized rather than local level (Matland, 1994).

In contrast, bottom-up approaches to policy implementation start with individuals and groups at the local level. According to this approach, policy implementation involves both the macro-decision-maker level and micro-implementer level (Berman, 1978). Once a policy is

adopted at the macro-level, individuals and organizations at the micro-level respond to the policy and devise their own implementation plans to fit local conditions. Street-level bureaucrats and others at the local level shape and change the implementation process in ways central decision-makers cannot envision and control (Lipsky, 1980). Therefore, if the same policy is implemented in multiple jurisdictions, the implementation process and outcomes can vary even if the central actors, policy language, and implementation resources are the same across jurisdictions.

According to Hjern and Porter (1981), understanding the implementation process involves uncovering the individuals and organizations, both public and private, involved in implementation of specific policy areas. Since bottom-up approaches emphasize the uniqueness of each local situation, this perspective is less prescriptive in how policies should be designed to improve implementation. Instead, bottom-up approaches stress the importance of policy flexibility and local input for successful implementation (Matland, 1994).

Scholars have attempted to bridge the gaps between top-down and bottom-up approaches in several ways. Some have sought to bring together elements of each within the same model while others have specified the conditions under which one approach is more applicable than the other (Matland, 1994). Elmore (1982) sought to combine the two approaches through forward and backward mapping. Forward mapping involves examining the levers central policymakers control while backward mapping consists of understanding implementation decisions at the individual or organizational level. According to Elmore, “the success of policy depends on more than choosing the correct combination of implements; it depends as well on conditions outside the control of policymakers and on decisions over which policy exercises only a marginal influence”(Elmore, 1982: 69). Sabatier (1985) also combines the two approaches in his advocacy coalition framework. According to Sabatier, one must start from a problem and identify all of the

individuals and organizations involved in the issue at various levels of government and in the private sector. Within this coalition, legal and socio-economic conditions may structure decision-making (Sabatier, 1985). Other scholars have sought to identify when top-down or bottom-up approaches are more applicable. According to Berman (1980), top-down approaches are more appropriate when the change is incremental and there is little uncertainty while bottom-up approaches should be utilized when uncertainty and instability exist.

In addition, empirical studies have tested the importance of top-down or bottom-up aspects of policy implementation. Berry, Berry and Foster (1998) examined the implementation of an electronic supervisory system in Florida using survey data. They found that many of the factors identified by Van Meter and Van Horn (1975), including communication from higher levels, the disposition of those implementing the system, and resources, were important in implementing Florida's Department of Highway Safety's Supervisor Assistance System. Utilizing Sabatier and Mazmanian's framework, Meier and McFarlane (1995) tested the importance of coherent statutes across four different policies. They found that statutory coherence is important for the successful implementation of these policies. Jennings and Ewalt (2000) examined the impact of local decisions on reducing welfare caseloads after the passage of Temporary Assistance for Needy Families. Jennings and Ewalt hypothesized that the degree of success in achieving national welfare reform goals depends largely on the decisions of state and local administrators. In testing their hypotheses, they found that administrative actions at the state level are important in reducing welfare rolls; however, contrary to expectations, they found that cultural change in welfare offices is not correlated with reductions in welfare rolls. Overall, empirical studies provide some support for both top-down and bottom-up approaches to conceptualizing policy implementation.

During the 1990s, contingency theories emphasized that implementation strategies depend on the characteristics of the policy and political environment. Arguing that there is no one size fits all approach to policy implementation, these scholars identified different implementation approaches based on the policy. According to Ingram (1990), "success in implementation must be evaluated within the context of particular problems, and critical factors affecting implementation will vary with what is being attempted"(Ingram, 470). Several of these approaches used two by two matrices to understand patterns in implementation. Matland (1995) found that the degree of policy ambiguity and conflict is important in determining whether top-down or bottom-up explanations are more appropriate and identified four types of implementation: administrative implementation, political implementation, experimental implemental, and symbolic implementation, depending on the characteristics of the policy. Ingram (1990) identified the importance of clientele relationships and administrative capability as key factors in successful policy implementation.

Another aspect of implementation research has focused on the role of cognition in implementing public policies. This approach argues that the implementation process is dependent on how those implementing the policy understand and interpret the policy (Spillman, Reiser, & Reimer, 2002). Policy implementers interpret a policy based on how it fits with their knowledge, previous experience, and existing beliefs. Therefore, implementers may have different conceptions of the policy than higher level decision-makers, depending on their understanding and interpretation of the statute or regulation in question. Within education policy, research suggests that educators and local officials may believe their teaching practices are consistent with new policies, but from the perspective of national or state level officials it is not (Spillman et al., 2002). This approach recognizes another potential avenue of policy failure at the local

implementers' level: policy implementation can fail because policy implementers understand and therefore implement the policy differently than decision-makers intended (Spillman et al., 2002). Hence, policy failure is not only possible when implementers intentionally ignore or interfere with the implementation process contrary to decision-makers intentions, but also when they implement the policy differently due to their own understanding of the policy. This approach combines aspects of the top-down and bottom-up perspectives by recognizing both the importance of the policy message and how it is communicated from decision-makers as well as the role of implementers' understanding of the policy based on their own knowledge, experiences, and world views.

Criticism of Policy Implementation Literature

A frequent critique of this literature is an overabundance of factors identified that impact implementation and a lack of a theoretical framework to structure research. Over the years, studies have identified hundreds of variables that influence public policy implementation, and the literature lacks parsimony (O'Toole, 1986; Matland, 1995). As a consequence, Meier (1999, 6) proposes “[a]ny new policy implementation scholar who adds a new variable or a new interaction should be required to eliminate two existing variables.” Due to the plethora of variables across studies, this research lacks an overarching theoretical or conceptual framework.

While many studies have sought to propose a framework for implementation research, the literature lacks consensus about the concept of implementation and what should be the dependent variable (Winter, 2012). Implementation research can focus on the implementation process or the output of the policy in question. Research that focuses on outputs evaluates the success or failure of the implementation process largely based on whether the policy objectives were achieved (Winter, 2012). An alternative focus is not on whether or not the policy outcome

was achieved but the process through which individuals and organizations sought to implement the policy (Lester & Goggin, 1998).

A second disagreement in the literature is whether top-down or bottom up approaches contribute to successful implementation. Each approach suggests that different factors are most important when implementing public policy. For example, top-down approaches, which emphasize the role of centralized decision-makers to structure the implementation process, may be incompatible with bottom-up approaches, which stress the importance of local control and discretion. With limited consensus, the policy implementation literature proposes contradictory suggestions for increasing the likelihood of successful policy implementation. For example, some research indicates that marginal policy changes are easier to implement while other research suggests that fundamental policy shifts are easier to implement (O'Toole, 1986). More recent literature has sought to combine aspects of both approaches to identify conditions where one approach may be more applicable than the other.

Due to the many variables identified, the lack of a theoretical framework, and disagreement in the literature about the benefits of top-down and bottom up approaches, the real world applications of policy implementation research are often limited. O'Toole (1986) indicates that there is little evidence that decision-makers are relying on implementation research when designing and implementing public policies. In designing policies, decision-makers cannot take into account all of the variables identified in the literature because there are so many. In addition, since there is a lack of a theoretical framework, the literature does not identify the variables that are most important. Also, some of the recommendations of policy implementation approaches are often unrealistic given political circumstances. For example, top-down approaches recommend policy clarity and selecting implementers with favorable views of the program. To

attract support and pass legislation, however, the goals and means of policies often need to remain ambiguous. In addition, in a federal system where states often play a key role in implementing public policies, decision-makers typically cannot select or control implementers to achieve a desired result. The recommendations of policy implementation research often do not give sufficient consideration to the political realities of policy development and administration.

Another criticism of implementation research is frequent reliance on the single case study design. Much of the early research on implementation examined in detail the challenges implementing a specific policy (Goggin, 1986). This approach contributed to the identification of a large number of relevant variables because each study uncovered different factors that impact implementation. According to Goggin (1986), this led to the “[t]oo few cases/[t]oo many variables problem in implementation research”. Within a single case, identifying the impact of the independent variables on the dependent variable is difficult because other factors cannot be controlled. As a result of this perceived weakness, Goggin et al. (1990) advocated for rigorous testing of implementation theories. Later research addressed this criticism to some degree by utilizing larger N studies (Berry, Berry & Foster, 1998; Meier & McFarlane, 1995). In addition, more recent studies adopt comparative case study designs examining implementation of a policy across different jurisdictions (Winters, 2012); however, many of these studies still involved the examination of a single policy.

Implementation of Long-Term Services and Supports and Home and Community-Based Services Policies

The implementation of Medicaid policies in general and HCBS policies specifically highlights the importance of the relationships between federal and state governments in implementing these policies. In Medicaid HCBS policy, the growth of HCBS waivers is an

example of executive federalism in which policy and decision-making occurs within the executive branches of state and federal governments and not in the legislative arena (Thompson & Burke, 2009). With Medicaid waivers, the major actors involved in drafting, negotiating, approving, and overseeing waivers are officials within Centers for Medicare and Medicaid Services (CMS) and state Medicaid offices. These officials are involved in the negotiations to implement Medicaid programs.

The relationships among these officials can vary depending on the specific type of waiver. In general, with 1915(c) waivers the federal government has given state governments more latitude than with 1115 demonstration waivers. According to Thompson and Burke (2009), “1915c waivers tend to be more exclusively bottom-up and state-driven than ... 1115 demonstration waivers. Once approved, oversight of the 1915c waivers by federal regional offices tends to be minimal and their renewal nearly automatic” (p. 37). In contrast, 1115 demonstration waivers often involve protracted negotiations between federal and state officials with additional federal requirements imposed on states. According to Thompson and Burke (2009), the amount of latitude the federal government gives states is dependent on whether the federal government has clear policy preferences and whether it believes the states will successfully carry out those objectives. When the federal government has concerns about states’ ability to achieve policy goals, more bargaining occurs when implementing the program.

A limited number of studies have examined the implementation of HCBS policies at the state level. Feinberg and Newman (2004, 2006) examined various approaches states pursued in implementing the National Family Caregiver Support Program. They found that the way states approached implementing the program varied depending on existing state-level supports for caregivers, the state’s administrative structure for HCBS and caregiver programs, and specific

aspects of the program such as whether the state utilized a uniform caregiver assessment tool or permitted self-direction (Feinberg & Newman, 2004). Thomas and Allen (2016) examined implementation of the Veteran-Directed Home and Community-Based Services, which is a collaboration between the Department of Veteran Affairs (VA) and the Aging and Disability network agencies, including State Units on Aging, Area Agencies on Aging, and Aging and Disability Resource Centers. Success implementing the Veteran-Directed Home and Community-Based Services program partly depended on the communication between the local VA and Aging and Disability network agencies, training in VA billing procedures, and a contact at the VA who championed the program and was involved in the development of the program (Thomas & Allen, 2016). The program and partnership between the local VA and Aging and Disability network agencies faced challenges when these conditions were not present. Miller (2014) explored the implementation of Rhode Island's Global Waiver. This study found that factors influencing the implementation process included stakeholder engagement; the fiscal and budget situation; federal legislation; and lack of sufficient state leadership, personnel, and IT resources.

Conclusion

The policy adoption and implementation literatures both provide insights into states' HCBS policymaking processes. The policy adoption literature highlights many factors within and outside of state borders that may influence the pursuit of new policies. This research provides the basis for a conceptual framework to understand HCBS policy adoption. Studies of implementation seek to uncover supports that help to facilitate implementation as well as the barriers policymakers may encounter along the way. Many of the challenges that arise in the implementation literature may have relevance for HCBS policy. As a result, this research

contributes to greater understanding of the adoption and implementation of HCBS policies across states. The next chapter proposes a conceptual framework, hypotheses, and propositions based on the policy adoption and implementation literature.

CHAPTER 3

CONCEPTUAL FRAMEWORK AND HYPOTHESES

The literature on state policy adoption and implementation has identified a number of factors that may impact the state policymaking process. This research builds on the existing literature to propose a conceptual framework that accounts for state adoption of the Balancing Incentive Program (BIP), Community First Choice (CFC), and the 1915(i) home and community-based services (HCBS) state plan benefit. The chapter begins with a summary of state Medicaid policymaking and HCBS policymaking specifically. Next, there is an overview of the conceptual framework proposed in this study indicating the key factors affecting the adoption of the Affordable Care Act's (ACA) HCBS policies. This section is followed by several hypotheses and propositions grounded in the literature on state policy adoption and implementation.

Overview of State Medicaid Policymaking

The Medicaid program is jointly administered and funded by the federal and state governments. The federal government establishes the broad regulations governing the program and provides at least half of the funding. State governments have significant discretion in operating the program and determining the specific eligibility criteria, services, and rates within federal regulations. At the federal level, the Centers for Medicare and Medicaid Services (CMS) is the operating agency of Medicaid, and CMS requires that each state identify a "single state

agency” to administer the program. In most states, the single state agency is an agency in the executive branch often within the public health agency, health and human services agency, or a “stand-alone” agency. The primary role of the single state agency is the day-to-day operation of the program, including enrolling eligible individuals, determining benefits, setting payment rates, and processing claims (Schneider & Wachino, 2002). The state Medicaid agency may delegate some responsibilities to another state agency, local government, or a private contractor. Indeed, most states delegate administrative functions to other entities, but there is significant variation in what responsibilities are delegated and to whom across the states (Schneider & Wachino, 2002). CMS also requires that each state have a Medical Care Advisory Committee that participates in policy development and program administration; its role also varies across states. The Advisory Committee includes representatives of consumers, providers, elected officials, and physicians.

The state legislature can take a more or less active role in Medicaid policymaking depending on the state. Some legislatures are more focused on overall spending levels and not the specific benefits offered or populations served. In nearly half of the states, changes to Medicaid depend on state appropriations (National Health Law Program, 2006). In these states, if the single state agency or governor sought to expand Medicaid by adding new optional benefits or increasing eligibility, the state legislature would need to appropriate the necessary funds since state governments are responsible for a portion of Medicaid spending. Other state legislatures take a more active role in Medicaid policymaking. In some states, the legislature has directed the state to pursue specific Medicaid options or cover certain populations (Edwards, Garcia, Lashbrook & Flowers, 2007). With the ACA, several state legislatures, including Kansas and Maine, have voted to expand health insurance but have been overridden by the governor while the Ohio legislature voted to freeze the Medicaid expansion.

Outside of state government other actors involved in Medicaid policymaking include provider organizations; including hospitals, physician groups, nursing facilities, and HCBS providers; and consumers and their advocacy organizations; including disability activists, elders, and low-income individuals. These interest groups often have different stakes in Medicaid policymaking. Provider organizations are most often focused on reimbursement rates and coverage of optional services while consumers and their advocates are more interested in regulation and eligibility policies (Kronebusch, 1997). These various interest groups often are incentivized to lobby the legislative branch for favorable policy changes; however, they have different relative strengths and influences. Previous research suggests that state officials perceive nursing homes and hospitals as the most or second most influential interest groups in 39 states (Thomas & Hrebener, 2004). Depending on the state, Medicaid interest groups may also seek to influence policymaking within the bureaucracy. Since interest groups and state bureaucrats often have common interests and work closely together on policy implementation, interest groups can impact bureaucratic decision-making (Schneider & Jacoby, 1996).

Each state has a Medicaid state plan that details its specific Medicaid program. The state plan includes eligibility criteria, services covered, and rates (Rudowitz & Schneider, 2006). To change existing Medicaid offerings, states must submit a state plan amendment (SPA) to CMS. SPA changes could include adding or removing optional benefits, changing eligibility, or altering provider rates. A SPA is often drafted by bureaucrats within the single state agency or another state agency, and the involvement of the legislature varies across states. According to a survey conducted by the National Health Law Program and National Association of Community Health Centers, four states require legislative approval of SPAs while several other states require legislative notification of SPAs (National Health Law Program, 2006). The Medical Care

Advisory Committee may also play a role in Medicaid changes; however, states are not required to utilize the Committee for the SPA process. The SPA public notification and public input processes also differ by state. After a state submits the SPA to its regional CMS office, CMS has 90 days to approve or deny the SPA; however, the 90 day clock may be stopped if CMS asks the state to provide additional clarification on their amendment.

In addition to SPAs, states may submit waiver applications to make changes to Medicaid options. States can adopt 1115 demonstration waivers or 1915(c) HCBS waivers. Once approved, the waiver is valid for three or five years, and the state has the option to renew. As with SPAs, the state bureaucracy often plays a key role in writing the waiver application and submitting it to CMS. Depending on the state, the extent of legislative and stakeholder involvement can vary. Thirteen states require legislative approval for Medicaid waivers (National Health Law Program, 2006). With the ACA, CMS made changes to the 1115 waiver process to ensure greater stakeholder engagement and transparency. For new Section 1115 waivers or renewals of existing waivers, the state must have a 30-day public notice and comment period and hold at least two public hearings about the waiver application (The Henry J. Kaiser Family Foundation, 2012b). For 1915(c) waivers, requirements differ; as a result, the public comment and stakeholder engagement processes vary across states.

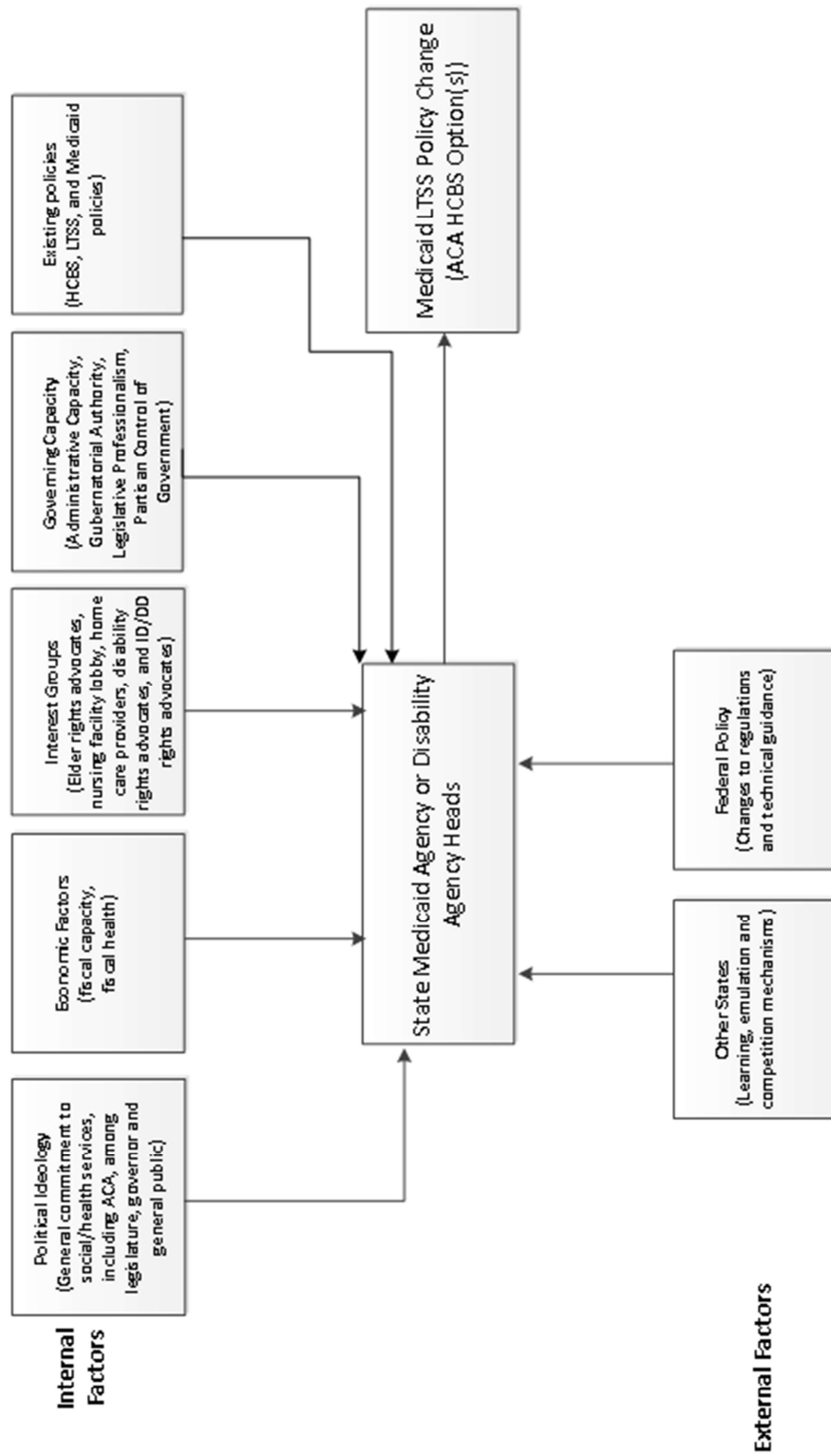
In HCBS policymaking, the major actors within government can include the single state agency, potentially other states agencies such as the disability or elder agency, and the legislature. Outside of government, groups with influence include provider interest groups such as HCBS providers and nursing facilities, and consumer advocates -- including those representing various disability communities including individuals with developmental disabilities, physical disabilities, serious mental health issues, and elders. The impetus for

adopting a new HCBS program could come from stakeholder advocacy, a desire within the state bureaucracy, legislative requirement, or a combination. Medicaid HCBS policymaking typically occurs through 1915(c) waivers but also through Medicaid state plan amendments and 1115 demonstration waivers. In writing waiver applications or SPAs the single state agency or another state agency play key roles. Depending on the state and type of change, stakeholders could have more or less input in the waiver application or SPA.

Conceptual Framework

Based on the existing processes for Medicaid HCBS policymaking and the state adoption literature, this research proposes the conceptual framework in Figure 3.1. The conceptual framework identifies state bureaucrats as the key actors. These state bureaucrats are agency heads within the Medicaid agency or disability services agencies such as aging, intellectual disability/developmental disability (ID/DD), or mental health. Existing research suggests that most Medicaid policymaking occurs within the state bureaucracy, particularly decisions about optional services (Schneider & Jacoby, 1996; Schneider et al., 1997). As discussed above, each state has a single state agency for the administration of the Medicaid program, and this agency often plays a key role in determining optional benefits. One reason state bureaucrats take a lead role is the specialized knowledge they have about the Medicaid program (Schneider et al., 1997). In addition, SPAs or 1915(c) waivers must be submitted to CMS by the single state agency; therefore, the Medicaid agency staff must play a key role in writing the amendments or applications needed to make those changes.

Figure 3.1: Conceptual Framework for Policy Adoption



Acronyms: ACA: Affordable Care Act, ID/DD: Intellectually disabled/developmentally disabled, HCBS: Home- and community-based services, LTSS: Long-term services and support

The factors that may influence bureaucratic decision-making include internal state characteristics such as political ideology, interest group power/activity, and economic climate/resources. State bureaucrats operate within the political climate of their state; therefore, the prevailing political ideology can shape whether bureaucrats favor more liberal or conservative policies. Bureaucrats are also likely to face challenges adopting policies incompatible with the political orientation of the governor, state legislature, or general public. In addition, officials within the state Medicaid agency often develop close relationships with various interest groups as a result of their administration of the program and working on issues of similar interest. These relationships can affect subsequent policy changes (Schneider & Jacoby, 1996). Bureaucrats must also work within the prevailing economic climate and available resources. Adding optional benefits typically entails additional Medicaid spending. In many states, the legislature must appropriate the funding for the Medicaid agency to expand services, and the legislature may be less likely to approve additional spending during periods of fiscal downturn.

Capacities to govern may also impede or facilitate the adoption of new HCBS policies as well. Within the single state Medicaid agency, there are a limited number of staff. Therefore, if state bureaucrats are focused on other Medicaid policies, such as the health insurance provisions of the ACA, they may not have the time or resources to pursue other opportunities, such as HCBS programs. State bureaucrats may also be influenced by others within state government. As discussed above, the legislature can play a more or less active role in Medicaid policymaking, depending on the state. States with active legislatures may instruct the state bureaucracy to pursue specific optional Medicaid programs. Alternatively, state legislatures can preclude the Medicaid agency from pursuing optional benefits either by denying approval of a SPA or waiver

or by blocking funding for the program. In this way, state legislatures can make the adoption of optional HCBS policies more or less likely.

Existing HCBS, long-term services and supports (LTSS), and Medicaid policies may influence bureaucratic decision-making. If the state already offers robust HCBS through waivers, state bureaucrats may feel that the needs of HCBS recipients are already being met through existing programs. In contrast, if states are funding significant HCBS through state-only programs and not receiving federal revenue, bureaucrats may be incentivized to pursue these new Medicaid options in an effort to maximize federal revenue for HCBS. In other efforts to constrain state LTSS spending, state officials may look to expand HCBS programs because these programs are often considered less costly than nursing facility care. However, states that already limit LTSS spending through certificate of need programs may have less incentive to adopt new HCBS programs.

In addition, the decisions of other states and the federal government are posited to shape state decision-making. States may adopt the ACA's HCBS expansion programs because neighboring states do. Through learning, emulation, and competition mechanisms, the decisions in one state may influence the likelihood of adoption in other states. Furthermore, federal policy changes may also shape state Medicaid policymaking. By easing or strengthening restrictions or requirements for the various ACA programs, the federal government may make program adoption more or less attractive for states. Based on the literature and conceptual framework, several hypotheses are proposed below.

Policy Adoption Hypotheses

The following hypotheses identify factors that may influence states' adoption of the ACA HCBS policies. This research measured policy adoption as a state submitting a state plan

amendment or application to CMS and receiving approval. The hypotheses posit that partisanship and ideology; governing capacity, interest groups; economic factors; existing HCBS, LTSS, and Medicaid policies; other states; and federal policy change may affect state HCBS policy adoption. The quantitative and qualitative analysis examined whether or not these factors influenced states' decisions to pursue the ACA HCBS expansion options.

Partisanship and Ideology

The political party in control of state government may influence a state's pursuit of new Medicaid HCBS opportunities. Previous research has found that states with Democratic governors spend more on Medicaid and are more likely to adopt 1915(c) HCBS waiver programs (Schneider, 1993; Nelson, 2007; Miller et al. 2008). States with Democratic legislative majorities may also be more likely to support expanding social programs. Previous research suggests that Democratic legislatures may be more likely to spend more on welfare, pass liberal social policies, and spend more on optional Medicaid services (Brown, 1995; Barrilleux, Holbrook, & Langer, 2002; Kousser, 2002; Williamson & Carnes, 2013). In adopting optional Medicaid HCBS benefits, evidence suggests that elected officials' political liberalism, as measured by Senators' voting records, is associated with a greater likelihood of offering the state plan personal care benefit (Kitchener et al. 2007). Since states with Democratic leadership tend to spend more and provide more generous Medicaid benefits, these states should be more likely to adopt the ACA's HCBS policies.

In addition, Republican governors have been leading the fight challenging the ACA's health insurance provisions. Since these governors often perceive the ACA as impeding on the ability of states to determine their own policies, they are likely see the Medicaid's HCBS options as an overreach of federal authority as well (Republican Governors Association, 2011). In many

states, the ACA is also a political ‘third rail’, and governors in states with strong opposition may be unable or unwilling to pursue the HCBS options.

Hypothesis 1: *States with Democratic leadership should be more likely to adopt the ACA’s HCBS provisions, all else being equal.*

Sub-hypothesis 1a: *States with a Democratic governor should be more likely to adopt the ACA’s HCBS provisions, all else being equal.*

Sub-hypothesis 1b: *States with a Democratic state legislature should be more likely to adopt the ACA’s HCBS provisions, all else being equal.*

Sub-hypothesis 1c: *Politically more liberal states should be more likely to adopt the ACA’s HCBS provisions, all else being equal.*

Governing Capacity

Bureaucratic capacity, legislative professionalism, gubernatorial power, and partisan control of state government may also all play a role in state HCBS policymaking. Previous research suggests that state level bureaucrats are important in determining Medicaid policy -- in particular, optional services (Schneider & Jacoby, 1996; Schneider, Jacoby, & Cogburn, 1997; Miller, 2006). Medicaid HCBS policies are nearly all optional benefits; therefore, bureaucrats are likely to play a key role. In addition, since the single state Medicaid agency must submit policy changes to CMS, staffers within the agency often take the lead in writing state plan amendments or waiver applications. States that lack the bureaucratic capacity and knowledge to research new HCBS opportunities, develop a Medicaid state plan amendment, and operate a new HCBS program may be less likely to pursue the ACA’s HCBS expansion opportunities. Indeed, this was the key conclusion of a Government Accountability Office (GAO) report examining state

decisions around the ACA's HCBS opportunities: limited staff resources posed an impediment to implementing the new HCBS options (GAO, 2012).

Bureaucrats' ability to determine Medicaid HCBS policy may also be influenced by the legislature. Research suggests that a more professional legislature can exert greater control over the state bureaucracy (Huber et al., 2001). In some states, the state legislature has taken an active role in determining whether the state pursues aspects of the ACA. In twenty-two states, the legislature passed laws or constitutional amendments opting out of various parts of the ACA, including the health insurance exchanges and Medicaid expansion (National Conference of State Legislatures, 2017). State legislatures may take similar approaches with the HCBS options within the ACA. In addition, the governor may exert influence and control over the state bureaucracy. The amount of gubernatorial influence on public policy likely varies across states and may depend on the governor's overall power (Woods, 2004; Barrilleaux, 1999). Gubernatorial power is often measured based on an index of institutional powers, including appointment powers, budgetary power, veto power, tenure, and party control. Since the governor proposes a budget with policy priorities to the legislature, s/he can play an important role in the financing of health care initiatives and programs (Schneider, 1989).

The impact of legislative and gubernatorial control over the bureaucracy on the issue of HCBS policymaking may depend on whether the government is divided across the two major political parties. When the legislative and executive branches are controlled by separate parties, the legislature may delegate less authority to executive bureaucracies (Epstein & O'Halloran, 1996). In addition, unified government tends to produce more policy and is more responsive to the public (Coleman, 1999). In general, a unified government, with both legislative bodies and the governor controlled by the same political party, poses fewer roadblocks for policy

development than divided government where the legislature and governor's office are controlled by separate parties, while a divided legislature occupies a middle position.

Hypothesis 2: *States with greater governing capacity should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 2a: *States with greater administrative capacity should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 2b: *States with greater legislative professionalism should be more like to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 2c: *States with greater gubernatorial power should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 2d: *States with unified government should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Interest Groups

Both provider lobbies and consumer advocates have an interest in Medicaid policy (Kronebusch, 1997). Within LTSS policymaking, the nursing facility lobby is less supportive of expanding HCBS than other LTSS providers. In a survey of individuals involved in LTSS policy, 80.1% of community-based providers (including home care, hospice, and assisted living providers) supported rebalancing as compared to 45.7% of nursing home providers (Miller et al., 2009). During the 1990s, the growth of the for-profit nursing facility industry created an influential lobbying block with interests in protecting its financial stake (Kitchner & Harrington, 2004). Nursing facilities are highly dependent on public funding as a source of revenue; therefore, nursing facility executives meet regularly with state officials, contribute to state

political campaigns, and hire lobbyists (Wiener & Stevenson, 1998). Consequently, strong nursing facility lobbies that oppose expanding HCBS programs may be well positioned to influence state decision-making in this regard. In contrast, HCBS providers are more supportive of increasing home care services (Miller et al., 2009). Studies suggest that more certified home health agencies per capita within a state are associated with more waiver participants and higher waiver spending per capita (Miller et al., 2006).

In addition to provider lobbies, consumer advocates representing elders or persons with disabilities may shape state LTSS policy. Advocates representing elders and disabled individuals strongly support rebalancing. In a survey of LTSS specialists, 92% of consumer advocates indicated the LTSS system should be rebalanced away from institutions to HCBS (Grabowski et al., 2010). Elder interest groups are often considered among the more influential groups because of their size and voting power (Day, 2017). The significant LTSS rebalancing that has occurred over the last several decades for individuals with developmental disabilities was largely driven by consumer advocacy efforts, including self-advocacy and family members (Braddock, 1992). In addition, advocacy efforts were important in the adoption of 1915(c) waivers for children and youth with Autism Spectrum Disorder in the 10 states that adopted the waiver for this population (Merryman et al. 2015).

Hypothesis 3: *States with stronger, more active interest groups should be more (less) likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 3a: *States with stronger, more active nursing facility lobbies should be less likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 3b: *States with stronger, more active HCBS provider lobbies should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 3c: *States with stronger, more active elder lobbies should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 3d: *States with stronger, more active disability lobbies should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Fiscal Capacity and Health

Since Medicaid is a joint federal-state program, states with greater fiscal capacity are better positioned to fund the state portion of Medicaid expenditures. The literature on Medicaid and HCBS spending suggests that state wealth is an important determinant in policymaking (Miller et al. 2001; Miller et al., 2002, Kitchener et al., 2004; Miller et al., 2005). In providing social services, states must also contend with the prevailing economic climate. Nearly all states have a balanced budget requirement; therefore, when revenues decline states must enact cost containment measures. Since Medicaid is one of the largest items within state budgets, the program is often targeted for cuts. During periods of slow economic growth, states policymakers can be reluctant to adopt new policies due to budgetary concerns. In 2012, the United States' GAO published a preliminary study about states' decisions to pursue the ACA's HCBS opportunities, which concluded that ongoing fiscal challenges and budget concerns were factors in most states' decision making processes (Government Accountability Office, 2012).

Hypothesis 4: *States with greater fiscal capacity should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Hypothesis 5: *States in better fiscal health should be more likely to adopt the ACA's HCBS provisions, all else being equal.*

Existing Home and Community-Based Services Policies

The impact of existing HCBS policies on the decision to adopt these new options is uncertain. States with already generous Medicaid HCBS programs may forgo adopting the ACA state plan benefits, CFC and the 1915(i), because officials believe their current HCBS service offerings are sufficient or these new benefits may conflict with existing policies. Developing and implementing HCBS programs can be time consuming and costly for states; therefore, if state officials believe the HCBS needs are met by current programs they may forgo new opportunities. In addition, the GAO report on the ACA's HCBS options found that state officials expressed concern about the impact of new HCBS offerings on existing programs (GAO, 2012).

Conversely, states may perceive the ACA's state plan options as providing new opportunities to either substitute or enhance existing services. Some states may be offering state-funded HCBS programs and have budgetary motivations to adopt these new options if the opportunity exists for additional federal funding. In some instances, states may seek to convert state-funded HCBS programs into Medicaid programs for the federal funding. In addition, states may be incentivized to transition existing Medicaid personal care services to the Community First Choice program to benefit from the 6% additional federal match. Therefore, while the existing HCBS offerings will impact the likelihood of adoption, the direction is unclear.

Unlike CFC and the 1915(i), BIP specifically targeted states which had made less progress rebalancing LTSS. States needed to be spending less than 50% of Medicaid LTSS spending on HCBS in fiscal year 2009 to be eligible for BIP. Therefore, states with lower investments in HCBS were more likely to be eligible and, thus, participate in BIP. As part of BIP, participating states also needed to implement three structural changes (i.e. No Wrong Door/Single Entry Point system, conflict-free case management, and core assessment domains).

On the one hand, these requirements may conflict with existing practices in some states. States that must remodel HCBS structures are likely to encounter institutional inertia, including the need to develop and promulgate necessary changes in addition to resistance from vested interests that benefit under the current system. As a result, some states may be reluctant to pursue BIP due to the necessary programmatic and structural changes required the program. On the other hand, states may already have the BIP requirements in place. States that already implemented a No Wrong Door/Single Entry Point system, conflict-free case management, and the core assessment domains may be more likely to participate in the program because they already met the structural change requirements.

Hypothesis 6: *States with comprehensive Medicaid HCBS policies should be more (less) likely to adopt the ACA's HCBS provisions, all else being equal.*

Sub-hypothesis 6a: *States with comprehensive Medicaid HCBS policies should be more (less) likely to adopt BIP, all else being equal.*

Existing Medicaid Policies

Decisions to adopt the ACA's HCBS options may also be shaped by efforts to control LTSS costs. LTSS spending is an increasing portion of state Medicaid budgets, and states pursue several approaches to constrain costs. One method is limiting the supply of LTSS through nursing facility or home health agency certificate of need (CON) programs. A second method is expanding HCBS options because state officials perceive HCBS programs as a less costly alternative to institutional care and therefore a cost saving measure. If a state has nursing facility or home health agency CON programs in place, officials may forego expanding HCBS policies because they are utilizing other policy instruments in an effort to control costs. Officials may not

feel the need to expand HCBS to contain LTSS spending if they are already doing so through CON policies.

The impact of CON programs on the adoption of HCBS policies may also depend on the type of CON program. Nursing facility CON programs may suggest a commitment to rebalancing, while home health agency CON programs may indicate a state is less committed to increasing HCBS. Research suggests that states with nursing facility certificate of need programs invest more in HCBS while states with home health agency CON programs devote relatively less LTSS spending to 1915(c) waivers (Miller, Ramsland, & Harrington, 1999; Miller et al., 2001). Therefore, states that limit the supply of nursing facilities may also be more likely to increase HCBS alternatives because they are committed to rebalancing and to meeting their citizens' demand for long-term care. On the other hand, states that limit home health agencies may be less likely to adopt new HCBS options because they may be less committed to rebalancing. Limits on home health agency supply may make it unfeasible to expand HCBS programs as well because the prevailing supply of providers may be inadequate to meet the expected rise in demand.

The decision to adopt these HCBS policies in an effort to control LTSS costs may also be influenced by a state's Medicaid eligibility rules. States with more liberal eligibility standards may have greater financial incentive to adopt HCBS policies as cost containment measures due to higher spending. Research suggests that states with more generous Medicaid eligibility may face greater pressure to constrain expenditures (Harrington et al., 2000; Miller and Wang, 2009b). Other research, however, suggests that states with expanded Medicaid eligibility may be less likely to pursue optional Medicaid benefits. Several studies have found that states with a medically needy program are less likely to adopt 1915(c) waivers (Lindsey, Jacobson, and

Pascal, 1990; Nelson, 2007). While Medicaid eligibility likely influences the adoption of optional HCBS benefits, the direction of the impact is uncertain.

Hypothesis 7: *States with nursing facility certificate of need programs should more likely to adopt the ACA's HCBS provisions, all else being equal.*

Hypothesis 8: *States with home health agency certificate of need programs should be less likely to adopt the ACA's HCBS provisions, all else being equal.*

Hypothesis 9: *States with more generous Medicaid eligibility should be more (less) likely to adopt the ACA's HCBS provisions, all else being equal.*

Other States

States' experiences adopting and implementing the ACA's HCBS provisions may influence other states' actions. Since the ACA's programs are primarily new HCBS options, states may be reluctant to initially adopt these policies due to concerns about unintended consequences, such as over enrollment or expenditures exceeding estimates. These concerns can be mitigated by observing the successful adoption and implementation of programs in nearby states (Walker, 1969), which often share close geographic proximity, shared political climate, similar economic circumstances. Previous research suggests that state policy adoption is affected by their neighboring states' policies (Miller, 2005; Miller, 2006; Berry & Berry, 1990). Within Medicaid policymaking, neighboring state adoption has impacted nursing facility reimbursement policy and wage policies for direct care workers (Miller, 2006; Miller et al., 2012).

Hypothesis 10: *States with a higher proportion (number) of neighboring states adopting the ACA's HCBS provisions should be more likely to adopt ACA's HCBS provision themselves, all else being equal.*

Federal Government

The issuance of new federal regulations and technical guidance can shape the timing of states' pursuit of new Medicaid policies. The growth of Medicaid waivers during the 1980s and 1990s suggests the importance of changes in federal policy on state Medicaid HCBS policy making. When the federal government initially authorized waivers in 1981, few states participated because of the lengthy approval process and stringent federal requirements. Initially, the federal Office of Management and Budget implemented a "cold-bed" rule which required states to demonstrate that each waiver slot was associated with an empty institutional bed (Thompson & Burke, 2008). The Clinton administration eliminated the cold-bed rule and weakened the interpretations of cost-neutrality. As a result, the number of waivers, the number of waiver participants, and expenditures on HCBS waivers increased dramatically following these changes. This example suggests that changes to federal regulations can shape whether states adopt Medicaid HCBS options. Regulations or guidance that make policies more attractive by simplifying or reducing the requirements for participating states are likely to increase uptake of new policies, while the opposite is expected for regulations that increase burdens for participating states.

In January 2014, CMS published federal regulations, known as the final rule, for several Medicaid funded HCBS programs, which could affect states' likelihood of adopting the ACA HCBS policies. Within the final rule, CMS provided implementing regulations for the 1915(i) HCBS state plan benefit; defined the requirements for HCBS settings for 1915(c) waivers, 1915(i) HCBS state plan benefit, and 1915(k) Community First Choice; and defined person-centered planning requirements under 1915(c) waivers and 1915(i) HCBS state plan benefit (CMS, 2014). Prior to the issuance of the final rule, states may have been uncertain about new

federal requirements for these programs and therefore reluctant to adopt these policies. With the issuance of the final rule, states have greater certainty around CMS requirements for each of these Medicaid authorities. Alternatively, the regulations may impose new mandates that are difficult for states to attain and therefore discourage the pursuit of new HCBS policies. For example, states that do not meet the person-centered planning requirements of the 1915(i) may be reluctant to adopt this option due to the additional burden of the federal requirements. The effect of the final rule on state decision-making will partly depend on the content of the rule as well as existing state policies consistent with the requirements of the regulations.

Hypothesis 11: *States should be more (less) likely to adopt the ACA's HCBS provisions after the publication of the final federal Home and Community-based services regulations, all else being equal.*

Implementation of Home and Community-Based Services Policies

This section discusses six propositions related to policy implementation. Policy implementation occurs after a state received CMS's approval of their state plan amendment or application. Aspects of implementation include enrolling participants and providers; providing training to entities involved; developing regulations; and publicizing the program. This section proposes propositions as opposed to hypotheses because most aspects of policy implementation are not measurable and testable. This research explored these propositions and the factors impacting implementation through the qualitative analysis. The qualitative case studies sought to identify factors that facilitated and impeded states' implementation of these policies.

The policy implementation literature has several relevant insights for this research on HCBS implementation. One often-cited challenge in implementing public policies is that the federal government enacts a policy but relies on state or local governments to implement the

policy. Individuals and organizations at each level of government may have different perceptions of the policy and how it fits with local conditions. Since all of the HCBS options contained in the ACA were new Medicaid programs, each requires cooperation between the federal and state government. Implementation research from a top-down perspective suggests that having clear objectives and a statute that structures the implementation process are important for successful implementation (Van Meter & Van Horn, 1975; Sabatier & Mazmanian, 1979). Therefore, having clear regulations and guidance from CMS may streamline the implementation process at the state level.

Proposition 1: *Greater clarity provided by federal government will facilitate states' implementation of the ACA's HCBS programs.*

From a bottom-up perspective, research suggests that greater flexibility at the state and local level can improve implementation (Berman, 1978; Hjern & Porter, 1981). The success implementing each HCBS program may depend, in part, on the flexibility the federal government allows states. While the ACA established these programs in legislation, many of the details of the programs were left to CMS to determine. Therefore, through regulation or guidance, CMS could provide states more or less flexibility to adjust the program for local conditions. Existing research suggests that the federal government may grant states less flexibility and leeway when the federal government has clear objectives and lacks confidence in states' ability to achieve these goals (Thompson & Burke, 2009).

With the Balancing Incentive Program, CMS provides states with flexibility in meeting some of the structural requirements. For example, the legislation authorizing BIP required states to have a core standardized assessment to conduct eligibility determinations for all individuals requiring Medicaid funded long-term care. *The Balancing Incentive Program: Implementation*

Manual, published in February 2013, articulated the specific requirements of BIP and provided states with flexibility to meet the core standardized assessment requirement. Instead of utilizing a single assessment instrument to determine eligibility across diverse populations, states could use different instruments for each population so long as the assessment contained core data elements such as questions about activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Such flexibility could assist states as they sought to implement the various requirements of BIP.

Proposition 2: *Greater flexibility provided by the federal government will facilitate states' implementation of the ACA's HCBS programs.*

Other factors identified in bottom-up approaches to policy implementation also have implications for the ACA's HCBS programs. Bottom-up approaches recognize that governmental organizations formally responsible for implementing a program are not the only ones who determine implementation success. Individuals and organizations, both public and private, also play a role. Within LTSS policy, advocacy organizations, provider associations, and local governments all have an influence. In implementing HCBS policies, states often decide to utilize local entities to implement certain aspects. The level of communication with and buy-in at the county or regional level may also determine program success. The networks of individuals and organizations involved in HCBS policy must be understood in order to examine the implementation process.

Proposition 3: *More buy-in among non-governmental stakeholders will facilitate states' implementation of the ACA's HCBS programs.*

In addition, existing policies may also shape the success implementing new HCBS policies. Implementation research suggests that policies that make modest changes and are

generally consistent with existing policies are easier to implement than policies that require substantial changes from the status quo or organizational change (Van Meter & Van Horn, 1975). Each state differs with respect to their Medicaid program and HCBS offerings. States that already operated similar programs may have found implementing the new HCBS policies easier than states that needed to start from scratch. For example, states that were already offering Medicaid state plan personal care services prior to the ACA may find the implementation process for Community First Choice easier than states that do not offer this benefit. States with a personal care benefit would already have systems and processes in place for enrolling consumers and providers, conducting eligibility determinations, and processing claims. When pursuing CFC, states could leverage these existing systems and processes to offer the new benefit.

Proposition 4: *Less change from existing policies will facilitate states' implementation of the ACA's HCBS programs.*

Many of the other factors identified in the literature, including bureaucratic capacity, timing, and financial resources (O'Toole, 1986), may have relevance for the implementation of the ACA's HCBS policies in states that decided to pursue them. Research on Rhode Island's implementation of the 1115 Global Waiver suggests that insufficient experienced staff within the state bureaucracy impeded implementation (Miller, 2014). Staff shortages could also present a challenge. Since many states implemented several of these programs while also implementing the health insurance provisions within the ACA, limitations with both budgetary and workforce resources could impact implementation. In addition, many state governments reduced bureaucratic staffing levels either through layoffs or incentive programs during and after the Great Recession (Greenstone & Looney, 2012). Due to competing priorities and lower staffing levels, states may have lacked sufficient staff to streamline the implementation process.

Proposition 5: *More state staffing resources will facilitate states' implementation of the ACA's HCBS programs.*

Related to staff resources, financial resources can also influence policy implementation. BIP and CFC provide participating states with enhanced federal match while the 1915(i) does not offer additional matching funds. This enhanced revenue may make it easier for implementation and allow for the hiring of additional staff or external consultants to assist in the implementation process. Timing likely also impacts the successes and challenges implementing these HCBS programs. In particular, BIP was a time limited program which ended in 2015; therefore, states needed to achieve significant progress in the LTSS spending and infrastructure in a short period of time.

Proposition 6: *More financial resources will facilitate states' implementation of the ACA's HCBS programs.*

Conclusion

Previous policy adoption research provides the basis for a conceptual framework to understand HCBS policy adoption. From this conceptual framework, several hypotheses identify key factors that may influence states' pursuit of optional HCBS benefits. Subsequent chapters will examine how well this framework explains state decision-making around the ACA's HCBS policies. The policy implementation research has several relevant insights for HCBS policy implementation and factors that may influence implementation success. This research utilizes case studies to uncover the factors that facilitate and impede the implementation of the ACA's HCBS policies. By evaluating how well these hypotheses and propositions explain adoption decisions and implementing processes, this research will advance knowledge about state HCBS

policymaking. The next chapter discussed the quantitative and qualitative methods used in this study to evaluate the hypotheses and propositions.

CHAPTER 4

RESEARCH METHODS

This study used a mixed methods research design to identify the factors that influenced state adoption and implementation of the various Affordable Care Act (ACA) home and community-based services (HCBS) policies and to assess the conceptual framework and hypotheses presented in Chapter 3. The quantitative portion of this research relied on several modeling approaches to identify the factors that affected states' decisions to adopt these policies. The qualitative research used case studies of several states to examine the state-level decision-making processes around adoption and then subsequent implementation of these policies. The quantitative and qualitative portions of this research complemented each other and together provided a more complete explanation of state processes around policy adoption and implementation of HCBS policies than either approach would alone.

This chapter begins with a discussion of the quantitative methods: first by describing the dependent variables, then the independent variables, and lastly the various modeling approaches. The next section discusses the qualitative methods. I provide an overview of the research design, case selection, data collection, analysis, and ways in which I addressed concerns about reliability and validity. The final section provides a summary of this chapter and discusses how the quantitative and qualitative aspects of this research complement one another.

Quantitative Methods

The primary quantitative analysis utilized was multivariate regression models with dependent variables that measured aspects of HCBS policy adoption. There were five different dependent variables that measured Balancing Incentive Program (BIP) adoption, Community First Choice (CFC) adoption, 1915(i) adoption, adoption of any of these three policies, and the percentage of eligible policies each state adopted. The independent variables measured factors thought to influence state level adoption decisions including political factors, governing capacity, interest groups, economic considerations, existing HCBS and long-term services and supports (LTSS) policies, and external factors. For the dependent variables measuring BIP adoption, CFC adoption, 1915(i) adoption, and adoption of any of these policies, the dataset was panel data with multiple observations for each state. These dependent variables were also dichotomous variables indicating whether the state adopted the policy in a specific year; therefore, these models utilized logistic regressions. The final model, with the dependent variable measuring the proportion of eligible policies each state adopted, was a cross-sectional model with one observation for each state. Since this dependent variable was a proportion, I utilized a generalized linear model for this regression. The following section describes the dependent variables, independent variables, and modeling strategies in more detail.

Dependent Variables

The first modeling approach modeled the adoption of BIP, CFC, and the 1915(i) state plan benefit separately. There were three different dependent variables: BIP adoption, CFC adoption, and 1915(i) adoption. For these three models, the unit of analysis was the state-year. In each model, the dependent variable was a dichotomous variable indicating whether the state adopted the specific policy that year. The variable was coded zero if the state had not adopted the

policy and one in the year of adoption. After the state adopted the specific policy it was dropped from the dataset in subsequent years. In these models, the data set was an unbalanced panel. Since a focus of this study was the state-level adoption processes, I utilized the year the state submitted their state plan amendment or application (in the case of BIP) to the Centers for Medicare and Medicaid Services (CMS) as the year of adoption. In some instances, the year that CMS approved a state's application was not the same year as when the state submitted their application. Table 4.1 displays which states adopted which ACA HCBS policies as of 2015. Data on the state adoption of each policy was obtained through CMS. All state applications for BIP were available on CMS's Balancing Incentive Program website (CMS, n.d.(a)). State plan amendments to add Community First Choice and the 1915(i) state plan benefits were available through a searchable CMS database (CMS, n.d.(b)). In addition, the National Association of State Units on Aging and Disability (NASUAD) and Kaiser Family Foundation publish information on states' adoption of these policies and this was utilized to confirm the data from CMS (Smith et al., 2015; NASUAD, 2018).

Table 4.1: State Adoption of ACA Policies (as of 2015)

	BIP	CFC	1915(i)	# of Policies
Alabama	No	No	No	0
Alaska	N/A	No	No	0
Arizona	N/A	No	No	0
Arkansas	Yes	No	No	1
California	N/A	Yes	Yes*	2
Colorado	N/A	No	Yes*	1
Connecticut	Yes	Yes	Yes	3
Delaware	No	No	Yes	1
Florida	No	No	Yes	1
Georgia	Yes	No	No	1
Hawaii	No	No	No	0
Idaho	No	No	Yes	1
Illinois	Yes	No	No	1
Indiana	Yes	No	Yes	2
Iowa	Yes	No	Yes*	2
Kansas	N/A	No	No	0
Kentucky	Yes	No	No	1
Louisiana	Yes	No	Yes	2
Maine	Yes	No	No	1

	BIP	CFC	1915(i)	# of Policies
Maryland	Yes	Yes	Yes	3
Massachusetts	Yes	No	No	1
Michigan	No	No	Yes	1
Minnesota	N/A	No	No	0
Mississippi	Yes	No	Yes	2
Missouri	Yes	No	No	1
Montana	No	Yes	Yes	2
Nebraska	Yes	No	No	1
Nevada	Yes	No	Yes*	2
New Hampshire	Yes	No	No	1
New Jersey	Yes	No	No	1
New Mexico	N/A	No	No	0
New York	Yes	Yes	No	2
North Carolina	No	No	No	0
North Dakota	No	No	No	0
Ohio	Yes	No	Yes	2
Oklahoma	No	No	No	0
Oregon	N/A	Yes	Yes	2
Pennsylvania	Yes	No	No	1
Rhode Island	No	No	No	0
South Carolina	No	No	No	0
South Dakota	No	No	No	0
Tennessee	No	No	No	0
Texas	Yes	Yes	Yes	3
Utah	No	No	No	0
Vermont	N/A	No	No	0
Virginia	No	No	No	0
Washington	N/A	Yes	Yes*	2
West Virginia	No	No	No	0
Wisconsin	N/A	No	Yes*	1
Wyoming	N/A	No	No	0
*Adopted Prior to ACA				

The second modeling approach used a dichotomous variable indicating whether the state adopted any one of the three ACA HCBS programs within a given year. In this approach the unit of analysis was also the state-year; however, observations were included for each state for all years in the dataset resulting in a balanced panel of fifty states for six years. I calculated this variable by summing the number of policies each state adopted each year. If the sum was one or greater, this variable was coded one, otherwise the variable was coded zero. The data sources for this variable were also CMS's Balancing Incentive Program website, CMS's state plan amendments database, NASUAD, and the Kaiser Family Foundation (CMS, n.d.(a); CMS, n.d.(b), Smith et al., 2015; NASUAD, 2018).

The third modeling approach was a cross-sectional model with one observation for each state. The dependent variable for this model was the proportion of eligible ACA HCBS policies that each state had adopted by December 31, 2015. In this model, the dependent variable ranged from zero to one. I calculated this variable by first summing the number of ACA HCBS policies each state had adopted as of December 31, 2015. Then I calculated the number of policies for which the state was eligible to participate. Twelve states were not eligible to participate in BIP because their spending on Medicaid HCBS exceeded 50% in 2009. In addition, for the 1915(i) state plan amendment, six states had adopted the 1915(i) prior to the ACA so these states were considered not eligible to submit a 1915(i) state plan amendment for purposes of this study. With CFC, any state could pursue CFC regardless of the state's existing HCBS programs. For this reason, all states could adopt at least one of the ACA HCBS programs. I then divided the number of policies each state had adopted by the number of policies for which the state was eligible. As with the other dependent variables, the data source for this variable was CMS's Balancing Incentive Program website, CMS's state plan amendments database, NASUAD, and the Kaiser Family Foundation (CMS, n.d.(a); CMS, n.d.(b), Smith et al., 2015; NASUAD, 2018). .

Independent Variables

There were 30 independent variables included in this study. These independent variables measure each state's political characteristics, governing capacity, interest group influence, economic conditions, existing HCBS and LTSS policies, and external factors. In some instances, the independent variable was lagged one year because a current year's policy decision was likely to be influenced by factors in existence during the previous year.

Political or ideological factors.

Three variables measured political or ideological factors. The variable Democratic governor was a dichotomous variable indicating the political party in control of the governor's office. The data for this variable was obtained from the National Governors Association annual Governors Roster (National Governors Association, 2015). The variable was coded one for Democrat and zero for non-Democrat (Republican, independent). In the dataset, two states had independent governors during this time period. Rhode Island's governor was an independent in 2011 and 2012, and Alaska's governor was an independent in 2014 and 2015.

The variable Democratic legislature was a continuous variable indicating the percentage of the state legislature that was Democratic. This measure was calculated utilizing data from the National Conference of State Legislatures' annual State and Legislative Partisan Composition report (National Conference of State Legislatures, 2018). This percentage was based on the number of Senate Democratic seats plus the number of House Democratic seats divided by the total number of seats in the state legislature. Data was missing for Nebraska since the state has a non-partisan unicameral legislature; therefore, Nebraska was not included in the analysis.

The variable liberal ideology was a continuous variable indicating the political liberalism of the state's congressional delegation. The measure was calculated utilizing the Americans for Democratic Action (ADA)'s Annual Voting Records (Americans for Democratic Action, n.d.). The ADA's Voting Records selects twenty votes each legislative session. If a legislator voted with ADA s/he receives five points otherwise zero points. Each legislator's score can range from 0 to 100 with higher scores indicating greater political liberalism. For this study, each state's individual legislators' scores were averaged to generate a political liberalism score for the state.

Governing capacity.

In this analysis, there were four measures of governing capacity: state employees per 1,000 residents, gubernatorial power, legislative professionalism, and partisan control of state government. The state employees per 1,000 residents variable was a continuous variable calculated based on the number of total full-time equivalent (FTE) employees for each state divided by the total state population from the U.S. Census Bureau's population projections divided by 1,000. The data for this measure came from the U.S. Census Bureau's Annual Survey of Public Employment & Payroll and the U.S. Census Bureau's population projections (Bureau of the Census, 2017; Bureau of the Census, 2016(b)).

The measure gubernatorial power measured governors' institutional powers using an index developed by Thad Beyle and Margaret Ferguson (Ferguson, 2017). The index has six components: separately elected executive-branch officials, tenure potential, appointment power, budget power, veto power, and party control. For each component, a governor can receive a score up to five. The six components were averaged to arrive at the governor's institutional-powers index with a higher score indicating greater power. The data to calculate the index was derived from the *Book of States* Tables 4.4, 4.9, and 4.10, National Governors Association annual Governors Roster, and National Conference of State Legislatures' annual State and Legislative Partisan Composition (The Council of State Governments, 2010-2015; National Governors Association, 2015; National Conference of State Legislatures, 2018).

This study utilized the average salary of state legislators as a proxy for legislative professionalism. The variable measuring legislative professionalism was the real annual salary of state legislators in 2009 dollars. For states that pay legislators a per diem salary, the salary was

calculated based on the per diem and length of the legislative session. The data for this variable comes from the *Book of States* Table 3.9 (The Council of State Governments, 2010-2015).

The variable measuring partisan composition of state government was coded one for divided government when the executive branch and legislative branch were controlled by different political parties, two for divided legislature when each legislative body was controlled by a different political party, and three for unified government when the governor's office and both legislative bodies were controlled by the same party. The data for this measure came from National Governors Association annual Governors Roster and National Conference of State Legislatures' annual State and Legislative Partisan Composition (National Governors Association, 2015; National Conference of State Legislatures, 2018). For this variable, data was missing for Nebraska due to its unicameral legislature.

Interest groups.

Three variables were proxy measures for interest group power and political influence of LTSS providers: number of nursing facility beds per elder, percentage of for-profit nursing facilities beds, and number of home health agencies per 100,000 residents. The first variable was a continuous variable that measured the number of nursing home beds per 1,000 individuals age 65 and older. The nursing facility bed data came from CMS's Nursing Home Compare dataset. This dataset includes the certified bed total for each facility in each state. I aggregated the total certified bed count by state and divided by the U.S. Census data for the population age 65 and older from the Census' population projections (CMS, 2016; Bureau of the Census; 2016b). The Nursing Home Compare dataset also identifies the ownership status of each nursing home as either for-profit, government, or non-profit. To calculate the percentage of for-profit nursing facility beds, I divided the number of certified beds in for-profit facilities by the total number of

certified beds. CMS's Home Health Compare dataset includes data on Medicare-certified home health agencies in each state. The measure of home health agencies per capita was calculated by dividing the number of home health agencies in each state by the state population per 100,000. The state population data was from the U.S. Census Bureau's annual population projections (CMS, 2017; Bureau of the Census; 2016b).

Three variables, percentage of elder population, percentage of population with a disability, and percentage of population with a cognitive disability, were proxy measures for interest group power and political influence of consumer advocates. The first variable was a continuous variable indicating the percentage of the state population that was age 65 years and older. This variable was calculated utilizing data from the U.S. Census Bureau's annual population projections (Bureau of the Census, 2016b). The variables measuring percentage of the population with a disability and a cognitive disability were also both continuous variables. The percentage of the population with a disability was calculated based on the percentage of the civilian noninstitutionalized population in each state with a disability from the U.S. Census Bureau's American Community Survey. The disability measure is inclusive of individuals with cognitive difficulty. The American Community Survey also collects data on the percentage of the civilian noninstitutionalized population age 5 and older with a cognitive disability. The cognitive disability variable was calculated based on the number of individuals age 5 and older in each state with a cognitive disability divided by the total state population age 5 and older (Bureau of the Census, 2016a).

Economic factors.

This study included three measures of fiscal health and capacity. All three variables were lagged one year because policies are often based on the prior year's fiscal outlook. Fiscal health

was measured by a continuous variable based on the state unemployment rate. Data for this variable came from the U.S. Department of Labor, Bureau of Labor Statistics (Bureau of Labor Statistics, 2016). The data was based on the annual average unemployment rate for each state. Fiscal capacity was measured by two continuous variables: per capita income and Gross Domestic Product (GDP). The data for per capita income and GDP were from the U.S. Department of Commerce, Bureau of Economic Analysis (Bureau of Economic Analysis, 2016). Income was measured by real per capita personal income, and GDP was the real per capita gross domestic product both in 2009 dollars.

Existing HCBS and LTSS programs.

Several variables measured existing Medicaid HCBS program and policies, including 1915(c) HCBS waivers, state plan personal care benefits, and spending levels. These variables were lagged one year because a prior year's HCBS programs and policies may influence the current year's policy adoption. The waiver variable indicated the number of 1915(c) HCBS waivers the state operated in each year. I calculated this variable based on CMS's State Waivers List which includes the approval date and termination date (if the waiver ended) for each waiver (CMS, n.d.(c)). The state plan personal care variable was a dichotomous variable indicating whether or not the state offered a state plan personal care benefit. This variable was calculated based on whether the state had personal care expenditures in the Truven Long-Term Services and Supports Expenditure data (Wenzlow, Eiken & Sredli, 2016). The variable HCBS percentage was the ratio of total Medicaid HCBS spending divided by total Medicaid LTSS spending from the Truven Long-Term Services and Supports Expenditure data. Lastly, the variable measuring HCBS spending per capita was measured based on the total Medicaid HCBS spending (from the Truven Long-Term Services and Supports Expenditure data) divided by the state population

from the U.S. Census Bureau's Population Projections (Wenzlow et al., 2016; Bureau of the Census, 2016b).

Three variables measured existing LTSS and Medicaid policies targeted at provider supply and program eligibility. Two dichotomous variables measured whether or not the state had a home health aide certificate of need program or nursing facility certificate of need program. The variables were coded zero if the state did not have a certificate of need program and one if the state had the program. The data for both measures came from the National Conference of State Legislatures' certificate of need state summary, which indicates the types of providers regulated and the dates when each state's certificate of need programs were adopted (if applicable) (National Conference of State Legislatures, 2017b). In addition, I included a dichotomous variable indicating whether or not the state provided Medicaid benefits to the medically needy. This variable was coded zero if the state did not have a medically needy program and one if the state did have the program. The data for this variable came from the Medicaid and Children's Health Insurance Program Statistics (Medicaid and CHIP Payment and Access Commission, 2017). All three variables were lagged one year.

One independent variable was a dichotomous variable indicating whether the state had adopted BIP, CFC, or the 1915(i) state plan benefit in the prior year. This variable was only included in the regression with the dependent variable that measured adoption of any policy within a specific year and was lagged one year. Including this variable in the model allowed me to measure whether adopting one of these policies in the prior year increased the likelihood of adopting a different policy in the subsequent year. For example, if a state adopted BIP in 2012, the adoption of BIP may make the state more or less likely to adopt CFC or the 1915(i) in 2013.

This variable was coded zero if the state had not adopted BIP, CFC, or the 1915(i) state plan benefit in the prior year and one if the state had adopted at least one of these policies.

External factors.

I included one variable to measure the impact of federal regulatory changes. In January 2014, CMS issued the HCBS Setting Requirements final rule. Among other things, the final rule specified the requirements of the CFC program and 1915(i) program. This variable was coded zero prior to 2014 before the final rule was issued and one in 2014 and 2015 after the publication of the final rule.

Several variables captured the impact of neighboring state adoption for the various policies. The neighboring state adoption variables were lagged one year because policy adoption is likely influenced by neighboring states' policies from prior years. For each ACA HCBS program, I calculated a neighboring state variable based on the cumulative percentage of contiguous states that had adopted the specific policy. In the models with the dependent variable of adoption of any of the three policies in a given year and the cross sectional model, I created the neighboring state variables based on the cumulative percentage of contiguous states that had adopted any of these three policies up to that point. These variables were lagged one year because a state's policy development may be influenced by observing the action of a nearby state the year prior. In models that utilize the neighboring state variables, Alaska and Hawaii were omitted because neither state shares borders with another state.

Descriptive Statistics and Bivariate Analysis

Before conducting the multivariate models, I summarized the dependent and independent variables by running descriptive statistics and bivariate regressions. For the dependent variables, I utilized several approaches. Three of the models utilized event history techniques and for these

dependent variables, I calculated the number of adoptions, cumulative number of adoptions, risk set, hazard probability, and survival probability by year for the BIP adoption, CFC adoption, and 1915(i) adoption separately. These statistics showed the fluctuations in policy adoption of the various policies over time. The number of adoptions indicates how many states adopted the policy in each year while the cumulative number of adoptions indicates the total number of states that adopted the policy as of each year. The risk set shows the number of states at risk of adopting the policy in a given year. The hazard probability is the conditional probability that a state will adopt a policy in a specific year given that it has not already adopted the policy. The survival probability indicates the likelihood a state will not adopt the policy in the given year (Allison, 2014; Willett & Singer, 2003). For the dependent variable measuring the adoption of any policy in a specific year, I calculated the number, mean, and standard deviation of adoptions by year. The last dependent variable measured the proportion of eligible policies each state adopted. For this variable, I calculated the mean and standard deviation as well as the frequency distribution.

For all of the independent variables, I calculated the mean, standard deviation, minimum and maximum of the panel dataset and the mean and standard deviation for each variable by year. By examining trends over time, I could understand if the independent variables increased, decreased, or remained stable from 2010 to 2015. In addition, I examined bivariate relationships between the independent variables by running a correlation matrix. A correlation matrix identified whether there was a high degree of correlation among the variables and also whether the relationship between independent variables was positive or negative.

To address bivariate relationships between the dependent and independent variables, I ran bivariate regression models. The bivariate regressions utilized the panel data with the state-year

as the unit of analysis for the first four dependent variables. These four dependent variables were dichotomous; therefore, for these models I utilized a logistic regression to assess the bivariate relationships: event history models for the BIP, CFC, and 1915(i) dependent variables and a panel model in the case of the all policies dependent variable. The final dependent variable was a proportion, and I used a generalized linear model for these bivariate regressions. To determine statistical significance of the bivariate relationships, I utilized one tailed tests because the hypotheses identified the direction of the relationship. The level of significance used was # $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$, with a $p < .10$ considered marginally significant.

Multivariate Models

Event History Analysis for BIP Adoption, CFC Adoption and 1915(i) Adoption.

As discussed above, the quantitative portion of this research relied on several different multivariate modeling approaches. The first approach employed event history analysis to model the probability that a state adopted one of the ACA HCBS options given that it had not already done so previously. The dependent variables for the event history models were the BIP adoption, CFC adoption, and 1915(i) adoption variables. In this approach, the unit of analysis was the state-year with an observation for each state for each year until the state adopted the policy, after which the state was dropped from the dataset for subsequent years. States that never adopted the policy during the timeframe of this study remained in the dataset for the entire period.

Key aspects of event history modeling include the risk set, the hazard probability, and the survivor probability. The risk set indicates the number of cases at risk of the event occurring within a given period (Allison, 2014). In this research, the cases were states, and the event was the adoption of a HCBS policy. As the number of states adopted a given policy, the risk set decreased. The hazard probability is the probability that the event occurs for a specific case in a

specific period. The dependent variables in this study measured the hazard rate of adopting each policy given that the policy was not adopted previously. More specifically, the hazard probability was the probability a state adopted either BIP, CFC, or the 1915(i) HCBS state plan benefit in a specific year given the state was in the risk set for policy adoption that year. The survivor probability indicates the likelihood that a case will remain in the risk set by not experiencing the event after a given period (Willett & Singer, 2003). It is the ratio of cases that experienced the event divided by the number of cases at risk of experiencing the event. In this research, the survivor probability was the number of states that adopted the specific policy divided by the number of states in the risk set.

For event history analysis, one has to define the start and end dates of the study. Congress enacted the ACA in 2010. BIP and Community First Choice were available for states to apply for beginning October 1, 2011. As a result, the starting date for the BIP and CFC models was 2011. The end date of BIP was September 30, 2015 but the last day for a state to submit an application to participate in the program was August 1, 2014. Therefore, the end date for the BIP model was 2014. The end date for the CFC model was 2015 because this was the most recent year for which data was available. The changes to the 1915(i) HCBS state plan benefit went into effect in October 1, 2010. Therefore, the timeframe for the 1915(i) HCBS state plan benefit model was from 2010 to 2015.

One consideration in event history models is whether the data is continuous or discrete. In a continuous model, the outcome of interest can occur at any time, whereas in a discrete model the outcome of interest occurs, or can only be observed, at discrete intervals (Box-Steffensmeier & Jones, 2004). For this study, a discrete model was utilized because the data was available annually. For a discrete event history model, the dataset is organized in a person-period

format. The dependent variable is a dichotomous variable indicating whether or not the event occurred during that period. Each case remains in the dataset until experiencing the event after which the case is dropped from the dataset. In this research, the dependent variable was zero in years the state did not adopt the policy in question and one the year the state adopted the policy.

Discrete event history models can be estimated utilizing regression models for binary dependent variables. The two frequently utilized models are logit, based on the logistic distribution, and probit, based on the standard normal distribution (Box-Steffensmeier & Jones, 2004). According to Box-Steffensmeier and Jones (2004), the logit and probit models produce very similar results, and the most common model utilized is the logit. For these reasons, this research also utilized a logistic regression to estimate the models. The functional form of the logit model is:

$$\log(P(t)/(1-P(t))) = \beta_0 + \beta_1\chi_1 + \beta_2\chi_2 + \dots \beta_k\chi_k$$

In the above equation, $P(t)$ is the conditional probability of experiencing the event at time t given that the case is at risk of experiencing the event while $1 - P(t)$ is the conditional probability of not experiencing the event at time t . The independent variables are denoted by χ , and β represents the logit coefficients. The coefficients of logistic regressions can be difficult to interpret. Therefore, in addition to the coefficients, I also report the odds ratios in the results. The odds ratio is the exponentiated value of coefficient. Odds ratios greater than one indicate a positive relationship while odds ratios of less than one indicate a negative relationship. For example, an odds ratio of 1.25 would indicate that a one unit change in the independent variable would result in a 25% increase in the odds of adoption, whereas an odds ratio of 0.25 would indicate that a one unit change in the independent variable would result in a 75% decrease in the odds of adoption.

In the above model, the baseline hazard would be constant. In reality, however, the baseline hazard may change with time. In a discrete model, it often makes sense to specify the baseline hazard function. It can take any number of forms including temporary dummy variables, a linear function, a quadratic function, natural log transformations, or smoothing functions (Box-Steffensmeier & Jones, 2004; Allison, 2014). When the number of time periods is small, Allison (2014) suggests including dummy variables for each time period. I tested several different functional forms for the baseline hazard function and compared the results using the Bayesian information criteria (BIC). The BIC is utilized to select a model, with a lower score indicating a better fit. The models with a baseline hazard function fit the data better than the model without; however, the specific form of the baseline hazard mattered little. Since the number of time periods in my models was small, I utilized dummy variables for each year to model the baseline hazard function. To estimate the discrete-time event history models, I utilized Stata 15 and the `logistic` command with the independent variables and dummy year variables (StataCorp, 2017).

One concern with event history analysis is censoring. In event history analysis, data can be either left or right-censored. Left censoring occurs if some units have already experienced the event being studied before the starting date of the event history analysis. Right censoring occurs because a case may experience an event after the end date of the study. For BIP, neither left nor right censoring was a problem because the full duration of the program was included in this study's timeframe. For CFC, only right censoring was a concern because states could only apply for CFC after 2011 but states could continue to adopt after this study timeframe ended in 2015. The 1915(i) program existed prior to the ACA's changes to the program, and six states pursued this option prior to 2010 when the changes went into effect. To account for left censoring, I did not include the six states that previously adopted the 1915(i) in this model. With the 1915(i)

program, right-censoring was also a potential concern because states may adopt the program after the timeframe of this study in 2015. The structure of the discrete event history model, however, accounts for right censoring. If a case is right-censored, the dependent variable is coded zero for all periods, which indicates right-censoring. Therefore, if a case does not experience the event during the study, it only provides information on the survival probability (Box-Steffensmeier & Jones, 2004). In this research, censored cases indicate that the states survived, or did not adopt CFC or the 1915(i), as of 2015. Although some states were censored and possibly adopted these policies after 2015, knowing that the censored states did not adopt the policies during the timeframe of this study still contributes information to the models.

A second concern with panel data and multiple observations for the same case is unobserved heterogeneity. Methods to address unobserved heterogeneity include robust standard errors and random effects models. However, according to Allison (2014), for a discrete event history model, since each case can only experience one event then is subsequently dropped from the dataset, these are not concerns. For this reason for the event history models, I did not utilize robust standard errors or random effects.

For each of the three event history models (BIP, CFC, and 1915(i)), I ran four different variations of the model. In the initial regression (Model 1), I included all of the independent variables including the year dummy variables but excluding the neighboring state variable. In Model 2, I added in the neighboring state variable. Since the neighboring state variable was lagged one year, Model 2 had one less year of observations compared to Model 1. In Models 1 and 2 with the dependent variable of CFC adoption, a combination of the binary independent variables predicted adoption or non-adoption of this program perfectly because of the limited number of states that adopted CFC during this time period. Thus, I dropped the independent

variables that predicted CFC adoption/non-adoption perfectly, running the regression with the remaining independent variables.

Models 3 and 4 employed reduced numbers of independent variables. Since there was a large number of independent variables and the number of observations was relatively limited, I ran a backwards stepwise regression to pare down the number of variables and identify the variables that were related to the dependent variables while eliminating independent variables that were irrelevant in the models. A stepwise regression can be used to determine variable selection when a large number of potential variables exist. The backwards stepwise method removes independent variables that do not achieve a specified p-value. The backwards stepwise model only includes the variables that have a p-value below the set threshold. In the third model (Model 3), I utilized a modified backwards stepwise regression. First, I set the stepwise threshold p-value at 0.25 and included all of the independent variables from Model 1, including the year dummy variables. The backwards stepwise regression identified the independent variables and year dummy variables with a p-value of less than .25. I then ran a regression including the variables that made it through based on the backwards stepwise regression and all of year dummy variables regardless of whether the year variables had a p-value of less than .25 in the stepwise model (Model 3). In Model 4, I added the neighboring state variable to Model 3. Since the neighboring state variable was lagged one year, Model 4 had one less year of observations compared to Model 3.

Adoption of Any ACA HCBS Policy Analysis.

In the second modeling approach the dependent variable was a dichotomous variable indicating whether or not the state adopted any of the three policies within a given year. The dataset for this model was a balanced panel with observations for each state for each year from

2011 to 2015. Since the dependent variable could only take the values of zero or one, I also used a logistic regression for this model. However, unlike the event history models where a state could only experience one event, in this model a state could experience multiple events if the state adopted policies in different years. According to Allison (2014), if a case can experience multiple events then one must account for dependence across observations. Unobserved heterogeneity, or frailty, occurs when unobserved case-specific factors are not captured by the independent variables. In this research, some states may be more (or less) likely to adopt these policies because of reasons not reflected in the independent variables. Failing to account for potential unobserved heterogeneity can impact the magnitude of the regression coefficients and affect the duration dependence (Jenkins, 2008). Using robust standard errors and adding a random effect that represents individual specific unobservable characteristics addresses unobserved heterogeneity.

Initially, I ran a random effects logistic regression for this dependent variable. The results from the regression suggested that a random effect was unnecessary. The p-value for the likelihood ratio test suggested that unobserved heterogeneity was not statistically significant. I subsequently re-ran the regression without the random effect estimator and compared the results of the two models. In both the models, the coefficients for all of the variables were identical. Therefore, in the final model, I reported the logistic regression without random effects.

For this model, I estimated the regression using robust standard errors. Traditional standard errors assume that the error term is independent across observations; if this is not true then the estimators of the variances are biased. In this research, since each state contributed five observations to the model, the assumption of independent errors may not be valid. By using

robust standard errors, the errors are not assumed to be independent. This allows for the presence of heteroscedasticity and produces improved variance estimates.

For this modeling approach, I ran two different regressions. The first regression included all of the independent variables including the neighboring state variable and year dummy variables (Model 1). Unlike the event history models, I included the neighboring state variable in Model 1 because in this model another variable, state adoption of an ACA HCBS policy in the prior year, was lagged one year. Since this variable was already lagged one year, including the neighboring state variable in Model 1 did not result in one less year of data observations. In Model 2, I utilized a modified backwards stepwise regression as with the event history models. Initially, I set the stepwise threshold p-value at 0.25 and included all of the independent variables from Model 1 including the year dummy variables. For Model 2, I then ran a regression including the variables that made it through based on a p-value of .25 and all of year dummy variables regardless of whether the year variables made it through the stepwise model.

Cross Sectional Analysis of Proportion of Eligible Policies Adopted.

The final model was a cross sectional model with only one observation for each state. The dependent variable in this approach was the proportion of eligible ACA HCBS policies each state adopted as of 2015. I measured this variable by dividing the number of policies the state actually adopted by the number of policies the state was eligible for. Since the dependent variable could range from zero to one, ordinary least squared regression was not appropriate. Consequently, I utilized a generalized linear model with a logit link and binomial family with robust standard errors. The generalized linear model is an appropriate model for this dependent variable because it can account for a dependent variable taking the value of zero, one or in between (Papke & Wooldridge, 1996). For this dependent variable, many states did not adopt

any of these policies, several adopted all of the policies for which the state was eligible, and the remaining adopted one or two of the policies in questions. Therefore, this dependent variable ranged from zero to one. This was a cross sectional model; therefore, the number of observation was limited to 50. If I were to include all the independent variable in the model, there would be insufficient degrees of freedom. Therefore, I ran this model utilizing a backwards stepwise approach. As discussed above, a backwards stepwise regression includes all of the independent variables and removes variables that do not achieve a specified p-value. For the cross sectional model, I set the p-value at 0.15 and five of the independent variables were included in the final model.

To determine statistical significance of all of the multivariable models relationships, I utilized one tailed tests because the hypotheses identified the direction of the relationship. The level of significance used was # $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$ with $p < .10$ considered marginally significant.

Qualitative Methods

The qualitative portion of the research design utilized structured comparative case studies to identify factors that influenced states' decisions to adopt the ACA's HCBS options and that facilitated or impeded implementation of these policies (Glaser & Strauss, 1967). Structured comparative case studies ask similar questions across each case to allow for cross-case comparisons (George & Bennett, 2005). For this study, the cases were U.S. states and the focus was on each state's decision whether to adopt the ACA's HCBS provisions. The cases included states that did and did not adopt the ACA's policies. The case studies of states that did adopt these policies examined both the adoption and implementation process while the case study of the state that did not adopt these policies explored the decision not to pursue these options.

Two case selection strategies used in comparative policy research are the most similar cases and the most different cases (George & Bennett, 2005). In the former, two cases that are similar in many respects but different on the dependent variable are examined while in the latter two cases that are different in many respects but perform the same on the dependent variable are explored (George & Bennett, 2005). This study utilized both approaches to understand the factors enabling and impeding the adoption and implementation of the new HCBS opportunities. The most similar case study included one state that adopted all three of the ACA's HCBS opportunities and a second state that did not adopt any. The states were similar with respect to demographics; political and economic climate; existing long-term services and supports programs; and Medicaid policies. In selecting cases for the most different case study, I selected two cases that have adopted all three ACA options but differ in most other respects. When using most similar and most different approaches simultaneously, there can be overlap in cases. In this study, I examined a total of three states. One of the states that adopted all three of the ACA's HCBS policies was utilized in both the most similar and most different approaches.

This case study design has benefits when studying implementation aspects of public policy. For implementation research, Goggin (1986) suggests relying on most similar and most different cases to address the problem of too few cases and too many variables. With most different cases, factors that differ between the cases can be rejected as explanations while common factors may account for implementation success or failure. With most similar cases, shared factors across cases can be eliminated as explanations while different factors potentially account for the varying outcomes (Goggin, 1986). Since implementation research is often plagued by a plethora of factors that contribute to implementation success or failure, the most

similar and most different case design allows for a narrowing down of potential explanatory factors.

Case Selection

In this study, three case studies were conducted. One state, which has adopted at least two of the ACA's programs, was compared to a similar state that has not adopted any and a different state that has adopted at least two policies. Table 4.2 presents the cases that were considered as case studies based on the number of ACA HCBS provisions the state had adopted. The left-hand side of Table 4.2 displays the twelve (12) states that had not implemented any of the ACA's HCBS opportunities while the right-hand side shows the eleven (11) states that had adopted at least two of the three HCBS programs that were the focus of this research. The potential cases excluded states that were ineligible to participate in BIP because the state already achieved 50% spending on Medicaid HCBS. The twelve states that were ineligible for BIP were excluded as potential cases for a few reasons. First, all of these states were spending over 50% of Medicaid LTSS spending on HCBS programs by 2009. Since these states had met this spending threshold already, these states would not be an ideal candidate in a most similar case study with a state that was eligible to participate in BIP. Second, for the case study of the state that did not adopt any of these programs, I wanted the state to have the opportunity to pursue any of the three programs but make the decision not to adopt any program. If states that were ineligible to participate in BIP were considered as cases the states only would have had the opportunity to consider adopting two programs. Two of the states, Iowa and Nevada, listed on the right hand side implemented 1915(i) state plan amendments prior to the ACA revisions under the Deficit Reduction Act of 2005. These states are indicated by italics and were not being considered as potential cases since their programs pre-existed the ACA and each state only adopted one policy

post-ACA. Three states (Connecticut, Maryland, and Texas) had adopted and implemented all three of this study's ACA HCBS programs.

Table 4.2: Potential Cases for Qualitative Analysis

Non-Implementers (None of the ACA HCBS Policies)	Implementers (2+ more ACA HCBC Policies)
Alabama (0)	Connecticut (3)
Hawaii (0)	Indiana (2)
North Carolina (0)	<i>Iowa (2)</i>
North Dakota (0)	Louisiana (2)
Oklahoma (0)	Maryland (3)
Rhode Island (0)	Mississippi (2)
South Carolina (0)	Montana (2)
South Dakota (0)	New York (2)
Tennessee (0)	Ohio (2)
Utah (0)	<i>Nevada (2)</i>
Virginia (0)	Texas (3)
West Virginia (0)	

Note: The parentheses indicates the number of ACA policies the state has adopted and takes a value of 0, 2, or 3. The number of states does not add up to 50 because Table 4.2 does not include states that have only implemented one of the ACA's HCBS policies and states that were ineligible to participate in BIP.

The *italics* indicates the state implemented the 1915(i) prior to the ACA and was not considered as a case for this research. Post-ACA, both of these states only implemented one of the programs that are the focus of this study.

Table 4.3 displays various characteristics of the states in Table 4.2, including political, economic, LTSS demand, LTSS supply, and existing LTSS policies, as of 2010 when the Affordable Care Act passed. The first column of this table identifies two potential pairs of states

for the most different case, and two potential pairs of states for the most similar case study. The states considered for the most different case were Maryland-Mississippi and Maryland-Texas while the states considered for the most similar case were Texas-Oklahoma and Alabama-Mississippi.

Ultimately, the states selected for the most different case study were Maryland and Texas. Maryland and Texas made a compelling most different case because both states have implemented all three policies but differed in many political, economic, and LTSS characteristics. Maryland was more Democratic and had higher per capita income. In 2010, 72.9% of Maryland's state legislature was Democratic compared to 47% in Texas. Per capita income was \$69,713 in Maryland and \$51,324 in Texas. In addition, Texas had more nursing facility beds and home health agencies per capita. In 2010, Texas had 47.7 certified nursing facility beds per 1,000 individuals age 65 and older compared to 34.7 in Maryland. In addition, the overwhelming majority of Texas' nursing facility beds were for-profit (87.7%) while 65.1% were for-profit in Maryland. Texas also spent less per capita on HCBS services but had a higher rebalancing percentage than Maryland. Lastly, Maryland had both nursing facility and home health agency certificate of need programs while Texas had neither.

The states selected for the most similar case study were Texas and Oklahoma. Oklahoma has not adopted any of the ACA's HCBS programs while, as discussed above, Texas adopted all three. Oklahoma and Texas were selected as most similar cases because they are neighboring states and had a Republican majority in the state legislature. In addition, these two states had median household income lower than the national average, \$51,324 for Texas and \$46,804 for Oklahoma. Oklahoma and Texas had a similar number of nursing facility beds per 1,000 residents age 65+, and the overwhelming majority of beds in both states were for-profit (87.5%

in Oklahoma and 87.7% in Texas). Oklahoma spent \$159 per capita on HCBS compared to \$144 in Texas, and both states did not have certificate of need programs for home health agencies.

Table 4.3: Case Selection Data

		Political		Economic		LTSS Providers				LTSS Demand		LTSS Policy	
		Governor's Political Party	% Legislature Democrat	Median Household Income	Unemployment Rate	Certified NF beds per 1,000 65+	% of NF beds for-profit	HHA per 100,000	% of Population 65+	% with Disability	HCBS Exp. per capita	CON - NF	CON - HHA
		Non-Implementers											
4	Alabama	R	57.9%	\$44,447	10.5%	39.4	82.2%	3.1	13.8%	16.2%	\$108	Yes	Yes
	Hawaii	D	89.5%	\$64,651	6.9%	13.7	55.6%	1.0	14.4%	10.7%	\$76	Yes	Yes
	North Carolina	D	57.6%	\$47,593	10.9%	32.8	77.2%	1.8	13.0%	13.2%	\$277	Yes	Yes
	North Dakota	R	40.4%	\$55,385	3.8%	63.7	8.7%	3.1	14.5%	10.4%	\$220	No	No
3	Oklahoma	D	41.6%	\$46,804	6.8%	51.0	87.5%	6.4	13.5%	15.7%	\$159	Yes	No
	Rhode Island	R	90.3%	\$56,055	11.2%	55.7	82.3%	2.2	14.5%	13.5%	\$323	Yes	No
	South Carolina	R	41.2%	\$45,278	11.2%	24.6	80.7%	1.5	13.7%	13.9%	\$125	Yes	Yes
	South Dakota	R	36.2%	\$49,246	5.0%	67.3	32.8%	4.8	14.3%	11.3%	\$160	No	No
	Tennessee	D	46.2%	\$41,905	9.7%	39.5	76.7%	2.2	13.5%	15.1%	\$161	Yes	Yes
	Utah	R	28.8%	\$61,569	7.8%	26.4	81.0%	3.2	9.1%	8.5%	\$74	No	No
	Virginia	R	43.6%	\$65,550	7.1%	31.1	69.3%	2.5	12.3%	10.8%	\$140	Yes	No
	West Virginia	D	72.4%	\$46,450	8.7%	13.8	72.9%	3.0	16.1%	18.9%	\$268	Yes	Yes
		Implementers											
	Connecticut	R	73.8%	\$71,665	9.1%	48.5	79.3%	2.3	14.2%	10.4%	\$352	Yes	No
	Indiana	R	46.0%	\$50,101	10.4%	54.7	69.1%	3.1	13.0%	12.5%	\$128	No	No
	Louisiana	R	52.1%	\$42,675	8.0%	62.0	80.8%	4.8	12.3%	15.1%	\$170	Yes	No
1,2	Maryland	D	72.9%	\$69,713	7.7%	34.7	65.1%	0.9	12.3%	10.2%	\$227	Yes	Yes
1,4	Mississippi	R	57.5%	\$41,436	10.4%	45.1	63.9%	1.9	12.9%	16.3%	\$122	Yes	Yes
	Montana	D	48.7%	\$44,824	7.3%	43.5	54.8%	3.3	14.9%	12.8%	\$234	Yes	Yes
	New York	D	66.5%	\$54,055	8.6%	41.3	49.4%	1.0	13.5%	10.6%	\$635	Yes	Yes
	Ohio	D	49.2%	\$49,825	10.3%	50.3	78.9%	4.5	14.1%	13.3%	\$191	Yes	No
2,3	Texas	R	47.0%	\$51,324	8.1%	47.7	87.7%	8.4	10.4%	11.6%	\$144	No	No
	National Average		54.9%	\$54,104	8.8%	38.4	65.6%	3.1	13.3%	12.5%	\$215		

Note: In Table 4.3, the highlighted rows are the states under consideration as case studies. The numbers in the first column indicate the dyad pairs for the most similar and most different case studies. Numbers 1-2 are the most different pairs and numbers 3-4 are the most similar pairs.

LTSS: long-term services and supports, NF: nursing facility, HHA: home health aide, HCBS: home and community-based services, CON: certificate of need, R: Republican, D: Democrat

Data Collection

Qualitative data was collected through interviews with national officials; national advocacy organizations; other policy experts; officials in both the bureaucracy and legislature of the state; members of state level interest groups including provider and consumer advocacy groups. National interviewees provided information on the common policy adoption and implementation facilitators and challenges across states while state level interviewees spoke to the specific adoption decisions and implementation processes within their respective states. The interviews were conducted by telephone due to geographic considerations. Appendices A-E show the interview recruitment forms, consent form, introductory script, and interview protocols, respectively. These forms were initially approved by the University of Massachusetts – Boston Institutional Review Board on August 10, 2016 with continuing approval granted on July 11, 2017 and July 3, 2018.

I developed five versions of the interview protocol: for national interviewees, for participating and non-participating states, and then for government officials and other stakeholders within those states (Appendix E). The national interviewee protocol asked questions about their overall perception of the programs; insights into what promoted states to pursue or not pursue these options; and factors that facilitated or impeded states' implementation. For Maryland and Texas, the interview protocol included questions about the adoption process and implementation of all three of the ACA's HCBS programs within their respective states. The

adoption process portion focused on which actors and organizations were involved; what factors influenced their decision; the benefits and drawbacks considered; and how those involved arrived at the final decision to pursue the BIP, CFC, and/or 1915(i) provisions. For each ACA program, the implementation questions asked about who was involved in the implementation process; how they approached implementing the program; what facilitated or impeded the implementation; and if there was anything that should have been done differently. The interview protocol for Oklahoma only asked questions about the decision not to adopt each ACA HCBS program. The questions focused on whether the state considered adopting BIP, CFC, and the 1915(i); who was involved in the decision; what factors shaped their decision; the benefits and drawbacks considered; and how the final decision was made.

To determine individuals to interview, I used a combination of purposive and snowball sampling. Initially, individuals and organizations knowledgeable about HCBS policymaking nationally as well as within each state were identified. I located potential interviewees via many sources, including applications for these programs, lists of state LTSS committee members, meeting minutes, presentations, newspaper articles, and websites of organizations involved in LTSS policy. In interviews with these individuals, I utilized snowball sampling in which interviewees suggest other potential interview subjects. Individuals were initially contacted by email utilizing the interview recruitment forms shown in Appendices A and B, which vary based on whether the prospective interviewee derived from an ACA HCBS participating or non-participating state. A few days later, I followed up with a second email inquiring about their potential participation in my study.

The total number of individuals contacted to participate in this study was 96. Forty-six individuals contacted agreed to participate in an interview for a response rate of 47.9%. Table 4.4

shows the response rate by state and national participants. The proportion of individuals contacted who agreed to be interviewed ranged from 40.9% in Oklahoma to 52.9% for individuals with a national perspective. The number of interviews per state was 14 for Maryland, 14 for Texas, 9 for Oklahoma, and 9 national interviewees. Forty-two interviews were one-on-one and 2 interviews were groups of two people.

Table 4.4: Response Rate by State

	# of Individuals Contacted	Number of Respondents	% of Contacted Interviewed
National	17	9	52.9%
Maryland	27	14	51.9%
Texas	30	14	46.7%
Oklahoma	22	9	40.9%
Total	96	46	47.9%

The number of interviews per type of respondent is shown in Tables 4.5 and 4.6. State bureaucrats were the primary interviewees because existing research suggests that they are the key actors in Medicaid policy change (Schneider & Jacoby, 1996; Schneider et al., 1997; Miller, 2006). Interviewees also included advocates for the elderly, physically disabled, intellectually disabled/developmentally disabled (ID/DD) populations, and individuals with serious mental illnesses; home and community-based provider associations; and state legislators. For some states, I was not able to conduct an interview with each respondent type. This was because approximately 50% of those contacted did not participate in the research. Some individuals declined to participate because they felt they were not knowledgeable enough about the subject or did not have the time to take part in an interview, while others did not respond to my request

for an interview. At the national level, interviewees included federal officials, national representatives of consumer and governmental organizations; and policy experts and consultants.

Table 4.5: # of Interviews per state by type

Interviewee Type	Maryland	Texas	Oklahoma
State Bureaucrat	4	5	3
Advocate – Elder		1	1
Advocate - Cross Disability	1	1	
Advocate - Physical Disability	2		2
Advocate - Developmental Disabilities		2	2
Advocate - Mental Health	3	1	
HCBS Provider	1	3	
Consultant	2	1	1
Legislator	1		

Table 4.6: # of National Interviews by type

Interviewee Type	National
Federal Official	3
Consumer Advocate	2
State Government Advocate	2
Consultant	2

Interviews were conducted between September 26, 2016 and January 3, 2018. A few days before the interview, I emailed each interviewee the consent form shown in Appendix C. Since the interviews were conducted by telephone, this research did not require a signature for consent. Each interview began with an introductory script informing them of their ability to refuse to answer any questions and terminate participation at any time and asking participants for their consent to audio record the interview (Appendix D). Forty-two of the 44 interviews were audio recorded. For the two interviews that were not recorded, I took detailed notes during the interview. The audio recordings of the interviews were professionally transcribed utilizing

rev.com. After receiving the transcripts, I read and edited each transcript, as needed, to ensure accuracy with the audio recording.

In addition to interviews, I collected documents pertaining to the adoption and implementation of the ACA HCBS policies. These documents included Maryland and Texas' BIP applications and CFC and 1915(i) state plan amendments. In addition, I also obtained legislative reports pertaining to HCBS, state presentations, press releases, stakeholder feedback, provider manuals, frequently asked questions documents about these programs, and newspaper articles. I located these documents by conducting web searches pertaining to these programs. During the interviews, I also asked respondents if they had any documents about these programs that they would be willing and able to share with me. In addition, I used LexisNexis to search for newspaper articles related to each program in Maryland and Texas. In total, I collected approximately twenty documents for each state. These documents provided background information on each state's HCBS system in general and specific aspects of each of the ACA HCBS programs. In addition, with these documents, I was able to confirm some of the assertions made during the interviews. For example, one interviewee indicated that Maryland had a goal of standardizing assessment instruments, and a report to the legislature confirmed the LTC Workgroup suggested exploring standardized assessment tools.

Qualitative Analysis

While reading the interview transcripts for the first time, I preliminarily coded the interviews in the margins of the transcripts to identify key words or concepts. After the transcripts were edited for accuracy, I utilized NVivo 12 to code and analyze the data. Prior to data collection, I developed an a priori coding scheme based on the preliminary conceptual framework related to policy adoption (Appendix F). Initial coding used this a priori scheme, and

new concepts emerged based on the interviews (Rubin and Rubin, 2005; Saldana, 2012). I also organized the interview transcripts by state. This allowed me to compare and contrast the policy adoption and implementation experiences of different states. After reading and coding all of the transcripts once, I reviewed the coding scheme. At this point, I reorganized the coding scheme by merging codes that captured similar concepts, deleting codes that were redundant, and reorganizing codes into themes and categories. I then coded the transcripts again with the revised coding scheme to ensure that all interviews were coded consistently.

The final coding scheme with example quotes is shown in Appendix G. The total number of codes was 70. The major changes from the a priori coding scheme included adding codes specifically related to HCBS programs and policies for individuals with serious mental health issues because many states' 1915(i) benefits are focused on serving this population. In addition, interviewees spoke of other existing HCBS policies and programs that were not included in the preliminary coding scheme including Aging and Disability Resource Centers and the institutes for mental disease exclusion. I also added codes related to specific program requirements such as clinical and financial eligibility and payment rates to providers. The preliminary coding scheme focused on factors that influenced state adoption decisions so I added codes related to implementation, including enrollment, procurement, and communication. In addition to adding codes based on concepts and topics that interviewees introduced, I also deleted codes from the preliminary coding scheme that were not used when coding the transcripts. The preliminary codes that I deleted included codes related to separation of powers; nursing facility and home health aide certificate of need programs; and policy diffusion.

After the interviews were coded, I ran queries and counts by code. The queries explored the codes by state and HCBS program. By analyzing the coded data within a code, I could look

for patterns and commonalities across interviews. I also created a count of each code by state and ranked them to understand which codes were more prevalent in the interview data (Rubin & Rubin, 2005). This process allowed me to examine if certain factors may have been more relevant in one state compared to another. The codes were grouped into broader categories. The categories were analyzed for overarching concepts or themes (Saldana, 2012). Based on this analysis, I developed explanatory narratives to explain how the states arrived at their policy decisions and approached the implementation process. I organized the narratives by program and by state based on the preliminary conceptual framework and added new categories as relevant based on the interview data. These narratives were used to refine and validate this study's preliminary conceptual framework.

Rigor in Qualitative Research

Within qualitative research, researchers should seek credibility, dependability, confirmability, and transferability (Shenton, 2004; Houghton, Casey, Shaw, & Murphy, 2013). Credibility is when the study's findings accurately reflect reality and what participants conveyed through interviews. One technique to address credibility is through triangulation, which is using diverse data sources and interviewees to obtain a complete understanding of the issue being studied (Shenton, 2004). In this study, I conducted interviews with individuals at both the state and national level who represented state government, consumer advocates, providers, and consultants. By collecting data from many different individuals and groups both within and outside of government who share an interest in Medicaid LTSS policy, I could be more confident when findings from individuals from diverse perspectives converged. In addition to triangulation across interviewees, I also sought triangulation across data sources. I reviewed written

documents such as memos, presentations, and reports. Reviewing these documents helped confirm findings from the interviewees.

Two additional criteria to ensure rigor in qualitative research are dependability and confirmability. Dependability is most akin to reliability in quantitative methods and can be demonstrated by carefully detailing how the research was conducted. To promote dependability, I developed interview protocols based on the preliminary conceptual framework to ensure consistent questions were posed to interviewees. In addition, using qualitative analysis software can demonstrate dependability. When text or coding queries indicate that multiple interviewees identify common factors, this promotes dependability (Houghton et al., 2013). In this study, I used text searches and coding queries in NVivo to identify common themes across different states and types of interviewees. Confirmability relates to the neutrality of the data to ensure that the researcher's biases and preconceived notions do not influence the results. To promote confirmability, a researcher should acknowledge his or her personal biases and document why specific decisions were made (Shenton, 2004). During this research, I worked for a state agency and have been directly involved in preparing applications and implementing some of the programs that are the focus of this study. When conducting this research, I made efforts to ensure that I was not focusing on certain factors based on my own experiences. In addition, when selecting the states for the case studies, I selected states that I had limited experience with to ensure objectivity.

A final element in qualitative research is the issue of transferability. The depth and detail of qualitative research typically limits the researcher to examining only a few cases. In this study, I examined the state adoption decisions of three states and implementation processes of two states. A concern is that the factors identified in the cases selected for this research are not

applicable to other states. I utilized several approaches to mitigate this concern. To promote transferability, I assessed the extent to which the qualitative findings were consistent with the findings of my quantitative analysis, which incorporated a broader range of states. When the results from the quantitative and qualitative portions of this research converged, I could be more confident in that the findings were more broadly applicable. In addition, I interviewed both state and national level individuals involved in HCBS policy. The state-level interviewees spoke about the specific adoption decisions and implementation processes in their respective states while the national-level interviewees identified common factors across multiple states. When the state-level and national-level factors in the adoption and implementation processes were in agreement, I could have greater confidence that the factors identified in the individual states applied in other states as well. Another concern related to transferability is whether the results are transferable to other programs beyond those studied in the research. The factors that influence the policy adoption and implementation of one program may not apply to a different program. I sought to mitigate this limitation by examining three different HCBS policies. When common factors influenced the adoption and implementation of BIP, CFC, and the 1915(i), I could be more confident that the findings apply to other HCBS policies and programs.

Conclusion

This study relied on a mixed methods research design to understand the factors that influenced state-level policy adoption decisions and implementation processes of three ACA HCBS policies. The quantitative portion of this research utilized multivariate regression models to analyze policy adoption. For the regression models, there were five different dependent variables measuring adoption of the individual HCBS policies as well as adoption of any of the policies. The qualitative aspect of this research explored both the policy adoption decisions and

the policy implementation process. By using most similar and most different case study designs, I could identify the common factors that contributed to policy adoption or non-adoption across three states. In addition, through the cases studies, I looked at the facilitators and barriers to HCBS policy implementation in two states.

The quantitative and qualitative portions of this research complemented one another. With the quantitative research, I was able to examine factors influencing the adoption process across all states while through the qualitative analysis I explored the adoption decisions of three states in depth. By looking at both at a broad level across states as well as the specific decisions of individuals states, I could be more confident in my research findings. While case studies are limited in their number, their strength is in the depth and detail provided. Findings from quantitative research can confirm that the relationships identified in case studies are observed more broadly (Creswell & Plano Clark, 2011).

I also utilized the qualitative data collected through interviews to cross-validate the results from the quantitative models (Miller, 2005). When the qualitative findings were consistent with the quantitative results, I could have greater confidence. In addition, the policy process is often more complex than a quantitative model suggests, and qualitative research can capture this complexity by identifying the causal mechanisms through which the relevant independent variables result in the observed dependent variable (George and Bennett, 2005). While quantitative results can identify correlations among variables, qualitative research can uncover the causal mechanisms linking them together.

The qualitative aspect of this research also allowed me to study the policy implementation process. Many of the aspects of policy implementation do not necessarily lend themselves to quantitative analysis. Factors that facilitate or impede policy implementation can

be difficult to operationalize as variables in a quantitative model. The most similar and most different cases study design allows for the identification of facilitators and barriers of implementation by examining the process in depth in a handful of cases. Examining both the adoption decisions and implementation processes provides a more comprehensive analysis of the development of HCBS policies within states than would have been the case if each had been studied alone.

CHAPTER 5

QUANTITATIVE RESULTS: ADOPTION OF THE AFFORDABLE CARE ACT’S HOME AND COMMUNITY BASED SERVICES PROGRAMS

This chapter presents the results from the quantitative models to understand the factors that influenced state adoption of the Affordable Care Act’s (ACA) home and community-based services (HCBS) policies. These models test the policy adoption hypotheses discussed in Chapter 3. Overall, the results strongly support the hypotheses related to the impact of political ideology and existing HCBS policies on a state's adoption of the optional HCBS policies within the ACA. For several of the dependent variables, states with a more liberal political ideology were more likely to pursue these policies. The results also suggest that states with a lower percentage of Medicaid HCBS spending and more 1915(c) HCBS waivers were more likely to pursue these policies. Other factors found to be significant across more than one model were the partisan control indicator, home health agencies per 100,000 residents, the percentage of the elder population, and neighboring state variable.

This chapter discusses these findings in more detail and is organized as follows. The chapter begins by detailing the five dependent variables and then presenting descriptive statistics for the independent variables. The next section presents bivariate statistics including bivariate regression results and a correlation matrix, followed by the results from the multivariate models. The final section summarizes the results.

Dependent Variables

This section describes each of the dependent variables in this study. As discussed in the prior chapter, three different modeling approaches were used. The first approach modeled the adoption of the Balancing Incentive Program (BIP), Community First Choice (CFC), and the 1915(i) HCBS state plan benefit separately using discrete event history models. In these three models, the dependent variable was zero in years the state did not adopt the specific policy and one in the year of adoption. After the year of adoption, the state was dropped from the observations. In the second approach, the dependent variable was zero in years the state did not adopt any of the policies and one in years the state adopted at least one policy. Each state remained in the dataset for all years. In the final modeling approach, the dependent variable was measured as the proportion of eligible policies the state adopted as of 2015. This variable could range from zero (if the state did not adopt any policies) to 1 (if the state adopted all of the policies for which it was eligible).

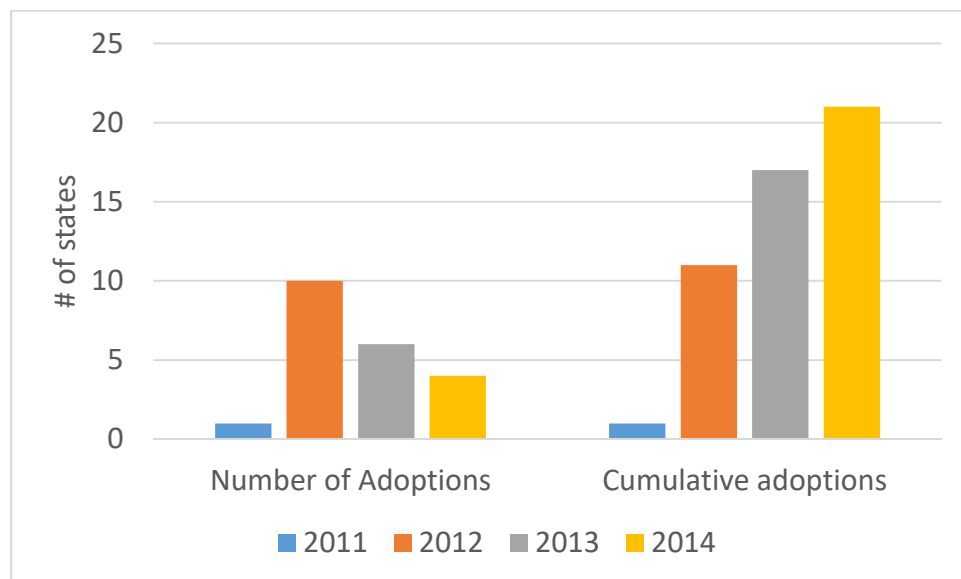
The first event history model utilized a dichotomous variable indicating whether the state adopted BIP within a specific year. States could apply for BIP between 2011 and 2014, and 38 states were eligible for BIP based on the requirement of spending less than 50% of all Medicaid long-term services and supports (LTSS) spending on HCBS in 2009. Of the 38 eligible states, 21 states (55.3%) pursued this program. Table 5.1 shows the number of states that adopted BIP each year, the number of cumulative adoptions, risk set, hazard probability, and survival probability. In 2011, the risk set was 38 because 38 states were eligible to participate in BIP. The hazard probability indicates the likelihood that a state will adopt BIP in a specific year given the state is at risk of adoption. The hazard probability was highest in 2012 when 10 states adopted BIP. Figure 5.1 displays the number of adoptions by year and the cumulative adoptions. As indicated

in the figures, only one state adopted BIP the first year while the second year saw the largest uptake in BIP adoptions. The number of states adopting BIP then declined in 2013 and again in 2014.

Table 5.1: States Adopting BIP, Risk Set, Hazard Probability, Survival Probability, by year

Year	States adopting	Number of Adoptions	Cumulative adoptions	Risk set	Hazard Probability	Survival Probability
2011	NH	1	1	38	0.026	0.974
2012	AR, CT, GA, IN, IA, MD, MS, MO, NJ, TX	10	11	37	0.270	0.711
2013	IL, KY, LA, ME, NY, OH	6	17	27	0.222	0.553
2014	MA, NE, NV, PA	4	21	21	0.190	0.447

Figure 5.1: Number of States Adopting BIP, by year



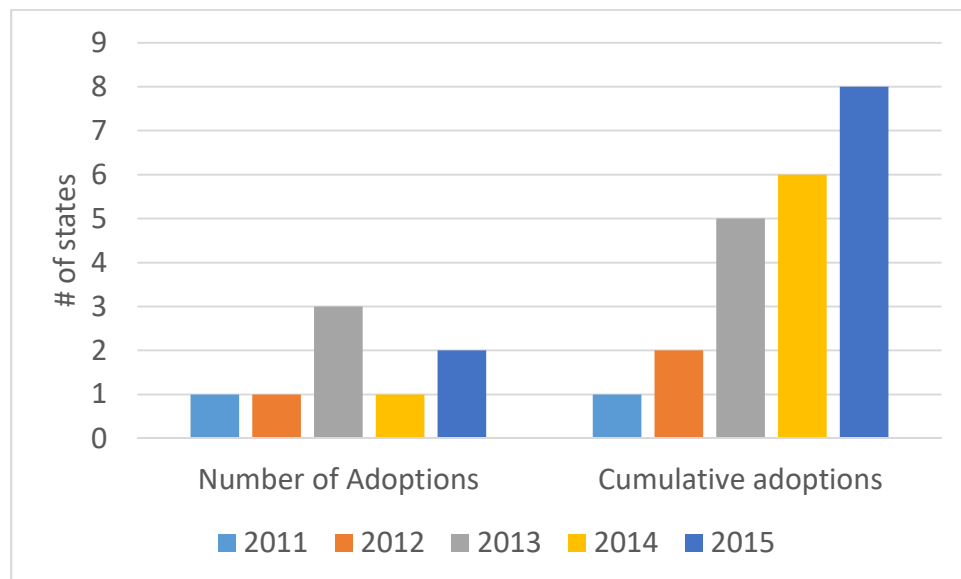
In the second model, the dependent variable was a dichotomous variable indicating whether the state pursued CFC in a given year. Unlike BIP, all states were eligible for CFC and could apply for the program beginning in 2011. Between 2011 and 2015, eight states (16%) pursued this new Medicaid HCBS option. Table 5.2 shows the states that adopted this option by

year. The initial risk set for CFC was 50 since all states were eligible for the program. Since fewer states adopted this option as of 2015, the hazard probability is lower and the survival probability higher for CFC than BIP. In 2015, 84% of states had not adopted CFC. Figure 5.2 shows the number of adoptions by year and the cumulative adoptions of CFC, respectively. In most years, only one state adopted CFC but in 2015 two states pursued this option and in 2013 three states did.

Table 5.2: States Adopting CFC, Risk Set, Hazard Probability, Survival Probability, by year

Year	States adopting	Number of Adoptions	Cumulative adoptions	Risk set	Hazard Probability	Survival Probability
2011	CA	1	1	50	0.020	0.980
2012	OR	1	2	49	0.020	0.960
2013	MD, MT, NY	3	5	48	0.063	0.900
2014	TX	1	6	45	0.022	0.880
2015	CT, WA	2	8	44	0.045	0.840

Figure 5.2: Number of States Adopting CFC, by year



In the third event history model, the dependent variable was a dichotomous variable representing whether the state adopted the 1915(i) HCBS state plan benefit that year. For the

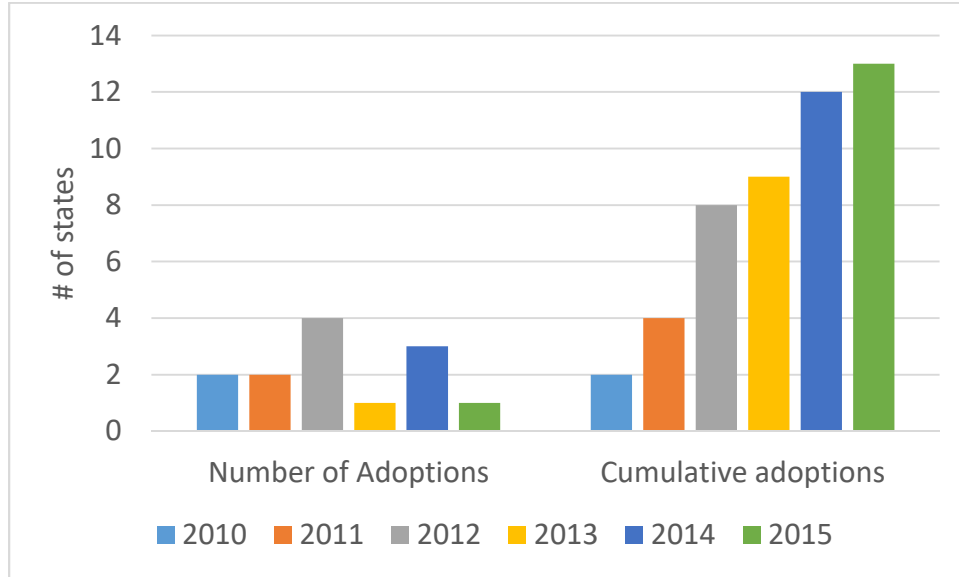
1915(i) program, all states were eligible to adopt a 1915(i) HCBS state plan benefit; however, several states pursued this option prior to the changes within the ACA. These states that adopted a 1915(i) prior to 2010 were excluded from this analysis. While one of the changes to the 1915(i) within the ACA was that states could have multiple 1915(i) state plan benefits, none of the previously adopting states submitted a second 1915(i) state plan amendment during this period. Because six states submitted a 1915(i) SPA prior to 2010 when the ACA changes were implemented, the initial risk set for the 1915(i) model was 44 states.

Table 5.3 displays the states that adopted the 1915(i) between 2010 and 2015, the cumulative adoptions, risk set, hazard probability, and survival probability. The number of adoptions per year ranged from one in 2013 and 2015 to four in 2012. At the end of the study, 13 states (29.5%) had adopted 1915(i) state plan benefits after the ACA revisions went into effect. Figure 5.3 show the number of adoptions per year and cumulative adoptions of the 1915(i) state plan benefit.

Table 5.3: States Adopting 1915(i), Risk Set, Hazard Probability, Survival Probability, by year

Year	States adopting	Number of Adoptions	Cumulative adoptions	Risk set	Hazard Probability	Survival Probability
2010	ID, OR	2	2	44	0.045	0.955
2011	FL, LA	2	4	42	0.048	0.909
2012	CT, IN, MI, MT	4	8	40	0.100	0.818
2013	MS	1	9	36	0.028	0.795
2014	DE, MD, TX	3	12	35	0.086	0.727
2015	OH	1	13	32	0.031	0.705

Figure 5.3: Number of States Adopting 1915(i), by year

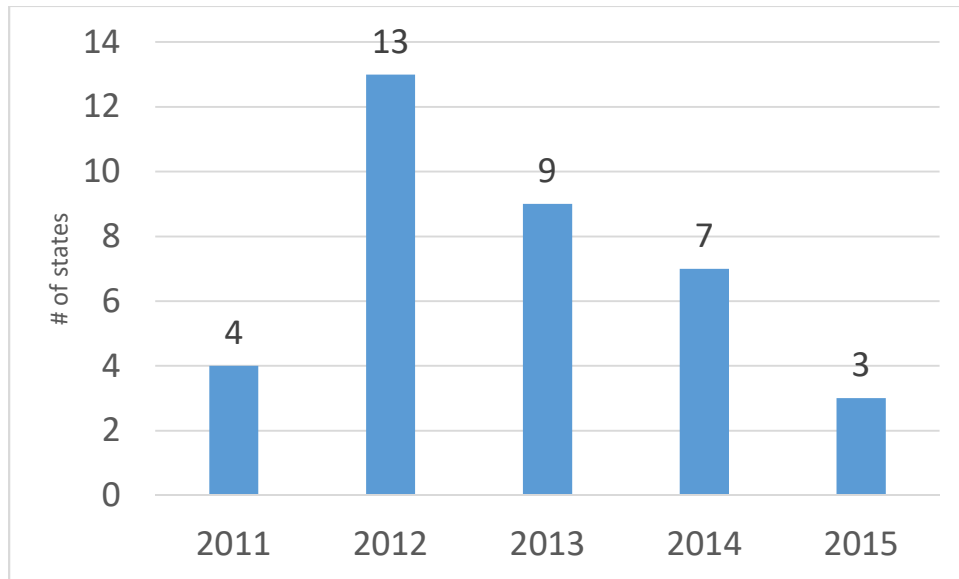


The second modeling approach utilized a dichotomous variable indicating whether or not the state had adopted any policy in the specific year. Table 5.4 presents the number of states, mean, and standard deviation by year for this variable. As shown in Figure 5.4, in 2012 there were the most adoptions with thirteen states adopting at least one of the ACA's HCBS policies in that year. The number of adoptions subsequently declined annually from 2013 to 2014 and 2015. One explanation for the low number of policy adoptions in 2015 is that states were no longer eligible to apply for BIP.

Table 5.4: States Adopting Any ACA HCBS Program, Mean and Standard Deviation, by year

Year	# of States	Mean	Standard Deviation
2011	4	0.080	0.274
2012	13	0.260	0.443
2013	9	0.180	0.388
2014	6	0.140	0.351
2015	3	0.060	0.240

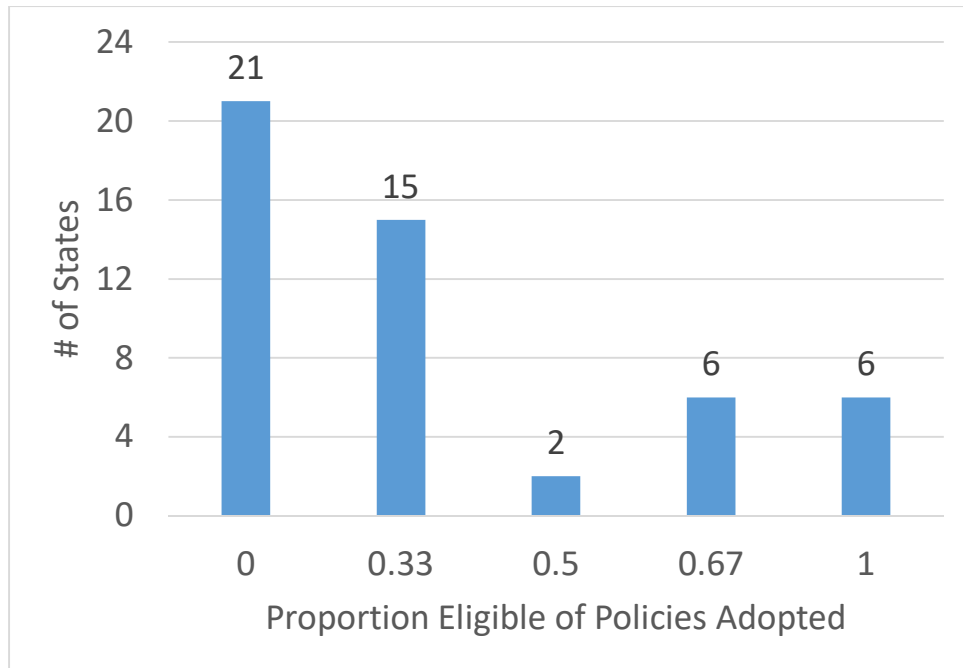
Figure 5.4: State Adoption of any Policy, by year



In the last modeling approach, the dependent variable was the proportion of eligible ACA HCBS policies that the state adopted. The mean and standard deviation for this variable were 0.320 and 0.341, respectively. Figure 5.5 indicates that 21 states (42%) did not adopt any of the ACA HCBS policies for which the state was eligible and that 15 states (30%) adopted one-third of the policies for which they were eligible. Two states (4%) adopted half of the ACA HCBS policies for which they were eligible while six states (12%) adopted two-thirds of eligible policies. Lastly, six states adopted all three of the ACA HCBS policies for which they were eligible.⁴

⁴ California and Washington were not eligible for BIP and adopted the 1915(i) state plan benefit prior to the ACA changes. Both states were therefore eligible for CFC and adopted CFC. Oregon was not eligible for BIP but adopted CFC and the 1915(i) state plan benefit during this study period.

Figure 5.5: Proportion of Eligible ACA HCBS Policies States Adopted



Explanatory Variables - Descriptive Statistics

Tables 5.5 and 5.6 present descriptive statistics for the explanatory variables included in this study. Table 5.5 shows the mean, standard deviation, minimum, and maximum of the study variables across all years while Table 5.6 shows the mean and standard deviation for each variable by year, from 2010 through 2015. As shown in Table 5.6, Democratic leadership decreased in both the governor's office and state legislature during this time period. The percentage of Democratic governors declined from 54% in 2010 to 34% in 2015, and the percentage of Democrats in the state legislature declined from approximately 55% to 43%. In addition, the ADA ideology index variable also decreased; indicating a decline in political liberalism during this period.

Table 5.5: Descriptive Statistics for State Policy Variables, 2010-2015

	N	Mean	SD	Min	Max
Political / Ideological					
Democratic Governor	300	0.57	0.50	0	1
% of Legislature Democratic	294	0.47	0.17	0.13	0.90
ADA Ideology Index	300	42.32	26.32	0	100
Governing Capacity					
FTE state employees per 1,000 pop.	300	17.18	6.08	8.83	42.61
Gubernatorial power index	300	3.46	0.51	2.20	5.20
Average state legislative salary	300	27006.15	21717.89	0	93753.19
Partisan control indicator	294	2.46	0.82	1	3
Industry Power (LTSS Supply)					
NF beds per 1,000 age 65+	300	37.45	13.91	9.51	67.31
Percentage of NF beds for-profit	300	67.14	17.78	4.00	89.73
HHA per 100,000	300	3.17	1.83	0.54	10.21
Advocacy Power (LTSS Demand)					
% of the population 65+	300	14.22	1.82	7.77	19.45
% of population with disability	300	12.87	2.17	8.50	20.20
% of the population with cognitive disability	300	5.19	1.01	3.26	8.00
Economic					
Per capita income (t-1)	300	41284.74	4946.56	32238.00	58315.00
GDP (t-1)	300	46713.91	8889.46	31111.00	74289.00
Unemployment rate (t-1)	300	7.53	2.05	2.70	13.70

	N	Mean	SD	Min	Max
Existing HCBS / LTSS Policies					
# of 1915(c) waivers (t-1)	300	6.09	2.94	0	14
Medicaid state plan personal care program (t-1)	300	0.69	0.46	0	1
% of Medicaid LTSS spending on HCBS (t-1)	300	49.34	12.67	17.71	91.55
Medicaid HCBS spending per capita (t-1)	300	226.27	118.45	65.84	651.74
NF certificate of need program (t-1)	300	0.70	0.46	0	1
HHA certificate of need program (t-1)	300	0.32	0.47	0	1
Medically needy program (t-1)	300	0.64	0.48	0	1
Prior year ACA HCBS policy (t-1)	250	0.14	0.35	0	1
External Factors					
HCBS Final Rule issuance	300	0.33	0.47	0	1
% of neighboring states adopting BIP (t-1)	144	21.41	27.10	0	100
% of neighboring states adopting CFC (t-1)	192	6.91	13.02	0	50
% of neighboring states adopting 1915(i) (t-1)	240	13.72	19.52	0	100
% of neighboring states adopting any policy (t-1)	240	33.14	30.98	0	100
% of neighboring states adopting any policy cross sectional (t-1)	48	61.14	24.44	14.29	100

N: number of observations, SD: standard deviation, ADA: Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, BIP: Balancing Incentive Program, CFC: Community First Choice

The number of state employees per capita declined between 2010 and 2015. In 2010, there were on average 17.48 full-time equivalent (FTE) state employees per 1,000 state residents

compared to 17 state FTEs per 1,000 state residents in 2015. The gubernatorial power index variable increased which indicates governors had gained powers between 2010 and 2015. The variables measuring the average state legislative salary and partisan control indicator did not change substantially during the period of this study.

The number of nursing facility beds per 1,000 age 65 and older generally remained unchanged between 2010 and 2015 while the percentage of for-profit nursing facilities increased slightly. In 2015, 68% of all nursing facilities were for-profit compared to 65% in 2010. The number of home health agencies per 100,000 residents also increased during this period. In 2010, there were 3 HHAs per 100,000 residents and in 2015 this ratio increased to 3.23.

During this time period, the percentage of the population age 65+, the percentage of the population with a disability, and the percentage of the population with a cognitive disability all increased. The percentage of the population age 65+ increased from 13.3% in 2010 to 15.2% in 2015 which is consistent with the aging of the Baby Boomer population. The percentage of the population with a disability increased from 12.5% to 13.2%, and the percentage of the population with a cognitive disability increased from 5.04% to 5.34%.

Between 2010 and 2015, the lagged economic variables utilized in this study suggest an overall improvement in states' economic situations. During this period, average per capita income and average per capita gross domestic product (GDP) both increased. In addition, the unemployment rate declined from an average of 8.48% in 2010 to 5.75% in 2015.

In this study, there were four variables measuring HCBS commitment all of which were lagged one year. Most of these variables suggested a greater commitment to HCBS between 2010 and 2015. The average number of 1915(c) waivers per state increased from 5.68 in 2010 to 6.2 in 2015. The percentage of Medicaid LTSS spending on HCBS also increased from 45.61%

in 2010 to 51.81% in 2015. In 2014, the percentage of Medicaid HCBS spending surpassed 50% for the first time and continued to increase in the subsequent year. In addition, Medicaid HCBS spending per capita increased from \$196.10 in 2010 to \$258.89 in 2015. The only HCBS variable that generally remained unchanged during the study period was the 70% of states offering state plan personal care services. The variables for nursing facility and home health aide certificate of need programs indicate little change during this study period, remaining steady at about 70% and 32%, respectively. Similarly, the percentage of states covering the medically needy under Medicaid remained at 64% during all but one year.

The prior year ACA HCBS policy variable was a dichotomous variable indicating whether the state adopted one of these policies in the prior year. The mean by year ranged from 0.04 in 2011 to 0.26 in 2013. Since this variable was lagged one year, these statistics reflect that very few states adopted one of these policies in 2010 while 2012 saw the largest number of state adopting these policies. After the increase in 2012, the number of adoptions dropped off in 2013 and 2014.

The variable measuring the Centers for Medicare and Medicaid Services' (CMS) issuance of the HCBS Final Rule was a dummy variable. This variable was 0 prior to the HCBS Final Rule publication and 1 in 2014 and 2015. The mean for this variable was 0.33.

The lagged variables that measured neighboring state adoption all reflect the cumulative percentage of contiguous states that adopted each specific policy. As the number of state adoptions increases, the percentage of states with a neighboring state that adopted the policy also increases. For BIP, the mean cumulative percentage of a state's neighbors that adopted BIP in the previous year increased from 3.19% in 2012 to 36.49% in 2014. Since fewer states adopted CFC compared to BIP, the mean cumulative percentage of neighboring states who adopted this

program in the previous year was lower: 1.35% in 2012 and 12.12% in 2015. With the 1915(i), the mean cumulative percentage of neighboring states pursuing this option in the previous year increased from 5.69% in 2011 to 22.40% in 2015. The mean cumulative percentage of a state's neighbors that adopted any policy in the previous year increased from 5.69% in 2011 to 61.14% in 2015. The mean cumulative percentage of neighboring states that adopted any policy in the prior year for the cross sectional model was 61.14% in 2015.

Table 5.6: Descriptive Statistics for State Policy Variables, by Year 2010-2015

	2010			2011			2012		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
Political / Ideological									
Democratic Governor	50	0.54	0.50	50	0.40	0.49	50	0.40	0.49
% of Legislature Democratic	49	54.92	15.07	49	46.55	17.01	49	46.08	16.91
ADA Ideology Index	50	51.24	25.08	50	44.56	25.42	50	41.80	25.17
Governing Capacity									
FTE state employees per 1,000.	50	17.48	6.25	50	17.34	6.21	50	17.16	6.16
Gubernatorial power index	50	3.33	0.47	50	3.39	0.45	50	3.39	0.44
Average state legislative salary	50	28043	23195	50	27115	22313	50	26619	21959
Partisan control indicator	49	2.22	0.90	49	2.43	0.82	49	2.49	0.79
Industry Power (LTSS Supply)									
NF beds per 1,000 age 65+	50	38.80	14.94	50	37.17	14.89	50	35.94	13.69
Percentage NF beds for-profit	50	65.32	17.37	50	65.38	17.36	50	66.99	17.87
HHA per 100,000	50	3.00	1.64	50	3.10	1.80	50	3.13	1.82
Advocacy Power (LTSS Demand)									
% of the population 65+	50	13.34	1.66	50	13.54	1.64	50	14.02	1.68
% of population with disability	50	12.47	2.20	50	12.57	2.17	50	12.68	2.16
% of the population with cognitive disability	50	5.04	1.04	50	5.06	1.01	50	5.12	1.04
Economic									
Per capita income (t-1)	50	39764	4267	50	40044	4547	50	41244	4885
GDP (t-1)	50	45614	8961	50	46208	8753	50	46694	8845

	2010				2011				2012			
	N	Mean	SD		N	Mean	SD		N	Mean	SD	
Unemployment rate (t-1)	50	8.48	1.99		50	8.75	2.05		50	8.12	1.93	
Existing HCBS / LTSS Policies												
# of 1915(c) waivers (t-1)	50	5.68	2.90		50	6.00	2.94		50	6.14	2.92	
Medicaid state plan personal care program (t-1)	50	0.70	0.46		50	0.68	0.47		50	0.70	0.46	
% of Medicaid LTSS spending on HCBS (t-1)	50	45.61	13.05		50	48.63	13.37		50	49.26	12.66	
Medicaid HCBS spending per capita (t-1)	50	196.10	111.03		50	213.93	112.84		50	220.23	115.26	
NF certificate of need program (t-1)	50	0.70	0.46		50	0.70	0.46		50	0.70	0.46	
HHHA certificate of need program (t-1)	50	0.32	0.47		50	0.32	0.47		50	0.32	0.47	
Medically needy program (t-1)	50	0.64	0.48		50	0.64	0.48		50	0.64	0.48	
Prior year ACA HCBS policy (t-1)	50				50	0.04	0.20		50	0.08	0.27	
External Factors												
HCBS Final Rule issuance	50	0.00	0.00		50	0.00	0.00		50	0.00	0.00	
% of neighboring states adopting BIP (t-1)									48	3.19	15.31	
% of neighboring states adopting CFC (t-1)									48	1.35	5.33	
% of neighboring states adopting 1915(i) (t-1)					48	5.69	16.78		48	8.02	17.42	
% of neighboring states adopting any policy (t-1)					48	5.69	16.78		48	12.57	23.32	

Table 5.6: Descriptive Statistics for State Policy Variables, by Year 2010-2015 (cont.)

	2013			2014			2015		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
Political / Ideological									
Democratic Governor	50	0.40	0.49	50	0.42	0.50	50	0.34	0.48
% of Legislature Democratic	49	46.98	17.81	49	46.58	17.86	49	43.11	17.02
ADA Ideology Index	50	39.94	26.85	50	39.82	25.10	50	36.54	28.86
Governing Capacity									
FTE state employees per 1,000.	50	17.09	6.10	50	17.03	6.08	50	16.98	6.00
Gubernatorial power index	50	3.40	0.46	50	3.38	0.44	50	3.90	0.57
Average state legislative salary	50	26377	21328	50	26235	21193	50	27647	21291
Partisan control indicator	49	2.63	0.73	49	2.57	0.79	49	2.39	0.84
Industry Power (LTSS Supply)									
NF beds per 1,000 age 65+	50	38.64	13.70	50	37.66	13.49	50	36.48	13.11
Percentage NF beds for-profit	50	67.96	18.03	50	68.72	18.34	50	68.48	18.29
HHA per 100,000	50	3.27	1.93	50	3.27	1.94	50	3.23	1.88
Advocacy Power (LTSS Demand)									
% of the population 65+	50	14.42	1.72	50	14.82	1.75	50	15.21	1.79
% of population with disability	50	13.12	2.17	50	13.19	2.19	50	13.20	2.14
% of the population with cognitive disability	50	5.24	0.97	50	5.32	1.01	50	5.34	1.00
Economic									
Per capita income (t-1)	50	42129	5229	50	41700	5054	50	42826	5139
GDP (t-1)	50	47106	9284	50	47040	8854	50	47621	8937
Unemployment rate (t-1)	50	7.34	1.71	50	6.73	1.54	50	5.75	1.26
Existing HCBS / LTSS Policies									
# of 1915(c) waivers (t-1)	50	6.26	2.95	50	6.24	3.07	50	6.20	2.98

	2013			2014			2015		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
Medicaid state plan personal care program (t-1)	50	0.68	0.47	50	0.68	0.47	50	0.70	0.46
% of Medicaid LTSS spending on HCBS (t-1)	50	49.69	12.50	50	51.06	12.58	50	51.81	11.46
Medicaid HCBS spending per capita (t-1)	50	227.16	118.96	50	241.28	121.47	50	258.89	126.22
NF certificate of need program (t-1)	50	0.70	0.46	50	0.70	0.46	50	0.70	0.46
HHA certificate of need program (t-1)	50	0.32	0.47	50	0.32	0.47	50	0.32	0.47
Medically needy program (t-1)	50	0.64	0.48	50	0.64	0.48	50	0.62	0.49
Prior year ACA HCBS policy (t-1)	50	0.26	0.44	50	0.18	0.39	50	0.12	0.33
External Factors									
HCBS Final Rule issuance	50	0.00	0.00	50	1.00	0.00	50	1.00	0.00
% of neighboring states adopting BIP (t-1)	48	24.55	25.08	48	36.49	28.10			
% of neighboring states adopting CFC (t-1)	48	3.85	11.11	48	10.31	15.06	48	12.12	15.15
% of neighboring states adopting 1915(i) (t-1)	48	15.33	19.23	48	17.16	19.85	48	22.40	19.96
% of neighboring states adopting any policy (t-1)	48	37.89	24.56	48	48.43	24.33	48	61.14	24.44
% of neighboring states adopting any policy cross sectional (t-1)							48	61.14	24.44

N: number of observations, SD: standard deviation, ADA: Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, BIP: Balancing Incentive Program, CFC: Community First Choice

Bivariate Results

Bivariate Regressions

I ran regressions to assess the bivariate relationship between the independent variables and each dependent variable. The bivariate regressions utilized the panel data with the state-year as the unit of analysis for the first four dependent variables. Since these dependent variables were dichotomous variables; I also used logistic regression. The final dependent variable was a proportion; therefore, I relied on a generalized linear model for this regression. The results from the bivariate regressions are presented in Table 5.7.

Table 5.7: Pooled Bivariate Regression Models of All Dependent Variables and Independent Variables

	BIP		CFC		1915(i)	
	N	OR	N	OR	N	OR
Political / Ideological						
Democratic Governor	123	1.500	236	13.203**	229	0.892
% of Legislature Democratic	119	1.013	231	1.030 [#]	224	0.588
ADA Ideology Index	123	1.001	236	1.031*	229	1.005
Governing Capacity						
FTE state employees per 1,000	123	0.887*	236	0.912	229	0.936
Gubernatorial power index	123	0.970	236	2.840 [#]	229	0.701
Average state legislative salary	123	1.000	236	1.000 [#]	229	1.000
Partisan control indicator	119	0.725	231	0.996	224	2.062 [#]
Industry Power (LTSS Supply)						
NF beds per 1,000 age 65+	123	1.038*	236	0.981	229	1.005
Percentage NF beds for-profit	123	1.005	236	1.030	229	1.035 [#]
HHA per 100,000	123	1.040	236	0.838	229	1.279*
Advocacy Power (LTSS Demand)						
% of the population 65+	123	0.934	236	0.896	229	1.061

	BIP		CFC		1915(i)	
	N	OR	N	OR	N	OR
% of population with disability	123	0.961	236	0.744 [#]	229	1.014
% of the population with cognitive disability	123	0.975	236	0.608	229	1.070
Economic						
Per capita income (t-1)	123	1.000 [#]	236	1.000	229	1.000
GDP (t-1)	123	1.000	236	1.000 [*]	229	1.000
Unemployment rate (t-1)	123	0.996	236	1.114	229	1.270 [*]
Existing HCBS / LTSS Policies						
# of 1915(c) waivers (t-1)	123	1.149 [*]	236	1.263 [*]	229	1.089
Medicaid state plan personal care program (t-1)	123	0.849	236	3.570	229	1.056
% of Medicaid LTSS spending on HCBS (t-1)	123	0.975	236	1.049 [*]	229	0.975
Medicaid HCBS spending per capita (t-1)	123	1.002	236	1.005 [*]	229	0.997
NF certificate of need program (t-1)	123	1.169	236	0.694	229	0.906
HHA certificate of need program (t-1)	123	0.878	236	2.257	229	0.500
Medically needy program (t-1)	123	1.196	236	1.783	229	0.438 [#]
Prior year ACA HCBS policy (t-1)						
External Factors						
HCBS Final Rule issuance	123	1.176	236	0.991	229	1.079
% of neighboring states adopting BIP (t-1)	82	1.006				
% of neighboring states adopting CFC (t-1)			178	1.041 [*]		
% of neighboring states adopting 1915(i) (t-1)					175	1.005

Table 5.7: Pooled Bivariate Regression Models of All Dependent Variables and Independent Variables (cont.)

Variable	All Programs		Proportion of Programs	
	N	OR	N	OR
Political / Ideological				
Democratic Governor	300	1.472	50	1.636
% of Legislature Democratic	294	2.235	49	1.024 [#]
ADA Ideology Index	300	1.005	50	1.013 [#]
Governing Capacity				
FTE state employees per 1,000	300	0.931 [*]	50	0.888 ^{**}
Gubernatorial power index	300	0.959	50	1.924 [#]
Average state legislative salary	300	1.000	50	1.000 [#]
Partisan control indicator	294	1.055	49	0.925
Industry Power (LTSS Supply)				
NF beds per 1,000 age 65+	300	1.017 [#]	50	1.009
Percentage NF beds for-profit	300	1.021 [*]	50	1.022 [#]
HHA per 100,000	300	1.091	50	1.057
Advocacy Power (LTSS Demand)				
% of the population 65+	300	1.029	50	0.945
% of population with disability	300	1.012	50	0.935
% of the population with cognitive disability	300	1.071	50	0.976
Economic				
Per capita income (t-1)	300	1.000	50	1.000
GDP (t-1)	300	1.000	50	1.000
Unemployment rate (t-1)	300	1.136 [#]	50	1.469 [*]
Existing HCBS / LTSS Policies				
# of 1915(c) waivers (t-1)	300	1.124 [*]	50	1.221 ^{**}
Medicaid state plan personal care program (t-1)	300	1.118	50	0.986
% of Medicaid LTSS spending on HCBS (t-1)	300	0.981 [#]	50	0.999
Medicaid HCBS spending per capita (t-1)	300	1.000	50	1.001
NF certificate of need program (t-1)	300	1.708	50	1.231
HHA certificate of need program (t-1)	300	1.121	50	1.094
Medically needy program (t-1)	300	1.112	50	1.257

Variable	All Programs		Proportion of Programs	
	N	OR	N	OR
Prior year ACA HCBS policy (t-1)	250	0.738		
External Factors				
HCBS Final Rule issuance	300	0.683		
% of neighboring states adopting any policy (t-1)	240	1.0012		
% of neighboring states adopting any policy cross sectional (t-1)			48	1.018*

N: number of observations, OR: Odds ratio, ADA: Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, BIP: Balancing Incentive Program, CFC: Community First Choice
#p<.10, *p<.05, **p<.01, ***<p<.001

As shown in the table, the BIP dependent variable had a positive association with the number of nursing facility beds per 1,000 age 65 and older and the number of 1915(c) HCBS waivers in the previous year. In addition, the variable measuring state per capita income in the previous year was marginally significant and positive. The BIP variable was negatively correlated with the number of state FTEs per 1,000 population. No other variable had a significant relationship in the bivariate panel regression with BIP as the dependent variable.

The second set of bivariate regressions utilized the CFC adoption variable as the dependent variable. Here, the variables measuring Democratic governor, ADA ideology index, GDP in the previous year, number of 1915(c) waivers in the previous year, the percentage of Medicaid LTSS spending on HCBS in the previous year, Medicaid HCBS spending per capita in the previous year, and the percentage of neighboring states adopting CFC in the previous year were all positively correlated with the CFC dependent variable. In addition, the variables

measuring the percentage of the legislature that was Democratic, gubernatorial power index, and average state legislative salary were marginally significant and positive while the variable measuring the percentage of the population with a disability was marginally significant but negative.

Variables positively correlated with the 1915(i) dependent variable were the number of home health agencies per 100,000 residents and the state unemployment rate in the previous year. In addition, the partisan control indicator and percentage of nursing facilities for-profit were both marginally significant and positive while the presence of a medically needy program in the previous year was marginally significant and negative.

Two variables were positively correlated with the dependent variable measuring adoption of any ACA HCBS policy in a given year. The percentage of for-profit nursing facilities and number of 1915(c) waivers in the previous year both had a positive relationship with this variable while the number of state FTEs per 1,000 population was negatively correlated with the adoption of any of these policies. In addition, the number of nursing facility beds per 1,000 age 65 and older and the unemployment rate in the previous year were marginally significant and positively related to this variable while the percentage of Medicaid LTSS spending on HCBS in the previous year was marginally significant and negatively related.

The final dependent variable measured the proportion of policies each state adopted as of 2015. Eight explanatory variables were positively correlated with this variable in bivariate regressions: the state's unemployment rate, number of 1915(c) waivers, and cumulative percentage of neighboring states that adopted any of these policies in the previous year were significant while the percentage of Democrats in the state legislature, ADA ideology index, gubernatorial power index, average state legislative salary, and percentage of nursing facilities

for-profit were marginally significant and positively related to the policy adoption percentage. The number of state employees was negatively correlated with this variable.

Correlation Matrix

To assess potential issues of multicollinearity, I ran a bivariate correlation matrix (Appendix H). The matrix identified pairs of independent variables that were highly correlated. Several variables showed a high degree of correlation – greater than or equal to .70. The percentage of the legislature Democratic and the ADA ideology index variables were positively correlated (.82) as were per capita income and GDP in the prior year (.78), and percentage of the population with a disability and the percentage of the populations with a cognitive disability (.96). Including independent variables that are highly correlated can make variables unstable and impact a model's standard errors. To address this issue of multicollinearity, I included only one of the two variables that was highly correlated in the final multivariate models. I chose to use the ADA ideology index as opposed to the percentage of legislature Democratic because the percentage of legislature Democratic had missing observations while the ADA ideology index did not. For the economic indicator variable, I chose to use per capita income rather than GDP because other studies exploring state variation in HCBS have utilized per capita income (Miller et al., 1999; Miller et al. 2008; Miller & Kirk, 2016). In the multivariate models, I also chose to use the percentage of the population with a disability rather than the percentage of the population with a cognitive disability. I made this decision because the percentage of the population with a cognitive disability is a subset of the percentage of the population a disability and the policies in this study were not specifically targeted to individuals with cognitive disabilities but could encompass all disabilities. When measuring the relationships among the variables, after excluding the three variables discussed above, the variance inflation factors (VIFs) did not

indicate any remaining issues with multicollinearity. All VIFs for the independent variables included in the models were less than 5.

Multivariate Results

As discussed in the previous chapter, I ran four different event history models for each dependent variable. In the first model, I included all of the variables except the neighboring state variable. For the second model, I added the neighboring state variable to Model 1, which resulted in the loss of one year of observations because the neighboring state variable was lagged one year. In the third model, I utilized a modified backwards stepwise approach. Initially, I ran a backwards stepwise regression in Stata including all of the independent variables in Model 1. The stepwise regression eliminated any variables with a p-value of greater than or equal to .25. For Model 3, I then ran the regression with the variables identified in the stepwise regression plus all of year indicator variables regardless of whether those variables were significant in the stepwise regression. In Model 4, I added the neighboring state variable to Model 3.

Two models were run for the dependent variable measuring the adoption of any policy in a given year. Model 1 presents the logistic regression with robust standard errors with all independent variables, including the neighboring state variable and the variable measuring adoption of one of the ACA's HCBS policies in the previous year. For Model 2, I utilized a modified stepwise approach. I ran a backwards stepwise regression including all of the independent variables. The stepwise regression eliminated variables with a p-value of greater than or equal to .25. The variables in the stepwise regression were then included in a regression with the year indicator variables, regardless of whether the year indicator variables had a p-value of less than .25 in the stepwise regression, for Model 2.

The final dependent variable was the proportion of policies the state adopted for which it was eligible. Since this variable was a proportion and only ranged from zero to one, I utilized a generalized linear model with logit link and binominal family with robust standard errors. Since the number of observations was small, I only ran a backwards stepwise regression. For this dependent variable, the results from one model are presented.

Balancing Incentive Program

The results from the BIP event history model are presented in Table 5.8. In Models 1 and 3, the timeframe is 2011 to 2014. Models 2 and 4 included the neighboring state variable, which was lagged one year; therefore, the timeframe for these models is 2012 to 2014. As a result, the number of observations in Models 2 and 4 is 79 compared to 119 observations in Models 1 and 3. In addition, Nebraska is omitted in all of the models due to missing data on the partisan control variable, while Hawaii is omitted in the neighboring state model because it does not share a border with another state.⁵

⁵ Alaska was omitted in all four models because the state was not eligible for BIP.

Table 5.8: Factors Influencing BIP Adoption Event History Model

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
Political Ideology								
Democratic governor	1.717 [#] (1.268)	5.570	-1.287 (1.804)	0.276	2.043 [*] (1.025)	7.715	1.243 (1.128)	3.465
ADA Ideology Index	0.128 [*] (0.057)	1.136	0.198 [*] (0.097)	1.219	0.143 ^{***} (0.043)	1.154	0.138 ^{**} (0.047)	1.148
Governing Capacity								
FTE state employees per 1,000.	-0.760 ^{**} (0.265)	0.467	-0.552 [*] (0.315)	0.576	-0.769 ^{**} (0.250)	0.463	-0.646 ^{**} (0.227)	0.524
Gubernatorial power index	-2.282 (1.822)	0.102	-0.782 (2.154)	0.457	-2.683 ^{**} (1.148)	0.068	-2.015 [*] (1.195)	0.133
Average state legislative salary	0.000 (0.000)	1.000	0.000 (0.000)	1.000				
Partisan control indicator	-0.921 [#] (0.623)	0.398	-2.498 [*] (1.349)	0.082	-0.971 [*] (0.517)	0.379	-1.242 [*] (0.666)	0.289
Industry Power (LTSS Supply)								
NF beds per 1,000 age 65+	0.042 (0.058)	1.043	0.130 [#] (0.098)	1.138				
% NF beds for profit	-0.008 (0.047)	0.992	-0.003 (0.089)	0.997				
HHA per 100,000	-0.149 (0.326)	0.862	0.261 (0.904)	1.299				
Advocacy Power (LTSS Demand)								

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
% of population 65+	-1.294** (0.520)	0.274	-1.961* (1.137)	0.141	-1.374*** (0.421)	0.253	-1.460*** (0.452)	0.232
% of population with disability	0.795* (0.425)	2.215	0.772 (0.879)	2.164	0.917** (0.371)	2.501	0.706* (0.382)	2.025
Economic								
Per capita income (t-1)	0.000 (0.000)	1.000	0.000 (0.000)	1.000				
Unemployment rate (t-1)	-1.079* (0.616)	0.340	-0.445 (0.651)	0.641	-1.306** (0.460)	0.271	-1.003* (0.457)	0.367
Existing HCBS / LTSS Policies								
# of 1915(c) waivers (t-1)	0.051 (0.196)	1.053	0.607# (0.443)	1.834				
Medicaid state plan personal care program (t-1)	-0.169 (1.053)	0.845	0.088 (1.941)	1.092				
% of Medicaid LTSS spending on HCBS (t-1)	-0.327** (0.107)	0.721	-0.350* (0.177)	0.705	-0.346*** (0.096)	0.708	-0.366*** (0.112)	0.693
Medicaid HCBS spending per capita (t-1)	0.002 (0.006)	1.002	-0.007 (0.008)	0.993				
NF certificate of need program (t-1)	-1.881 (1.479)	0.152	-4.045# (2.689)	0.018	-2.437* (1.269)	0.087	-2.871* (1.339)	0.057
HHA certificate of need program (t-1)	0.915 (1.335)	2.498	5.066# (3.142)	158.555	1.555# (1.046)	4.737	2.115* (1.160)	8.291
Medically needy program (t-1)	0.031 (1.062)	1.032	-1.126 (1.326)	0.324				

External Factors		Model 1		Model 2		Model 3		Model 4	
		Coef.	OR	Coef.	OR	Coef.	OR	Coef.	OR
		(SE)		(SE)		(SE)		(SE)	
HCBS Final Rule issuance [^]									
% Neighboring states adopting BIP (t-1)				0.052 [#]	1.053			0.034 [#]	1.034
				(0.038)				(0.024)	
Year Indicator									
2011		-6.014 ^{**}	0.002			-5.542 ^{**}	0.004		
		(1.984)				(1.846)			
2012		-1.197	0.302	-1.820	0.162	-0.777	0.460	-0.260	0.771
		(1.294)		(2.075)		(1.095)		(1.244)	
2013		-0.258	0.772	-1.073	0.342	0.062	1.064	-0.124	0.884
		(1.098)		(0.038)		(0.989)		(0.024)	
Constant		49.700 ^{**}		42.800 [*]		51.263 ^{***}		50.154	
		(19.917)		(21.421)		(14.145)		(15.166)	
Number of Observations		119		79		119		79	
Log likelihood		-28.779 (p<.001)		-21.145 (p<.01)		-29.709 (p<.001)		-25.239 (p<.001)	
BIC		172.257		147.539		131.105		116.020	

^ Variable omitted from Stata output because of collinearity

OR: odd ratio, SE: standard error, Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, CFC: Community First Choice, BIC: Bayesian information criterion

#p<.10, *p<.05, **p<.01, ***<p<.001

Model 1: The results from Model 1 suggest that several of the factors identified in the conceptual framework influenced the BIP adoption decision. Variables measuring political ideology, governing capacity, interest groups, and existing policies were all significant. The variable measuring political ideology, ADA Ideology Index, was significant ($b = .128$, $p < .05$) and consistent with expectations. The odds ratio of over 1.00 (1.136) indicates that states were 13.6% more likely to pursue BIP with each unit increase on the ADA political liberalism index. The variable measuring the political party in control of the governor's office was marginally significant ($b = 1.717$, $p < .10$) with states with Democratic governors being more than five and a half times more likely to pursue BIP compared to states with Republican governors ($OR=5.570$).

The results also suggest that a state's governing capacity influenced the pursuit of BIP. The variable measuring the number of state FTEs per 1,000 population was significant ($b = -0.760$, $p < .01$) but the opposite sign of expectations. In particular, states were 53.3% less likely to adopt BIP with each additional state FTE per 1,000 population ($1-(OR=0.467)$). The partisan control variable ($b=-0.921$, $p < .10$) was marginally significant. This indicates that each unit increase towards more unified government was associated with a 60% decrease in pursuing BIP ($1-(OR=0.398)$) which is opposite of expectations. The gubernatorial power index and average state legislative salary variables were not significant ($p > .10$).

The variables measuring the influence of nursing facility and HCBS providers were not significant ($p > .10$); however, the variables measuring the influence of advocates for elders ($b = -1.294$, $p < .01$) and individuals with disabilities ($b = 0.795$, $p < .05$) were significant. The negative coefficient for the percentage of elders was opposite of what was expected. It indicates that states were about three-quarters less likely to pursue BIP with each percentage point increase in the elderly population ($1 - (OR = 0.274)$). However, as expected, the variable measuring the influence of the disability community had a positive sign with states being nearly two and a quarter times more likely to adopt BIP with each percentage point increase in the proportion of people with disabilities in the population ($OR = 2.215$).

The unemployment rate in the previous year was significant with a negative coefficient ($b = -1.079$, $p < .05$). This result indicates that states were 66% less likely to pursue BIP with each percentage point increase in the unemployment rate during the previous year ($1 - (OR = 0.340)$). These results are consistent with expectations that the state's economic health influences the pursuit of new public policies. By contrast, state per capita income during the previous year was not significantly related to BIP adoption ($p > .10$).

Only one variable measuring existing HCBS and LTSS policies during the previous year was significant. The percentage of Medicaid LTSS spending on HCBS was significant and negative ($b = -0.327$, $p < .01$). This indicates that states were about 28% less likely to adopt BIP with each percentage point increase in Medicaid LTSS devoted to HCBS during the previous year ($1 - (OR = 0.721)$). The variables measuring the number of waivers, HCBS spending per capita, and the presence of state plan personal care in the previous year were not significant ($p > .10$). Similarly, the variables measuring nursing facility and HHA certificate of need programs and medically needy program in the previous year were not significant ($p > .10$).

Model 2: The results from Model 2 utilized the same independent variables as Model 1 with the neighboring state variable added. As with Model 1 and consistent with expectations, the ADA Ideology Index was significant ($b = 0.198$, $p < .05$) indicating that each unit increase in the index increased the likelihood of adopting BIP by 21.9% ($OR=1.219$). The variable measuring whether the state had a Democratic governor was not significant ($p > .10$).

Consistent with Model 1, the results also suggest that a state's governing capacity influenced the pursuit of BIP. The variable measuring the number of state FTEs per 1,000 population was significant ($b = -0.552$, $p < .05$) but the opposite sign of expectations. In particular, states were 42.4% less likely to adopt BIP which each additional state FTE per 1,000 population ($1-(OR=0.576)$). The partisan control variable was significant ($b=-2.498$, $p < .05$). This indicates that each unit increase towards more unified government was associated with a 92% decrease in pursuing BIP ($1-(OR=0.082)$) which is not consistent with expectations. The gubernatorial power index and average state legislative salary variables were not significant ($p > .10$).

The variable measuring the number of nursing facility beds per population aged 65 and older was marginally significant ($b = 0.130$, $p < .10$) but the opposite sign of expectations suggesting that each unit increase in the number nursing facility beds per population aged 65 and older was associated with a 13.8% increased likelihood of pursuing BIP ($OR=1.138$). The variables measuring the percentage of for-profit nursing facilities and the number of home health agencies per 100,000 population were not significant ($p > .10$). As in Model 1, the variable measuring the influence of advocates for elders was significant ($b = -1.961$, $p < .05$) and inconsistent with expectations. This suggests that that states were 85.9% less likely to pursue BIP with each percentage point increase in the elder population ($OR=0.141$). Unlike Model 1, the

variables measuring the influence of advocates for individuals with disabilities and the unemployment rate in the previous year were not statistically significant ($p > .10$). In Model 2, the state per capita income in the previous year was also not significant ($p > .10$).

The percentage of Medicaid LTSS spending on HCBS in the previous year was significant and negative ($b = -0.350$, $p < .05$) while the number of 1915(c) waivers in the previous year was marginally significant ($b = 0.607$, $p < .10$). This indicates that states were about 30% less likely to adopt BIP with each percentage point increase in Medicaid LTSS expenditures devoted to HCBS during the previous year ($1 - (OR = 0.705)$) while states were 83.4% more likely to adopt BIP with each additional 1915(c) waiver ($OR = 1.834$). The variables measuring HCBS spending per capita and the presence of state plan personal care in the previous year were not significant ($p > .10$). The variables measuring nursing facility ($b = -4.045$, $p < .10$) and HHA ($b = 5.06$, $p < .10$) certificate of need programs in the previous year were marginally significant while the medically needy program in the previous year variable was not significant ($p > .10$).

The variable measuring the percentage of neighboring states that adopted BIP in the prior year was marginally significant ($b = 0.052$, $p < .10$) and consistent with expectations. Each percentage point increase in neighboring states adopting BIP in the previous year was associated with a 5.3% increased likelihood of pursuing BIP ($OR = 1.053$).

Model 3: Model 3 presents the results of the modified backwards stepwise regression. As with Model 1, the time period of Model 3 is 2011 to 2014, and there were 119 observations. The goodness of fit statistics indicate that Model 3 ($BIC = 131.105$) was a better fit than Model 1 ($BIC = 172.257$). Moreover, statistically significant variables were similar in Models 1 and 3. The variables measuring whether the state had a Democratic governor ($b = -2.043$, $p < .05$) and the ADA Ideology index ($b = 0.143$, $p < .001$) were significant. Consistent with expectations, these

findings indicates that states with Democratic governors were seven and three-fourths more likely to adopt BIP than states with non-Democrat governors ($OR=7.715$), and that states were 15.4% more likely to adopt BIP with each unit rate increase on the ADA Liberalism scale ($OR=1.154$).

The results from Model 3 also indicate that a state's governing capacity influenced states' adoption of BIP. The variable measuring state FTEs per 1,000 population was significant ($b = -0.769$, $p < .01$) but opposite of expectations, indicating that states were 53.7% less likely to pursue BIP with each additional state FTE per 1,000 population ($1-(OR=0.463)$). Moreover the variables measuring gubernatorial power ($b=-2.683$, $p<.01$) and partisan control ($b=-0.971$, $p<.05$) of state government were also significant but opposite of expectations. These results indicate that states were 93.2% less likely to pursue BIP with each unit increase in the gubernatorial power index ($1-(OR=0.068)$) and states with more unified government ($OR=0.379$) were less likely to pursue this program.

Consistent with Model 1, measures for the influence of advocates for elders ($b = -1.374$, $p < .001$) and individuals with disabilities ($b = 0.917$, $p < .01$) were significant. On the one hand, states were about three quarters less likely to pursue BIP with each percentage point increase in the elderly population ($1-(OR=0.253)$) which is inconsistent with expectations. On the other hand, consistent with expectations, states were more than two and a half times more likely to adopt BIP with each percentage point increase in the proportion of people with disabilities in the population ($OR=2.501$). As in Model 1, the unemployment variable was significant ($b= -1.306$, $p < .01$) and the expected sign. This suggests that states were 72.9% less likely to adopt BIP with each percentage point increase in the unemployment rate during the previous year ($1-(OR=0.271)$).

In Model 3, the percentage of Medicaid LTSS spending on HCBS during the previous year was significant and negative ($b = -0.346$, $p < .001$). This finding indicates that states were about 30% less likely to adopt BIP with each percentage point increase in Medicaid LTSS devoted to HCBS in the prior year ($1 - (OR = 0.708)$). In addition, the variable indicating whether a state had a nursing facility certificate of need program during the previous year ($b = -2.437$, $p < .05$) was significant but the opposite sign of expectations. States with a nursing facility certificate of need program were 91.3% less likely to pursue BIP than states without a nursing facility CON ($1 - (OR = 0.087)$). The variable measuring whether a state had a home health aide CON program in the previous year was marginally significant ($b = 1.555$, $p < .10$) but inconsistent with the hypothesis. This indicates that states with a HHA CON program during the previous year were about four and three fourths more likely to pursue BIP than states without this program ($OR = 4.737$).

Model 4: The results from Model 4 used the same variables as Model 3 with the neighboring state variable added. As with Model 2, the time period of Model 4 is 2012 to 2014, and there were 79 observations. The goodness of fit statistics indicate that Model 4 ($BIC = 116.020$) was a better fit than Model 2 ($BIC = 147.537$). Similar to the previous models, the ADA Ideology index variable was statistically significant and supports the hypothesis ($b = 0.138$, $p < .01$). This indicates that states were 14.8% more likely to pursue BIP with each unit increase on the ADA political liberalism index ($OR = 1.148$). The variable measuring whether the state had a Democratic governor was not statistically significant ($p > .10$). As in Model 3, three variables measuring governing capacity were significant but inconsistent with expectations: state employees per 1,000 population ($b = -0.646$, $p < .01$), gubernatorial power ($b = -2.015$, $p < .05$), and partisan control ($b = -1.242$, $p < .05$). States were 47.6% less likely to pursue BIP with each

additional state FTE per 1,000 population ($1-(OR=0.524)$). Again, the results also indicate that states with governors with more institutional powers ($OR=0.133$) and states with more unified government ($OR=0.289$) were less likely to adopt BIP.

The variables measuring the percentage of the population aged 65 and older ($b = -1.460$, $p < .001$) and the percentage of the population with a disability ($b = 0.706$, $p < .05$) were significant which is consistent with the previous model. In this case, findings indicate that states were 77% less likely to pursue BIP with each percentage point increase in the elderly population ($1-(OR=0.232)$) and approximately two times more likely to adopt BIP with each percentage point increase in the proportion of people with disabilities in the population ($OR=2.025$). The findings related to the elder population are opposite of expectations while the findings related to the percentage of the population with a disability are consistent with the hypothesis. The unemployment rate in the previous year variable ($b=-1.003$, $p < .05$) signified that states with higher rates of unemployment in the previous year were less likely to adopt BIP as expected. Specifically, states were 63.3% less likely to adopt BIP with each percentage point increase in unemployment during the previous year ($1-(OR=0.367)$).

The variable measuring HCBS spending as percentage of Medicaid LTSS spending during the previous year was significant and negative ($b = -0.366$, $p < .001$), indicating that states were 30.7% less likely to adopt BIP with each percentage point increase in Medicaid LTSS directed toward HCBS in the prior year ($1-(OR=0.693)$). In addition, the variables measuring nursing facility ($b = -2.871$, $p < .05$) and home health aide ($b = 2.115$, $p < .05$) certificate of need programs during the previous year were significant. These findings imply that states with nursing facility CON programs were 94.3% less likely to pursue BIP ($1-(OR=0.057)$), whereas states with home health aide CON programs were more than eight times more likely to pursue the program

(OR=8.291). In Model 4, the neighboring state adoption in the previous year variable was marginally significant ($b = 0.034$, $p < .10$) which suggests that states were 3.4% more likely to adopt BIP if a neighboring state adopted this program in the previous year (OR=1.034).

Community First Choice

The Community First Choice models are shown in Table 5.9. I initially ran Model 1 including all of the independent variables, with the exception of the percentage of neighboring states that adopted CFC; however, several of the binary independent variables were perfect predictors of adoption or non-adoption of CFC. These variables were the home health aide certificate of need, Medicaid state plan personal care program, and medically needy program in the previous year. Consequently, I re-ran the model omitting these variables. In the models without the neighboring state variable (Models 1 and 3), the time period was 2011 to 2015 and there were 231 observations. In the second and fourth models with the neighboring state variable, several of the independent variables in combination perfectly predicted the adoption or non-adoption of CFC. These variables were the Democratic governor and nursing facility certificate of need variables. These models were thus re-run without these variables. In these models with the neighboring state variable, the time period was 2012 to 2015 and there were 174 observations. Similar to the BIP model, Nebraska was omitted from all models due to missing data on the partisan control indicator variable, and Alaska and Hawaii were dropped from the neighboring state model because they have no adjacent states.

5.9: Factors Influencing CFC Adoption Event History Model

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
Political Ideology								
Democratic governor	4.508* (2.697)	90.716			3.022* (1.673)	20.537	2.652# (1.693)	14.183
ADA Ideology Index	0.063 (0.066)	1.065	0.072 (0.063)	1.074				
Governing Capacity								
FTE state employees per 1,000.	-0.139 (0.251)	0.870	-0.517 (0.429)	0.596				
Gubernatorial power index	1.880 (1.752)	6.553	2.189 (1.800)	8.922	0.940 (0.862)	2.561	0.793 (1.016)	2.210
Average state legislative salary	0.000 (0.000)	1.000	0.000* (0.000)	1.000				
Partisan control indicator	-1.036 (1.110)	0.355	-0.343 (0.825)	0.710				
Industry Power (LTSS Supply)								
NF beds per 1,000 age 65+	-0.095 (0.075)	0.909	0.090 (0.121)	1.094	-0.097* (0.046)	0.908	-0.078# (0.054)	0.925
% NF beds for profit	0.071 (0.087)	1.074	0.067 (0.096)	1.070	0.073# (0.047)	1.076	0.047 (0.046)	1.048
HHA per 100,000	0.617 (0.529)	1.853	-0.267 (0.534)	0.766	0.363 (0.333)	1.438	0.406 (0.350)	1.501
Advocacy Power (LTSS Demand)								
% of population 65+	-0.303 (0.975)	0.739	-0.213 (1.020)	0.808				

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
% of population with disability	-0.104 (0.791)	0.902	-0.484 (0.942)	0.616				
Economic								
Per capita income (t-1)	0.000 (0.000)	1.000	0.000# (0.000)	1.000				
Unemployment rate (t-1)	0.123 (0.556)	1.131	-0.857 (0.776)	0.424				
Existing HCBS / LTSS Policies								
# of 1915(c) waivers (t-1)	0.191 (0.237)	1.210	0.705* (0.341)	2.024	0.247* (0.129)	1.281	0.254* (0.143)	1.289
Medicaid state plan personal care program (t-1)								
% of Medicaid LTSS spending on HCBS (t-1)	-0.020 (0.081)	0.981	0.027 (0.086)	1.027				
Medicaid HCBS spending per capita (t-1)	0.009# (0.006)	1.009	0.016# (0.010)	1.016	0.009* (0.004)	1.009	0.008* (0.005)	1.008
NF certificate of need program (t-1)	-1.012 (1.740)	0.363						
HHA certificate of need program (t-1)								
Medically needy program (t-1)								
External Factors								
HCBS Final Rule issuance [^]								

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
% Neighboring states adopting CFC (t-1)			0.107# (0.067)	1.113			0.026 (0.036)	1.026
Year Indicator								
2011	-2.804 (3.584)	0.061			-0.680 (1.483)	0.507		
2012	-1.486 (2.920)	0.226	1.837 (3.169)	6.280	-0.585 (1.450)	0.557	-0.145 (1.591)	0.865
2013	0.748 (2.477)	2.113	3.638 (2.916)	38.004	0.884 (1.152)	2.420	1.136 (1.228)	3.115
2014	-0.468 (2.116)	0.626	0.711 (2.050)	2.037	-0.431 (1.412)	0.650	-0.393 (1.422)	0.675
Constant	-2.796 (16.135)		12.400 (21.318)		-15.718** (6.192)		-14.233 (6.149)	

Number of Observations	231	174	231	174
Log likelihood	-20.276 (p<.15)	-16.846 (p<.20)	-23.082 (p<.05)	-19.505 (p<.05)
BIC	160.287	136.873	111.472	100.919

^ Variable omitted from Stata output because of collinearity

OR: odd ratio, SE: standard error, Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, CFC: Community First Choice, BIC: Bayesian information criterion

#p<.10, *p<.05, **p<.01, ***<p<.001

Model 1: Model 1 included all but the perfectly predicting variables noted above, and percentage of neighboring states adopting CFC in the prior year. Overall, the results suggested that the model was not statistically significant ($p>.10$). In this model, the variable measuring whether the governor was a Democrat was statistically significant with a positive sign as expected ($b=4.508$, $p<.05$). This result indicates that states with a Democratic governor were 90 times more likely to pursue CFC than states with a Republican governor ($OR = 90.716$). The ACA Ideology index was not statistically significant nor were the variables measuring governing capacity; the influence of nursing facility and HCBS providers; the influence of advocates for elders and individuals with disabilities; and economic factors ($p>.10$).

The variable measuring HCBS spending per capita in the previous year was marginally significant and positive ($b= 0.009$, $p<.10$). This indicates that states were nearly 1% more likely to adopt CFC with each dollar increase in per capita HCBS spending in the previous year ($OR = 1.009$). The other variables measuring existing HCBS and LTSS policies were not statistically significant ($p>.10$).

Model 2: In Model 2, the ADA ideology index variable was not statistically significant nor were the variables measuring the number of state FTEs per 1,000, gubernatorial power, or the partisan control indicator variable ($p<.10$). The variable measuring the average legislative salary was statistically significant and negative ($b=-0.000$, $p<.05$) which is not consistent with

expectations. This finding suggests that each dollar increase in legislative salary slightly decreased the likelihood of a state adopting CFC (OR=0.999).

The variables measuring the influence of nursing facility providers, home health aide providers, advocates for elders, and advocates for individuals with disabilities were not statistically significant ($p>.10$). The per capita income in the previous year variable was marginally significant and negative ($b=-0.000$, $p<.10$) but the opposite sign of expectations. This finding indicates that states with lower income were more likely to pursue this program (OR=.999).

The variable measuring the number of 1915(c) waivers in the previous year was significant ($b=0.705$, $p<.05$) while the variables measuring Medicaid HCBS spending per capita ($b=0.016$, $p<.10$) and the cumulative percentage of neighboring states that adopted CFC ($b=0.107$, $p<.10$) in the previous year were marginally significant. Each additional waiver doubled the likelihood of pursuing CFC (OR=2.024) while each dollar increase in Medicaid HCBS spending per capita increased the likelihood of adopting this policy by 1.6% (OR=1.016). Each percentage point increase in the cumulative percentage of neighboring states that adopted CFC in the prior year increased the likelihood of adopting the program by 11.3% (OR=1.113).

Model 3: Model 3 utilized a modified backwards stepwise approach. As in Model 1, the number of observations in Model 3 was 231. Comparing the goodness of fit statistics of Model 1 (BIC = 160.287) and Model 3 (BIC = 111.472) indicated that Model 3 was a better fit. In addition, overall the model was statistically significant ($p <.05$) whereas Models 1 and 2 were not.

In this model, the political party of the governor ($b = 3.022$, $p <.05$) was statistically significant and positive, consistent with Model 1 and expectations. This result suggests that

states with Democratic governors were 20 times more likely to adopt CFC compared to states with Republican governors. The gubernatorial power index variable, however, was not statistically significant ($p > .10$).

In addition, the ratio of nursing facility beds per population aged 65 and older was statistically significant ($b = -0.097$, $p < .05$) while the percentage of for-profit nursing facilities ($b = 0.073$, $p < .10$) was marginally significant. The results indicate that each unit increase in the number of nursing facility beds per 1,000 aged 65 and older decreased a state's likelihood of adopting CFC by about 9% ($1 - (OR = 0.908)$) which is consistent with expectations. Opposite of the hypothesis, each percentage point increase in for-profit nursing facilities was associated with a 7.6% increase in the likelihood of adopting CFC ($OR = 1.076$).

Two variables measuring HCBS policies in the previous year were significant. The number of 1915(c) HCBS waivers in the previous year ($b = 0.247$, $p < .05$) and Medicaid HCBS spending per capita in the previous year ($b = 0.009$, $p < .05$) were statistically significant and positive. Each additional HCBS waiver in the previous year was associated with a 28.1% increased likelihood of pursuing CFC ($OR = 1.281$) while each dollar increase in HCBS spending per capita in the previous year was associated with about a 1% increase in adopting this program ($OR = 1.009$).

Model 4: The fourth model adds the CFC neighboring state variable to Model 3. As with Model 2, the timeframe is 2012 to 2015 with 174 observations. Comparing the goodness of fit statistics of Model 2 ($BIC = 136.873$) and Model 4 ($BIC = 100.919$) indicated that Model 4 was a better fit than Model 2. In addition, as with Model 3, the overall the model was statistically significant ($p < .05$) whereas Models 1 and 2 were not. In Model 4, the Democratic governor variable was marginally significant ($b = 2.652$, $p < .10$). Consistent with expectations, this result

indicates that states with Democratic governors were 14 times more likely to pursue CFC than states with Republican governors. As with Model 3, the gubernatorial power index variable was not statistically significant ($p > .10$).

The variable measuring the number of nursing facility beds per person aged 65 and older was marginally significant ($b = -0.078$, $p < .10$) while the percentage of for-profit nursing facilities was not significant ($p > .10$). As expected, each unit increase in the number of nursing facility beds per 1,000 age 65 and older was associated with a 7.5% decrease in a state's likelihood of adopting CFC ($OR = 1 - (0.925)$)

Consistent with Models 2 and 3, the variables measuring the number of HCBS waivers a state offered in the previous year ($b = 0.254$, $p < .05$) and HCBS spending per capita in the previous year ($b = 0.008$, $p < .05$) were statistically significant. Each additional HCBS waiver in the previous year was associated with a 28.9% increased likelihood of pursuing CFC ($OR = 1.289$) while each dollar increase in HCBS spending per capita in the previous year was associated with about a 1% increase in adopting this program ($OR = 1.008$). The variable measuring the percentage of neighboring states that adopted CFC in the prior year was not statistically significant ($p > .10$).

1915(i) Home and Community-based Services State Plan Benefit

The results of the event history model for the 1915(i) HCBS state plan benefit are shown in Table 5.10. As with the previous dependent variables, four different models are presented. In the initial model, all the independent variables except the neighboring state variable were included. The second added in the neighboring state variable to Model 1. The third model utilized a modified backwards stepwise approach, excluding the neighboring state variable. The fourth model added the neighboring state variable to Model 3. In both Model 1 and Model 3, the

timeframe was 2010 to 2015, and there were 223 observations. The second and forth models added the neighboring state variable, and the timeframe was 2011 to 2015 with 170 observations. Nebraska was omitted from all models due to missing data on the partisan control indicator variable, and Alaska and Hawaii were dropped from the neighboring state models because of missing data for this variable.

Table 5.10: Factors Influencing 1915(i) Adoption, Event History Model

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
Political Ideology								
Democratic governor	0.138 (1.017)	1.148	-1.482 (1.812)	0.227				
ADA Ideology Index	0.053* (0.032)	1.054	0.204* (0.090)	1.226	0.030* (0.015)	1.030	0.043** (0.018)	1.044
Governing Capacity								
FTE state employees per 1,000.	-0.043 (0.119)	0.958	-0.093 (0.230)	0.911				
Gubernatorial power index	-0.762 (1.112)	0.467	0.400 (1.564)	1.492				
Average state legislative salary	0.000 (0.000)	1.000	0.000 (0.000)	1.000				
Partisan control indicator	0.856# (0.592)	2.354	1.347# (0.890)	3.847	0.632 (0.521)	1.881	0.349 (0.578)	1.418
Industry Power (LTSS Supply)								
NF beds per 1,000 age 65+	0.029 (0.045)	1.030	0.207* (0.122)	1.231				
% NF beds for profit	0.002 (0.038)	1.002	0.068 (0.072)	1.070				
HHA per 100,000	0.153 (0.198)	1.165	0.493 (0.415)	1.638	0.253* (0.135)	1.287	0.442** (0.183)	1.555
Advocacy Power (LTSS Demand)								
% of population 65+	0.133	1.142	0.874#	2.396				

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
% of population with disability	(0.322) -0.012 (0.308)	0.988	(0.659) 0.246 (0.523)	1.279				
Economic								
Per capita income (t-1)	0.000 (0.000)	1.000	0.000# (0.000)	1.000				
Unemployment rate (t-1)	0.407 (0.324)	1.502	-0.316 (0.817)	0.729	0.402* (0.195)	1.495	0.170 (0.251)	1.185
Existing HCBS / LTSS Policies								
# of 1915(c) waivers (t-1)	0.095 (0.143)	1.100	0.601* (0.317)	1.824				
Medicaid state plan personal care program (t-1)	1.214# (0.946)	3.367	2.134# (1.506)	8.446	1.071# (0.752)	2.917	0.891 (0.904)	2.438
% of Medicaid LTSS spending on HCBS (t-1)	-0.063 (0.054)	0.939	-0.289* (0.158)	0.749	-0.048# (0.033)	0.953	-0.138** (0.057)	0.871
Medicaid HCBS spending per capita (t-1)	-0.002 (0.006)	0.998	-0.019 (0.018)	0.982				
NF certificate of need program (t-1)	-0.923 (1.253)	0.397	-2.695 (2.429)	0.068				
HHA certificate of need program (t-1)	0.047 (1.247)	1.048	2.338 (2.132)	10.363				
Medically needy program (t-1)	-1.154 (1.041)	0.315	-0.171 (1.549)	0.843	-1.318* (0.728)	0.268	-0.543 (0.839)	0.581
External Factors								
HCBS Final Rule issuance^								

	Model 1		Model 2		Model 3		Model 4	
	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR	Coef. (SE)	OR
% Neighboring states adopting 1915(i) (t-1)			-0.018 (0.054)	0.982			0.001 (0.033)	1.001
Year Indicator								
2010	-3.240* (2.126)	0.039			-1.946 (1.562)	0.143		
2011	-2.642* (1.924)	0.071	-4.433* (3.335)	0.012	-1.808 (1.551)	0.164	-2.097 (1.947)	0.123
2012	-1.071 (1.656)	0.343	-1.417 (2.654)	0.242	-0.393 (1.319)	0.675	-0.505 (1.599)	0.603
2013	-2.020 (1.760)	0.133	-2.737 (2.546)	0.065	-1.403 (1.525)	0.246	-1.486 (1.622)	0.226
2014	-0.451 (1.425)	0.637	-0.727 (1.839)	0.484	0.095 (1.273)	1.100	-0.005 (1.382)	0.995
Constant	-2.961 (11.162)		-11.332 (22.904)		-6.638** (2.832)		-1.514 (3.356)	
Number of Observations	223		170		223		170	
Log likelihood	-38.750 (p>.10)		-24.262 (p>.10)		-40.317 (p>.10)		-30.335 (p<.10)	
BIC	218.086		171.580		150.927		127.437	

^ Variable omitted from Stata output because of collinearity

OR: odd ratio, SE: standard error, Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, CFC: Community First Choice, BIC: Bayesian information criterion

#p<.10, *p<.05, **p<.01, ***<p<.001

Model 1: In Model 1, the ADA Ideology index variable ($b = 0.053$, $p < .05$) was statistically significant and positive. As expected, each unit increase in the ADA Ideology index increased the likelihood of pursuing a 1915(i) state plan amendment by 5.4% ($OR = 1.054$). The Democratic governor variable was not statistically significant ($p > .10$). The variable measuring partisan control of state government ($b = 0.856$, $p < .10$) was marginally significant and positive. Consistent with expectations, this finding suggests that states with unified government were more likely to pursue a 1915(i) state plan amendment than states with divided government or a divided legislature ($OR = 2.354$). The variables measuring the number of state FTEs per 1,000 population, gubernatorial power index, and legislative salary were not statistically significant ($p > .10$). In addition, the variables measuring the influence of nursing facility providers, HHA agencies, advocates for elders, and advocates for individuals with disabilities were not statistically significant ($p > .10$). The variables measuring income per capita and the unemployment rate, both in the previous year, were also not statistically significant ($p > .10$).

The variable measuring whether a state offered the Medicaid state plan personal care benefit in the previous year ($b = 1.214$, $p < 0.10$) was marginally significant. States with Medicaid state plan personal care in the previous year were more than three times more likely to adopt a 1915(i) state plan benefit ($OR = 3.367$). The variables measuring other HCBS and LTSS policies in the previous year were not statistically significant ($p > .10$).

Model 2: In Model 2, the ADA ideology index variable was statistically significant and positive ($b=0.204$, $p<.05$) indicating each unit rate increase in the index increased the likelihood of adopting the 1915(i) state plan benefit by 22.6% ($OR=1.226$). This finding is consistent with Model 1 and the hypothesis. The Democratic governor variable was not significant nor were the variables measuring the number of state FTEs per 1,000, gubernatorial power index, and average state legislative salary ($p>.10$). The partisan control indicator variable was marginally significant ($b=1.347$, $p<.10$) with states with unified government more likely to adopt a 1915(i) state plan benefit than states with divided government ($OR=3.847$) which is consistent with expectations.

The number of nursing facility beds per 1,000 population aged 65 and older was statistically significant ($b=0.207$, $p<.05$) but the opposite sign of expectations. This finding indicates that each unit increase in the number of nursing facility beds per 1,000 population aged 65 and older was associated with a 23.1% increased likelihood of adopting this policy ($OR=1.231$). The variables measuring the percentage of for-profit nursing facilities and number of home health agencies per 100,000 population were not statistically significant ($p>.10$). As expected, the percentage of the population aged 65 and older was marginally significant and positive ($b=0.874$, $p<.10$). Each percentage point increase in the elder population increased the likelihood of adopting a 1915(i) state plan benefit by 2.40 times ($OR=2.396$). The variable measuring the percentage of the populations with a disability was not statistically significant ($p>.10$).

The variable measuring per capita income in the previous year was marginally significant ($b=-.000$, $p<.10$) with states with higher per capita income less likely to pursue the 1915(i) state plan benefit which is the opposite sign of expectations. The unemployment rate in the previous year was not statistically significant ($p>.10$).

Several of the variables measuring HCBS policies in the previous year were statistically significant. The number of 1915(c) waivers in the previous year ($b=0.601$, $p<.05$) and the percentage of Medicaid spending on HCBS in the previous year ($b=-0.289$, $p<.05$) were significant while the presence of a state plan personal care benefit in the previous year was marginally significant ($b=2.134$, $p<.10$). These findings suggest that each additional 1915(c) waiver in the previous year increased the likelihood of adopting the 1915(i) by 82.4% ($OR=1.824$) while states with a state plan personal care benefit in the previous year were nearly eight and a half more likely to pursue a 1915(i) ($OR=8.446$). Each percentage point increase in Medicaid LTSS spending on HCBS in the previous year was associated with a 25.1% decreased likelihood of adopting this benefit ($1-(OR=0.749)$). The variables measuring HCBS spending per capita, nursing facility certificate of need, home health aide certificate of need, and medically needy program in the previous year were all not statistically significant ($p>.10$). In addition, the variable measuring the cumulative percentage of neighboring states adopting the 1915(i) in the previous year was not statistically significant ($p>.10$).

Model 3: Similar to Model 1, Model 3 was from 2011 to 2015 with 223 observations. In comparing Model 3 to Model 1, the goodness of fit statistics indicate that Model 3 ($BIC = 150.927$) is a better fit than Model 1 ($BIC = 218.086$). As in Model 1 and consistent with expectations, the ADA Ideology index variable ($b = 0.030$, $p <.05$) was significant with each unit increase in the index increasing the likelihood of adopting the 1915(i) HCBS state plan benefit by 3% ($OR=1.030$). The variable measuring partisan control of state government was not statistically significant ($p>.10$).

The variable measuring the number of home health agencies per 100,000 was statistically significant and consistent with expectations ($b=0.253$, $p<.05$). This finding suggests that each

additional home health agency per 100,000 increased the likelihood of adopting this program by 28.7% (OR=1.287). Additionally, states with a higher unemployment rate in the previous year ($b = 0.402$, $p < .05$) were more likely to adopt a 1915(i) state plan benefit which is opposite of expectations. More specifically, each percentage point increase in the unemployment rate increased the likelihood of adopting a 1915(i) state plan benefit by 49.5% (OR=1.495).

Three variables measuring existing HCBS and LTSS policies were significant or marginally significant. The variable measuring the presence of a medically needy program in the previous year was significant ($b = -1.318$, $p < .05$) while the variables measuring the percentage of Medicaid LTSS spending on HCBS in the previous year ($b = -0.048$, $p < .10$) and the presence of a personal care state plan benefit in the previous year ($b = 1.071$, $p < .10$) were marginally significant. These results suggest that states with a medically needy program in the previous year were 73.2% less likely to adopt the 1915(i) benefit ($1 - (OR = 0.268)$). In addition, each percentage point increase in Medicaid LTSS spending on HCBS in the previous year was associated with approximately a 5% decrease in the likelihood of pursuing a 1915(i) state plan benefit ($1 - (OR = 0.952)$) while states offering a Medicaid state plan personal care benefit in the previous year were nearly three times more likely to pursue this option (OR=2.917).

Model 4: Model 4 adds the cumulative percentage of neighboring states that adopted the 1915(i) variable in the previous year to Model 3. The timeframe for this model is 2012 to 2015 with 170 observations. In comparing Model 4 to Model 2, the goodness of fit statistics indicate that Model 4 (BIC = 127.437) is a better fit than Model 2 (BIC = 171.580). As in all previous models, the ACA liberalism index ($b = 0.043$, $p < .01$) was statistically significant and consistent with expectations. This finding indicates that each unit rate increase in this variable was

associated with a 4.4% increased likelihood of pursuing a 1915(i) state plan benefit (OR=1.044). The partisan control of state government variable was not statistically significant ($p>.10$).

As in Model 3, the number of home health agencies per 100,000 residents was statistically significant and consistent with expectations ($b=0.442$, $p<.01$). Each additional home health agency per 100,000 increased the likelihood of adopting this program by 55.5% (OR=1.555). Unlike Model 3, the unemployment rate in the previous year was not statistically significant ($p<.10$).

The only significant variable measuring HCBS and LTSS policies in the previous year was the percentage of Medicaid LTSS spending on HCBS ($b = -0.138$, $p <.01$). Each percentage point increase in Medicaid HCBS spending in the previous year decreased the likelihood of adopting this option by approximately 13% ($1-(OR=0.871)$). The presence of a state plan personal care benefit and medically needy program in the past year were not statistically significant ($p>.10$). Lastly, the variable measuring neighboring state adoption was not statistically significant ($p>.10$).

All Policies

Table 5.11 displays the results from the panel model where the dependent variable was the adoption of any of the three policies in the given year. The timeframe for this model is 2011 to 2015. Since states are included in the model for all years of the study, the number of observations is 235. Consistent with previous models, Nebraska was omitted because of missing data on the partisan control variable due to its unicameral non-partisan legislature. In addition, Alaska and Hawaii were omitted due to missing data for the neighboring state variable. I ran two models for this dependent variable, one model with all of the variables and a second modified backwards stepwise regression.

Table 5.11: Factors Influencing Adoption of Any ACA HCBS Program

	Model 1		Model 2	
	Coef. (Robust SE)	OR	Coef. (Robust SE)	OR
Political Ideology				
Democratic governor	0.603 (0.684)	1.827		
ADA Ideology Index	0.061** (0.023)	1.063	0.052*** (0.015)	1.054
Governing Capacity				
FTE state employees per 1,000.	-0.079 (0.086)	0.924		
Gubernatorial power index	0.449 (0.689)	1.567		
Average state legislative salary	0.000 (0.000)	1.000		
Partisan control indicator	-0.338 (0.312)	0.713	-0.452* (0.252)	0.636
Industry Power (LTSS Supply)				
NF beds per 1,000 age 65+	0.035 (0.028)	1.035		
% NF beds for profit	0.005 (0.018)	1.005		
HHA per 100,000	0.183# (0.143)	1.201	0.260* (0.123)	1.297
Advocacy Power (LTSS Demand)				
% of population 65+	-0.327 (0.257)	0.721	-0.414* (0.218)	0.661
% of population with disability	0.162 (0.188)	1.175	0.208# (0.148)	1.231
Economic				
Per capita income (t-1)	0.000 (0.000)	1.000		
Unemployment rate (t-1)	-0.062 (0.245)	0.940		
Existing HCBS / LTSS Policies				
# of 1915(c) waivers (t-1)	0.227* (0.126)	1.255	0.246** (0.081)	1.279
Medicaid state plan personal care program (t-1)	0.902# (0.604)	2.465		
% of Medicaid LTSS spending on HCBS (t-1)	-0.102** (0.036)	0.903	-0.088*** (0.025)	0.916
Medicaid HCBS spending per capita (t-1)	-0.002 (0.003)	0.998		

	Model 1		Model 2	
	Coef. (Robust SE)	OR	Coef. (Robust SE)	OR
NF certificate of need program (t-1)	-0.259 (0.892)	0.772		
HHA certificate of need program (t-1)	0.842 (0.696)	2.321	0.752 [#] (0.581)	2.121
Medically needy program (t-1)	-0.262 (0.571)	0.769		
Prior year ACA HCBS policy (t-1)	-1.320* (0.585)	0.267	-1.221* (0.627)	0.295
External Factors				
HCBS Final Rule issuance [^]				
% Neighboring states adopting any policy (t-1)	0.013* (0.008)	1.013	0.014* (0.007)	1.014
Year Indicator				
2011	-0.180 (1.477)	0.836	-0.030 (1.116)	0.970
2012	2.130* (1.035)	8.416	2.100** (0.825)	8.167
2013	1.633* (0.891)	5.118	1.608* (0.774)	4.991
2014	0.998 (0.874)	2.714	1.054 [#] (0.810)	2.869
2015				
Constant	2.543 (7.027)		0.327 (2.833)	
<hr/>				
Number of Observations		235		235
-2 Log pseudolikelihood		150.396 (p<.01)		155.606 (p<.01)
BIC		297.805		237.501

[^] Variable omitted from Stata output because of collinearity

OR: odd ratio, SE: standard error, Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, CFC: Community First Choice, BIC: Bayesian information criterion

[#]p<.10, *p<.05, **p<.01, ***p<.001

Model 1: Model 1 included all of the independent variables. Consistent with expectations, the ADA Ideology index variable was statistically significant and positive ($b = 0.061$, $p < .01$). States were 6.3% more likely to pursue the ACA HCBS policies with each unit increase on the ADA Ideology index ($OR = 1.063$). The Democratic governor variable was not significant ($p > .10$). The four variables measuring governing capacity: the number of state FTEs per 1,000, gubernatorial power index, legislative salary, and partisan control indicator variables were not significant ($p > .10$).

The variable measuring the number home health agencies per 100,000 population was marginally significant ($b = 0.183$, $p < .10$) while the two variables measuring the influence of nursing facility providers were not significant ($p > .10$). This finding indicates that each unit rate in the number of home health agencies per 100,000 population increased the likelihood of adopting the ACA HCBS policies by 20.1% ($OR = 1.201$) as expected. The variables measuring the influence of advocates for elders and the variable measuring the influence of advocates for individuals with disabilities ($p > .10$) were not significant. The state per capita income during the previous year and the unemployment rate in the previous year were not significantly related to adoption of the ACA HCBS policies ($p > .10$).

Several variables measuring HCBS policies in the previous year were significant. The variable measuring the number of 1915(c) waivers in the previous year was significant ($b = .227$, $p < .05$). Each additional waiver in the previous year was associated with a 25.5% increased likelihood of pursuing these policies. The percentage of Medicaid LTSS spending on HCBS in the previous year was also significant but negative ($b = -0.102$, $p < .01$). This indicates that states were 9.7% less likely to adopt the ACA HCBS policies with each percentage point increase in Medicaid LTSS spending on HCBS during the previous year ($1 - (OR = 0.903)$). The variable

measuring the presence of a state plan personal care benefit was marginally significant ($b=.902$, $p<.10$). This finding indicates states with a state plan personal care benefit in the previous year were about two and a half times more likely to adopt one of the ACA HCBS policies ($OR=2.465$). In addition, the variable measuring whether a state adopted one of the ACA HCBS policies in the previous year was statistically significant and negative ($b=-1.320$, $p<.05$). States that adopted these policies in the previous year were 73.3% less likely to adopt a policy in the subsequent year ($1-(OR=0.267)$). The variables measuring HCBS spending per capita, nursing facility certificate of need programs, HHA certificate of need programs, and medically needy programs in the previous year were not significant ($p>.10$).

As expected, the percentage of neighboring state variable was statistically significant and positive ($b=0.013$, $p<.05$). States were 1.3% more likely to adopt these policies with each percentage point increase in this variable ($OR=1.013$).

Model 2: Model 2 displays the results of the modified backwards stepwise regression. In comparing the results of Model 1 ($BIC = 297.805$) to Model 2 ($BIC = 237.501$), Model 2 was a better fit. As in Model 1 and consistent with expectations, the ADA Ideology index variable ($b = 0.052$, $p < .001$) was significant and positive. Each unit rate increase in the ADA Ideology index increased the likelihood of pursuing these programs by 5.4% ($OR=1.054$). The partisan control indicator was significant ($b=-0.452$, $p<.05$) indicating that states with more unified government were less likely to pursue the ACA HCBS policies ($OR=0.636$) which is opposite of expectations.

The number of home health agencies per 100,000 residents ($b = 0.260$, $p < .05$) was significant and consistent with expectations, suggesting that each unit rate increase in home health agencies per 100,000 population increased the likelihood of adopting these policy by

approximately 30% (OR=1.297). In addition, the percentage of the population that is aged 65 or older ($b = -0.414$, $p < .05$) was significant and negative while the percentage of the population with a disability was marginally significant ($b=0.208$, $p<.10$). Opposite of expectations, each percentage point increase in the population aged 65 and older decreased the likelihood of pursuing these policies by 33.9% ($1-(OR=0.661)$) while, consistent with expectations, each percentage point increase in the population with a disability increased the likelihood of pursuing these policies by 23.1% (OR=1.231).

In addition, the number of 1915(c) waivers ($b=0.246$, $p < .01$) and percentage of Medicaid LTSS spending on HCBS in the previous year ($b = -0.088$, $p < .001$) were also significant but opposite signs. Each additional 1915(c) waiver in the previous year increased the likelihood of adopting the ACA HCBS policies by 27.9% (OR=1.279) while each percentage point increase in Medicaid LTSS spending on HCBS decreased the likelihood of adopting these policies by 8.4% ($1-(OR=1.916)$). The variable indicating whether the state had a home health aide certificate of need program in the previous year was marginally significant ($b=0.752$, $p<.10$) with states with this program over two times more likely to adopt the ACA HCBS programs (OR=2.121). Consistent with Model 1, states that adopted one of the ACA's HCBS policies in the prior year ($b = -1.22$, $p < .05$) were less likely to adopt an ACA policy in the subsequent year. More specifically, states that adopted an ACA HCBS policy in the prior year were 70.5% less likely to adopt a policy the next year. Lastly, the variable measuring the cumulative percentage of neighboring states adopting the ACA HCBS policies in the previous year was significant ($b = 0.014$, $p < .5$) and consistent with expectations. This finding indicates that states were 1.4% more likely to adopt these policies with each percentage point increase in the cumulative percentage of neighboring states that adopted these policies (OR = 1.014).

Cross-Sectional Model

The final model was a cross-sectional model with one observation for each state. The dependent variable was the proportion of this study's policies for which the state was eligible and adopted as of December 31, 2015. Since the number of observation was limited to the 50 states, I did not run this model with all the variables as in the prior models. I utilized a backwards stepwise approach removing any variables with a p-value greater than 0.15. As with previous models, Nebraska was omitted because of missing data on the partisan control variable due to its unicameral non-partisan legislature. In addition, Alaska and Hawaii were omitted due to missing data for the neighboring state variable. The results are shown in Table 5.12.

Table 5.12: Generalized Linear Model with Proportion of Eligible Policies Adopted as the Dependent Variable

	Coefficient (Robust Sd. error)	OR
Political Ideology		
ADA Ideology Index	0.023** (0.009)	1.023
Advocacy Power (LTSS Demand)		
% of the population 65+	-0.281* (0.167)	0.755
Economic		
Per capita income (t-1)	-0.000* 0.000	1.000
Existing HCBS / LTSS Policies		
# of 1915(c) waivers (t-1)	0.264*** (0.074)	1.302
External Factors		
% of neighboring states adopting any policy cross sectional (t-1)	0.024* (0.011)	1.025
Constant	3.624 (3.666)	

	Coefficient (Robust Sd. error)	OR
Number of Observations		47
-2 Log pseudolikelihood		41.090

SE: Standard error, OR: Odds ratio, ADA: Americans for Democratic Action, LTSS: long-term services and supports, HCBS: home and community-based services

#p<.10, *p<.05, **p<.01, ***<p<.001

Based on the backwards stepwise regression, five variables were statistically significant. Consistent with several of the other models and expectations, the ADA Ideology index variable was significant ($b = 0.023$, $p < .01$). Each unit rate increase in the ADA Ideology index was associated with a 2.3% increased likelihood in the proportion of eligible policies adopted. The percentage of the state population age 65 and older was statistically significant and negative (-0.281 , $p < .05$) which is opposite of expectations. Each percentage point increase in the percentage of elders decreased the likelihood of adopting these policies by approximately 25% ($1 - (OR = 0.755)$). Also opposite of expectations, state per capita income in the previous year was statistically significant and negative ($b = -0.000$, $p < .05$) with higher per capita income associated with a decreased likelihood of pursuing these policies. The number of 1915(c) waivers in the previous year was significant ($b = 0.264$, $p < .001$) suggesting that each additional waiver in the previous year was associated with a 30.2% increased likelihood in the proportion of eligible policies adopted. Lastly, the cumulative percentage of neighboring states adopting these policies was significant ($b = 0.024$, $p < .05$) and consistent with expectations. This finding indicates each percentage point increase in the cumulative percentage of neighboring states adopting these

policies was associated with a 2.5% increased likelihood in the proportion of eligible policies adopted (OR=1.025).

Summary of Multivariate Results

Tables 5.13 and 5.14 compare the results of the models with the five different dependent variables to the hypotheses. The results presented in Tables 5.13 and 5.14 are based on Model 4 (modified backwards stepwise with neighboring state variable) for the three event history models and Model 2 (modified backwards stepwise) for the model with the dependent variable measuring adoption of any policy in a year. Based on the literature and hypotheses, the expected sign column in Table 5.14 identifies whether the explanatory variables were expected to have a positive or negative impact on the dependent variables. In Tables 5.13 and 5.14, there are empty cells because the modified backwards stepwise regressions did not include all of the independent variables in this study. These regressions only included the variables below a specific p-value and the year indicator variables.

Table 5.13: Summary of Odds Ratio from last Model of each Dependent Variable

	BIP	CFC	1915(i)	All	Proportion
	OR	OR	OR	Policies	of Policies
				OR	OR
Political Ideology					
Democratic governor	3.465	14.183 [#]			
ADA Ideology Index	1.148 ^{**}		1.044 ^{**}	1.054 ^{***}	1.023 ^{**}
Governing Capacity					
FTE state employees per 1,000 pop.	0.524 ^{**}				
Gubernatorial power index	0.133 [*]	2.210			
Average state legislative salary					
Partisan control indicator	0.289 [*]		1.418	0.636 [*]	
Industry Power (LTSS Supply)					
NF beds per 1,000 age 65+		0.925 [#]			
% NF beds for profit		1.048			
HHA per 100,000		1.501	1.555 ^{**}	1.297 [*]	
Advocacy Power (LTSS Demand)					
% of population 65+	0.232 ^{***}			0.661 [*]	0.755 [*]

	BIP OR	CFC OR	1915(i) OR	All Policies OR	Proportion of Policies OR
% of population with disability	2.025*			1.231#	
Economic					
Per capita income (t-1)					1.000*
Unemployment rate (t-1)	0.367*		1.185		
Existing HCBS / LTSS Policies					
# of 1915(c) waivers (t-1)		1.289*		1.279**	1.302***
Medicaid state plan personal care program (t-1)			2.438		
% of Medicaid LTSS spending on HCBS (t-1)	0.693***		0.871**	0.916***	
Medicaid HCBS spending per capita (t-1)		1.008*			
NF certificate of need program (t-1)	0.057*				
HHA certificate of need program (t-1)	8.291*			2.121#	
Medically needy program (t-1)			0.581		
Prior year ACA HCBS policy (t-1)				0.295*	

	BIP	CFC	1915(i)	All Policies	Proportion of Policies
	OR	OR	OR	OR	OR
External Factors					
HCBS Final Rule issuance^					
% Neighboring states adopting (t-1)	1.034#	1.026	1.001	1.014*	1.025*
Year Indicator					
2011			0.123	0.970	
2012	0.771	0.865	0.603	8.167**	
2013	0.884	3.115	0.226	4.991*	
2014		0.675	0.995	2.869#	
Number of Observations					
	79	174	170	235	50
-2 Log likelihood					
	50.48	39.01	60.67	155.61	41.09

^ Variable omitted from Stata output because of collinearity

OR: Odd ratio, Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, CFC: Community First Choice

#p<.10, *p<.05, **p<.01, ***<p<.001

Table 5.14: Summary of Results from last Model of each Dependent Variable

	Expected Sign	BIP	CFC	1915(i)	All Policies	Cross Sectional
Political Ideology						
Democratic Governor	+	+	+ [#]			
ADA Ideology Index	+	+ ^{**}		+ ^{**}	+ ^{***}	+ ^{**}
Governing Capacity						
FTE state employees per 1,000	+	- ^{**}				
Gubernatorial power index	+	- [*]	+			
Average state legislative salary	+					
Partisan control indicator	+	- [*]		+	- [*]	
Industry Power (LTSS Supply)						
NF beds per 1,000 age 65+	-		- [#]			
% of nursing facility for profit	-		+			
HHA per 100,000	+		+	+ ^{**}	+ [*]	
Advocacy Power (LTSS Demand)						
% of the population 65+	+	- ^{***}			- ^{**}	- [*]
% of the population with disability	+	+ [*]			+ [#]	
Economic						
Per capita income (t-1)	+					- [*]
Unemployment rate (t-1)	-	- [*]		+		

	Expected Sign	BIP	CFC	1915(i)	All Policies	Cross Sectional
Existing HCBS / LTSS Policies						
# of 1915(c) waivers (t-1)	+ / -		+		** +	*** +
Medicaid state plan personal care program (t-1)	+ / -			+		
% of Medicaid LTSS spending on HCBS (t-1)	+ / -	*** -		** -	*** -	
Medicaid HCBS spending per capita (t-1)	+ / -		+			
NF certificate of need program (t-1)	+	* -				
HHA certificate of need program (t-1)	-	* +			# +	
Medically needy program (t-1)	+			-		
Prior year ACA HCBS policy (t-1)					* -	
External Factors						
HCBS Final Rule issuance	+ / -					
Percentage of neighboring states (t-1)	+	+ #	+	+	* +	* +

Americans for Democratic Action, FTE: full time equivalent, NF: nursing facility, HHA: home health aide, GDP: gross domestic product, LTSS: long-term services and supports, HCBS: home and community-based services, ACA: Affordable Care Act, CFC: Community First Choice

#p<.10, *p<.05, **p<.01, ***p<.001

Overall, the results suggest that political ideology and existing HCBS policies were the most important determinants of whether a state adopted the HCBS policies within the ACA. Across all of the models, with the exception of CFC, states with a higher ADA Ideology index were more likely to pursue these policies. In addition, in three models, a state's percentage of Medicaid LTSS spending on HCBS in the previous year was negatively associated with policy adoption. These findings suggest that states are utilizing these new options to achieve greater Medicaid HCBS rebalancing. The number of 1915(c) HCBS waivers a state operated in the previous year was also positively associated with the adoption of these policies in three models. States may be using these policies to consolidate waiver programs and simplify HCBS services.

Conclusion

The results presented in this chapter provide support for some of these hypotheses and conceptual framework presented in Chapter 3. Based on these findings, political ideology and existing HCBS policies were the most consistent predictors of whether or not a state adopted the HCBS policies within the Affordable Care Act. These results provide evidence that internal factors within the state and also neighboring states are important in policy adoption decisions. The next chapter presents the findings from the qualitative methods.

CHAPTER 6

QUALITATIVE RESULTS: ADOPTION OF THE AFFORDABLE CARE ACT'S HOME AND COMMUNITY-BASED SERVICES PROGRAMS

This chapter discusses the qualitative results related to state adoption of the Affordable Care Act (ACA)'s home and community-based services (HCBS) programs. The data from this chapter draws from interviews with federal officials, advocates, and consultants involved in long-term services and supports (LTSS) policies and programs, in addition to state bureaucrats, consumer advocates, provider representatives, and legislators from Maryland, Texas, and Oklahoma. Information was also obtained from reviewing state documents including applications, presentations, and meeting minutes as well as reports and other documents related to these programs.

For the Balancing Incentive Program (BIP), Community First Choice (CFC), and the 1915(i) HCBS program, two consistent factors were influential in both Maryland and Texas' adoption of each policy. The first was leadership within state government, specifically in the state Medicaid agency and disability services agencies. In both states, interviewees highlighted the important role that specific state officials within these agencies played in advocating for each program and convincing others within state government of the value of adopting these initiatives. Specifically, state bureaucrats recognized the synergies between the ACA policies and existing HCBS programs or goals and were able to persuade others in state government, including the

governor and legislature, of the benefits of pursuing these options for their state. While advocates and state legislatures played a role in the adoption decision, the key impetus for pursuing these options largely came from bureaucrats within the state agencies. In contrast to Maryland and Texas, the lack of bureaucratic leadership in Oklahoma was reiterated by several interviewees as one reason the state did not pursue these policies. Due to turnover in state leadership and the inability to convince others in state government of the benefits of these programs, Oklahoma did not pursue any of the three HCBS options provided by the ACA.

The second key factor in Maryland and Texas' adoption of the ACA options was the states' existing HCBS programs. In both states, BIP and CFC complemented or substituted for extant HCBS options. With BIP, state officials perceived the enhanced match as providing funding for initiatives the states were already working on or wanted to achieve. Interviewees also highlighted that Maryland and Texas were well on their way to achieving many of the programmatic requirements of BIP. With CFC, both Maryland and Texas refinanced existing state plan personal care and waiver benefits to take advantage of the enhanced match. This additional funding allowed each state to provide expanded HCBS to underserved individuals with LTSS needs. With the 1915(i), state bureaucrats in both Maryland and Texas recognized gaps in HCBS for individuals with serious mental illness. For many years, both states had been grappling with ways to remedy the lack of HCBS offerings for this population. With the changes to the 1915(i) in the ACA, state officials in Maryland and Texas realized the potential of this Medicaid benefit to address this problem. For BIP, CFC, and the 1915(i), state bureaucrats in Maryland and Texas recognized how each of these benefits could improve their Medicaid HCBS offerings and continue a commitment to rebalancing LTSS.

This chapter discusses the role that each of the factors identified in the conceptual framework played in the state adoption decision. The first section provides a brief overview of HCBS programs in Maryland, Texas, and Oklahoma, respectively. For Maryland and Texas this section includes their timelines for adopting BIP, CFC, and the 1915(i) as well as the main features of the programs within each state. The second section focuses on the state adoption decisions related to BIP, CFC, and the 1915(i) HCBS state plan benefit. These sections are organized based on the preliminary conceptual framework presented in Chapter 3. The final section is a conclusion and summarizes the main findings of this chapter.

State Home and Community-based Services Policies and Programs

Maryland

Prior to the ACA, Maryland offered Medicaid state plan personal care services and seven 1915(c) HCBS waivers (The Henry J. Kaiser Family Foundation, 2012). As shown in Table 6.1, in fiscal year 2009, the state spent approximately \$2.1 billion on Medicaid LTSS of which \$796 million (37%) was on HCBS (Wenzlow, Eiken & Scredl, 2016). Maryland provided services to nearly 17,000 individuals through 1915(c) waivers, including older adults, individuals with physical disabilities, and individuals with developmental disabilities. In 2011, the state had approximately 26,000 individuals on a waiting list for waiver services, most of whom were older adults (The Henry J. Kaiser Family Foundation, 2012). Maryland's state plan personal care benefit is substantially smaller than its 1915(c) waiver program. In 2009, Maryland provided services to 4,608 individuals (The Henry J. Kaiser Family Foundation, 2012).

Table 6.1: Comparison of LTSS and HCBS Spending in Maryland, Texas, and Oklahoma, fiscal year 2009

	HCBS Spending	LTSS Spending	% HCBS	Total Waiver Spending	Waiver Aging / Physically Disabled	Waiver ID/DD	Personal Care Spending
Maryland	\$796,052,470	\$2,148,021,402	37%	\$710,537,417	\$112,563,002	\$594,890,116	\$35,065,822
Texas	\$3,050,407,892	\$6,540,341,796	47%	\$1,416,959,629	\$559,082,983	\$788,701,467	\$1,255,806,388
Oklahoma	\$592,245,796	\$1,351,143,259	44%	\$507,623,505	\$222,354,905	\$285,268,600	\$11,662,984
National Average	\$1,165,370,666	\$2,575,090,357	45%	\$690,480,728	\$179,305,356	\$496,453,627	\$271,922,667

LTSS: long-term services and supports, HCBS: home and community-based services, ID/DD: intellectual disability/development disability

Source: [Wenzlow, Eiken & Scredl, 2016](#).

Maryland had a robust Money Follows the Person program. Prior to the federal Money Follows the Person program, the Maryland legislature enacted the Money Follows the Individual policy in 2002, which allowed individuals in institutions to enroll in a HCBS waiver. The state also participated in the federal Money Follows the Person demonstration grant beginning in 2007 and had transitioned nearly 1,200 individuals out of institutions into community settings (Maryland Department of Health and Mental Hygiene, 2012). A key aspect of Maryland's LTSS policy development process was the Long Term Care Reform Workgroup, which was founded in 2010. The workgroup had 38 members comprising advocates, program recipients, state legislators, and providers of LTSS; its purpose was to improve HCBS offerings in the state.

Maryland was the second state to apply for the Balancing Incentive Program and submitted its application on February 10, 2012. The state was eligible for the program because spending on HCBS in fiscal year 2009 was 36.8%, far below the threshold of 50% established by the ACA (The Balancing Incentive Program: Implementation Manual, 2013). The Centers for Medicare & Medicaid Services (CMS) approved Maryland's application effective April 1, 2012 and estimated the state would receive an additional \$106.34 million in enhanced Federal Medical Assistance Percentage as a result of BIP. As part of BIP, Maryland focused on expanding Maryland Access Point sites, which are the state's Aging and Disability Resource Center network. The sites provide information, referrals, and counseling for individuals seeking long-term services and supports in Maryland. At the time of the BIP application, Maryland had sixteen Maryland Access Point sites and expanded to twenty statewide sites in 2012. In addition, Maryland utilized the BIP opportunity to streamline HCBS assessment instruments. The state adopted the interRAI Home Care for the physical disability and aging assessment and the Daily

Living Activities - 20 for individuals with mental illness.⁶ Maryland also used the BIP opportunity to develop and implement the CFC program.

Maryland was the third state to adopt CFC and submitted its state plan amendment on September 17, 2013. CMS approved the state's state plan amendment on April 2, 2014 with an effective date of January 1, 2014. As part of CFC, a state must establish a Development and Implementation Council, which Maryland did in December 2011. In developing the CFC state plan amendment, state officials solicited feedback from the council. Maryland pursued CFC as a way to consolidate services from three existing programs: the State Plan Medicaid Assistance Personal Care program, the Living at Home Waiver, and the Older Adults Waiver.⁷ One reason the state sought to consolidate these existing programs was due to inequities across the programs. While individuals in all three programs could have similar acuity levels, the amount of services differed substantially between the state plan program and waivers. In addition, the state plan personal care program paid a per diem rate, which was significantly lower than comparable rates in the waiver programs. Participants in the personal care program experienced challenges finding providers because of the discrepancy in rates. Through CFC, state officials sought to ensure consistency across HCBS offerings.

⁶ The interRAI Home Care is a tool to assess adults for home and community-based services. The tool includes questions related to physical functioning; cognitive patterns; disease diagnoses; mood and behavior; and informal supports. The Daily Living Activities – 20 is a tool utilized for individuals of all ages with mental illness. The tool has twenty indicators (i.e. health practices, communication, safety, managing time), and clinicians and case managers use the tool to identify and address functional deficits.

⁷ The State Plan Medicaid Assistance Personal Care program was a state plan benefit that provided assistance with activities of daily living to Medicaid recipients. The Living at Home waiver was a 1915 b/c waiver that provided services to individuals age 18 to 65 at an institutional level of care. The Older Adults waiver was a 1915 b/c waiver serving individuals age 50 and older at an institutional level of care who resided in the home or in an assisted living. The services provided through the Living at Home and Older Adults waivers were similar and included personal care, medical day care, assistive technology, environmental modifications, and personal emergency response systems.

In Maryland's CFC program, the state provides personal assistance services, nurse monitoring, personal emergency response systems, home delivered meals, environmental assessments, technology that substitutes for human assistance, and transition costs. In addition, in the process of adopting CFC, and to meet the requirements of BIP, Maryland adopted the interRAI - HC assessment instrument to determine eligibility for the program. The state utilized the interRAI Resource Utilization Group score⁸ to develop a budget category for each CFC participant. The budgetary category is a recommended budget but individual enrollees can exceed the budget amount if their needs warrant additional services. Maryland initially allowed CFC to be provided either via self-direction or through an agency model. However, in 2015, as a result of changes to federal overtime pay for home care workers, Maryland had to eliminate the self-directed option and moved to an agency only model. In 2015, Maryland had 9,590 enrollees in CFC and spent a total of \$195.4 million on the program. The average annual expenditure per enrollee was \$20,375, and participants averaged 32 hours of personal assistance services each week (Davis et al., 2018).

Maryland submitted its state plan amendment for the 1915(i) HCBS state plan benefit on March 13, 2014. The state plan amendment was approved by CMS on October 14, 2014 with an effective date of October 1, 2014. Prior to adopting the 1915(i) HCBS benefit, Maryland operated a Community Alternatives to Psychiatric Rehabilitation Treatment Facility Demonstration Grant to serve children with serious emotional disturbances.⁹ Maryland was one

⁸ The interRAI Resource Utilization Group score is based on seventy-four (74) items within the interRAI Home Care that is used to predict service utilization. Based on the responses to the items, there are twenty-three groups an individual could be in depending on the types (i.e. impaired cognition, behavior problems, reduced physical functions) and intensity of impairments.

⁹ The Community Alternatives to Psychiatric Residential Treatment Facilitates was a federal grant opportunity to provide home and community-based services to children with serious mental health issues who might otherwise reside in a Psychiatric Residential Treatment Facility. The Deficit Reduction Act of 2005 authorized up to \$218 million for this program and it ended on September 30, 2012.

of nine states to participate and provided HCBS to children and youth with significant mental health conditions. The demonstration grant ended on September 30, 2012. Maryland explored the 1915(i) and other options as a way to continue to provide HCBS to children with serious mental health conditions after the end of the demonstration grant.

Consequently, Maryland's 1915(i) benefit is focused on children with serious mental health conditions. To be eligible for 1915(i) services, children must be under age 18 at the time of enrollment and "exhibit a significant impairment in functioning, representing potential serious harm to self or others" (State of Maryland, 2014). Maryland offers seven services through the 1915(i): intensive in-home services, mobile crisis response services, community-based respite care, out-of-home respite care, family peer support, expressive and experiential behavioral services, and customized goods and services. In the initial year, Maryland projected that 200 children would be served through the program. In conjunction with the 1915(i) state plan amendment, Maryland also submitted a state plan amendment to provide targeted case management to children with serious mental health issues because the 1915(i) financial eligibility income threshold is lower than Maryland's Medicaid income eligibility limit for children. As a result, some children with serious mental health issues on Medicaid would be ineligible for 1915(i) services because their income was too high. With the targeted case management service, these children could, at a minimum, receive case management while children financially eligible for the 1915(i) would receive Medicaid targeted case management as well as the 1915(i) services. The 1915(i) and targeted case management state plan amendments went hand in hand to address the needs of children with serious mental health issues in Maryland.

Texas

As shown in Table 6.1, in fiscal year 2009, Texas spent over \$6.5 billion on Medicaid long-term services and supports of which approximately \$3.1 billion (46.6%) was on HCBS programs (Wenzlow et al., 2016). Before the ACA, Texas had eleven 1915(c) waivers. The state served over 76,000 individuals through 1915(c) waivers. Texas also had over 150,000 people on a waiting list for waiver services (The Henry J. Kaiser Family Foundation, 2012).¹⁰ The majority of those on the waiting list were individuals with ID/DD. In addition to waiver services, Texas also offered Medicaid state plan personal care services. In 2009, the state served 52,628 individuals through this benefit (The Henry J. Kaiser Family Foundation, 2012). As part of the state plan personal care program, Texas offered state plan personal care services to individuals with income up to 300% of the federal Supplemental Security Income (SSI) benefit under 1929 of the Social Security Act¹¹ (Texas Department of Aging and Disability Services, 2012).

Texas also had a long history with the Money Follows the Person program. The state was one of the first Money Follows the Person Demonstration grantees in 2007. Prior to the federal Money Follows the Person demonstration project, Texas operated its own program to transition individuals from institutional settings to the community. Rider 37 of the Texas' 2002-2003 General Appropriation Act allowed funding for Medicaid-eligible individuals in a nursing facility to transfer to community services when they discharged from the nursing facility. Under this program, an individual returning to the community did not need to go on a waiting list for 1915(c) waiver services. Through these initiatives, Texas transitioned more than 35,000

¹⁰ Texas refers to their waiting list as an interest list.

¹¹ Texas participated in a Section 1115 demonstration waiver to cover individuals with income up to 300 percent of SSI. At the conclusion of the demonstration, Congress added a clause to Section 4711 of OBRA 1990 amending Section 1929 of the Social Security Act to allow Texas to continue providing Medicaid state plan personal care benefits to individuals with income up to 300% of SSI (Kitchener, Ng, Willmott, and Harrington, 2006).

individuals from institutional settings since 2001 (Texas Department of Aging and Disability Services, 2012).

In addition, in response to the 1999 Olmstead decision, Texas created the Promoting Independence Advisory Committee. The Promoting Independence Advisory Committee includes advocates representing those in need of care due to aging, physical disabilities, developmental disabilities, and mental health issues; provider organizations; health plans; and state agency representatives. This committee meets regularly and makes recommendations to the Health and Human Services Commission about how to expand community options. Since the late 1990s, a priority for the state has been to expand managed care within Medicaid LTSS. In 1998, Texas piloted STAR+PLUS, its LTSS managed care system for people with disabilities or aged 65 years and older. STAR+PLUS was expanded in subsequent years and largely eliminated waiting lists for nursing facility waivers. Individuals enrolled in the Supplemental Security Income program can skip the waiting list for 1915(c) waiver services but instead can receive the services immediately through their managed care organization. One policy goal of the state has been to transition more and more of the LTSS fee-for-service programs into a managed care system.

Since Texas was spending 47% of Medicaid LTSS dollars on community services in fiscal year 2009 (below the BIP threshold of 50%), the state was eligible for the program. Texas submitted its application for BIP on June 29, 2012 and received approval on September 4, 2012. At the time of the application in 2012, Texas' HCBS spending percentage had slightly surpassed the 50% BIP requirement (Eiken et al. 2015); however, the state was still eligible for the program because BIP eligibility was based on fiscal year 2009 spending. In its application, Texas estimated an additional \$301.5 million in enhanced Federal Medical Assistance Percentage through BIP. Texas' focus with BIP was on the No Wrong Door/Single Point of Entry system

because the state determined that requirements for conflict free case management and the core standardized assessment were largely already met. Prior to BIP, Texas had 14 Aging and Disability Resource Centers, which did not cover the entire state; as part of BIP, Texas added six additional Aging and Disability Resource Centers to cover all of the state. In addition, Texas developed a LTSS Level 1 screen on Your Texas Benefits.¹² Through the Level 1 screen, potential recipients of HCBS and their caregivers could learn about available services and obtain referrals (Mission Analytics Group and New Editions Consulting, Inc., 2017).

In 2013, the Texas Legislature Senate Bill 7 instructed the Health and Human Services Commission to pursue “a cost-effective option for attendant and habilitation services for people with disabilities.” To achieve this mandate, Texas submitted its CFC state plan amendment in October 2014. CMS approved the state plan amendment on April 2, 2015 with an effective date of June 1, 2015. Texas pursued CFC as a way to provide personal care and habilitation services to individuals on a waiting list for ID/DD waivers. CFC services in Texas include personal assistance services, habilitation services, emergency response services, and support management. In the state plan amendment, Texas elected to allow individuals to self-direct their CFC personal assistance services or habilitation through a Consumer Directed Services option. In Texas, CFC is available through Medicaid managed care organizations and waiver programs. Individuals not enrolled in a 1915(c) waiver receive CFC services through a managed care organization while individuals in a waiver receive CFC services through their comprehensive waiver provider. In the first year operating the program, Texas enrolled over 41,000 individuals in CFC.

Approximately 54% of CFC enrollees received CFC services through their managed care

¹² Your Texas Benefits is an online portal for Texas residents to apply for public benefits, such as Medicaid, food stamps, or temporary assistance for needy families.

organization, 41% were enrolled in a 1915(c) waiver, and the remaining were children in traditional Medicaid (Mission Analytics Group and New Editions Consulting, Inc., 2017).

Prior to adopting the 1915(i), Texas evaluated ways to improve its behavioral health services. House Bill 1 of the 82th Texas legislative session required the Health and Human Services Commission to contract with an external organization to analyze and make recommendations for Texas' behavioral health services system redesign. In addition, House Bill 2725 of the same legislative session required the Department of State Health Services and Health and Human Services Commission to explore options to provide HCBS to individuals with repeat commitments to state psychiatric facilities to restore competence to stand trial. Both reports identified the 1915(i) HCBS state plan benefit as one option to expand behavioral health services in Texas.

Texas submitted its 1915(i) state plan amendment on July 22, 2014 and received approval from CMS on October 13, 2015, with an effective date of September 1, 2015. To be eligible for the program, an individual must have a functional need of two or higher on the Adult Needs and Strengths Assessment.¹³ In addition, an individual must have resided in an inpatient psychiatric hospital three or more years consecutively or cumulatively during the last five years. In the state plan amendment, Texas anticipated enrollment for the initial year to be 50 individuals and approximately 100 individuals in subsequent years. The Texas 1915(i) state plan amendment provides a variety of services including HCBS psychosocial rehabilitation services, transportation, peer support, respite, and substance use disorder services. Texas later amended its 1915(i) to cover additional populations. The expanded 1915(i) focused on diverting individuals

¹³ The Adult Needs and Strengths Assessment is a tool used to determine level of care and service plan for adults receiving behavioral health services. The domains include: risk behaviors, behavioral health needs, family/caregiver strengths and needs, and psychiatric hospitalizations.

with serious mental illness from jails and emergency rooms. To qualify under these provisions, an individual must have experienced four or more arrests and two or more psychiatric crises in the last three years or 15 or more emergency department visits and two or more psychiatric crises in the last three years.

Oklahoma

In fiscal year 2009, Oklahoma spent approximately \$1.4 billion on Medicaid LTSS, of which, \$592 million (43.8%) was on HCBS programs as shown in Table 6.1 (Wenzlow et al., 2016). The state offered five 1915(c) waivers based on nursing facility level of care and for individuals who meet an intermediate care facility/intellectual disability level of care. Oklahoma served over 30,400 individuals through 1915(c) waivers in 2009. The state also had approximately 6,000 individuals on a waiting list for waiver services, the overwhelming majority waiting for an intermediate care facility/intellectual disability slot (The Henry J. Kaiser Family Foundation, 2012). In addition, the state offered state plan personal care services for individuals who require assistance with activities of daily living. In fiscal year 2009, Oklahoma provided state plan personal care services to nearly 3,500 individuals (The Henry J. Kaiser Family Foundation, 2012).

One of Oklahoma's intermediate care facility/intellectual disability waivers was specifically targeted to individuals previously residing at the Hissom Memorial Center, a state-run institution for people with developmental disabilities. A major turning point in the development of Oklahoma's HCBS programs for the developmentally disabled population was the *Homeward Bound et al. v. The Hissom Memorial Center et al.* U.S. District Court case. In the 1980s, a group of family member of Hissom residents sued the center for neglect, abuse, and inadequate care. The judge ruled in favor of the family members and ordered that the state close

Hissom within four years and move everyone living there to the community. In response to that judgment, the state of Oklahoma developed the Homeward Bound waiver to transition individuals residing at Hissom to services in the community. In the late 1990s, in response to the demand for waiver services for individuals with ID/DD who had not resided at Hissom, the Oklahoma Department of Human Services developed two additional waivers to provide services to children and adults with ID/DD in their homes.

Oklahoma also participated in the Money Follows the Person program. The state received a Money Follows the Person demonstration grant in 2007 and was one of five states to receive funding through the Money Follows the Person Tribal Initiative in 2013. As of 2016, Oklahoma had transitioned approximately 700 individuals from institutional settings to the community (Coughlin et al., 2017). Through grants from the Administration on Community Living, Oklahoma has also worked on developing its Aging and Disability Resource Center program. The Aging and Disability Resource Center system involves coordination among the Department of Human Services, the state's eleven Area Agencies on Aging, and five Centers for Independent Living. Another policy goal of the state has been to increase care coordination for the aged, blind, and disabled populations through managed care. The Oklahoma Health Care Authority, the state Medicaid agency, issued a request for proposals for a SoonerHealth+ program, which would be a fully capitated care coordination program for this population. However, due to a lack of funding, the Oklahoma Health Care Authority canceled this request for proposals and put the state's move to managed care for these populations on hold.

Balancing Incentive Program

Interviews with national-level and state-level individuals confirmed that several factors identified in the preliminary conceptual framework shaped states' adoption or lack of adoption of

BIP. National-level interviewees identified common barriers and facilitators to adoption across states while state-level interviewees spoke of the factors that influenced the decision-making process in their respective states. In both Maryland and Texas, leadership within the state Medicaid or disability agencies was a key factor in the adoption decision. State bureaucrats recognized that the BIP funding was substantial, and that the program was consistent with their states' existing LTSS policies or goals. In addition, in both states, officials realized that their state was already working towards many BIP requirements. One barrier posited to impede some states' adoption of BIP was political opposition to the ACA. However, Texas did elect to participate in BIP despite strong opposition to the ACA. Leadership within the state Medicaid agency was able to demonstrate that the economic benefits of BIP outweighed political opposition to the ACA. This is in contrast to Oklahoma, where political opposition to the ACA also extended to the HCBS opportunities.

Political and Ideological Factors: Opposition to Affordable Care Act and Federal Grant Opportunities

Since BIP was included in the Affordable Care Act legislation, political and ideological resistance to the ACA posed a barrier to pursuing BIP in some states. Opposition to the Medicaid expansion, the individual mandate, and health insurance exchange aspects of the ACA ran deep in many states. Twenty-five states challenged the individual mandate and Medicaid expansion requirements of the legislation through litigation (The Henry J. Kaiser Family Foundation, 2012). Interviewees reported that in some states, the opposition to the health insurance aspects of the ACA precluded the state from considering the LTSS provisions. According to a national consultant, for some states "the political climate was very hostile to the Affordable Care Act, and so anything that came out of the ACA was just immediately tainted ... In a number of states, it

[BIP] was just politically dead on arrival.” Traditionally, rebalancing long-term services and supports was not a partisan issue. Both Democrats and Republicans recognize the benefits of providing services to individuals within their homes and communities rather than institutional settings. However, by including BIP in the ACA, some states did not apply for BIP because of opposition to the controversial bill and not the specifics of the BIP program.

In addition to the association with the ACA, another impediment to states’ adoption of BIP was ideological opposition to federal involvement in state policy. Some states can be reluctant to pursue federal grant opportunities because of concerns over accepting federal money with strings attached. These barriers were conveyed by a few interviewees, who indicated, “in some states if there's a conservative Republican governor and Republican control, they have a kind of ‘we don't want anything from the federal government’ mentality” (federal bureaucrat) and “some states they think of grant, or funding opportunities from CMS with a very critical eye to make sure that it's not somehow inviting in a position of federal involvement in the running of their program” (national ID/DD advocate). In these quotes, both national interviewees are indicating that some states are hesitant to participate in federal programs because they do not want the federal government interfering in their states’ policies. With BIP, states had the potential to realize substantial additional federal revenue; however, for some states this additional revenue did not outweigh the federal requirements for participating in the program. As part of BIP, states needed to achieve a specific rebalancing threshold and implement the three structural change requirements before the end of the program.¹⁴ Some states with conservative

¹⁴ The three BIP requirements were: develop a No Wrong Door/Single Entry Point system, utilize a core assessment instrument to determine eligibility for HCBS programs, and ensure that HCBS case management services were conflict free.

leadership perceived the additional federal funding and requirements from BIP as an overreach of federal government authority.

Both the association with the ACA and ideological opposition to federal involvement in state policy partly influenced the decision Oklahoma made not to pursue the HCBS opportunities within the ACA. Oklahoma did not enact the health insurance exchanges or expand Medicaid. In addition, the state filed an amicus brief in the *King v. Burwell*, No. 14-144 case challenging the constitutionality of the ACA. According to several interviewees in Oklahoma, “anything that has to do with the Affordable Care Act, even those things that benefit those in need in the state, is not palatable to decision makers” (ID/DD advocate) and “there was a lot of opposition from our state as a whole, to the Affordable Care Act” (state bureaucrat). In Oklahoma, the deep-seated opposition to the health care aspects of the ACA, in part, prevented the state from pursuing the BIP opportunity within the legislation. In addition to strong opposition to the ACA specifically, officials in Oklahoma were also wary of perceived federal overreach. According to one former state bureaucrat, “I think there is a general hostility to the federal government in Oklahoma that everything that is federal is looked at with suspicion.” This skepticism about federal action was one impediment to Oklahoma’s pursuit of aspects of the ACA including the BIP provision.

However, the case of Texas and other states demonstrates that some states were able to overcome political and ideological opposition to the ACA and pursue the HCBS options. Of the twenty-five states that challenged the constitutionality of the ACA, ten adopted BIP (The Henry J. Kaiser Family Foundation, 2012; CMS, n.d. (a)). As with Oklahoma, Texas did not adopt the Medicaid expansion and health care exchanges. In addition, Texas Governor Rick Perry had been an outspoken critic of the ACA. However, officials in Texas adopted BIP because the state Medicaid director was able to make a compelling argument that, even though BIP was part of the

ACA, it was in the best interest of Texas to pursue the opportunity. For Texas, the additional revenue associated with BIP was too substantial to forgo even given the governor's and many state legislators' opposition to the health insurance expansion provisions of the law. To be able to move forward with BIP, however, officials in Texas were careful to not associate BIP with the ACA. A few advocates indicated that state officials did not link BIP to the ACA. According to a cross-disability consumer advocate, "they avoided using the words, 'Affordable Care Act,' or, 'Obamacare,' when talking about them." Through skilled leadership in the state Medicaid agency and disassociating BIP from the ACA, Texas state officials pursued this opportunity because of the substantial budgetary benefit to the state.

Economic Factors: Additional Federal Revenue Supported State Goals and Initiatives

A key aspect of BIP was the 2% or 5% enhanced Federal Medical Assistance Percentage on Medicaid HCBS during the BIP period. Among participating states, the amount of funding states could expect to receive from BIP ranged from \$6.5 million (Nevada) to \$600 million (New York) (CMS, n.d. (a)). The actual amount of enhanced federal revenue states realized was based on when each state joined the program and state spending on Medicaid HCBS during their participation in BIP. While the enhanced funding was substantial and important for states to participate in the program, many states were already working towards the goals of BIP without the enhanced federal match. Participating in the BIP program helped speed up state progress and the additional funding made it easier for states to achieve existing LTSS goals. According to a national ID/DD advocate, some states realized that "they would potentially be leaving money on the table for stuff they're already doing, and already committed to." In several states, pursuing BIP was a natural decision because they would be working towards the same goals and the enhanced federal match was an added bonus.

In Maryland, deciding to pursue BIP was an obvious choice given where the state was headed with HCBS and the BIP enhanced federal revenue. Most interviewees indicated the extra 2% federal match was viewed through the lens of the state already moving towards greater rebalancing and working on several of the structural change requirements mandated by participation in the program. For Maryland, “we were already working on a number of areas that were deliverables under the program. So it looked like something that we would reasonably be able to achieve and the funding was substantial”(state bureaucrat) and “it dovetailed with where the state wanted to go anyway, so why not get the couple more million bucks out of the feds” (consultant). Prior to BIP, Maryland was looking at ways to improve its existing HCBS assessment tools. In 2010, the LTSS workgroup reported that it was exploring validated assessment tools as a way to better target services (Maryland Department of Health and Mental Hygiene, 2010). The BIP requirement of a core standardized assessment and \$100 million in additional federal revenue made the goal of adopting standardized tools more feasible. In addition, Maryland had an aim of expanding its Maryland Access Point sites statewide by the end of 2012. The No Wrong Door BIP requirement was consistent with where the state was headed and again the additional money allowed for Maryland to enhance its Maryland Access Point system and ensure all regions of the state were covered. The Balancing Incentive Program helped hasten the changes Maryland was looking to make to its LTSS system and the additional federal funding made it easier for the state to enact the desired changes.

As with Maryland, in Texas, the decision to pursue BIP was uncontroversial based on the state’s progress in rebalancing and the substantial federal revenue Texas would realize through BIP. According to a state bureaucrat, BIP “was widely regarded as something we would obviously take advantage of.” Since Texas had already achieved most of the requirements of

BIP, participating in the program and collecting the additional federal match was the clear decision. In addition, for Texas, the additional money helped allay political concerns associated with participating in an ACA program. According to a Texas state bureaucrat, “even with a very conservative Texas legislature, we were able to demonstrate the sort of resources we were able to draw down in the enhanced funding.” In this quote, the interviewee indicates that the substantial amount of additional revenue Texas expected to receive helped convince state legislators, many of whom were opposed to the ACA, to move forward with BIP.

Interest Groups: Advocacy and Provider Communities were not Impetus for States’

Pursuit of the Balancing Incentive Program

The impetus for pursuing BIP largely came from within state government and not the advocacy or provider communities. State bureaucrats recognized the benefits of participating in BIP for their state and were able to convince others of the value of pursuing this opportunity. While most advocates were not opposed to BIP, in general, they were not putting pressure on the states to adopt BIP. According to a national consultant, in the decision to adopt BIP,

The prime movers were people fairly high up in the Medicaid agency or in one of the, I'll call them operating agencies ... we have heard almost nothing about the role of advocacy groups or provider groups in the decision to apply for BIP ... I don't think there were in any states that I'm aware of, there was any pressure coming from providers or advocacy groups.

In this quote, the national consultant highlights the role of those in high-level leadership positions in Medicaid and dismisses the role of providers and advocacy groups. In many states, officials within the state Medicaid agency or aging and disability agencies played a key role in the decision-making process. Consumer advocates and provider representatives were often

consulted but generally felt like the decision to pursue BIP was largely made with the state agencies. Advocates and provider representatives typically were not opposed to pursuing BIP; however, they felt their involvement in the decision was limited.

In Maryland, the decision to pursue BIP was made within the state Medicaid agency but the agency shared information with the Long-Term Care Reform Work Group, which included program participants, aging and physical disability advocates, and provider representatives. According to one state bureaucrat, “that group [the Long-Term Care Reform Work Group] was also consulted, and we discussed the options, and where the department wanted to go, and how we would do it, and everyone was in support of the proposed plan.” While advocates and providers were generally supportive of pursuing BIP, some felt like they were consulted only after state officials had already made the decision to pursue it. In describing the decision to pursue BIP, two physical disability advocates noted that “Maryland is a very top down state here ... Maryland is a very closed state in a lot of ways, they don't have a lot of good quote-unquote ‘Public involvement’ in decision-making. Things just happen” and “I just sort of remember it coming out ... I don't remember having any involvement in that at all.” In these quotes, advocates for individuals with physical disabilities highlight that decisions are often made by officials in state government with limited input from external stakeholders. In addition, a provider representative indicated the state Medicaid director was the key driver in pursuing BIP. In Maryland, advocates for the disability community and providers conveyed that they had little involvement in the decision-making process to pursue BIP. Although state officials shared the plan to pursue BIP with the Long-Term Care Reform Work Group, advocates and providers indicated the state had largely already made a decision to adopt BIP without input from external organizations.

While interest groups were not leading the effort to pursue BIP in Texas, they did play a role in supporting the state's adoption of the program. Similar to Maryland, Texas shared information about BIP through its Promoting Independence Advisory Committee. Interviewees corroborated that the decision was largely made within state government with support from the advocacy and provider communities. Several advocates and provider representatives in Texas suggested that the decision to pursue BIP "was primarily made at the state level, but I was definitely on one of those committees that was very supportive of it" (cross-disability advocate), "we were all supportive of it, in our roles on statewide advisory councils, work groups, and committees, we were supportive of it", (ID/DD advocate) and "that [the decision to pursue BIP] was done at the state level" (provider representative). In both Maryland and Texas, advocates and provider representatives felt as if the decision to pursue BIP was made by state officials independent of their influence; however, they were supportive of their state's decision to adopt this program.

The case of Oklahoma also demonstrated the limited role advocacy and provider organizations played in the BIP decision-making process. In Oklahoma, BIP was on very few people's radar, including provider groups and advocates for individuals who could benefit from the program. According to an advocate for the developmentally disabled in Oklahoma, "I think I've read something about it [BIP], but that's not something that has come up in the policy discussions here." This quote highlights that BIP was not widely discussed or known about in Oklahoma. The lack of awareness about BIP in Oklahoma was echoed by an advocate for older adults who only learned about the BIP opportunity by attending a national conference in Washington, D.C. After learning of BIP, the interviewee tried to get officials in Oklahoma state government to consider the program but could not get anyone to listen.

Overall, in the BIP decision-making process, interest groups tended to play a peripheral role. In states that pursued BIP, like Maryland and Texas, consumer advocates and providers representatives were informed of the decision to pursue this opportunity through state-level workgroups and were generally supportive of their state's participation in the program. In Oklahoma, many advocates and providers were not aware of the program and those who favored pursuing BIP could not convince state officials to consider BIP because of a lack of interest within state government.

Governing Capacity: State Bureaucrats Took Initiative in Adopting the Balancing Incentive Program

Leadership within the state Medicaid office or health and human service agencies was important to states' pursuit of BIP. According to a national consultant, in most states, the decision to pursue BIP "really came from the leadership of Medicaid or its sister agency, people who knew how to make the argument in the right way and persuade their leadership ... and say we'd like to do this." These individuals recognized the substantial amount of funding the state stood to gain and that many of the BIP deliverables were objectives the state had already achieved or wanted to achieve. These state bureaucrats were able to convince others within state government that adopting BIP made sense for their state.

In Maryland, the state Medicaid director played an important role in the decision to pursue BIP. The Medicaid director at the time wanted to reform the LTSS system and was described by interviewees as "very savvy" and "a very strong leader." According to a state bureaucrat,

As soon as when we first learned about what was within the Affordable Care Act and the various programs that were options, coming from a state Medicaid director that was

interested and wanted to do long-term care reform after seeing our system, and seeing the recommendations, we wanted to do something.

Under the Medicaid director's leadership, state bureaucrats examined which LTSS provisions in the ACA would make sense for Maryland to pursue. This team, consisting of the Medicaid director, the director of long-term services and supports, and several analysts, conducted an analysis of BIP to understand the impact and benefits to Maryland. After developing an initial proposal for BIP, the Medicaid agency engaged stakeholders through the Long-Term Care Reform workgroup. The initiative and decision to pursue BIP, however, came from the Medicaid agency and more specifically the Medicaid director who recognized the need for reform in Maryland's LTSS system.

In Texas, state bureaucrats within the state health and human services agencies, specifically the Department of Aging and Disability Services, played a crucial role in the state's decision to pursue BIP. These bureaucrats recognized that BIP made sense for the state and were able to convince elected officials of the budgetary benefits of the program. In describing Texas' adoption of BIP, a national consultant indicated

It really came from leadership in their Medicaid agency, folks who said look, this is a really good idea. Given the amount of money we spend on LTSS, this will be a huge windfall for the state. And they were strategic about the way they described it.

The important role of state bureaucrats was reiterated by several interviewees in Texas.

According to one state bureaucrat, "I think I was pretty instrumental in pursuing that [BIP]. I'm the one who wrote the position paper. I persuaded my boss ... that it was in our best interest to pursue it." The individual was respected in state government and had substantial experience in long-term services and supports policymaking. Both quotes identify that the impetus for pursuing

BIP came from state bureaucrats who were able to convince others in state government to apply for the program. Thus, in Texas, the leadership of well-positioned state bureaucrats played a key role in the state's adoption of BIP by making a compelling argument about the benefits of the program to agency heads.

In contrast, competing priorities of state bureaucrats and a lack of state leadership impeded other states' adoption of BIP. One reason states did not apply for the program had to do with capacity at the state level. BIP was only available for states to apply for from 2011 to 2014. During this time, states were implementing many others aspects of the ACA, and some states did not have the staff bandwidth to avail themselves of all programs the ACA had to offer. Many states were more focused on the Medicaid expansion, health insurance exchanges, health homes, and other aspects of the ACA than the LTSS provisions. According to two national advocates,

For the Balancing Incentive Program, it was bad timing, because ordinarily, I think, states would have jumped all over it, but they had so many things they were trying to juggle that it took a while for states to come on board and adopt the program (national aging advocate)

I think that was probably the biggest factor, is that there were competing priorities (consultant).

Rather than the LTSS provisions such as BIP, states were often more focused on the health insurance aspects of the ACA, which received more attention and could potentially benefit a larger population.

In addition, the BIP opportunity came as states were still recovering from the Great Recession. The economic downturn contributed to reductions in state government workforce. According to an ID/DD national advocate, states "do have a limited number of staff positions

that they can use to run the Medicaid program. You do kind of just run out of FTEs [full-time equivalents] to apply for and manage all of these different projects.” In Oklahoma staffing shortages and turnover has posed a challenge to the state. According to one state bureaucrat,

Both in Aging Services and Development Disabilities, we've lost a lot of our real experience. People have taken retirement that did those for a long time then we have shed those positions ... I think that the reduction in manpower has really impacted our ability to be innovative.

In the quote above, the state bureaucrat identifies reductions in the number and experience of state employees as an impediment to pursuing new policies. Insufficient staff combined with a focus on key programs meant that Oklahoma and other states lacked the bandwidth to pursue optional opportunities like the Balancing Incentive Program.

Existing Home and Community-based Services: BIP Complemented States' Existing Programs

A state's existing HCBS programs and infrastructure was a key factor in the decision to pursue BIP. Over the last several decades, states have been rebalancing their LTSS systems by increasing waiver offerings and transitioning individuals out of institutional settings. In addition, many states have been working on improving their LTSS infrastructure by developing Aging and Disability Resource Centers and adopting information technology systems to better manage programs. According to a national HCBS consultant,

Some states that really were pretty far along in the process of developing their community LTSS ... saw BIP as a way to fund things that they were already in the process of doing. So it just defrayed the expense of doing things that they wanted to do anyway.

These states recognized that BIP was consistent with their LTSS goals and vision for their HCBS system. The enhanced federal match from BIP facilitated many of the LTSS projects states were already working towards.

In Maryland, officials perceived BIP as complementing existing policies and achieving LTSS goals. According to a Maryland state bureaucrat,

It was a very natural fit for us to pursue the Balancing Incentive Program, just because a lot of the requirements were already things that we were working on in one way or another. I think it made it easier for us to see that we would be able to achieve those deliverables.

In this quote, the state bureaucrat highlights that Maryland did not have concerns about meeting the BIP structural change or rebalancing requirements because the state was working on them before BIP. Maryland was enhancing its No Wrong Door system, Maryland Access Points, and developing a 1-800 number for information about HCBS. Maryland also had a goal of standardizing the state's HCBS assessment tools. In a 2010 report to the state legislature, Maryland's Long-Term Care Reform Workgroup recommended improving assessment tools as a way to better target services. According to a state bureaucrat, prior to BIP, "the core standards assessment was certainly a want, attaching what ended up being \$106 million [from BIP] made that a 'You can't not do this'". In this quote, the state bureaucrat conveys that Maryland wanted to adopt a new assessment tool prior to BIP, and the funding from the program made it feasible to achieve this goal. In addition, meeting the 50% rebalancing requirement was not a concern for Maryland. By the time the state was approved for BIP, Maryland was already spending more than 50% of Medicaid LTSS on home and community-based services, but qualified anyway because BIP eligibility was determined based on spending in fiscal year 2009.

Similarly, state officials in Texas perceived pursuing BIP as an obvious decision because many of the goals and requirements of BIP the state had already achieved or was working towards achieving. According to a Texas state bureaucrat, “I think it was just a practical thing because we were already so close to accomplishing the things that you had to accomplish under BIP.” Texas had largely achieved two of the three structural change requirements prior to BIP. Texas’ case management system was mostly conflict free with most case management/eligibility determinations being conducted by different entities than those providing services. In instances where the same entity provided case management and service provision, the state ensured that the organization had firewalls in place to separate the two functions. In addition, the state only needed to make a few changes to existing assessment tools to be compliant with BIP. Texas was also actively working on its No Wrong Door system by expanding Aging and Disability Resource Centers statewide. A state bureaucrat conveyed,

We had an aging and disability resource center program that we had been looking to expand anyway. With BIP funding it was a clear, obvious way to establish the no wrong door system and a way to get the money to go ahead and do that.

As with Maryland, Texas exceeded the 50% threshold for HCBS spending prior to participating in BIP but qualified anyway because BIP eligibility was based on HCBS spending in fiscal year 2009; therefore, the state was already increasing spending on Medicaid HCBS consistent with the BIP objective.

External Factors: Lack of Clarity from Centers for Medicare and Medicaid Services on Deliverables Slowed Initial Adoption

One factor that may have contributed to the timing of states’ adoption of BIP was information from CMS. In the first year of the program, only one state (New Hampshire)

submitted an application. A reason states were slow to pursue BIP was that they were waiting for more clarification from CMS about the specific requirements of the program. According to one national advocate for aging policy,

...there were a lot of questions that states had about those [the structural changes], so I think it took some time to see what CMS was going to say about what they had to do, in terms of the structural changes or what the expectations were.

In particular, there were questions around the core standardized assessment requirement. The legislation did not make it clear whether states were required to utilize a single assessment instrument across all populations. CMS and their consultant for BIP, Mission Analytics Group, issued guidance that states could have different assessments as long as all of the assessments included the same core domains. By clarifying this requirement and giving states more flexibility, the Balancing Incentive Program was more attractive to states. States also had some concerns over what would happen if the state failed to achieve the required rebalancing percentage and structural change requirements at the end of the BIP period. State officials were uncertain if CMS would make states pay back the enhanced federal match if the program requirements were not met. According to one state official in Maryland,

I think the only thing that gave a little bit of pause initially was what would happen to the funding if the state failed to achieve all the deliverables. So if the state would be on the hook to give the funding back. I think that was the major question.

If states failed to demonstrate progress towards the BIP requirements, CMS did not require states to return the enhanced federal revenue received. However, two states, Indiana and Louisiana terminated participation earlier because they were not meeting the requirements. Once CMS and

Mission Analytics provided states with more clarification about the program requirements and enhanced funding, the number of states participating in BIP increased.

Community First Choice

In Maryland and Texas, a key factor in pursuing CFC was leadership from the state Medicaid office. Influential leaders in both states were able to convince the governor and legislature of the benefits of adopting CFC. In addition, officials in both states realized that they could obtain additional federal revenue for existing Medicaid services, and the new revenue could address issues with which the state had been grappling. Maryland and Texas moved state plan personal care services and some 1915(c) waiver services into CFC to take advantage of the additional 6% federal match for CFC services. With this additional revenue, Maryland sought to remedy inequities across HCBS recipients while Texas offered personal care and habilitation through CFC to individuals on an ID/DD waiting list. While Maryland and Texas pursued this option, they are two of only eight states that adopted CFC as of 2017 (Congressional Research Service, 2017). A key reason why states such as Oklahoma have not elected this option is that CFC is an entitlement benefit, and states were concerned with the budgetary implications of making a new Medicaid benefit available statewide without the option of a waiting list.

Political and Ideological Factors: Political Opposition to Expanding Medicaid Influenced Some States' Position on Community First Choice

Ideological opposition to expanding Medicaid benefits played a role in some states' CFC adoption decisions. However, with CFC, as discussed in more detail below, the entitlement nature and potential budgetary impact of the program played a larger role in state decision-making processes than ideological considerations. Still, one reason Oklahoma has not pursued CFC was due to political opposition to adding new Medicaid benefits. According to an ID/DD

advocate, “we’re a red state and we don’t do things that increase Medicaid.” Since Oklahoma is a conservative state, adopting CFC was inconsistent with the role of limited government espoused by many state government leaders.

Texas was similar to Oklahoma in that both states had conservative leadership and were opposed the health insurance expansion and exchange portions of the ACA. In addition, both Texas and Oklahoma had long and lengthy waiting lists for ID/DD HCBS waivers, with individuals likely to remain on a waiting list for over ten years. Although both states were similar, Texas adopted CFC as a way to offer services to individuals on the waiting list while Oklahoma did not. Savvy state bureaucrats in Texas were able to convince others within state government of the benefits of CFC while disassociating the program from the controversial health insurance legislation. According to a cross-disability advocate, the Health and Human Services commissioner

...managed to convince our then governor that, while this was part of the Affordable Care Act, we didn't have to call it that. We could actually help the state out budgetarily, as well as help out more people.

Officials in Texas determined that by folding existing personal care and waiver services into the CFC and receiving the 6% enhanced federal match for these services, the state could offer services through CFC individuals on an ID/DD waiting list while they were waiting for a waiver slot to open. By providing services to individuals who were waiting for a waiver slot, the state could potentially delay more costly care for these individuals down the road. While officials recognized the budgetary benefits of CFC for Texas, they were cautious not to associate CFC with the ACA. According to a provider representative, “the Affordable Care Act, Obama, none of that ever came up in any of those discussions.” In addition, the Texas legislature ultimately

directed Health and Human Services Commission to pursue CFC through Senate Bill 7 of the 83rd legislative session. Senate Bill 7 did not explicitly refer to Affordable Care Act or Community First Choice. Instead, the legislation instructed the Health and Human Services Commission to “pursue cost effective personal care” which officials, advocates, and providers understood to mean CFC.

Economic Factors: States Concerned about Budgetary Implications and State Share of Cost

Cost concerns and budgetary considerations were key factors in states’ CFC adoption decisions. CFC is a Medicaid entitlement benefit; therefore, anyone who meets the eligibility criteria for the program can enroll. States cannot target the benefit based on age or type of disability nor can states use waiting lists to control costs, as with 1915(c) waiver services. Several national interviewees indicated that cost concerns were limiting states’ take up of CFC, “everyone that’s eligible has to be able to receive the services. And not all states are ready to put those services out there in the manner in which the (k) [CFC] prescribes” (consultant) and “states probably are concerned about the cost associated with the program because once it's adopted, then it's an entitlement program that has to be ... the benefits have to be statewide” (aging advocate). Without the ability to limit by age, population, geography or utilize waiting lists, a larger number of individuals may be eligible for CFC than states may be willing to serve. Therefore, states were concerned that expenditures could exceed expectations and cost the state more than budgeted. Several states considering CFC modeled the cost implications of the program. For example, Colorado hired an outside consultant to estimate the cost of adopting CFC. Colorado’s CFC Feasibility Study, which was finalized in December 2013, estimated the additional cost of CFC to the state General Fund ranged from \$46.7 million to \$79.2 million

depending on the services included and assumptions (Kako, Gunther, O'Brien-Strain, Rosenberger, 2013). Based on these cost estimates, Colorado has not pursued CFC to date.

In addition to concerns about an entitlement benefit and the inability to control costs, states were concerned about funding the state match for the program. For all Medicaid spending, the federal government reimburses states for a portion of the costs but states are responsible for the remainder from the state general fund.¹⁵ CFC represents an expansion of HCBS Medicaid offerings; therefore, states would need additional state revenue to cover the new expenses. Even though many states adopting CFC converted existing HCBS programs, such as state plan personal care programs and 1915(c) waivers, into CFC, states can expect to spend more on HCBS with CFC even with the 6% enhanced match to the extent that they end up serving a large number of additional beneficiaries. With 1915(c) waivers, states have the ability to limit enrollment which is not an option when services are moved to the state plan. According to a national consultant, “it ends up costing money ... moving a bunch of services out of waivers and into the state plan would cost money. And so states have, I think, rightly, been pretty cautious about it.” In addition, one requirement of CFC is that in the first twelve months of the program states must maintain or exceed the prior year’s Medicaid HCBS expenditures. Therefore, states cannot use CFC to reduce HCBS expenditures. To be able to expand services, states need to have funding available in the state appropriation for the additional cost. For some states, the added cost of CFC was not something the state was able or willing to shoulder.

In Oklahoma, the entitlement nature of the program and the added state cost were among the reasons the state has not pursued CFC. Officials in Oklahoma were concerned about increased demand if the state decided to offer a new Medicaid entitlement benefit. “[I]t is a

¹⁵ In FY2015, the percentage of the state share of Medicaid ranged from 26.42% to 50% of Medicaid spending.

program that would be available to everyone. So we have a little concern about the woodwork effect it might create,” one state bureaucrat in Oklahoma conveyed. The woodwork effect is the concern that offering HCBS may result in people ‘coming out of the woodwork’ to take advantage of the benefit. Individuals not receiving Medicaid funded HCBS may seek to enroll in services if CFC were added to the Medicaid state plan. In addition to the woodwork effect, officials in Oklahoma felt the state could not commit additional state dollars for Medicaid HCBS programs. Most interviewees indicated that the state faced budgetary challenges. According to one bureaucrat in Oklahoma, CFC “requires additional state dollars, which the Health Care Authority doesn’t feel that they have the flexibility to pursue this amendment.” Said a physical disability advocate, “it was going to be really, really hard if not impossible because we don’t have any money.” In recent years, Oklahoma has been confronted with budget shortfalls and has been looking at cuts in Medicaid HCBS programs; therefore, officials felt that adding new Medicaid programs was not a financially viable option. The state could not come up with the state share to add the CFC program to Oklahoma’s state plan.

For states that have adopted CFC, the 6% enhanced federal match for CFC services helped states to address the entitlement nature of the benefit and additional costs to the state. In both Maryland and Texas, the additional 6% Federal Medical Assistance Percentage for CFC services was crucial for each state to pursue the program. Several bureaucrats in the Maryland state government highlighted the importance of the enhanced funding, noting that “without the 6% enhanced match, the initial year or so would not have been feasible” and “I think that the enhanced match made all the difference.” In addition to the CFC additional 6% match, Maryland also utilized the BIP enhanced revenue to move forward with CFC. One reason the enhanced match was crucial for Maryland was that the state combined three existing programs into CFC:

two 1915(c) HCBS waivers and state plan personal care services. Prior to CFC, recipients of state plan personal care services were receiving far fewer hours of services compared to recipients of waiver services even if their acuity levels were similar. By merging the three programs into CFC, state officials expected that individuals previously enrolled in the state plan personal services would receive services more comparable to those enrolled in the waiver. A state bureaucrat conveyed that “the 6% enhanced match gave us additional dollars that allowed people in the state plan programs to increase their number of hours, number of services.” Without the enhanced match, the state may not have been able to afford the additional services individuals in the state plan program were to receive through CFC.

In Texas, the enhanced match was also critical for the state to pursue CFC: without the additional federal revenue the state would have been unlikely to have adopted this option. Most interviewees highlighted the important role the enhanced match played in the decision to pursue CFC. Interviewees conveyed “I don’t think without an enhanced FMAP [Federal Medical Assistance Percentage] that they would have pursued it” (provider representative) and “I think that was crucial and that it wouldn’t have happened without that enhanced match” (state bureaucrat). The extra 6% Federal Medical Assistance Percentage was important for Texas because the state utilized this additional revenue to offer services to an underserved population – individuals on an ID/DD waiver waiting list. Prior to CFC, Texas had over 100,000 individuals with ID/DD waiting for 1915(c) services who were not eligible for other Medicaid HCBS benefits. With CFC, these individuals were now eligible for habilitation and personal assistance services. The enhanced match also helped address concerns about the entitlement nature of CFC. According to a state bureaucrat, “I’m sure that there was also probably some concern about creating a new entitlement benefit and that the enhanced match sort of helped mitigate those

concerns.” The 6% enhanced match is critical for Texas to continue offering CFC services. In 2017, the American Health Care Act passed by the U.S. House of Representatives proposed eliminating the 6% enhanced match for CFC, and several interviewees indicated that they expected Texas would eliminate CFC if the enhanced match ended.

Interest Groups: Advocates Encouraged States’ Pursuit of Community First Choice

Advocates for individuals with disabilities played a larger role in some states’ adoption of CFC than BIP; however, the final decision to pursue CFC was made by officials within state government. According to national interviewees, “in some of the states that adopted it, I think it came from the advocates really pestering the state to take a look at it and to run the numbers” (aging advocate) and “we’ve had a number of conversations with states who have reported to us that their advocates are pressing the state to move forward with it” (ID/DD advocate). According to a national consultant, the role of interest groups has varied by state,

Oregon, it was the union that really led the state to the water. California, it was common sense. New York, I think the advocates were really instrumental there, in getting the governor to agree to take it up. I think it depends on the state and the advocacy community. Like they tried to do in Colorado, but they weren’t successful in persuading the state to take it up.

Although consumer advocates have been vocal in their support of CFC, many states have been cautious because CFC is an entitlement that could impose significant new costs in the state budget. States adopting CFC are exposed to the additional costs in the transition to CFC, the ongoing expenditures of the program, and the potential added cost to the state if the federal government eliminates the 6% enhanced match. Therefore, many states that adopted CFC modeled the cost implications and sought to understand what this new benefit would entail.

While consumer advocates were important for some states to consider CFC, strong endorsement from high level state agency officials was also necessary for states to pursue this option.

In Maryland, advocates were supportive of the state pursuing CFC and worked to encourage the adoption of this program. Between the advocacy community and the Maryland Department of Health and Mental Hygiene, there was consensus that CFC would be beneficial for the state. Even before CFC was in federal legislation, advocates in Maryland supported this program at the national level. According to a physical disability advocate, “we were trying to get this option through at the federal level. And we really felt it offered some new opportunities for people with disabilities in Maryland ...we asked the state to apply. We encouraged them.” After CFC was included in the ACA, physical disability advocates met with officials in the state, including the governor, to promote Maryland adopting this program. A physical disability advocate conveyed

We got involved because of a strong relationship between DHMH [Department of Health and Mental Hygiene] and the advocates. I had an opportunity to sit down with our governor at the time and let him know, along with several other people, how important it was and that it was the right thing to do.

In the quote above, the interviewee highlights that advocates’ relationship with the state agency and governor played a role in the adoption of CFC. The collaboration and consensus between the advocates for individuals with physical disabilities and the state Department of Health and Mental Hygiene facilitated Maryland’s decision to pursue the program.

In Texas, consumer advocates and providers were supportive and played a role getting the state’s adoption of CFC into state legislation. Key stakeholders in HCBS policy, both within and outside of state government, agreed that pursuing CFC made sense for Texas. According to

one representative of local ID/DD authorities¹⁶, “there was fairly broad consensus from stakeholders, from the advocacy communities, from the provider community, and from the state that this [CFC] would be a good thing.” Consumer advocates, provider representatives, and officials within state government worked with the Texas Legislature to pass Senate Bill 7 which required the Health and Human Services Commission to pursue the most cost-effective option for basic attendant and habilitation services to individuals with disabilities. According to one cross disability advocate, “we were very strongly involved. We got it actually in legislation. We were one of the principle advocacy organizations involved.” In addition to external advocacy organizations, state bureaucrats also played key role in enacting Senate Bill 7. As discussed in more detail below, the Health and Human Services Commissioner was perceived as a pivotal figure in discussions with state legislators regarding Texas’ pursuit of CFC.

In Oklahoma, which did not pursue CFC, the program did not receive a lot of attention from consumer advocates. According to a consultant, “(k) waivers [CFC], I don't even think was on the radar of many people. And certainly not many advocates.” This sentiment was reiterated by an advocate for individuals with physical disabilities who indicated, “I am not as familiar with it [CFC] as I need to be.” Both quotes reiterate that most advocates lacked awareness about CFC. One reason advocates in Oklahoma have not pushed the state to explore CFC was that their primary focus over the last few years was on avoiding cuts to existing HCBS programs rather than looking to expand HCBS offerings. The lack of advocacy effort around CFC was likely among the reasons Oklahoma has not explored in depth adopting CFC.

¹⁶ In Texas, local intellectual and developmental disability authorities conduct eligibility determinations and provide case management to individuals receiving publically funded ID/DD services including institutional services and HCBS services.

Governing Capacity: State Medicaid Officials Played Key Role in Adoption Decision

Although interest groups were active in prompting states to explore CFC, the ultimate decision to adopt this option was decided by officials in state government. In both Maryland and Texas, specific individuals in the state Medicaid office played a crucial role convincing others within state government that pursuing CFC made sense for their state. In Maryland, the Medicaid director and in Texas the Health and Human Services Commissioner played a key role. Both were champions of CFC within their respective states. While consumer advocates and provider representatives were also supportive of the program and advocated for the program at the legislature and governor's office, interviewees in both states highlighted the importance of state bureaucratic leaders in their state's adoption of CFC.

In Maryland, the state Medicaid director at the time CFC was adopted was Chuck Milligan. Under his leadership, officials in the state Medicaid office examined the different LTSS opportunities in the ACA to see which made sense for the state to pursue given its HCBS goals. Based on their analysis, Maryland decided pursuing BIP and CFC would benefit Maryland's HCBS system and achieve several of the goals of the Long-Term Care Workgroup. Staff from several different organizations highlighted the importance of the Medicaid director in pursuing CFC. "At the time we had a Medicaid director who was very focused on the whole long-term care and how much that was costing Medicaid ... I think it [CFC] was kind of personally driven by him" (provider representative) and "having a Medicaid director in our state that, may not always agree with him but most of the time his heart was in the right place and he understood it and he wanted to make sure it [CFC] was implemented" (physical disability advocate). Maryland's Medicaid director recognized the benefits of CFC in addressing inequities across programs and in ensuring a consistent service planning process for individuals who

receive personal care services. He was able to convince the governor and state legislators that pursuing CFC was the right decision for the state.

Similarly, in Texas, the Health and Human Services Commissioner, Chris Traylor, played a crucial role in the state's adoption of CFC. The Commissioner was able to convince both the governor and state legislature that Texas should adopt CFC. He was also able to help allay political concerns of CFC being within the ACA. Said one cross-disability advocate, "the Health and Human Services Commissioner at that time ... Chris Traylor, was instrumental in getting CFC." According to a state bureaucrat, a key factor in Texas' adoption of CFC was "strong leadership at the state agency level, to the extent that when we were faced with the opportunities in the Affordable Care Act, specifically the Balancing Incentive Program, and CFC program, we were able to maximize those opportunities." In Texas, Senate Bill 7 required the Health and Human Services Commission to pursue CFC; however, Chris Traylor played an important role in getting the legislature to include CFC in Senate Bill 7. Reported one state bureaucrat, that while the

Promoting Independence Advisory Committee...was definitely vocal in support of adding that benefit [CFC]. Really, I would say, probably, the biggest champion was our executive commissioner of Health and Human Services at the time. His name was Chris Traylor. He was very active in talking to legislators about the benefit.

This quote from a state bureaucrat highlights advocates and, more importantly, the Health and Human Services commissioner were lobbying the legislature to adopt CFC. With strong advocacy from state agency leadership, the Texas state legislature included CFC in Senate Bill 7 which focused on redesigning the LTSS system for individuals with intellectual and developmental disabilities.

While both Maryland and Texas had strong advocates for CFC within state government, this leadership was lacking in Oklahoma. In Maryland and Texas, bureaucratic leaders within state government recognized the potential benefits of CFC to the state to address existing problems – inequities across programs in Maryland and long waiting lists in Texas – through the enhanced match. Several interviewees in Oklahoma indicated that innovative or strategic thinking and leadership was lacking within HCBS policy development in their state. Said interviewees “we’re as guilty as the state and not being enough forward thinkers,” “leadership at the time just was not, I don’t know a good word, they just weren’t aligned with Community First,” (state bureaucrat) and a former state bureaucrat conveyed “I think that we could look back on that as probably a lack of strategic foresight.” Without advocates or state officials contemplating how the state could potentially utilize CFC, Oklahoma lacked a leader to shepherd the state through the policy adoption decision.

Existing Home and Community-based Services Programs: States Moved Existing Offerings into Community First Choice

States are largely utilizing CFC to refinance existing Medicaid HCBS benefits and take advantage of the additional 6% federal match for services already provided to offer additional services. Many states offer services similar to CFC through state plan personal care programs or 1915(c) waivers but are receiving the traditional federal match for these services. According to one federal official, “it’s [CFC’s] most attractive to a state where you can literally refinance your personal care program and then just not change one iota of what you’re doing but walk away with six more federal match points.” California was one example of a state with an extensive state plan personal care program and was the first state to apply for CFC. Several other states are utilizing the enhanced match from refinancing an existing benefit to address problems in their

LTSS systems. By receiving additional federal money for existing services, states can address inequities across populations or offer services to new populations.

The adoption of CFC in Maryland allowed the state to address several issues with existing HCBS programs. Prior to CFC, Maryland provided personal care through the state plan personal care benefit and 1915(c) waivers. Recipients of state plan personal care and two waivers had similar needs but the waivers provided more hours of the same types of services to participants. In addition, each program had different provider rates, which created further inequities across programs. Lastly, one of Maryland's 1915(c) waivers was out of compliance with CMS's cost neutrality requirement, which necessitates that waiver services be less costly than institutional care. According to a state bureaucrat, "we ended up being out of compliance in our process, so being able to implement Community First Choice kind of made everything consistent." This quote indicates that the adoption CFC addressed Maryland's issues of being out of compliance with its 1915(c) waiver and inequities in services across programs. By moving both the personal care in the state plan and personal care in waivers to CFC, the state received extra matching funds, which allowed the state to increase the service plans for personal care recipients and ensure consistent rates for providers. In the process of adopting CFC, Maryland merged its Living at Home and Older Adults waivers and took personal care services out of the waivers because these services were now being provided through CFC. With these changes, Maryland's waiver now met CMS's waiver cost neutrality requirement. By adopting CFC, Maryland was able to address inequities in services and compliance issues across its HCBS system.

Similar to Maryland, Texas also refinanced its state plan personal care program to take advantage of CFC's additional match and provide services to a new population. Texas' CFC

program was largely enacted to serve individuals on an ID/DD waiting list. In Texas, over 100,000 individuals were on the waiting list for ID/DD waiver services and waited, on average, ten to twelve years. The state was able to expand services to this population through the additional 6% federal match on services Texas was already providing. According to one former state bureaucrat, “we already had that [personal care] as a state plan amendment, the idea was, ‘Okay we get 6% enhanced for that piece.’” The additional 6% match for the state’s existing personal care program allowed Texas to expand HCBS to the ID/DD population. According to one ID/DD advocate,

We were already largely providing the services. So this was an enhanced match on services that we were already providing, and so those funds that we got on top of those services that we were already providing paid for the people who weren't getting those services.

The additional federal revenue Texas received for existing state plan and waiver services allowed the state to offer personal care and habilitation to individuals with ID/DD.

Texas also saw CFC as a way to expand managed care within the state. Over the last several decades, Texas has been moving more and more long-term services and supports into managed care. The state has a robust managed care system, STAR Plus, for many Medicaid recipients. Prior to pursuing CFC, Texas expanded managed care to include its 1915(c) waiver, which serves individuals who are elderly or physically disabled. By moving these waiver services into managed care, the state largely eliminated the waiting list for that waiver. Before CFC the ID/DD population was largely served through fee-for-services programs; therefore, an additional goal of CFC was to enroll individuals with ID/DD into a managed care plan.

According to a former Texas state bureaucrat CFC “would be an introduction of the [ID/DD]

program into a managed care type of system. I think that was sort of a side benefit” and CFC “was also going to be a piece of moving us towards managed care” (ID/DD advocate).

Individuals with ID/DD enrolled in CFC would receive services through a managed care organization. The individuals would develop relationships with managed care organizations and the managed care organizations would learn more about the services and supports for individuals with ID/DD. For Texas, a benefit of pursuing CFC was greater integration of LTSS programs in a managed care environment.

External Factors: Lack of Centers for Medicare and Medicaid Services Clarification on Requirements Created Confusion

One impediment to states’ adoption of CFC was the initial lack of guidance from CMS around the specific requirements of the program. According to one national consultant, the low number of states adopting CFC may be due to “uncertainty about certain requirements of 1915(k) [CFC] because there’s no manual or guide of any kind ... I just think that CMS needs to do more work to explain what the expectations are.” One specific question states had about CFC was whether participants needed to meet an institutional level of care. California submitted its CFC state plan amendment prior to CMS clarifying that participants need to meet an institutional level of care. As a result, the state needed to submit a subsequent state plan amendment limiting the CFC program to only those who were clinically eligible for institutional care.

State officials in both Texas and Maryland also confirmed that there was some confusion around the program requirements during the state plan amendment approval process. One state bureaucrat from Maryland conveyed that CMS lacked programmatic details. According to the interviewee,

There was a lot discussion about case management, what's allowed, what's not allowed, what is technology, what isn't technology, those types of details. That took a lot to figure out for them [CMS]. Since we were one of the first couple to be approved for CFC, we were kind of one of the guinea pigs.

This interviewee highlights that, because Maryland was one of the first states to apply for CFC, CMS lacked clear requirements for the program and needed to figure them out with the state. Other states may have similarly been reluctant to pursue this new benefit when CMS was unclear about what specific benefits were available through the program.

Texas' experience adopting CFC also suggested uncertainty from CMS around the program requirements. According to one state bureaucrat in Texas, "there was a lot of confusion at CMS, too, about what they meant by 100% or 300% or 150 ... there was confusion about what the eligibility criteria really was." In this quote, the state bureaucrat identifies that CMS was unclear about what the financial eligibility was for CFC. Texas had projected potential CFC demand based on an initial understanding of the program requirements but needed to re-run their numbers after further clarification from CMS. Other states were likely reluctant to consider a new program when there was uncertainty about the program requirements and eligibility. Since eligibility criteria is a key factor in determining how much a new program will cost a state, some states were likely dissuaded from taking up this option because of the initial lack of clarity from CMS around who can enroll in CFC. Subsequently, CMS issued further guidance to the states about CFC. In 2012, CMS released a fact sheet about the Community First Choice Option final rule and in 2016 CMS sent a letter to state Medicaid directors regarding eligibility and specific requirements of the program.

1915(i) Home and Community-based Services State Plan Benefit

State bureaucrats played an important role encouraging more HCBS in the mental health arena through Maryland and Texas' adoption of the 1915(i) HCBS state plan benefit. For several years, both states were focused on providing Medicaid HCBS benefits to individuals with serious mental health conditions. However, due to Medicaid regulations, states had limited options to serve these individuals because of the institutions for mental disease exclusion.¹⁷ The 1915(i) opportunity provided leaders within state government with an option to serve this population. However, since the 1915(i) is an entitlement benefit, both Maryland and Texas very narrowly defined the population they are serving in an effort to manage costs. For other states, the entitlement nature of this benefit and the inability to implement a waiting list were barriers to adopting the 1915(i) option. The main reasons states have not adopted the 1915(i) were that states were concerned about the potential cost of the program and coming up with the state match for a new benefit.

Political or Ideological Factors: Political Opposition to Affordable Care Act Less Relevant for 1915(i) Benefit

Opposition to the ACA was less relevant in states' decisions regarding the adoption of the 1915(i) HCBS state plan benefit compared to BIP and CFC. One reason for this was that 1915(i) was enacted prior to the Affordable Care Act, under the Deficit Reduction Act of 2005. It was therefore less closely linked with the ACA than BIP or CFC. Prior to the ACA, few states (just 6) had adopted the 1915(i) state plan option (CMS, (n.d. (b))). Thus, the ACA modified the 1915(i)

¹⁷ States have historically used 1915(c) waivers to provide HCBS. 1915(c) waivers require that an individual be at an institutional level of care to be eligible for services. Institutional level of care includes nursing facilities and intermediate care facilities for individuals with ID/DD but excludes institutions for mental disease for individuals with serious mental illness under the age of 65. As a result, states have not been able to utilize 1915(c) waivers to provide HCBS benefits to individuals under age 65 with serious mental illness because institutes for mental diseases are not qualified institutes under the 1915(c) statute.

to further encourage state take-up, including allowing states to target benefits to specific populations, adding new service options, and expanding financial eligibility. Thus, the changes to the 1915(i) in the ACA were largely viewed as correcting issues with the original 2005 legislation that had limited its adoption. One issue was the available services under the 1915(i). Under the 1915(c) waiver authority, states could add other services not specifically enumerated in the statute as long as they receive approval from CMS. The original 1915(i) statute, however, listed specific services, and states could not propose additional services. In addition, before the ACA, states could only serve individuals with income up to 150% of the federal poverty level while waiver eligibility has a high income threshold. The changes within the ACA allow states to also provide services to individuals who meet an institutional level of care with income up to 300% supplemental security income. According to one national consultant,

The changes to the [1915](i) were seen as more technical in nature. ...[The available services] was kind of like a drafting error. The services that are enumerated in the statute are limited...that needed to be addressed and cleared up. ... [The financial eligibility criteria] were mismatched ... [and] made it really difficult to end up taking the benefit up. That was one thing that needed to be addressed.

In in this quote, the interviewee identifies some of the issues in the original 1915(i) statute that were remedied in the ACA. Due to the technical nature of the changes, opposition to the ACA was less influential in states' decision-making processes.

Economic Factors: Concerns about Costs Influenced Adoption and State 1915(i) Eligibility Criteria

While BIP and CFC offered states enhanced federal match to encourage adoption, the 1915(i) state plan benefit does not provide states with additional federal revenue. States that

pursue this program receive their traditional Medicaid match rate, which ranged from 50% to 73.58% in fiscal year 2015. The lack of additional federal revenue provided states with less financial incentive to adopt this option. According to one national aging advocate, “what's missing [from the 1915(i)] is an incentive to get states to take it up.” Without extra federal revenue, the state share of 1915(i) services is not partly offset by additional federal money as with CFC and BIP. The difficulty states face coming up with money for new Medicaid programs was one barrier to states’ adoption of this benefit. According to a federal bureaucrat, “the reason why we haven't seen more than what we have today ... [is] the state match.” States faced challenges enacting the 1915(i) without additional federal revenue to reduce the cost to the state.

Another reason states were wary about pursuing the 1915(i) despite changes by the ACA was cost. Prior to the ACA, states were able to limit the number of enrollees and enact waiting lists for 1915(i) services. With the ACA changes, a state must offer the benefit statewide and cannot cap the number of enrollees. Therefore, states must allow anyone who qualifies to receive services; however, the ACA changes also allowed states to target the 1915(i) benefit to specific populations. Under the ACA, states can define the 1915(i) population very, very narrowly in an effort to contain costs. Even with the ability to target specific populations, the inability to limit the number of participants created concerns in some states about the potential demand for this benefit and, in turn, its potential cost, which could limit uptake. According to one national ID/DD advocate, the changes within the ACA “removed the ability of the state to limit the number of people who were served. States have been a little more tepid in taking it up just because they want to make sure that they understand what the potential demand for the services are.” Seconded another national advocate in aging policy, “I think the states also had some concerns about just the sustainability of the program when Congress removed the ability to

create enrollment caps and waiting lists.” States were leery of pursuing 1915(i) state plan amendments due to program costs potentially exceeding expectations and the lack of a mechanism to grow the program slowly. Of the states that have adopted this option, most designed the clinical eligibility criteria very narrowly in an effort to limit enrollment and manage program expenditures.

In Maryland, the inability to cap the number of enrollees was a concern and influenced program design. Maryland’s 1915(i) benefit is limited to children under the age of 18 with serious mental illness. Several interviewees indicated cost concerns were a consideration when pursuing this option: A state bureaucrat reported that “there were a number of concerns about this budget impact ... there were definitely concerns about, since there's no waiting list, how we would limit the influx of people, of kids, into this.” According to a consultant:

One of the challenging things was this idea that you couldn't cap it and that you had to go statewide within five years. So, I think those made the state a little nervous. And in response, the state was more restrictive in its design because it couldn't cap participants, so it had to make sure it could control costs somehow.

To address these concerns, Maryland adopted very stringent eligibility criteria for the program in an effort to limit the number of children eligible for 1915(i) services and control costs. To be eligible for 1915(i) services, children need to have three psychiatric hospitalizations in the past twelve months. One mental health advocate lamented that the eligibility criteria for the 1915(i) is more stringent than criteria for an institutional setting. However, without the ability to limit the number of enrollees, the state felt that there needed to be a high eligibility threshold to manage program costs.

In Texas cost concerns were similarly a paramount focus and shaped the state’s eligibility criteria for 1915(i) services. According to one ID/DD advocate, the thinking was “1915(i), it’s gonna be an entitlement, so we’re at risk of a cost explosion. So let’s define the population very, very, narrowly and that’s how we will anticipate or prospectively control costs.” As with Maryland, Texas set the eligibility threshold for 1915(i) services very high. In the state’s original 1915(i) state plan amendment¹⁸, an individual needed to reside in an inpatient psychiatric hospital for three or more consecutive or cumulative years over the last five years. Based on available data, the state estimated that approximately 100 individuals statewide would meet this eligibility criterion. Instead of limiting the number of enrollees based on the clinical eligibility criteria, Texas state officials indicated they would have preferred having the option to grow the program more gradually by utilizing a waiting list for this program, which the ACA eliminated. According to a state bureaucrat in Texas, it would be beneficial “to have limits on the number of people or service areas so that you can target the approach a little bit more. It would be very helpful and would actually increase adoption I think.” In this quote, the interviewee indicates that more states might adopt the 1915(i) if states could cap the number of enrollees or limited the benefit to specific geographic regions within the state. Without the ability to limit enrollees or target regions, Texas required 1915(i) enrollees to have a lengthy stay in an inpatient psychiatric hospital. With this stringent eligibility criterion, state officials were confident they knew who would be eligible for services and could manage the cost of the program.

As with CFC, the entitlement nature of the 1915(i) and the state share program spending were among the reasons Oklahoma has not pursued a 1915(i) state plan benefit. With Medicaid

¹⁸ In 2016, Texas revised its 1915(i) state plan amendment to provide services individuals who experienced 4 or more arrests and 2 or more psychiatric crises in the last three years or 15 or more emergency department visits and 2 or more psychiatric crises in the last three years.

entitlement benefits, states cannot utilize waiting lists and are at risk of cost overruns. Although with the changes to the 1915(i) in the ACA, states can now target specific populations in an effort to limit enrollment and control costs. An Oklahoma consultant indicated one reason the state did not pursue the 1915(i) was “because it would make services an entitlement, because you could put them into the state plan and, that means, you know, you can't turn anybody away.” Oklahoma’s ability to offer new HCBS programs such as the 1915(i) has thus been hampered by budgetary limitations and an inability to come up with the state match from the state general fund to provide this benefit. According to two state bureaucrats, “it [the 1915(i)] is off the table because, again, we would have to come up with a state match” and “since it [the 1915(i)] is an expansion of existing services, we're just trying to kind of stay above water right now.” Both state bureaucrats identify the added cost of a new state plan benefit as one reason Oklahoma has not adopted a 1915(i) benefit. Without budgetary resources, Oklahoma has not been able to expand HCBS programs and instead has focused on preserving existing benefits. Interviewees indicated that if Oklahoma were to explore expanding HCBS offerings, the state would do so in a way that was manageable and potentially target unserved regions of the state rather than be available statewide to everyone who met the criteria.

Interest Groups: Advocacy Groups Encouraged and Worked with State Officials on Developing 1915(i)

In Maryland, interest groups were involved in the decision to pursue the 1915(i). Under the Psychiatric Rehabilitation Treatment Facility grant, Maryland state officials were working with the core services agencies, which are the local mental health authorities in the state, along with advocates for children with mental health issues. When the grant ended, individuals involved in the grant -- including the state Behavioral Health Administration and the core service

agencies -- wanted to figure out a way to continue providing services to this population. A group of representatives from core service agencies met with the Behavioral Health Administration, the state Medicaid office, and The University of Maryland School of Social Work contractors to develop the 1915(i) program. They held a weekly workgroup meeting to discuss the design of the program including eligibility criteria and services offered through the 1915(i) benefit. According to several interviewees, stakeholders played an important role in the state's decision to pursue this option. "There was a lot of stakeholder interest in, you know, these very vulnerable youths who otherwise require inpatient treatment" (state bureaucrat) and "I think it was [the] five core service agencies that really, really pushed to get this done" (representative from local authority). Others from the advocacy community, however, felt like the decision to pursue the 1915(i) was largely made within state government. According to another interviewee from a different local authority, "I did participate in that discussion, but I'm going to be very honest. When it came to the actual decision, I feel like that was a decision made between Medicaid and the Behavioral Health Administration." This perspective is reflected in the views of one mental health consumer advocate who reported that "the decision to submit the amendment was made independent of our organization. It was the decision of BHA [Behavioral Health Administration] and Maryland Medicaid." While stakeholders may have encouraged and supported the state of Maryland to pursue this option, the Behavioral Health Administration and state Medicaid office were responsible for the final decision and deciding the specific features of the program.

In Texas, the decision to pursue the 1915(i) for individuals with serious mental illness brought together the state legislature, state bureaucrats, and advocates for individuals with mental illness. According to one Texas state bureaucrat,

A lot of the stakeholders are very connected with the legislatures and want to make sure when session comes around that they understand what some of the main barriers are and some of the past several sessions mental health or behavioral health if you will, had a lot of focus and it is due to external stakeholders as well as internal stakeholders in the department raising these issues in front of the legislators.

With both state bureaucrats and mental health consumer advocates supporting increased emphasis on mental health, the Texas state legislature required the state to examine this issue. Prior to the adoption of the 1915(i), the Texas state legislature directed the Department of State Health Services and the Health and Human Services Commission to explore options to address the HCBS needs of individuals with mental health issues. In 2011, House Bill 1 of the 82nd legislative session required the Department of State Health Services to contract for a “review of the state’s public mental health system and make recommendations to improve access, service utilization, patient outcomes, and system efficiencies.” During the same legislative session, House Bill 2725 required that the Department of State Health Services and the Health and Human Services Commission to examine providing HCBS to individuals repeatedly committed to state psychiatric facilities so they could be competent to stand trial. In addition, after Texas submitted its initial 1915(i) state plan amendment, the state revised it to include individuals in jails and those with repeat emergency room visits for mental health conditions. These changes came about through legislation out of the 84th Texas Legislative session and external stakeholders, including the National Alliance on Mental Illness, Mental Health America, and community mental health centers, played a key role in the expansion of 1915(i) eligibility to these populations. According to a state bureaucrat, “the external stakeholders spoke with the

legislature and identified these two other high risk populations for individuals with serious mental illness and it was kind of a natural inclusion.”

Similar to other ACA HCBS programs, interest groups did not play an active role in pressuring state officials in Oklahoma to consider adopting a 1915(i) program. The 1915(i) had not been on many advocates’ radar because the attention in recent years has been on preserving existing services rather than adding new programs. In addition, according to a physical disability advocate, in the state of Oklahoma, the focus is on providing Medicaid services to the very neediest. Since the 1915(i) requires a lower level of need than institutional level of care, the state of Oklahoma was unlikely to provide services to these populations. Given the state’s priorities, advocates were less focused on the 1915(i) option. According to a state bureaucrat,

I don't think I have heard anyone in the advocacy community flat out say, "Hey, 1915(i) is a good idea. What do you guys think about it?" I haven't heard any of our advocates that are the most vocal and most frequent spokesperson really talk about this.

Without advocates encouraging the state to pursue a 1915(i), this Medicaid option was not something that the state of Oklahoma has explored in depth. Even if advocacy support existed, the fiscal concerns of a 1915(i) posed a barrier in the state.

Governing Capacity: Bureaucrats in Behavioral/Mental Health Agencies Played an Important Role

In both Maryland and Texas, leadership within the behavioral health/mental health agencies was an important factor influencing the pursuit of the 1915(i) HCBS option. In each state, respondents identified key agency staff who were instrumental in bringing the 1915(i) to fruition. These individuals wanted to increase services for individuals with serious mental illness within their states and recognized that the 1915(i) was a potential avenue to offer these benefits.

In Maryland, the Behavioral Health Administration is responsible for policy and program development for individuals with behavioral health conditions. Within that department, two state bureaucrats within the Child, Adolescent and Young Adult Service division played a critical role in the development of the 1915(i). According to a mental health advocate, Al Zachik “is a very strong leader in the behavioral health administration ... he and Tom Merrick ... were behind the decision to apply for the 1915(i) ... they are very aggressive in trying to bring services to Maryland families and youth.” This point was similarly conveyed by an interviewee at a local behavioral health authority, “Dr. Zachik and Tom Merrick were probably the biggest drivers of that.” Both individuals were involved in the Psychiatric Rehabilitation Treatment Facility grant and had been trying to provide Medicaid services to youth with serious mental illnesses prior to the grant. With the grant ending, they were instrumental in finding another mechanism, the 1915(i) option, to continue to serve this population.

In Texas, state bureaucrats also played an important role in the state’s decision to pursue a 1915(i) state plan amendment. The Department of State Health Services is responsible for behavioral health services in the state of Texas. Prior to the 1915(i), state officials had been exploring ways to better serve individuals with serious mental health conditions and realized the 1915(i) was a mechanism to address these needs. According to a ID/DD consumer advocate in Texas,

We had just really strong state agency bureaucrats, who had been working on projects and who recognized the opportunity and who were able to advocate at the agency level, that, "Hey, we're working on this project, and we've already got support for this thing that we're doing, and this is going to make it cheaper for us to do." So it was really Dina

Stoner at Department of State Health Services ... but she was the person who was really the architect of that program.

The role of the Department of State Health Services in pursuing a 1915(i) was reiterated by an advocate for individuals with mental health, who conveyed “my best guess is that it was largely driven by people within the State Health Agency.” The desire to address issues in behavioral health led state bureaucrats to settle on the 1915(i) as the best option to offer these services.

Existing Home and Community-based Services Programs: 1915(i) Addressed Lack of Existing Programs for Mental Health

The 1915(i) has often been used by states to fill the void of Medicaid HCBS programs for individuals with serious mental illness. Historically, one challenge to providing Medicaid HCBS to this population was the institutions for mental disease exclusion. Under this exclusion, institutions for mental diseases cannot determine eligibility for 1915(c) waiver services for individuals under age 65. Therefore, states cannot use 1915(c) waivers, which have been the main vehicle for HCBS, to provide services to individuals with serious mental illness who are under age 65. Thus, according to one federal bureaucrat,

[The] 1915(i) is primarily being used for people with serious mental illness. It's necessary there because in the past it wasn't possible to cover people with serious mental illness under HCBS waivers because the institutions they were at risk of entering were not Medicaid-funded institutions for the most part.

In the quote above, the federal bureaucrat highlights that states are using the 1915(i) option to provide HCBS to individuals with serious mental illness because the 1915(c) waiver is not an option for providing HCBS to this population. The reason being the 1915(c) waiver requires that eligible individuals meet an institutional level of care for hospital, nursing facility or

intermediate care facility. In contrast, since the 1915(i) requires that eligibility be less than an institutional level of care, this Medicaid benefit allows states to cover individuals with serious mental illness.

Prior to the 1915(i), some states were providing HCBS to individuals with serious mental illness through other funding sources such as state general funds or grants. With this Medicaid option, some states recognized that they could receive federal funding for services they were already providing through the state budget. According to national interviewees, “1915(i) provides a way for states to capture federal financial participation for services that they were already providing in many cases, but doing so through unpredictable grants from SAMSA [Substance Abuse and Mental Health Services Administration] or through general fund revenues” (national consultant) and “in some cases, they were services that they were providing under state only funds that they were now bringing into the 1915(i) so that they could receive the FFP [federal financial participation]” (federal bureaucrat). Therefore, some states have adopted the 1915(i) as a way to substitute existing state or grant funded services with 1915(i) services for this population. By moving these services from the state general fund to Medicaid, states can take advantage of new federal revenue.

As with other states, Maryland had struggled with providing Medicaid HCBS to individuals with serious mental illness for several decades. The state sought several avenues to offer these services to children and adolescents with mental health issues. According to a state bureaucrat, the “1915(i) was sort of a replacement for a couple of decades of efforts on our part to get home and community based services for kids and their families.” Maryland initially submitted a 1915(c) waiver to serve this population but was denied by CMS due to the institutions for mental disease exclusion. Subsequently, the state participated in the Community

Alternatives to Psychiatric Rehabilitation Treatment Facility Demonstration Grant beginning in 2005. Through the grant, Maryland had 80 slots per year to provide individual ages 6-21 with care coordination, mental health, and medical services. Congress did not extend the grant and it ended on September 30, 2012; therefore, Maryland looked for other ways to continue providing these services. In addition to the 1915(i), state officials and their consultants at the University of Maryland School of Social Work explored other options including targeted case management, 1915(b), 1915(c), 1115 waiver, Money Follows the Person, and Health Homes pilot. However, the 1915(i) was seen as the best option to replace the demonstration grant. According to a consultant in Maryland, “Congress hadn't done anything that would enable states to make that [the Psychiatric Rehabilitation Treatment Facility grant] a permanent waiver option, that [1915](i) came along just at the right time pretty much for states to be able to use it as ... not a perfect match, but pretty close in many instances.” The benefits of the 1915(i) as a replacement for the grant were that individuals did not need to meet an institutional level of care, the program was not time-limited, and it could offer services similar to the demonstration grant.

For Texas, the 1915(i) was a mechanism to address an issue the state had been grappling with. In the years prior to adopting the 1915(i) Texas explored ways to improve its behavioral health services. In 2011, two Texas state legislative bills required the Health and Human Services Commission to conduct studies that explored ways to improve the behavioral health system and deliver HCBS to individuals with repeat commitments to state psychiatric facilities. According to an ID/DD advocate, “it was, right place, right time kind of thing. We were already in the process of trying to do something on the mental health side, and specifically addressing people who were churning in and out of state hospital facilities.” The state was spending a significant amount of money on inpatient treatment for individuals with serious mental illness.

According to a state bureaucrat, “it's quite expensive for the state to pay for individuals to reside in an inpatient setting 'cause of the staffing, the facility costs and everything that goes into that.”

To address this issue, the state of Texas proposed either a 1915(i) state plan amendment or Regional Healthcare Partnership Delivery System Reform Projects under the Texas 1115 transformation waiver.

External Factors: States Observe how Other States Use the 1915(i) Option

External factors played a role in some states' pursuit of the 1915(i). One benefit of this Medicaid option is the flexibility it provides states. With this option, states can target benefits to a specific population and, with the changes made by the ACA, offer targeted services. In addition, unlike 1915(c) waivers, the eligibility criteria does not require an individual be at an institutional level of care to qualify for 1915(i) services. Since there is substantial flexibility to design a 1915(i) benefit, states are looking at what other states are doing with this option to address HCBS needs, particularly for individuals with behavioral health issues. One national consultant indicated the number of states with 1915(i) benefits should increase as states observe what other states have done with this Medicaid option. “States that are thinking about it are looking at the states that have adopted it. And seen that it's been successful, and so that tends to turn into a virtuous cycle and I think more and more states will adopt 1915(i),” according to the interviewee.

Both Maryland and Texas looked at how other states were providing services to individuals with serious mental illness when considering their policy options. In Maryland, the University of Maryland School of Social Work, with which the Behavioral Health Administration contracted for the demonstration grant and development of the 1915(i) application, had ties with other states through other grant opportunities. Through the Children's

Health Insurance Program Reauthorization Act Quality Demonstration grant, the School of Social Work was partnered with the Center for Health Care Strategies and the Human Service Collaborative, which was “very in tune with what different states were doing.” In addition, Maryland connected with other demonstration grantees to see how other states would continue these services after the grant ended. According to a consultant, “we had our other PRTF [Psychiatric Rehabilitation Treatment Facility] demonstration waiver states that we were talking to. You know, we had lots of conversations with all them as we debated different options to sustain the demonstration project.” By talking with other states, Maryland explored potential replacement options for the Psychiatric Rehabilitation Treatment Facility grant.

Prior to adopting the 1915(i), Texas produced several reports on how to improve its behavioral health services. In a 2012 report prepared by Public Consulting Group, one recommendation was to pursue a 1915(i) to provide services for individual with mental illness. The report cited Louisiana, Oregon, and Wisconsin as three states that have utilized the 1915(i) to serve this population and “call[ed] for Texas to develop a 1915(i) SPA [state plan amendment] for their target population to provide supportive services similar to those covered under the Wisconsin 1915(i) SPA, notably the community living support services, supported employment, and peer supports” (Public Consulting Group, 2012). Through their research on other states' HCBS programs for individuals with serious mental illness, Public Consulting Group recognized that potential of the 1915(i) to meet the needs of Texas' behavioral health system redesign.

Conclusion

As discussed in the cases of Maryland and Texas, two key factors in states' adoption of the ACA HCBS policies were leadership within state government and the existing HCBS

programs and goals within the state. In both states, state bureaucrats recognized the potential benefits of these programs to improve HCBS offerings in their state. These leaders within the Medicaid and health and human service agencies were able to demonstrate the value of these programs to the governor, legislators, and external stakeholders. In addition, these programs aligned with the vision and goals of what the states were doing in HCBS policy and where they wanted to go. The three programs from the ACA complemented the existing HCBS offerings and goals of both states; therefore, leadership within these states was able to leverage these new policy opportunities to achieve rebalancing goals.

The main barriers to states' adoption of the ACA's HCBS policies were budgetary and cost concerns. States were wary of adopting CFC and the 1915(i) because both options are entitlements, lacking the ability to limit enrollment as a way to control costs. A state official from Oklahoma indicated that if the state were looking at expanding HCBS programs in the future, waivers would be more attractive than state plan services because of the ability to create a waiting list, if needed. For states, another barrier to offering these new HCBS programs was funding the state match for these services. State officials in Oklahoma felt that they could not budgetarily support adding new Medicaid HCBS programs given the state's economic situation. For CFC, the 6% enhanced match helped offset the added state costs but for some states, that was not sufficient incentive to make this program attractive to their state. A final barrier to some of these programs was their inclusion within the Affordable Care Act. Traditionally, rebalancing long-term services and supports enjoys bipartisan support. However, the inclusion of these policies within the contentious ACA legislation hindered the ability of some states to pursue these opportunities.

CHAPTER 7

QUALITATIVE RESULTS: IMPLEMENTING THE AFFORDABLE CARE ACT'S HOME AND COMMUNITY-BASED SERVICES PROGRAMS

This chapter discusses the facilitators and barriers states have encountered when implementing the Balancing Incentive Program (BIP), Community First Choice (CFC), and the 1915(i) Home and Community Based Services (HCBS) state plan benefit. As with the previous chapter, the data from this chapter is based on national interviews and interviews with state-level individuals involved in HCBS policy in Maryland and Texas. Interviewees included federal bureaucrats, national advocates, state bureaucrats, state-level consumer advocates and provider representatives, and consultants. National interviewees spoke of the facilitators and barriers across states while state-level interviewees identified facilitators and barriers to implementation in their respective states. Implementation facilitators and barriers varied across the three programs. Common facilitators of policy implementation across at least two of the programs included communication with federal officials, enhanced funding, and integration with existing programs, while common challenges included aggressive timelines, limited engagement with stakeholders, and federal regulations.

The remaining sections of this chapter are structured as follows. The first section discusses the facilitators and challenges implementing the Balancing Incentive Program, the second section focuses on Community First Choice, and the third section concentrates on the

1915(i) HCBS state plan benefit. Each of these sections is organized first discussing facilitators of implementation and then barriers. The final section summarizes this chapter.

Balancing Incentive Program

The Balancing Incentive Program was unique in that the program existed for a relatively short time period but participating states received a substantial amount of funding. Factors that facilitated Maryland's and Texas' implementation of BIP were regular communication with the Centers for Medicare and Medicaid Services (CMS) and their consultants, Mission Analytics Group (Mission Analytics),¹⁹ and merging BIP with existing programs including Money Follows the Person and Aging and Disability Resource Centers. In addition, leadership within state government and the substantial amount of funding associated with BIP helped the implementation process. The short duration of BIP presented a challenge for states because they needed to enact multiple changes within a limited period of time. In addition, state processes, especially around procurement and contracting, impeded the speed with which the BIP requirements could be met within the limited timeframe provided for implementing the program. External stakeholders, including consumer advocates and provider representatives, often felt as though their state implemented BIP with minimal input from external groups. Determining how to spend the enhanced BIP match also posed a challenge for some states.

Facilitators of Policy Implementation

Communication with the federal government and its contractor.

For BIP, CMS contracted with Mission Analytics to develop the BIP program manual, BIP website, and provide technical assistance to states. The BIP program manual and website provided detailed information about the requirements of BIP and examples of the structural

¹⁹ Mission Analytics is based in San Francisco and provides technical assistance, analysis, and program evaluation to government entities with a focus on health and human services programs.

change requirements. As part of BIP, states needed to meet a spending percentage threshold, either 25% or 50% of all Medicaid LTSS expenditures on HCBS, by the end of BIP in 2015. In addition, states participating in BIP needed to meet three structural change requirements: develop a No Wrong Door/Single Entry Point system to access long-term services and supports (LTSS), ensure HCBS case management was conflict free, and include core questions in HCBS program assessment instruments. The BIP program manual clarified for states what the specific requirements were for each of the structural changes. For example, the manual identified the required components of a No Wrong Door/Single Entry Point system, including a website that was accessible for individuals with disabilities and a single 1-800 telephone number for individuals to learn more about HCBS options. In addition, the BIP website provided examples of how states were meeting these requirements.

As part of BIP, officials from participating states also had regular calls with Mission Analytics and CMS to discuss their progress achieving program requirements. State officials in Maryland and Texas recognized the benefits of routine and frequent communication with Mission Analytics. According to a few state bureaucrats in the Medicaid and disability services agencies, “Mission Analytics had a lot of regularly scheduled meetings, and they were very, very helpful” (Texas state bureaucrat) and “we had monthly calls with Mission. They were helpful. I really liked them” (Maryland state bureaucrat). The regular check-in calls were particularly beneficial because of the BIP’s short timeframe from 2011 to 2015. State officials felt that monthly check-ins with Mission Analytics and CMS kept them accountable and ensured they were on track to achieve the various BIP deliverables, including the three structural change requirements and spending a specific percentage of Medicaid LTSS expenditures on HCBS by 2015.

In Maryland, stakeholders outside of state government also appreciated that Mission Analytics was willing to engage with them on BIP's structural change requirements. The core standardized assessment requirement presented challenges for HCBS recipients with behavioral health issues. The state of Maryland was exploring the use of the interRAI assessment tool,²⁰ and individuals in the behavioral health field felt that the questions in that tool were not appropriate for the population they served. Behavioral health providers and advocates supported using the Daily Living Activities - 20²¹ as opposed to the interRAI for individuals with behavioral health issues but faced challenges convincing officials in state government to use this tool. According to a mental health provider representative,

One of the first things that [we] engaged in was a conversation with the consultants to CMS on the uniform assessment tool. The state of Maryland decided to go with the interRAI, which is a very impressive tool, but for purposes of behavioral health it didn't really fit too well...I think what also helped was talking to the consultants at CMS. They were, I think, a lot more open to it and they seemed open to the arguments that that was a much better match for the people we serve.

In the above quote, the mental health provider representative identifies that Mission Analytics was helpful in settling on an assessment tool that better fit the needs of individuals with serious mental illness. The openness of Mission Analytics to consider other assessment tools helped Maryland settle on the Daily Living Activities – 20 for individuals with mental illness who required HCBS. Individuals both within and outside of state government thus recognized the

²⁰ The interRAI Home Care is a tool to assess adults for home and community-based services. The tool includes questions related to physical functioning; cognitive patterns; disease diagnoses; mood and behavior; and informal supports.

²¹ The Daily Living Activities – 20 is a tool utilized for individuals of all ages with mental illness. The tool has twenty indicators (i.e. health practices, communication, safety, managing time), and clinicians and case managers use the tool to identify and address functional deficits.

benefits of consulting with Mission Analytics and the willingness to consider other avenues to meet the structural change requirements of BIP.

CMS and Mission Analytics also tried to give states some flexibility in achieving the structural requirements within the boundaries of the legislation, which facilitated implementation. As discussed earlier, BIP required that states implement three structural change requirements: a No Wrong Door/Single Entry Point system, conflict free case management, and a core standardized assessment. CMS gave states leeway, when possible, based on their interpretation of the requirements. According to a national consultant,

In terms of the assessment instrument, one way of reading the legislation is to say you have to use one instrument for all populations and we argued to CMS that that would pretty much make BIP dead on arrival for all states... We also thought about conflict free case management and how to make that not seem scary. And also how to think about what a no wrong door system would look like for states, and how to make that doable, achievable, within the timeframe that they were given.

In this quote, the national consultant is pointing out not only that CMS gave leeway, but even worked to anticipate ahead of time what might be difficult for states to achieve to head off some of those anticipated challenges. For the assessment instrument, CMS did not require that states adopt a single assessment instrument for all HCBS populations; instead all of the states' assessment tools had to include core elements such as questions about activities of daily living and instrumental activities of daily living. The BIP program manual acknowledged that a

Mass substitution [of existing assessment instruments to a single instrument] would be practically impossible. Instead ... States can make adjustments *to their existing instruments* in a way that will satisfy the requirements of the Balancing Incentive

Program with *minimal effort and with little or no change to existing practices* (emphasis in original) (BIP program manual, 2012).

By allowing states to have multiple assessment tools for different populations, CMS made it easier for participating states to meet this requirement.

With conflict free case management, CMS allowed providers to be case management entities in certain circumstances as long as firewalls and safeguards were in place. Typically, the entity providing case management and conducting eligibility determinations must be separate from the entity providing services to ensure that conflicts of interest do not exist. With BIP, CMS allowed the same entity to provide case management and services as long as the state could demonstrate that policies and oversight were in place to mitigate potential conflicts. The BIP requirement involved “making sure that there were mitigation strategies in place...so that they [the states] could achieve the goal of conflict free, which under BIP wasn't truly conflict free because we permitted mitigation strategies” indicated a national consultant. In this quote, the consultant identifies that states had flexibility in how they could meet the requirement of conflict-free case management which included allowing states to implement mitigation strategies.

CMS and Mission Analytics also sought to make the No Wrong Door/Single Entry Point requirement achievable for states. According to a national consultant, CMS and Mission Analytics considered “how to think about what a No Wrong Door system would look like for states, and how to make that doable, achievable, within the timeframe that they were given.” In addition, the BIP program manual stated that “[t]he NWD/SEP [No Wrong Door/Single Entry Point] system should build on established community LTSS networks to the greatest extent possible.” With the No Wrong Door/Single Entry Point, CMS and Mission Analytics identified

key components of the system for BIP including a single 1-800 telephone number and website for individuals interested in learning more about HCBS options in their state. By giving states flexibility in meeting the program requirements, states were more likely to participate in the program and achieve the structural changes required.

Integration with Money Follows the Person and Aging and Disability Resource Centers.

States that were effective in implementing BIP were able to integrate BIP with existing programs, most notably Money Follows the Person and Aging and Disability Resource Centers. According to several national interviewees, “states that were the most successful, I think, combined it with other things. They combined what they were doing with BIP with what they were doing with Money Follows the Person with what they were doing moving to managed care” (national aging advocate) and “some of them, I think, leveraged the synergy between the MFP [Money Follows the Person] money and the BIP monies to good advantage” (federal bureaucrat). By integrating BIP with existing HCBS initiatives, states were able to utilize existing staff’s experience and knowledge in this policy area. In addition, initiatives the states were already working on helped meet the BIP requirements.

These insights were echoed in findings from my case studies. In Maryland and Texas, state officials perceived BIP as continuing their work rebalancing and strengthening their LTSS systems. Both states had robust Money Follows the Person programs that existed prior to the federal Money Follows the Person demonstration and leveraged existing workgroups and staff resources for BIP. Prior to BIP, Maryland had a Money Follows the Person Program workgroup composed of state agency staff, consumer advocates, provider representatives, and program

participants. After the state adopted BIP, the program was combined with the Money Follows the Person workgroup.

In addition, in Maryland the BIP program was managed by the Money Follows the Person program director. In Texas, the state official who oversaw Money Follows the Person also led the BIP effort. By having the same individuals oversee both BIP and Money Follows the Person, Maryland and Texas leveraged staff resources and expertise. According to a national consultant, “since those two programs...have similar goals at a high level, it often made sense to have the same person oversee both programs.”

In both states, many stakeholders outside of government often perceived the two programs as deeply intertwined. Interviewees commented “again, MFP [Money Follows the Person] is part of BIP” (Maryland physical disability advocate), “MFP sort of rolled in with BIP” (Maryland physical disability advocate), and “I can't remember if it was MFP or BIP, 'cause what happened was...some of the things that we were paying for, for MFP, knowing that the money was going to go away, got supplanted by the BIP funds”(Texas intellectual disability/developmental disability (ID/DD) advocate).

In Maryland and Texas, the BIP and Aging and Disability Resource Center opportunities also complemented one another. Both states had successes leveraging their Aging and Disability Resource Center networks to meet the No Wrong Door/Single Entry Point requirement of BIP. In addition, the enhanced BIP funding allowed Maryland and Texas to add additional Aging and Disability Resource Centers and enhance the capabilities of existing entities. Prior to BIP, one challenge states faced with Aging and Disability Resource Centers was that the funding was limited and provided through temporary grants. According to a Texas state bureaucrat,

The ADRCs [Aging and Disability Resource Centers] were excited about [BIP] because they had been struggling along as these sort of unofficial entities that were just grant funded. Pulling money from wherever they could so the BIP gave them an opportunity to professionalize and get more consistent across the state and get on the same IT system and stuff like that.

The BIP funding not only helped support Aging and Disability Resource Centers but existing efforts around Aging and Disability Resource Centers also helped to support BIP. This is reflected in BIP's No Wrong Door/Single Entry Point requirement. Maryland was already working towards a statewide 1-800 number and improved website that aligned with the BIP requirements. A Maryland Medicaid state bureaucrat conveyed,

We did use BIP funds at the Department of Aging. They oversee the ADRC efforts in Maryland. So we helped support their efforts that they were already working on for the No Wrong Door website, for the statewide toll free phone number so we gave them funds for that as well.

Leveraging the already existing Aging and Disability Resource Center infrastructure and initiatives facilitated Maryland's and Texas' achievement of the No Wrong Door/Single Entry Point BIP requirement.

Enhanced federal revenue helped states realize policy goals and meet Balancing Incentive Program requirements.

Through BIP, states received a substantial amount of additional funding which both facilitated implementation but, as discussed later, also created challenges. The enhanced funding made it easier for Maryland and Texas to implement desired changes to their LTSS systems and meet the BIP requirements. Both states had LTSS initiatives that they hoped to implement but

lacked the funding for it prior to BIP. Before BIP, Maryland recognized the need for reliable and validated assessment instruments. In 2010, the state's Long Term Care Reform Workgroup recommended exploring new assessment tools to eliminate homegrown instruments, and the BIP funding helped the state achieve this goal. According to a state Medicaid bureaucrat, before BIP “the core standardized assessment was certainly a want, attaching what ended up being \$106 million made that a, ‘You can't not do this.’” In Maryland, the BIP enhanced funding also made it easier to the state to pursue and implement CFC. State officials knew that in transitioning to CFC, the service costs for the first few years of the program would be high. Under CFC, individuals previously enrolled in the state plan personal care program were expected to receive an increase in services. According to one state bureaucrat,

Rolling out Community First Choice was definitely a big budget impact for the folks that had been previously only been getting personal care, to be able to provide them with the additional waiver-like services. The BIP funding made that a lot easier.

This state bureaucrat highlights that the state expected the initial cost of CFC to be high, and the BIP funding helped the state pay for the ramp up costs of the program. With the BIP funding, the state of Maryland was able to support the additional cost associated with enrollees in the state plan personal care program who transitioned to CFC.

In Texas, the enhanced BIP funding helped the state achieve policy goals of enhancing its Aging and Disability Resource Center network. Before BIP, not all regions of the state had an Aging and Disability Resource Center. A state bureaucrat in a disability agency indicated,

We had an aging and disability resource center program that we had been looking to expand anyway. With BIP funding it was a clear, obvious, way to establish the no wrong door system and a way to get the money to go ahead and do that.

In addition, prior to BIP, one goal of some advocates in Texas was to create a level one screening tool for anyone looking for HCBS programs in the state.²² According to a provider representative, “the funding from the federal government for that piece was absolutely essential to streamline that stuff and get it done.” Before BIP, advocates were told by officials within the state that there was not sufficient funding to implement level 1 screening. The enhanced funding associated with BIP was substantial and it made it easier for states to achieve long-term policy goals to improve their LTSS systems, which aligned with the BIP’s structural change requirements.

State leaders provided resources and leadership.

In Maryland, a few interviewees also highlighted the role of state leadership and staff in the implementation process. With BIP, states needed to achieve many different requirements in a relatively short period of time. According interviewees in Maryland, “this could not have happened without a very strong leader in Medicaid and without very strong state staff on the Medicaid long term care side” (consultant) and “I think we had a really involved Medicaid director at that time. Rebalancing was a really big priority for him and he was very personally involved in a lot of the aspects” (state Medicaid bureaucrat). The state Medicaid director during BIP was Chuck Milligan, who played a key role in the state’s decision to pursue this opportunity. States officials indicated that he gave them the resources they needed to address issues and ensure the deliverables of BIP were met.

²² A level 1 screening is an initial screening for individuals interested in LTSS to determine what programs or services they might need. The tool asks preliminary questions about an individual’s financial situation and functional needs prior to a more comprehensive financial and functional eligibility determination if they are in need of services.

Barriers to Policy Implementation

Short duration of the Balancing Incentive Program presented challenges.

The limited duration of BIP and the need to enact many requirements posed a challenge to both Maryland and Texas. Based on the federal statute, BIP was to end on September 30, 2015. Both states applied for BIP in 2012 and had slightly more than three years to implement the requirements and meet the 50% rebalancing threshold. Even states that applied in the first year had less than four years to meet BIP requirements. This short timeframe put significant pressure on states. Many state-level interviewees lamented BIP's very short timeframe and the challenges that posed for states. According to interviewees in Maryland, “we were trying to do a lot at once, and it was intense” (consultant) and “I think that timeframes were really ambitious” (state Medicaid bureaucrat). Interviewees in Texas concurred that the BIP time period was too short and conveyed that “BIP wasn’t enough time to really do this well. And I think that was probably the ultimate lesson learned” (state disability agency bureaucrat) and that “I think it should have been probably twice as long” (cross disability advocate). CMS did offer states the opportunity to extend the timeline for spending the enhanced federal match. Initially, all states were required to spend the BIP enhanced funding by September 30, 2015. However, CMS allowed states to submit a request to invest the BIP enhanced revenue through September 30, 2017.

State procurement processes and obtaining approvals contributed to delays.

The limited duration of BIP posed particular challenges for state procurement and contracting practices. Interviewees with a national perspective highlighted that several states sought to hire contractors to complete aspects of BIP such as developing information technology (IT) systems and websites; however, by the time states put out Requests for Procurement,

received bids, and selected a contractor, the program was winding down. According to national consultant,

Several states ran into sort of procurement nightmares. They either had a really hard time with their acquisitions procurement folks getting an RFP [Request for Procurement] out the door. It took a while for a couple of states to even get an RFP out.

State officials in both Maryland and Texas also indicated challenges with the state procurement process for BIP. Both states' internal procurement processes slowed down the program implementation. In Maryland, "the items that required procurement just took longer than we had anticipated because Maryland has a lot of rules around the procurement process" conveyed a state Medicaid bureaucrat. In Texas, according to a state bureaucrat in a disability agency, "by the time you even put out bids and contracts and all that, I mean that's a couple years right there...to then do the actual work." In this quote, the Texas state bureaucrat underscores that the state did not have much time for contractors to work on the BIP requirements because it took so long to bring contractors onboard. Since the procurement process was slow and BIP only lasted a few years, both Maryland and Texas needed to scale back some of their aspirations with BIP. As part of BIP, Maryland had originally planned on issuing grants for innovative ideas for service delivery but was unable to achieve this due to delays in the contracting process. Texas initially had ambitions of inter-operability and cloud-based IT systems but needed to scale back these plans due to delays. Thus, the combination of the short BIP timeframe and state procurement rules presented challenges for states that wanted to contract out portions of the BIP work.

Another challenge faced by some states was the amount of approval needed to achieve changes or determine where the BIP money would be spent. Within state government, delays occurred when many different agencies or branches of government needed to sign off on aspects

of BIP. A national consultant noted that “if they were in an environment where everything was scrutinized and things had to go through three or four levels of approval, then it took a really long time for things to get done.” In addition, since BIP could be a substantial amount of funding, some state legislatures became very involved in determining how the BIP-enhanced federal match was spent. According to one Texas bureaucrat, “that's where things got really hard with BIP. I would say that we had to get legislative approval on all the projects and they got much more into the minutiae details than we were used to.” The Texas state bureaucrat draws attention to the fact that the legislature was more involved in the BIP decision-making process compared to other programs in the past which presented challenges.

Challenges communicating and gaining buy-in from stakeholders.

One challenge states faced implementing BIP was seeking input from, gaining buy-in from, and communicating with external stakeholders. In both Maryland and Texas consumer advocates, provider representatives, and local organizations -- including Aging and Disability Resource Centers, Area Agencies on Aging, and local intellectual and developmental disability authorities -- often felt they had limited input in the BIP decision-making process. Those outside of state government indicated that state officials determined where the BIP enhanced funding was spent without adequately considering their input. In Maryland, providers in the mental health realm felt as if the state neglected funding additional mental health services through BIP. While mental health providers were required to adopt a new assessment tool, the Daily Living Activities- 20, because of BIP, they did not realize any additional services or rate increases from the BIP funding. In Texas, state officials compiled a list of potential projects to fund through BIP. While the state sought input from interest groups, stakeholders felt state officials neglected

their input and the final list consisted of initiatives that state officials wanted to pursue. A provider representative in Texas said,

I feel like a lot of the other things that were funded, the things that just made the list for consideration by the committee that I was on just seemed to be like a list of pet projects that people sat around in an ivory tower somewhere at HHSC [Health and Human Services Commission] decided.

While state officials seemed open to stakeholder engagement, the projects ultimately funded were largely based on the desires of bureaucrats and consistent with state government priorities.

States also faced challenges obtaining buy-in from stakeholders around BIP's structural change requirements. Two BIP requirements were that states must have a single 1-800 number for individuals interested in LTSS and that states create a level 1 screening tool. Many states' LTSS systems are decentralized and rely on many different local entities and organizations to provide information and referral and services. Therefore, changes to the LTSS system for BIP required coordination and buy-in with many organizations outside of state government. In Maryland, some local Aging and Disability Resource Centers were hesitant to adopt a statewide telephone number. According to one interviewee,

I think it was pretty complicated getting the statewide phone number up and running.

Every site had their own number and so sometimes they were reluctant to give up their number or to give up some of their control or having these calls come in from this outside source (Medicaid state bureaucrat).

In addition to the 1-800 number, BIP required that states implement a level 1 screening tool for individuals seeking LTSS prior to a full functional and financial assessment. The screening tool was designed to encompass all LTSS populations including aging, physical disability,

development disability, and mental health. In Texas, stakeholders were reluctant to implement the screening tool based on the questions included. One aging advocate reported that “There was a lot of pushback regarding the tool. It had a really, and has, it still exists, has a really strong focus on behavior health issues...Some of the questions were extremely intrusive.” Another ID/DD advocate elaborated

We as an advocacy community were not super impressed with some of the ways that the implementation of some of the pieces went down...the assessment and the intake for No Wrong Door we thought was really weird in terms of the focus. It was trying to meet the needs of so many different individuals, it was kind of confusing.

In the quotes above, the two advocates identify some of the issues with the level 1 screening tool, namely some questions were not appropriate and the tool was confusing. By creating a screening tool to cover all individuals with very different needs, state officials received opposition from the local organizations administering the tool. In addition, interviewees indicated that Aging Disability Resource Centers, local authorities, consumers and/or their advocates were not involved in the development of the tool.

Stakeholders also felt that changes due to BIP were not adequately communicated. In Maryland, as part of BIP, providers needed to utilize new assessment instruments to determine eligibility for programs. For behavioral health services, an interviewee conveyed that there was not sufficient communication or training for mental health providers using the Daily Living Activities-20. According to a provider representative,

I think providers, quite frankly, had a hard time understanding the purpose of what they were doing. And why they were going to have to use the DLA-20 [Daily Living Activities- 20]. It was, you know, the training was very not well-coordinated...And I'm

not sure that they did a really effective job in helping providers to make the connection...the system perspective doesn't always do a great job of understanding that direct care perspective.

The provider representative highlights that state officials did not adequately convey to providers why the state adopted the new assessment tool or provide adequate training on the new tool. The limited communication and training on the new assessment contributed to some reluctance among providers in switching from their existing assessment instruments to the Daily Living Activities-20.

States faced challenges determining how to spend the enhanced revenue.

While enhanced BIP funding helped states implement program requirements, it also posed a challenge to states in deciding how and where to spend the additional funding. Maryland, in particular, was wary of expanding services and creating new entitlements because once the enhanced funding ended in 2015 the state would need to continue the new services. According to one Medicaid bureaucrat in Maryland,

I think one of the down sides of the Balancing Incentive Program is since it's temporary funding, any increase in service or any increase in people cannot be sustained long term...spending the money makes it a little more difficult when it's not a consistent source.

Consequently, states were strategic in how they used the BIP funding and in some instances were able to find other funding sources after the BIP money ended. For Aging and Disability Resource Center related activities, Maryland worked with CMS to develop federal matching revenue based on the number of calls received. In addition, since the enhanced funding ended in 2015, there was added pressure on BIP states to finalize expensive projects prior to then. According to one

Maryland Medicaid bureaucrat, “we definitely were concerned about making sure that we were getting all the [IT] development within the BIP timeframe because that's obviously the most costly part of the system is that initial development.” The limited duration of the enhanced funding put additional pressure on states to implement the needed changes before the funding ended.

Community First Choice

With CFC, Maryland and Texas undertook substantial changes to their states’ HCBS offerings. Communication with CMS and the enhanced federal match facilitated implementation. In addition, Maryland and Texas leveraged existing HCBS infrastructure and, when feasible, sought to make the program changes largely invisible to enrollees. Both states also encountered several challenges implementing CFC. One was the need to continue offering existing services so that enrollees did not lose their eligibility. In addition, Maryland needed to abandon its self-directed option in CFC due federal regulations around overtime pay for home care workers. Ambitious timelines, limited staff resources, and communication with external stakeholders also presented challenges for Maryland and Texas while implementing CFC.

Facilitators of Policy Implementation

Communication with Centers for Medicare and Medicaid Services during development of state plan amendment.

Prior to implementing CFC, states pursuing this option needed CMS to approve their state plan amendment. In both Maryland and Texas, state officials recognized the value of consulting with CMS throughout the process. In Maryland, state bureaucrats appreciated that officials from CMS were willing to work with them on the development of their CFC program. According to a Maryland Medicaid state bureaucrat,

I think CMS was really available to us which I think was really important when you're talking about being able to think through different options and implications of different decisions across the board. I think it's really helpful to have their input and their feedback and kind of work as a team. So any state that was looking at implementing, I would highly suggest that they involve CMS early and often.

With Texas' CFC state plan amendment, CMS also worked closely with the state to ensure their final submitted state plan amendment was approvable and that the approval happened in a timely manner. Working with CMS throughout the development of the state plan amendment facilitated the approval process. The state was on a tight timeframe to obtain approval and implement the program, and appreciated that CMS was willing to accommodate their timeline. According to a Texas state bureaucrat,

CMS was really great. Working with us as we developed the SPA [state plan amendment]. We sent it back and forth a million times before we actually submitted it and got feedback from them. At one point, for some months, we were having weekly meetings and calls with CMS to negotiate so that by the time we actually submitted it, we knew that it was gonna be approvable because they had been so involved with us in developing the SPA.

By engaging with CMS early, Texas expedited the state plan amendment approval process and ensured that the program design met federal requirements.

Enhanced federal revenue allowed for IT enhancements.

The key incentive for states to adopt CFC was the 6% enhanced match for CFC services. In Maryland, the enhanced match was also important for implementation because it enabled the state to make significant IT improvements during the process. In implementing CFC, the state

consolidated two existing waivers and the state plan personal care program into CFC. These programs had different enrollment tracking systems that were not well integrated. As part of both BIP and CFC, the state developed a new inter-operable IT system called LTSS Maryland to be able to track enrollees across various programs. The development of the IT system was costly and the enhanced funding from both programs helped in the development and implementation. According to one interviewee, “I think the enhanced nudge from both BIP and CFC were really important to getting CFC rolled out and making changes with IT systems which are really costly.”

Leveraging existing HCBS infrastructure and providers.

Most states that pursued CFC moved existing HCBS offerings, such as state plan personal care or waiver services, to CFC. Transitioning existing programs had both benefits and, as discussed next, drawbacks. With preexisting HCBS programs, states already had enrollees and a provider base; therefore, states could focus less attention on developing infrastructure, marketing the program, and enrolling new providers. For enrollees and providers, state officials tried to make the transition to CFC as seamless as possible. According to a few interviewees in Maryland and Texas “I think most participants probably don't even know what has happened” (Maryland consultant) and “we tried to make it pretty much invisible for the clients ... the providers had to change the way they billed slightly but overall it was supposed to just be just sort of a money swap on the backend” (Texas Medicaid bureaucrat). Leveraging existing HCBS infrastructure and provider networks facilitated states’ implementation of CFC.

Barriers to Policy Implementation

Adding CFC contributed to administrative burdens, rate issues, and budget overruns for preexisting HCBS programs.

While existing HCBS programs facilitated CFC implementation in some respects, they also posed challenges for states in other ways. Both Maryland and Texas experienced issues due to the impact of CFC on existing programs and policies. One challenge both states faced was the need to maintain existing HCBS programs because not all individuals would meet the income or functional eligibility of CFC. In addition, Maryland and Texas opted to change provider payment rates so that there was consistency in CFC. Both states encountered issues implementing new provider rates for CFC because HCBS rates prior to CFC differed across programs. In streamlining provider rates to ensure consistency, some providers saw a rate increase while other providers experienced a rate decrease, which was controversial. Lastly, Texas experienced cost overruns when moving personal care and habilitation services out of waivers to CFC.

One challenge faced by CFC states was the need to continue to operate preexisting waiver and personal care programs in addition to CFC. Since the income and functional eligibility for CFC were different from existing HCBS programs, states often needed to maintain preexisting programs to ensure individuals, who were not financially or clinically eligible for CFC, did not lose their benefits. To be financially eligible for CFC, an individual must have income at or below 150 percent of the federal poverty level. Individuals with higher income are eligible for CFC if they are participating in a waiver program or eligible for nursing facility services under the state plan. Many states pursuing CFC have moved personal care or habilitation provided through a waiver to CFC to take advantage of the 6% enhanced federal match. With HCBS waivers, states have the option of allowing individuals with income up to 300

percent of the Supplemental Security Income benefit to enroll in Medicaid if they are functionally eligible for waiver services. For waiver enrollees with income above 150% of the federal poverty level; however, they need to continue to receive at least one waiver service per month or they would be ineligible for CFC. According to several national interviewees,

If you put people in CFC who were previously in a waiver, some of them you're going to have to keep them in the waiver so that you can have them in CFC. Then it's administratively, it becomes very difficult to track. You always have to make sure that this person's eligibility for the waiver stays current so that they're not kicked out of CFC (federal bureaucrat)

You see states having to play some fun games by keeping essentially a shell of 1915(c) waiver open in order to continue eligibility for people so they don't get kicked off of

Medicaid because their service is moved into a 1915(k) [CFC] (national aging advocate)

In both quotes, the national interviewees identify a challenge with CFC in that individuals who are eligible for the program by virtue of their waiver services must continue to receive waiver services otherwise they will no longer be eligible for CFC. States have adopted different techniques to address this issue. For example, Texas developed a targeted case management service to deliver at least one waiver service to all waiver enrollees; however, not all of the state's waivers include case management. For waivers without case management, service coordinators needed to ensure waiver participants received at least one waiver service each month in addition to services through CFC. The need to provide additional waiver services and track a subset of CFC consumers eligible for the program due to waiver enrollment created added administrative burdens for states.

In addition to continuing waiver services to maintain CFC eligibility, Maryland and Texas also needed to keep their preexisting personal care state plan programs to avoid loss of services for some recipients. CFC requires that an individual meet an institutional level of care to be eligible for the program. In Maryland, while the majority of state plan personal care enrollees were at an institutional level of care, not all were. Therefore, the state needed to reassess everyone enrolled in the state plan personal care program to determine eligibility for CFC. According to a state bureaucrat in Maryland,

A few hundred [enrollees] did not [meet nursing facility level of care]...So we had to maintain their services. So we had to distinguish between one program and another, and then make sure they were getting services appropriate. So that was another issue with transition.

The Maryland state bureaucrat highlights that some enrollees in the pre-existing state plan personal care benefit were not clinically eligible for CFC, and the state needed to ensure each enrollee was in the appropriate program. Although one of the goals of CFC in Maryland was to streamline programs, this could not be fully realized because of the need to maintain the existing state plan personal care program. Similarly, prior to CFC, Texas offered personal care attendant services to individuals with income up to 300% Supplemental Security Income. The CFC income threshold is lower; therefore, Texas needed to maintain this program so individuals did not lose services. A Texas state bureaucrat conveyed, the “300% program we have, it's called Community Attendant Services that still does exist. Because we didn't go up to 300% in CFC.” Since the clinical and financial eligibility criteria for CFC differed from pre-existing HCBS programs, many states needed to maintain other programs in addition to CFC to ensure recipients did not

lose eligibility or services. The operations of multiple HCBS programs added administrative complexities for states.

Another challenge both Maryland and Texas faced implementing CFC related to different provider rates that existed across programs prior to CFC. Before adopting CFC, Maryland had different rates for the waiver programs and state plan personal care program with the later receiving lower rates than the former. According to a Maryland Medicaid state bureaucrat, “some people, depending on what program they were in, were now going to be getting a higher rate and there were some people that saw a rate cut.” In addition, in Texas different rates existed between ID/DD providers and personal care providers. According to several consumer advocates and provider representatives, the CFC rates have been a challenge for ID/DD providers in particular. Noted a provider representative, “The rate that was offered was substantially lower than what we had initially discussed and anticipated that it was gonna look like. So that really created a barrier for IDD providers in particular participating in the program.” An ID/DD advocate agreed,

People on the DD side have sustained a 21% rate reduction and will probably have another one. And so they're sort of in the process over time of equalizing the rates, and not bringing up the low rates but taking down the higher rates.

In the above quote, the ID/DD provider and advocate highlight that ID/DD providers experienced a substantial rate cut, and the CFC rate was significantly lower than expected. In Texas, for ID/DD providers offering services through CFC, the rate they received was lower than the rate they were receiving through the waiver. The low rates in CFC had an impact on the availability of providers. According to an aging advocate in Texas, “the provider rates are

incredibly low. Even if CFC services are authorized, it's really difficult to find qualified providers because of the low reimbursement rates.”

Another issue Texas encountered was budget overruns from moving personal assistance services and habilitation services from 1915(c) waivers into CFC to take advantage of the 6% additional match on CFC services. When implementing CFC, Texas moved a subset of services from 1915(c) waivers to CFC but many waiver participants remained in the waiver to continue receiving other services not covered by CFC. Within the Texas Home Living waiver for individuals with intellectual and developmental disabilities, the state had a \$15,000 annual cap on services, which did not exist in CFC. Since services were limited in the waiver but not in CFC, many Texas Home Living waiver enrollees’ overall services increased significantly when some of their services were moved to CFC. Officials in Texas “had not anticipated that people currently receiving services would be now eligible for significantly more than what they had been receiving” according to a provider representative. The expansion of services for individuals served through both the waiver and CFC created budgetary challenges for the state. In reaction to the service plan increases, Texas enacted limits on waiver slots in an attempt to reduce the budgetary impact. The intention of implementing CFC was to simply swap waiver habilitation and personal assistance services with CFC habilitation and personal assistance to take advantage of the enhanced match for CFC services. However, without the cost limits that existed in the waiver, enrollees’ service plans increased substantially when some of their services were now covered under CFC. According to one state bureaucrat in a disability agency,

That was a major unintended consequence that the waiver cost for this one particular waiver just spiraled and we had to immediately stop enrollment into that waiver because the people that were already in it were suddenly starting to get a lot more services.

The state bureaucrat highlights that state officials did not anticipate that service costs for individuals enrolled in that specific waiver would increase as they did and, in an effort to control costs, the state stopped enrolling individuals in the waiver. The intention was that individuals enrolled in a waiver would not realize a change in the amount of services received when some of their services were moved to CFC. The only change would be the funding source of services. However, without the limit on services in CFC that existed within the waiver, Texas experienced a substantial increase in services for individuals enrolled in the Texas Home Living waiver and needed to halt enrollment in the waiver in an effort to restrain increased growth in spending.

Federal regulations presented a challenge for Maryland's CFC self-directed option.

Maryland encountered challenges implementing CFC due to the federal Department of Labor's overtime regulation for home care workers. This overtime regulation change applied to all home care services and was not strictly related to CFC; however, it impacted CFC and other HCBS programs. In Maryland's CFC state plan amendment, the state elected to provide CFC either through an agency model or self-directed option. With an agency model, CFC participants receive their services from a home care worker who is employed by a provider agency. Under the self-directed option, the home care worker works directly for the participant who can hire, train, and supervise the individuals providing the services. In June 2015, the Maryland Department of Health and Mental Hygiene sent a letter to CFC participants that the program was changing to an agency-only model effective October 1, 2015 due to federal regulatory changes. The federal change protected home care workers, who were previously exempt, under the Fair Labor Standards Act. Under this regulation change, all home care workers, including those working for individuals under self-direction and workers employed by a provider agency, needed to receive overtime pay if they worked more than 40 hours a week. The state of Maryland

determined that it would be very difficult to limit those employed under self-direction to 40 hours a week because some were employed by multiple individuals. The elimination of the self-directed option was controversial and opposed by many CFC participants and advocacy organizations. According to one physical disability advocate, the move to an agency only option “causes issues for people and disruptions in people's lives once they have been able to ... get some kind of stability and regular services and the same person.”

Aggressive timelines and limited staffing resources presented challenges.

The implementation of CFC in both Maryland and Texas was a massive undertaking. In both states, the implementation timeline was aggressive given the amount of change needing to make to their LTSS systems. Implementing this new program consumed a large amount of state staff time in the Medicaid and disability services agencies. Interviewees in both states acknowledged that implementing CFC was a monumental task. In Maryland, in the process of implementing CFC, the state also moved to a new system of determining participants’ service budgets based on their resource utilization group score.²³ According to a state bureaucrat in Maryland’s Medicaid agency, it was

A pretty heavy lift because it was also all in the same day. The new tracking system went up, budgets were calculated based on the RUGs [resource utilization group] budget, services were covered under Community First Choice instead of the waiver... hindsight's 20/20 so it was a rough period ... but I don't know that we could've really separated out many of those changes or I don't know that we could've piloted them or rolled them out any differently.

²³ The interRAI Resource Utilization Group score is based on seventy-four (74) items within the interRAI Home Care. Based on the responses to the items, there are twenty-three groups an individual could be in depending on the types (i.e. impaired cognition, behavior problems, reduced physical functions) and intensity of impairments. The Resource Utilization Group score is used to predict service utilization.

The interviewee emphasizes that many changes were implemented on the same day which, while presenting challenges, may have been unavoidable. Interviewees in Texas also conveyed that the amount of work in transitioning existing waivers and state plan services to CFC was substantial. According to two Texas state bureaucrats, “we had to just touch so many different systems and so many different authorities and every waiver had to be amended and every set of rules about every program had to be amended” and “our biggest challenge was the timeline. It was a massive.” In both Maryland and Texas, therefore, implementing CFC required substantial changes to their existing LTSS systems and processes.

Since implementing CFC was a large undertaking, state staff in both Maryland and Texas needed to focus on rolling out CFC, often to the exclusion of other responsibilities. In Maryland, state staff approved every new service plan for individuals previously enrolled in the state plan personal care program to ensure the amount of services met participants’ needs. In addition, staff needed to respond to inquiries from consumers, advocates, and providers about this new program. During this transition to CFC, state employees’ time needed to be redirected from their normal responsibilities to focus on CFC implementation. According interviewees in Maryland,

That process [of approving service plans] took a long time. It was a major training effort, and kind of shifted a lot of staff time here in what they were doing, so that we could actually review all those new plans. So that's a considerable amount of time (state Medicaid bureaucrat)

I think that we ended up getting permission to hire a bunch of temporary emergency staff just because we didn't have the staffing level necessary to respond to all the phone calls and inquiries that were coming in. So it definitely would've been better if we'd had more staff when that happened (state Medicaid bureaucrat)

Advocates concurred that the state did not have sufficient staff to approve all of the new service plans consistently and in a timely manner. According to one Maryland physical disability consumer advocate, “I didn't think they have enough staff then. I don't think they have enough or the right, or qualified, or experienced enough people now.” The implementation of CFC in Texas also involved multiple agencies within state government and a substantial amount of staff time. According to a Texas state bureaucrat, the implementation of CFC “involved three agencies and staff had to just go completely on to CFC and not do their other work.”

In addition to sufficient state staff, Maryland also faced some challenges ensuring that there were sufficient support planners to act as case managers for CFC participants. Under the previous state plan personal care program, participants had a nurse monitor, but under CFC they would have a supports planner to develop and oversee their care plan.²⁴ As a result, many individuals who previously did not have a case manager under the original personal care benefit now needed one under CFC. According to one state bureaucrat in Maryland’s Medicaid agency, “ensuring we have enough case managers statewide, kind of always an issue. Which we're making sure that every person has at least two options ... so ensuring that there is capacity there has been an issue.”

Insufficient stakeholder engagement and outreach to potential enrollees.

Putting CFC into place was a large undertaking that involved many stakeholders both inside and outside of government. States encountered issues implementing CFC because external stakeholders were not sufficiently engaged in the process and state officials did not adequately

²⁴ Supports planners provide case management and are responsible for assisting participants access Medicaid and non-Medicaid HCBS; maintaining Medicaid eligibility; developing the service plan through a person-centered planning process; supporting applicants in locating and accessing housing options, and coordinating services and supports. Nurse monitors have a more limited role and are responsible for personal assistance services only. The nurse monitor determines eligibility and amount of personal assistance and provides quality oversight. CFC participants who receive personal assistance would have a nurse monitor in addition to a supports planner.

reach out to potential enrollees. According to one national consultant, “doing outreach, training across the state, making sure they've got sufficient partners in the implementation” was important for CFC implementation success; however, some interviewees in Maryland and Texas indicated that both states did not do these things. While officials in both Maryland and Texas sought input through their CFC implementation councils, external stakeholders hoped state officials would be more receptive to feedback from the council members. In Maryland, consumer advocacy groups conveyed that state officials were not open to feedback specifically around the resource utilization group budget categories and the elimination of the self-directed option. In Texas, consumer advocacy groups and provider representatives felt that officials could have done a better job publicizing and explaining the program to potential participants.

In implementing CFC, Maryland faced challenges communicating with external stakeholders and interest groups. As part of CFC, Maryland rolled out a new assessment tool, the interRAI, and budget categories based on resource utilization group scores. All CFC enrollees were assessed with the new instrument and their recommended CFC budget was based on their resource utilization group score. Among external stakeholders there was confusion around whether a CFC participant’s actual service plan could differ from the resource utilization group recommended budget. According to a Maryland Medicaid state bureaucrat, “I think we didn't have a clear process for that at the beginning and I think that if that had been clear at the beginning, that would've really improved a lot of things 'cause I think there was a lot of confusion and hesitation and fear and frustration at the beginning.” In addition, advocates for individuals with disabilities felt as though state officials were not open to input particularly around the resource utilization group budget categories and eliminating the self-directed option. Reported a physical disability advocate, "We knew that interRAI was a major issue...And then

when they sort of just stopped taking any input or taking your input with a smile on their face and then turning around and doing whatever the hell they wanted was very much how it felt."

Said another physical disability advocate

The Community Options Advisory Council was unanimously opposed [to eliminating the self-directed option] and said all kinds of comments, et cetera, and the state went ahead and did it anyway. So, I only give you this to illustrate that we are an advisory council, period, and advice is just exactly that, it's cheap.

In the above quotes, both advocates emphasize that while the state of Maryland accepts feedback from stakeholders, this feedback has little impact on policy decisions. Members of the Community Options Advisory Council felt as if state officials in Maryland did not adequately consider their feedback and input during the implementation process.

Interviewees in Texas indicated that the state experienced issues communicating about CFC to potential enrollees. The state did not make the program widely known, resulting in confusion among potential enrollees. According to an ID/DD advocate in Texas, "we requested, repeatedly, [for] a consumer public awareness program associated with this service. That has not happened." This lack of awareness and confusion contributed to a lower than expected number of enrollees in CFC. Texas had over 100,000 individuals on a waiting list (known as an interest list in Texas) for ID/DD waivers. Many of these individuals would qualify for CFC; however, a much smaller than anticipated number of people actually enrolled. One reason the number of enrollees was lower than expected was due to a lack of public information about CFC.

Interviewees conveyed that individuals on a waiting list for an ID/DD waiver may have also been reluctant to accept CFC for fear of losing their spot on the interest list. According to a state bureaucrat,

A lot of people really didn't understand the program. And I don't think they ever really got the numbers that they anticipated...people were afraid that they'd be losing their place in line for waiver services, and so yeah there was a lot of information problems.

The state bureaucrat identifies one reason for low CFC enrollment being that individuals on a waiting list for waiver services did not understand the program and how CFC would impact their spot on the waiting list. The waivers offer more robust services than are available through CFC, and individuals wait on average over 10 years for a waiver slot to open. Due to confusion about being eligible for both the waiver and CFC, individuals may have been hesitant to enroll in CFC. The lack of a public awareness campaign and confusion about CFC limited enrollment in the program initially.

1915(i) HCBS Benefit

Maryland and Texas encountered several challenges implementing their 1915(i) programs. Both states' 1915(i) programs serve individuals with serious mental illness - a population that has historically been underserved in HCBS programs. The implementation has been hampered by the financial and functional eligibility criteria for services; challenges attracting participating providers; and communication difficulties with external stakeholders including potential enrollees, providers, and local authorities. To facilitate implementation, Maryland and Texas both contracted with local universities to provide assistance with aspects of their 1915(i) programs. Interviewees in both states concurred that university consultants were better positioned than state officials to assist in the implementation process.

Facilitators of Implementation

Hiring university-based consultants with experience in implementation.

Both Maryland and Texas hired external consultants at local universities to assist with the 1915(i). In Maryland, the University of Maryland School of Social Work Institute for Innovation and Implementation (the Institute) was involved in the decision to pursue the 1915(i) and writing the state plan amendment but played a lesser role once the program was approved by CMS. While the Institute remained involved in the initial roll out, officials in the state of Maryland decided to handle the implementation internally. Stakeholders at Maryland's core service agencies, which are governmental or non-profit local behavioral health authorities, recognized the value the Institute brought to the implementation process. According to a representative from a local authority,

There were a series of learning communities held for the core service agencies or local behavioral health authorities to assist us with that transition. But, they seemed to be led more heavily by the Institute... They were in a position because they've got people who recognize the need and had information kind of pushed forward, whereas the Administration just, kind of, was hanging back. So, I think they took the lead because somebody had to.

In this quote, the representative from a local authority highlights that the state Behavioral Health Administration did not initiate learning forums about the 1915(i); instead, the Institute realized this gap and filled the need. The Institute was better positioned to roll out this new benefit than the Behavioral Health Administration because of their expertise and experience with policy implementation. The limited assistance the Institute provided in the roll out was valued and an

interviewee conveyed that if they had played a greater role, the implementation of the 1915(i) in Maryland may have gone smoother.

The state of Texas also contracted with a local university to help with the 1915(i). The Texas Institute for Excellence in Mental Health, which is part of the School of Social Work at the University of Texas-Austin, assisted in the implementation process. According to one interviewee, the implementation of the 1915(i) was facilitated by “partnering with some of the universities since there was such a small team to help develop web based trainings and information [and] help get the word out so that we weren't constantly traveling.” The Texas Institute for Excellence in Mental Health was able to create user friendly content to introduce the 1915(i) benefit to potential providers and participants. In addition, through their contract, staff at the Institute supported new providers who were interested in offering 1915(i) services.

Barriers to Implementation

Impediments posed by federal financial eligibility criteria.

One challenge states encountered in implementing the 1915(i) was the financial eligibility criteria of this benefit. The 1915(i) statute allows states to offer services to individuals with income up to 150% of the federal poverty level, and states can opt to increase the income threshold up to 300% of Supplemental Security Income for individuals who meet the functional eligibility for a 1915(c) waiver. However, many states that are pursuing the 1915(i) option are focusing the benefit on individuals with serious mental illness because 1915(c) waivers are not appropriate for serving this population. Consequently, for states utilizing the 1915(i) for individuals with serious mental illness, the financial eligibility criterion is capped at 150% of the federal poverty level. This financial eligibility limit presented a challenge to both Maryland and Texas because both states cover individuals with a higher income level through Medicaid.

The state of Maryland sought permission from CMS to expand the income eligibility criteria of their 1915(i) benefit. In the state plan amendment process and during discussions with CMS, Maryland asked if the state could cover children at an income level above 150% of the federal poverty level. However, based on the statute, CMS did not have the flexibility to allow Maryland to serve higher income eligible children. According to interviewees in Maryland,

The [1915(i)] authority caps financial eligibility at 150% of [the] federal poverty [level]. Which, in our state, we cover children and families [up] to 300[% of FPL]...We entered into this negotiation with CMS thinking can we cover higher than 150%? ...Can we cover every kid who has a Medicaid card in our state to enter this program? And after a 12 month negotiation, the answer was no. We asked like six times, just to make sure. But the answer was no. So that was a problem...So some Medicaid eligibles can get in and others are just financially not eligible (Maryland state bureaucrat)

The biggest downside with the [1915](i) is the way the federal government has interpreted the financial restrictions. We had submitted some language to the Senate Finance Committee and elsewhere suggesting to CMS that they could have a more broad interpretation of the financial eligibility...With the current read of it, it basically creates this bifurcation of our current Medicaid system where we have kids who are eligible for regular Maryland Medicaid, not CHIP [Children's Health Insurance Program], but just Medicaid and they are not financially eligible for the (i). So that's pretty difficult (Maryland consultant).

In both quotes, the interviewees emphasize that they urged CMS to allow Maryland to cover children at a higher income level through the 1915(i) but were unsuccessful. This means that in Maryland some children on Medicaid are eligible for 1915(i) services while other children on

Medicaid are not eligible. Since Maryland could not cover children with income above 150% of the federal poverty level through the 1915(i), the state pursued a targeted case management state plan amendment in conjunction with the 1915(i) state plan benefit. The targeted case management benefit provides case management to children on Medicaid at the higher income levels while the 1915(i) is available for children with income less than 150% of the federal poverty level. The need to submit and operate two state plan amendments (targeted case management, 1915(i)) and offer a case management service separate from the 1915(i) benefit added administrative complexity to this service offering and to the process of obtaining approval from CMS. According to a Maryland state bureaucrat,

I think we kind of compounded our approval process a little bit there because we had to somehow convey to CMS that there are two target case management SPAs [state plan amendments] and a 1915(i) SPA in review and you can't review them independently. They're all working part of a whole program.

Due to the low financial eligibility threshold and the lack of flexibility to modify it, Maryland had to pursue other options to provide some services to Medicaid eligible children to whom it wished to expand coverage, but who did not financially qualify for 1915(i) services.

Similarly, Texas had some individuals on Medicaid who might meet functional eligibility criteria, but whose higher income made them ineligible for 1915(i) services. The state had to develop processes to ensure that Medicaid-eligible individuals who had income above 150% of the federal poverty level were not enrolled in the 1915(i). According to a state bureaucrat in Texas, “if we got people who might be exceeding 150% [of the federal poverty level who are] existing Medicaid eligible, we have to have a way to screen them out... for 1915(i) [benefits] to avoid serving them because we can't give them the benefits.” The limit that states could only

cover individuals with income at or below 150% of the federal poverty level created added administrative burdens for states.

Impediments posed by functional eligibility criteria.

Each state determines the functional eligibility criteria for 1915(i) services. States, however, were no longer able to cap the number of participants or establish waiting lists for 1915(i) services pursuant to changes made by the ACA. Thus, to control costs, states 1915(i) state plan amendments have generally been adopted that put into place very stringent functionality eligibility criteria to limit the number of participants. Both Maryland and Texas set high functional eligibility thresholds to enroll in their 1915(i) programs. In Maryland, children or youths needed to have at least three psychiatric hospitalizations within 12 months. This stringent eligibility criterion posed a challenge in the state's implementation of the program because the number of potential enrollees has been small. According to one state bureaucrat in Maryland,

There were definitely concerns about, since there's no waiting list, about how we would limit the influx of people, of kids, into this. As it turned out, we did too good of a job of setting the clinical criteria, medical necessity criteria for people to get in because of that fear.

Maryland's 1915(i) program experienced lower than expected enrollment. While the state estimated approximately 200 children would receive 1915(i) services, interviewees indicated the actual number of children enrolled was approximately 30. The lower enrollment numbers were due, in part, to the stringent eligibility criteria because of the state's concern about serving too many children.

As with Maryland, Texas set a high clinical threshold to be eligible for 1915(i) services. In Texas, an individual needed to reside (cumulatively or consecutively) in a state psychiatric

hospital three of the past five years. The high eligibility threshold was a mechanism for the state to limit enrollment in the program as a way to control costs. According to an ID/DD advocate,

The notion that we're gonna create this 1915(i), it's gonna be an entitlement, so we're at risk of a cost explosion. So let's define the population very, very, narrowly and that's how we will anticipate or prospectively control costs and I know that caused a lot of challenges.

In the 1915(i) state plan amendment, Texas anticipated serving approximately 100 individuals annually through the program. According to interviewees, the actual number of enrollees was approximately 30. The low number of participants presented challenges because it offers providers little incentive to participate in the 1915(i) program.

Challenges attracting providers due to low reimbursement rates and small caseloads.

Prior to the 1915(i) option, many states provided limited Medicaid HCBS to individuals with serious mental illness. Due to the institutions for mental diseases exclusion, states could not provide HCBS to individuals with mental illness under age 65 through 1915(c) waivers, which have been the primary HCBS Medicaid option states utilize. By requiring a lower level of need, the 1915(i) allowed states to design a benefit to serve this population. However, since this population has historically been excluded from HCBS services, some states lacked a Medicaid HCBS service provider network to serve individuals with serious mental illness. Both Maryland and Texas thus experienced difficulty attracting providers to offer services through the 1915(i). Since both states' 1915(i) programs are serving individuals with serious mental illness in the community, many potential providers have not historically been Medicaid providers. In addition,

low reimbursement rates and small caseloads have hampered the enrollment of providers of 1915(i) services in the two states.

Some of the benefits offered through Maryland's 1915(i) waiver – namely, expressive and experimental behavioral services – proved challenging to implement. The expressive and experimental services include, but are not limited to, art, music, equine, and horticultural therapies. Finding providers who are willing to offer these services through the 1915(i) has been particularly problematic. According to several interviewees in Maryland, attracting providers is challenging “even more so for equine assisted therapy. ...A barn manager, it's a good service, it just doesn't seem to be a good match for a Medicaid fee-for-service program” (state bureaucrat) and “our experiential therapies have been really, really challenging to get; so our horticulture, our equine therapies, our movement therapies” (representative from local behavioral health authority). Both interviewees emphasize that the state of Maryland encountered challenges offering non-traditional Medicaid services because of provider availability. Many of these non-traditional providers were not interested in becoming Medicaid providers because of federal requirements associated with the program around staff background checks, audits, and quality assurance. For many providers, the drawbacks of becoming a Medicaid provider outweigh the benefits of providing services through the 1915(i).

Another challenge Maryland faced attracting 1915(i) providers was due to low reimbursement rates and small caseloads. Due to low rates, many providers elected not to participate in the program. According to a representative of a local behavioral health authority, for the in-home service, “it became a rate issue...I think we trained nine providers and...[just] one ... has decided to provide the service because they [the others] believed the rate was too low.” The small number of children enrolled in the 1915(i) also exacerbated the challenges

attracting providers. According to a state bureaucrat in Maryland, “another thing that makes it a little bit more difficult to attract providers is that currently we don't have many children enrolled.” Since the number of children who receive services is small, many providers do not feel that this program can be financially viable for their organization. The requirements to become a Medicaid 1915(i) provider outweighed the revenue gains of providing services to a small number of children. According to several interviewees in Maryland “there just isn't an economic justification for people to go in to that line of provision of services” (mental health advocate) and “there are a lot of providers who are finding it difficult to remain financially sound. So, some of them have been dropping the program” (state bureaucrat).

As with Maryland, Texas also faced difficulty getting enough providers to offer 1915(i) services. Since the state had not previously offered HCBS programs to individuals with mental health issues, the state had to find and convince providers to enter this line of business. In Texas,

It was a real struggle to start that from scratch because it's not the kind of thing that mental health authorities did for that population...there wasn't like a traditional HCBS provider base for adults with serious mental illness” (state bureaucrat)

It's a hard sell ... they weren't looking for a new program, and we're trying to convince them that this could be something that they could take on as well as what they already do.

The only incentive is, well, you can bill Medicaid. So it's kind of a hard sell (consultant). To incentivize providers to participate in the 1915(i) program, the state of Texas offered provider agencies an incentive grant of \$40,000 to help them launch these services. The funding generated increased interest in the program and attracted some providers, but it was time limited and ended in September 2017.

In Texas, attracting providers has been a challenge for several reasons. Similar to Maryland, providers in Texas felt that the rate was low and the number of enrollees was small. According to interviewees in Texas, what “we’ve heard from providers is that the rates are too low” (mental health advocate) and “one of the biggest hurdles was just getting providers willing to deliver the service and then we don’t have a threshold of people or a rate that’s attractive” (provider representative). The program served approximately 30 individuals in 2016. For a state as large as Texas, 30 individuals statewide meant that many counties had very few or no enrollees. Some providers participating in the program only serve one or two clients. With such a small potential caseload, providers could not justify expending resources to become a 1915(i) provider.

In addition, some providers were reluctant to serve adults with serious mental illness who had resided long-term in a state psychiatric hospital. According to a state bureaucrat, “a lot of people were scared off by the initial population that’s the folks that have been long term in psychiatric hospitalizations.” A potential provider conveyed that “I know it’s for severe and persistent mental illness, or people that are mentally ill and are frequently either in jail or in hospitals for a period of time. But the rates were nowhere near that would even come close to approaching the risk involved in managing that population.” For many providers in Texas, the risks of participating in the 1915(i) program far outweighed the financial benefits because the rates were low and there were few participants.

Insufficient communication with providers and potential enrollees.

Another challenge both Maryland and Texas encountered implementing the 1915(i) program was communicating with external stakeholders and individuals who might benefit from these programs. In both states, interviewees indicated that state officials lacked the ability to

market and explain this new benefit to prospective participants, resulting in low enrollment. In addition, confusion existed among providers and local entities responsible for administering the 1915(i) benefit. According to a representative of a local behavioral health authority in Maryland, “it's not like the state did anything to, kind of, launch this service and make it really publicly known to families.” Interviewees indicated the state officials lacked a well thought out implementation plan and did not provide sufficient assistance to local behavioral health authorities who were responsible for administering the program at the local level. Representatives from local authorities felt that the implementation process would have gone smoother if the state provided additional training and resources. According to two interviewees in Maryland,

It is not how we would suggest anybody do implementation because there is not a consistent rollout plan. There was a lot of rough moments where providers didn't know how to enroll and what to do and what they needed to do. Forms weren't clear (consultant).

While there was discussion about what we should be doing, there wasn't support in assisting us in doing that in any way when it came to manpower, when it came to funding, when it came to any of that; resources of actual documents or things (representative from local behavioral health authority).

In Maryland, communication and support from the state to local authorities and providers was lacking.

The implementation of the 1915(i) benefit in Texas encountered similar challenges. Interviewees indicated that the state of Texas did not engage in a public awareness campaign and that many people did not even know that the 1915(i) benefit existed. According to a consultant,

“I think there also may be lack of awareness of the program broadly, and I don't know how much the state has done to really make it well known.” In addition, state officials contributed to confusion among providers by not providing clear answers and changing instructions after issuing guidance. During provider forums, state officials were vague regarding how the program would operate and how potential enrollees would be assessed. The state of Texas also changed who was responsible for which aspects of the program after communicating instructions. According to a consultant, “we have people who are just confused about how it all works...I think the state, maybe it was unavoidable, but there was miscommunication in the beginning”. The lack of communication with potential enrollees limited enrollment. In addition, vague and miscommunication to providers about the 1915(i) hampered the implementation process.

Conclusion

The implementation of BIP, CFC, and the 1915(i) in Maryland and Texas varied by program but there were common factors that facilitated or impeded the implementation process. Overall states had an easier time implementing BIP while CFC and the 1915(i) posed larger challenges. In Maryland and Texas, policy implementation of BIP and CFC was facilitated by communication with federal officials and consultants. With BIP, state bureaucrats appreciated the frequent communication with CMS and Mission Analytics because of the program's short duration. In addition, CMS provided valuable assistance to states during the CFC state plan amendment development process. States also facilitated the implementation process of BIP and CFC by integrating these new initiatives with existing programs including Money Follows the Person, Aging and Disability Resource Centers, 1915(c) waivers, and state plan personal care benefits. The enhanced federal revenue for BIP and CFC allowed states to achieve LTSS policy goals and improve IT systems. With the 1915(i) HCBS state plan benefit, interviewees

recognized the benefits of hiring external university-based consultants to aide in the implementation process.

A common barrier to implementing all three policies was communicating with external stakeholders and potential enrollees. Consumer advocates and provider representatives indicated that state officials did not adequately consider their feedback and input when implementing BIP and CFC. In addition, interviewees conveyed that state officials did not sufficiently make CFC and the 1915(i) benefits known to individuals who might enroll in these programs. With BIP and CFC, states encountered challenges due to aggressive implementation timeframes. Both Maryland and Texas were trying to get a lot accomplished in a relatively short period of time when implementing both programs. When implementing CFC, Maryland and Texas encountered issues because of impact of CFC services on other HCBS programs and provider payment differentials among existing HCBS offerings. With the 1915(i), the lack of a sufficiently developed provider base and HCBS infrastructure for individuals with serious mental health issues posed a challenge. Both the challenges and facilitators implementing these programs can contribute to lessons learned, and the experiences of Maryland and Texas implementing these programs can inform the development of future federal HCBS policies. The next chapter discusses the quantitative and qualitative findings in the context of the existing literature and the hypotheses and propositions presented in Chapter 3.

CHAPTER 8

DISCUSSION

This chapter provides a discussion of the study's findings and places the results within the context of previous literature on policy adoption and implementation. The discussion highlights areas where the quantitative and qualitative findings align and draws attention to areas where the two approaches to this research suggest different conclusions. Overall, the findings from this study are generally consistent with policy adoption literature identifying the importance of political ideology, state bureaucratic leaders, and existing policies on states' adoption of public policies. This study; however, also underscores that the factors influencing the adoption of HCBS policies vary depending on the program. The findings from this study confirm that factors identified in implementation research, including state government communication with the federal government and local stakeholders; sufficient staffing; and financial resources, facilitate the implementation of HCBS policies.

This chapter is structured as follows: the first section provide a brief summary of the main findings. The second section discusses whether this study's findings are consistent with the policy adoption hypotheses in Chapter 3 and the policy adoption literature. This section is organized by hypothesis, including the importance of political factors, governing capacity, interest groups, economic factors, existing HCBS policies, and external factors in HCBS policy adoption. The next section presents a revised conceptual framework for policy adoption based on

the results of this study. The fourth section discusses this study's findings related to policy implementation within the context of the propositions in Chapter 3 and the literature. The fifth section is a discussion of study limitations, and the final section is a conclusion.

Summary of Findings

This study used a mixed methods research design to examine the state-level adoption decisions and implementation processes of three HCBS programs in the Affordable Care Act (ACA). The Balancing Incentive Program (BIP), Community First Choice (CFC), and 1915(i) HCBS state plan benefit were optional Medicaid policies that states could elect to adopt. BIP provided eligible states with either 2% or 5% additional federal match for participating states to increase their percentage of Medicaid long-term services and supports (LTSS) spending on HCBS. States could participate in BIP between 2011 and 2015 and were required to meet several structural and rebalancing requirements. CFC is a state plan benefit that assists participants, who require an institutional level of care, with activities of daily living. States offering CFC receive an additional 6% federal match for these services. Lastly, the 1915(i) is also a state plan benefit that provides states with flexibility in determining a target population and services. Unlike BIP and CFC, the 1915(i) does not provide states with a higher federal match.

In this study, the quantitative methods employed five sets of multivariate models. The dependent variables measured BIP adoption, CFC adoption, 1915(i) adoption, adoption of any of the three programs, and the proportion of eligible programs each state adopted. The regression results provide the strongest support for the impact of political factors and existing HCBS programs on adoption of the ACA HCBS expansion options. More liberal political ideology, more 1915(c) waivers, and lower Medicaid LTSS spending on HCBS increased the likelihood of state adoption of the ACA HCBS programs in the multivariate models.

The qualitative analysis focused on case studies of three states. Maryland and Texas adopted all three of the ACA HCBS options while Oklahoma did not adopt any of these policies. These findings identified the important role that leaders within the state Medicaid agency or disability services agencies played in the policy adoption decisions. Consistent with the quantitative analysis, the qualitative results also highlighted that state leaders perceived these policies as being aligned with the existing HCBS policies and rebalancing goals of the state. These leaders recognized that the three ACA policies would complement or substitute for existing HCBS policies and fill gaps in HCBS offerings. The case studies also identified facilitators and barriers to implementing these programs in Maryland and Texas. Additional financial resources, frequent communication with the Centers for Medicare and Medicaid Services (CMS), and leveraging existing HCBS programs and infrastructure facilitated the implementation process. Barriers to implementation included aggressive timelines, insufficient staff, and limited engagement with external stakeholders.

Policy Adoption Hypotheses

This study proposed several policy adoption hypotheses and a preliminary conceptual framework based on the literature. The conceptual framework identified state bureaucrats as the key actors in HCBS policy adoption. Factors influencing states bureaucrats included the political environment, governing capacity, interest groups, economic situation, and existing LTSS and Medicaid policies. In addition, external factors, such as the actions of other states and federal policy changes, may influence bureaucratic decision making. The following section discusses each of the policy adoption hypotheses and whether or not the quantitative and qualitative findings of this study support them.

Political Factors

The first hypothesis posited that states with Democratic leadership and more liberal political ideology were more likely to adopt the ACA HCBS policies. The quantitative findings offer limited support for the role of a Democratic governor but stronger evidence for the importance of liberal ideology, as measured by the Americans for Democratic Action liberalism index, in the adoption process. In some models with the BIP and CFC dependent variables, states with Democratic governors were more likely to pursue these programs; however, the Democratic governor variable was not significant in models with the other three dependent variables, i.e., 1915(i) adoption, adoption of any of the three programs, and the proportion of eligible programs each state adopted. These findings for BIP and CFC thus offer some evidence for the role of partisanship in Medicaid HCBS policymaking. This conclusion is consistent with several studies focused on Medicaid policy which have found that Democratic control of the legislature or Democratic control of the governor's office and state legislature is associated with increased spending, more generous eligibility policies, and faster adoption of the ACA health care expansion (Grogan and Rigby, 2009; Lukens, 2014; Jacobs and Callaghan, 2013).

The findings of this study suggest that political ideology was a more consistent predictor of adoption than the political party of the governor. States with a more liberal political ideology were more likely to pursue BIP, the 1915(i), any of the three policies, and adopt a higher proportion of policies for which the state was eligible. These findings are consistent with literature examining the role of ideology in Medicaid HCBS policy adoption. Research suggests that more liberal states are more likely to offer optional Medicaid state plan personal care benefits (Kitchener et al. 2007). Of the policies studied, political liberalism did not play a role in

the adoption of CFC but, as noted above, the political party of the governor influenced the adoption of this program.

The results suggesting that ideology was a more important predictor than the political party of the governor could be attributable to a few factors. Foremost, political parties are not uniform across states. A Democrat in one state may be more akin to a Republican in another state because there can be conservative Democrats and liberal Republicans depending on the state and politician. Therefore, the party affiliation of the governor may not always be a clear indicator of the degree of liberalism or conservatism in public policies. For this reason, the political liberalism of a state may be a better measure of ideological support for adding optional Medicaid programs than partisanship. A second reason ideology may be a better predictor of adoption than the political party of the governor could be related to the rather limited role governors play in HCBS policymaking. Research suggests that the design of Medicaid services and policies occurs within state agencies rather than in the legislature or governor's office (Schneider & Jacoby, 1996; Schneider, Jacoby, & Cogburn, 1997; Miller, 2006). The qualitative findings from this study also confirm that Maryland and Texas' governors played a periphery role, and the efforts to adopt these policies were largely led by the state Medicaid director.

The qualitative findings suggest a nuanced relationship between partisanship, ideology, and state adoption of these policies. The case study of Oklahoma identified some of the underlying reasons why states with Republican leadership and conservative ideology were less likely to pursue these policies, including opposition to the ACA, reluctance to participate in federal grant initiatives, and an unwillingness to expand Medicaid. Texas shared a similar political outlook to Oklahoma—conservative ideology, Republican control of state government, and opposition to the ACA but adopted all three of the initiatives. The differing experiences of

Oklahoma and Texas suggest that partisanship or ideology is not deterministic in whether states pursued the ACA HCBS policies. In Texas, leaders within the state Medicaid agency were able to overcome political and ideological opposition to the ACA by demonstrating the benefits to the state of the various HCBS options.

Governing Capacity

The second set of hypotheses examined the role of governing capacity in policy adoption. This study posited that four elements of governing capacity: bureaucratic capacity, gubernatorial power, legislative professionalism, and partisan control of state government may influence the adoption of the ACA's HCBS expansion options. The first hypothesis proposed that states with greater administrative capacity would be more likely to adopt these opportunities. Federal reports suggest that limited state staff was one impediment to states' adoption of the ACA HCBS policies (Government Accountability Office, 2012; CMS, 2015). The quantitative findings; however, offer limited evidence for the role of bureaucratic capacity in states' adoption decisions. In most of the models, the measure of bureaucratic capacity, as measured by the number for full-time equivalents per 1,000 population, was not significant. In the BIP model, states with fewer state employees per capita were more likely to pursue this policy, contrary to expectations. One reason for this unexpected finding could be that state officials realized that they could use the enhanced BIP funding to hire additional staff within HCBS programs, thereby bolstering limited state capacity in this area. The enhanced BIP revenue was substantial, and states that experienced significant reductions in staff due to the Great Recession may have perceived the BIP funding as a mechanism to increase staffing levels. Subsequently, states may have incorporated those positions into the state budget after BIP ended given that funding through the program was time limited (i.e., 2011 to 2015).

While the quantitative results did not indicate that greater bureaucratic capacity increased the likelihood of policy adoption, the qualitative findings provide a different perspective on bureaucratic capacity. In particular, the case studies suggest the determinative element in state policy adoption may be specific bureaucratic leaders rather than the overall size of the bureaucracy. In Maryland's and Texas' policy adoption decisions, a common factor across all three policies was leaders within the Medicaid or disability agencies who advocated for the pursuit of each policy. These leaders were key drivers in getting their states to consider and ultimately adopt these policies. In contrast, top leaders in the Oklahoma Medicaid and disability service agencies were not pushing for the adoption of these policies in their state. This finding is consistent with literature on Medicaid policymaking which identifies states bureaucrats, rather than legislators or the governor, as leading Medicaid policy change (Schneider & Jacoby, 1996; Schneider, Jacoby, & Cogburn, 1997; Miller, 2006).

The importance of bureaucratic leaders to shepherd the adoption of the ACA's HCBS expansion options is akin to Kingdon's (1995) policy entrepreneurs' argument. According to Kingdon, policy entrepreneurs are individuals, inside or outside of government, who advocate and push for their desired policies to be enacted. The presence of a policy entrepreneur can be an important determinant in whether governments adopt specific policies by coupling policy problems with policy solutions. The findings from this study provide evidence for Kingdon's argument about the importance of policy entrepreneurs in the policymaking process. Both Maryland and Texas had Medicaid directors and agency heads who recognized the benefits of the ACA HCBS programs to expand access and address existing issues in their HCBS systems. By coupling the solution, represented by the ACA expansion options, with the problem of meeting the increasing demand for HCBS; state bureaucratic leaders in Maryland and Texas

played a crucial role by investing time and resources to make the case to elected officials and interests groups of the value of pursuing these options.

The second governing capacity hypothesis proposed that states with greater gubernatorial power would be more likely to adopt the ACA's HCBS expansion options. Overall both the quantitative and qualitative results provided limited support for the importance of strong governors in HCBS policy adoption. In the quantitative portion of this research, gubernatorial power was measured using an index of six components of gubernatorial power: separately elected executive-branch officials, tenure potential, appointment power, budget power, veto power, and party control. The only models for which this variable was significant were with the BIP dependent variable, and it was the opposite sign as expected. Contradictory to expectations, states with governors with weaker powers were more likely to pursue BIP.

The empirical literature on the importance of gubernatorial power in policymaking is ambiguous. While some studies demonstrate that stronger governors increase the likelihood of state policy adoption, other studies do not find a statistically significant relationship between state policymaking and gubernatorial power (Dye, 1969; Ferguson, 2003; Bowling & Ferguson, 2001). Bowling and Ferguson find that strong governors have more success spurring policy adoption in some policy areas but not others (Bowling & Ferguson, 2001). Studies focused on health care and Medicaid LTSS specifically have not found a significant relationship between gubernatorial power and state policy adoption (Bowling & Ferguson, 2001; Miller & Wang, 2009; Miller et al. 2012). This study is consistent with other studies in this area and finds that Medicaid HCBS policymaking is a policy area where gubernatorial power does not seem to have a discernable impact. One potential reason for this lack of effect is that the details of Medicaid HCBS policymaking are often the purview of state bureaucrats rather than the governor. That

this is the case is supported, again, by the qualitative interviews where the governor was not mentioned as a significant player in Medicaid HCBS decision making in any of the states studied.

This study also posited that states with more professional legislatures would be more likely to adopt the ACA HCBS policies. However, in nearly all the models, the variable measuring legislative professionalism (i.e., the average state legislator salary) was not statistically significant. Some scholars have argued that more professional legislatures have access to additional staff and resources which can lead to earlier policy adoption and increase the likelihood of states' adopting generous social welfare policies (Walker, 1969; Hayes, 1996; Rom, 2014). However, empirical studies testing the impact of legislative professionalism on policy innovation suggest the impact depends on the specific policy area examined (Carter and LaPlant, 1997; Karc, 2006). Studies specifically focused on health care and Medicaid LTSS policies have found legislative professionalism to influence state adoption of some policies but not others (Bowling & Ferguson, 2001; Miller & Wang, 2009; Miller et al. 2012). The results from this study indicate that HCBS policy is an area where the degree of legislative professionalism does not influence policy adoption. As with gubernatorial power, one explanation for this result is that the state bureaucrats, rather than the legislature, often make decisions about adopting new Medicaid policies while the legislature is more focused on overall Medicaid spending.

The final governing capacity hypothesis relates to the impact of partisan control on policy adoption. This study predicted that states would be more likely to adopt the ACA HCBS policies under unified government, when the legislature and governor's office were controlled by the same party, because with unified government, there are fewer roadblocks to policy adoption

(Berry & Berry, 1990). In this study, the impact of partisan control varied depending on the policy. In models predicting the adoption of BIP and any of the ACA HCBS expansion policies partisan control of government had statistically significant and negative impacts on adoption, opposite of expectations. With the 1915(i) program, the partisan control variable was marginally significant and positive in some models while in the CFC model, this variable was not significant. The 1915(i) and CFC findings are consistent with most of the literature on partisan control within health care which found either unified government increases policy development or is not statistically significant (Miller, 2005). The negative relationship between unified government and BIP adoption was contradictory to expectations but there is some evidence that unified government decreases the likelihood of adopting specific policies (Berry & Berry 1990; Bowling & Ferguson, 2001).

The different impacts of partisan control on BIP and 1915(i) adoption may be attributable to programmatic differences between these two options. BIP was a time-limited grant opportunity with enhanced revenue while the 1915(i) is a permanent state plan benefit with no enhanced match. Since BIP resulted in additional federal revenue, states with divided government may not have encountered opposition from the political party controlling the other branch of government when pursuing this option. In contrast, unified government may have increased the likelihood of pursuing the 1915(i) because the benefit is permanent and requires the legislature to appropriate additional funding for the program. Some states also require legislative approval or notification prior to submitting a state plan amendment which may have made pursuing a state plan benefit easier under unified government.

Interest Groups

This study also examined the role that interest groups play in policy adoption. Within HCBS policymaking, several different groups may have an interest in the adoption of the ACA expansion options including provider groups, both institutional and home care, and consumer advocates, including those representing elders and individuals with physical disabilities, developmental disabilities, and mental illness. This research hypothesized that states with stronger nursing facility lobbies would be less likely to pursue these options while states with stronger home care provider, elder, and disability lobbies should be more likely to adopt these policies. This study measured the strength of the nursing facility lobby as the number of nursing facility beds per 1,000 age 65+ and the percentage of for-profit nursing facility beds. The measure for the strength of the home care industry was the number of home health agencies per 100,000 population. The percentage of the population aged 65 and older and the percentage of the population with a disability measured the strength of the elder and disability lobbies, respectively. These variables were proxies for interest group influence under the assumption that the respective lobbies would be stronger when whomever they were representing had a greater presence in the state.

The results provide mixed evidence for the impact of nursing facility providers on HCBS policy adoption. While the literature suggests that more institutional beds per capita is associated with less spending and use of HCBS options by states (Miller, Harrington & Goldstein, 2002; Miller et al. 2008), the findings of this study indicate that the influence of nursing facility providers on policy adoption may depend on the policy in question. On the one hand, in the adoption decisions of BIP and the 1915(i), the nursing home variable was positively related to

adoption of these policies. On the other hand, with the adoption of CFC, states with more nursing facility beds per elder were less likely to pursue this option.

The negative impact of the number of nursing facility beds on CFC adoption but not the other two programs may be due to differences in these programs and the populations served. CFC had the potential to have a larger impact on the industry than BIP or the 1915(i). To achieve BIP's requirement of spending at least 50% of Medicaid LTSS spending on HCBS, states did not necessarily need to reduce expenditures on nursing homes. States could meet this goal by increasing spending on HCBS while maintaining the same level of spending in the institutional sector. With the 1915(i) HCBS state plan benefit, the eligibility criteria requires that individuals enrolled in this benefit do not require an institutional level of care; therefore, this program is not exclusively targeting potential nursing home residents. Also, many states are utilizing the 1915(i) benefit to provide HCBS in the community to individuals with serious mental illness. Thus, for many states, potential 1915(i) enrollees and nursing home eligible individuals do not overlap. In contrast to BIP and the 1915(i), CFC could result in fewer nursing home residents. CFC requires that individuals meet an institutional level of care to be eligible for the program and does not allow states to target the benefit by age or type of disability. Therefore, in states pursuing CFC, the program could be a substitute for nursing home care and could contribute to more people receiving services in the community through CFC.

This study used the number of nursing home beds per 1,000 elders as a proxy for the strength of the nursing home industry. In analyzing these findings, one consideration is that this variable might not reflect the lobbying strength or influence of this industry but instead could be an indication for nursing home supply. A high number of nursing facility beds per elder population may indicate that a state spends a high percentage of Medicaid LTSS spending on

institutional care. These states may have been more likely to pursue BIP because they needed to make more progress on rebalancing consistent with the goal of the program. States with more nursing facility beds per elders may have been more likely to pursue the 1915(i) HCBS option because of gaps within the state in providing HCBS to individuals who do not meet an institutional level of care. The 1915(i) state plan benefit eligibility is a lower level of need than an institutional level of care. If a state has a high number of nursing facility beds per elder population, the state may have sufficient capacity to meet the needs of the population in need of an institutional level of care but may desire to provide Medicaid LTSS to other individuals who are not as impaired. States with more nursing facility beds per elder population may have been less likely to pursue CFC because these states have a sufficient supply of institutional LTSS providers to meet the needs of the population. On the other hand, states with fewer nursing home beds may have perceived CFC as a way to increase LTSS options for individuals who need institutional care because nursing home supply was low.

This research also hypothesized that the strength of the home care industry would increase the likelihood of adopting the ACA HCBS programs. The literature suggests that more home health agencies contribute to greater HCBS participants and expenditures (Kitchener, Carrillo, and Harrington, 2004; Miller et al., 2006). As with the nursing facility findings, the results are mixed and suggest that the role of the home care industry depended on the specific policy. The home care industry variable had a positive impact on adopting the 1915(i) or any of the ACA HCBS policies, consistent with expectations. This variable, however, was not statistically significant in the BIP or CFC models.

The influence of home care industry on the adoption of the 1915(i) and not BIP or CFC is somewhat counterintuitive. The positive impact of this variable in the 1915(i) model was

consistent with the hypothesis; however, one might expect that the home care industry would have the smallest impact on the 1915(i) adoption as compared to BIP or CFC. Many states' 1915(i) programs are focused on individuals with serious mental illness and serve a small number of individuals; therefore, the home care industry may not realize an increase in clients under this option. In contrast, BIP and CFC had the potential to be much larger programs and possibly result in greater numbers of new home care recipients which could provide a larger benefit to the industry. A possible explanation for why there was not a positive relationship between home health agency supply and BIP adoption is that home care providers may have been wary of some of the requirements related to BIP. As part of BIP, states needed to ensure that their assessment instruments captured core elements and case management was conflict free. These requirements could have placed added burdens on home care providers. With CFC, the impact of the program on the home care industry may have varied depending on each state's CFC program. If a large portion of a state's CFC participants ending up self-directing their care rather than utilizing home care agencies then the positive impact of adoption on the home care industry could be minimized.

This research used the number of home health agencies per 100,000 population as a proxy for the strength of the home care industry. As with the nursing home measure, the number of home health agencies per population could be an indicator of the strength of the home care industry but is most directly an indication of supply. The positive relationship between the number of home health agencies and 1915(i) adoption may make more sense when considering this variable as a measure of supply. On the one hand, this finding may indicate that states with stronger home care lobbies may have been more likely to adopt the 1915(i) program which, potentially, might benefit the industry despite a predominant focus on persons with serious

mental illness. On the other hand, the findings may indicate that states with more home health agencies may have excess HCBS provider capacity and be able to serve new populations such as individuals with serious mental illness under the 1915(i) program.

This research hypothesized that the strength of advocacy groups for elders and persons with disabilities would increase the likelihood of adopting the ACA HCBS programs. These variables were measured as the percentage of the population aged 65 and older and the percentage of the population with a disability. As with the provider results, this study's findings suggest that the impact of advocacy groups for elders and persons with disabilities varied depending on the policy. Contrary to expectations, the proportion of elders within the population negatively predicted the adoption of BIP, any ACA HCBS expansion policy, and proportion of eligible ACA HCBS expansion policies each state adopted. The percentage of the population with a disability was statistically significant and positive in the BIP and adoption of any ACA HCBS expansion policy regressions which is consistent with expectations. Thus, the results indicate that a higher percentage of elders in the population decreased the likelihood of pursuing BIP and any of the ACA HCBS policies while a higher percentage of individuals with a disability increased the likelihood of adopting these policies. The negative finding of the percentage of elders on states' adoption of BIP is unexpected. Most states have achieved less rebalancing of Medicaid LTSS spending for elders compared to individuals with intellectual disabilities and developmental disabilities (ID/DD). In addition, the majority of elders express a desire to age in their own homes and communities. For these reasons, one would expect elder advocacy groups to support BIP which encouraged states to increase HCBS spending.

One possible reason for the contradictory findings is that the percentage of elders could reflect demand for HCBS programs among older adults rather than the strength of consumer

advocacy organizations. If this variable measures demand, as opposed to advocacy strength, one explanation for the unexpected result may be that this measure was not sensitive enough. This variable used the percentage of the population age 65 and older; however, nearly 75% of individuals age 65 and older living in the community do not have functional limitations (Congressional Budget Office, 2013). The percentage of the population age 65 and older may, therefore, not sufficiently captured the demand for HCBS among elders. An alternative measure might be the population age 85 and older because 54% of this subset of elders has a functional limitation (Congressional Budget Office, 2013). In contrast to the elder measure, the disability variable may better capture the percentage of the population who have HCBS needs. The American Community Survey disability measure includes questions about whether an individual has an ambulatory, self-care, or independent living difficulty which may be a better indication of HCBS needs than the population age 65 and older.

The qualitative findings also indicate that the elder and disability variables may be capturing demand for LTSS rather than the strength of consumer advocacy organizations. Both national and state-level interviewees highlighted that, in general, advocates were not pressuring states to pursue BIP. Instead, bureaucrats within the state Medicaid or disability services agencies were the main driving force for adopting this program. With CFC and the 1915(i), consumer advocates were more influential in the policy adoption decision; however, interviewees also highlighted the important role state bureaucratic leadership played in the adoption of these policies.

Economic Factors

This research hypothesized that economic factors impacted states' adoption of the ACA's HCBS policies. More specifically, higher state wealth and stronger fiscal health were posited to

increase the likelihood of policy adoption. Within LTSS and HCBS policies, research indicates that higher state per capita income is associated with higher nursing facility and HCBS expenditures per capita (Miller et al., 2001; Miller et al. 2002; Kitchener et al., 2003; Miller et al., 2005, Miller et al., 2006). The results from this study; however, indicate that, in general, state per capita income was not associated with a greater likelihood of adopting the HCBS policies examined. In most models, state per capita income was not significant and in the model with the dependent variable measuring the percentage of eligible policies adopted the per capita income variable was significant, but it had a negative impact. This finding contradicts research that state per capita income is associated with greater HCBS spending and may imply that within HCBS policymaking, the factors that influence the level of spending once a policy is adopted may differ from the factors that influence the adoption decision.

The quantitative analysis also examined the role that fiscal health, as measured by the state's unemployment rate, had on HCBS policy adoption. This study hypothesized that states in better fiscal health would be more likely to adopt these policies. States in poor fiscal health often do not adopt new policies with added costs and instead look at cutting back existing Medicaid programs by modifying eligibility requirements, decreasing provider rates, or eliminating benefits (Wides, Alam, & Mertz, 2014; Snyder & Rudowitz, 2016). In addition, a GAO study about states' decisions to pursue the ACA's HCBS opportunities found that ongoing fiscal challenges and budget concerns were a barrier to adopting these policies (GAO, 2012). The quantitative findings from this study offer support for the role of fiscal health in the BIP policy adoption decision but not the other policies. Consistent with expectations, states with lower unemployment rates were more likely to adopt BIP; however, the quantitative findings suggest that the state unemployment rate did not influence the adoption decisions related to CFC and the

1915(i). The BIP finding supports the fiscal health hypothesis, as states with a lower unemployment rate may have been better positioned to increase spending on HCBS as required by the program.

The findings that the unemployment variable was not significant in the CFC and 1915(i) models is unexpected. Both programs are state plan benefits; as such, states pursuing these options would need to match any increases in federal Medicaid revenue with state funding. This ability to match should be more challenging in adverse fiscal environments. Contrary to the quantitative findings, the qualitative analysis suggests that one barrier to adopting CFC and the 1915(i) was the state share of Medicaid spending. One reason Oklahoma and other states have not pursued these policies is because the state would need to come up with additional state revenue to match the federal portion of Medicaid spending. This finding is consistent with research suggesting that the state share of Medicaid spending is a barrier to adopting new HCBS programs more generally (Merryman et al., 2015; GAO, 2012).

A third fiscal factor identified in the qualitative research is the role of the enhanced federal match in the policy adoption decision. States adopting BIP and CFC received additional federal matching revenue for HCBS expenditures related to these programs. The enhanced match reduces the state share of Medicaid spending. For both programs, states pursued these options, in part, because the federal government provided additional revenue. In Maryland and Texas, the enhanced federal revenue associated with the program was essential for both states' adoption of CFC. Research suggests that enhanced federal revenue under the ACA has made the HCBS expansion options more attractive for states (GAO, 2012).

Existing Home and Community-based Services and Long-Term Services and Supports Policies

This study hypothesized that existing HCBS, LTSS, and Medicaid policies would impact states' adoption of the ACA HCBS opportunities. Research on Medicaid policymaking suggests that previously adopted policies are crucial to understanding the adoption of subsequent policies (Satterthwaite, 2002; Jacobs & Callaghan, 2013). The quantitative results provide evidence of the impact of existing HCBS policies and programs on the adoption of the ACA's HCBS options. States with more 1915(c) waivers and higher HCBS spending per capita were more likely to pursue some of these programs indicating that states with a commitment to HCBS took advantage of new opportunities to further rebalance LTSS. In addition, states with a lower percentage of Medicaid LTSS spending on HCBS programs were also more likely to pursue these options because a goal of these programs, especially BIP, was to encourage states, which had made less progress in rebalancing, to increase HCBS spending.

The quantitative results suggest that states with more 1915(c) waivers were more likely to pursue CFC and any of the ACA HCBS policies, and adopted a higher proportion of the ACA HCBS policies for which they were eligible to adopt. In addition, HCBS spending per capita was positively related to CFC adoption. States were also more likely to pursue the ACA HCBS programs if they were spending a lower percentage of Medicaid LTSS on HCBS. Specifically, states were more likely to pursue the BIP, 1915(i), and any ACA HCBS option if they had a lower percentage of Medicaid LTSS spending devoted to HCBS. This finding suggests that states with a lower percentage of LTSS spending on HCBS pursued the BIP and 1915(i), in part, as a means of increasing spending on HCBS programs.

The findings that states with a large number of 1915(c) waivers and a lower percentage of Medicaid LTSS spending on HCBS were more likely to adopt the ACA HCBS options may seem contradictory because the former suggests a greater commitment to rebalancing LTSS while the latter does not. However, these findings could be explained because the number of waivers and Medicaid HCBS spending percentage had an impact on different programs. The number of 1915(c) waivers had a positive impact on CFC while the percentage of Medicaid LTSS spending had a positive impact on BIP and the 1915(i). The quantitative and qualitative findings suggest that some states are using CFC to receive the enhanced match for existing HCBS services, such as 1915(c) waivers and state plan personal care benefits, to streamline HCBS offerings. States adopting CFC are moving some services offered through waivers into this benefit. In contrast, the results related to BIP and the 1915(i) indicate states are using these programs to increase spending on HCBS and not necessarily to substitute existing services with a new program. A goal of BIP was to increase state spending on HCBS; therefore, this finding is consistent with the purpose of the program. BIP and the 1915(i) complemented states' policy goals of increasing the percentage of Medicaid LTSS spending devoted to HCBS and providing HCBS benefits to underserved populations, including individuals with serious mental illness.

The results also indicate that states that adopted an ACA HCBS policy in the previous year were less likely to adopt another one of these policies in the subsequent year. The findings provide some support for research that states have limited staff bandwidth to pursue multiple HCBS programs at the same time. A GAO report about states' adoption of these options highlighted that, within state government, the individuals responsible for writing the state plan amendment, working with CMS to approve the amendment, and implement the program are often the same individuals (GAO, 2012). In addition, in the case studies of Maryland and Texas,

the state bureaucrats who were involved in the policy adoption decision were also responsible for implementation. During the interviews, state bureaucrats indicated that, when pursuing these policies, they needed to focus their attention on these new programs to the detriment of their other responsibilities. Since states have limited staff, many states may be unable to pursue multiple new HCBS programs at the same time.

This study also examined the impact of other existing LTSS policies on adoption of the ACA HCBS policies. Specifically, the hypotheses proposed that nursing facility and home health aide certificate of need programs (CON) would influence policy adoption. Research suggests that states with nursing facility CON programs invest more in HCBS while states with home health agency CON programs devote relatively less LTSS spending to 1915(c) waivers (Miller, Ramsland, & Harrington, 1999; Miller et al., 2001). Nursing facility CON programs may suggest a greater commitment to rebalancing HCBS while home health aide CON programs may indicate less of a commitment to rebalancing. The results of this study are opposite of expectations with states with nursing facility CON programs less likely to adopt BIP while states with home health aide CON programs more likely to adopt this program. These counterintuitive findings should be interpreted with caution. Many states, such as Maryland, have both a nursing facility and home health aide CON program which would suggest an ambiguous commitment to rebalancing while others, such as Texas, have neither. Interviewees in both Maryland and Texas indicated that a goal of their respective states was rebalancing LTSS; therefore, the presence or lack of CON programs may, in fact, not be reflective of a state's attitude towards rebalancing. While both states were committed to rebalancing, the role of nursing facility or home health agency certificate of need programs was not cited as a factor in the adoption decisions in the qualitative findings.

This study also hypothesized that a state's Medicaid eligibility policies may influence policy adoption. Specifically, it was posited that the direction of the relationship could go either way, that states that allowed the medically needy to enroll in Medicaid could be more or less likely to adopt the ACA policies. On the one hand, research suggests states with more generous Medicaid eligibility may face increased pressure to control spending (Harrington et al., 2000; Miller and Wang, 2009b) and may perceive HCBS programs as a less costly alternative to institutional care. On the other hand, research indicates that states with a medically needy program are less likely to pursue 1915(c) waivers (Lindsey, Jacobson, and Pascal, 1990; Nelson, 2007). The findings from this study indicate that offering a medically needy program did not influence states' adoption decisions. In the quantitative models, the variable indicating whether the state had a medically needy program was not significant for nearly all programs with the exception of one of the models for the 1915(i) program. The qualitative findings confirmed these results with interviewees in Maryland, Texas, and Oklahoma not mentioning state financial eligibility policies factoring into the ACA HCBS policy adoption decisions.

External Factors

This study posited that the policy adoption process was not only shaped by factors internal to the state but also external factors including federal policy and the policy adoption decisions of other states. In the quantitative analysis, this study measured federal policy change based on CMS's issuance of the HCBS final rule in January 2014. Through the final rule, CMS provided implementing regulations for the 1915(i) HCBS state plan benefit and defined the requirements for HCBS settings for 1915(c) waivers, the 1915(i), and CFC. Unfortunately, the impact of federal policy in this study could not be examined in the quantitative methods because of the high correlation with other variables included in the regression models. However, the

qualitative case studies suggested that communication and clarification from CMS partly influenced the timing of when states adopted the ACA HCBS options. Interviewees conveyed that, in some instances, states were waiting on further information from CMS before making a decision. Future research should consider alternative ways to quantitatively measure the influence of federal policy change on state policy adoption decisions in this area.

This study provides some support for the role of neighboring states in policy adoption decisions. The literature indicates that states may look to nearby states to address common policy problems or learn from the experiences of other states (Balla, 2001; Berry & Baybeck, 2005; Miller & Banaszak-Holl, 2005). The findings of this study suggest states were more likely to adopt BIP and any of the three ACA HCBS policies, and a higher portion of policies for which they were eligible to adopt, if neighboring states had adopted these policies previously. The quantitative findings indicate that the policy adoption decisions of neighboring states did not impact the 1915(i) or CFC policy decisions. One reason neighboring states' adoption of BIP may have influenced the policy decisions of nearby states is that BIP was available for states to adopt only between 2011 and 2014. Thus, states needed to make a decision about whether to participate in BIP within a short timeframe. To make the decision quickly, states may have looked to nearby states' experiences with the program.

Interestingly, in the qualitative analysis of the 1915(i) adoption, interviewees and reports suggested the decisions of other states played a role in Maryland and Texas' adoption of this policy option. However, the states that influenced Maryland and Texas' decision were not contiguous states. Officials in Maryland consulted with other Community Alternatives to Psychiatric Residential Treatment Facilities state grantees while Texas looked at the experiences of Louisiana, Oregon, and Wisconsin. The findings of this study suggest for some HCBS policies

neighboring states played a role in the decision but for other policies, broader interstate networks may play a more important role.

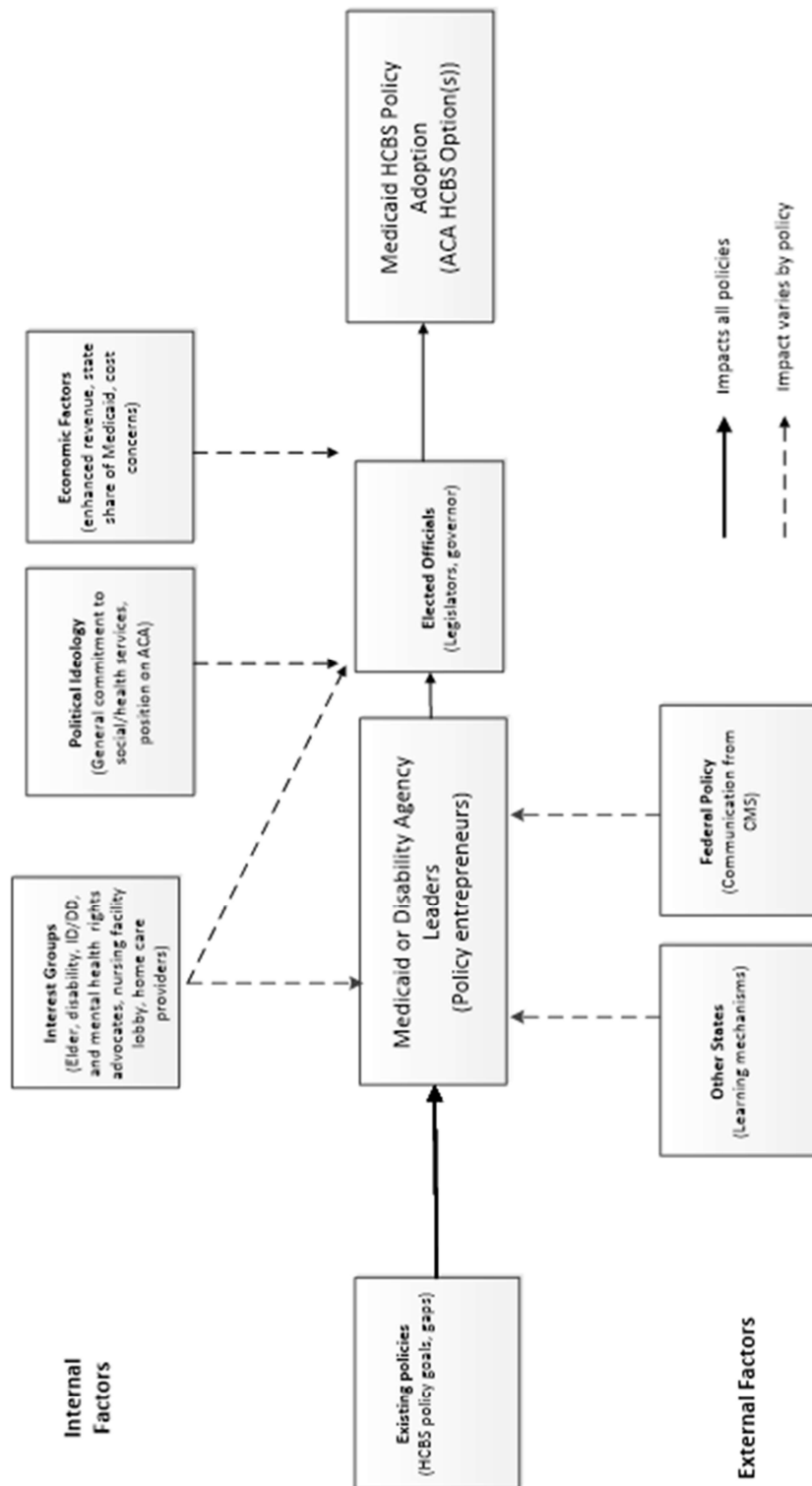
Revised Policy Adoption Conceptual Framework

This study proposed a preliminary conceptual framework that identified state bureaucrats as the key factor in HCBS policy adoption, and factors internal and external to the state that could influence the decision making process. Figure 8.1 presents a revised conceptual framework based on the quantitative and qualitative results. In the revised conceptual framework, state bureaucrats are high level administrators in the state Medicaid agency or disability service agencies including the state department of aging, intellectual disability/developmental disability (ID/DD) department, and mental health department. Leadership in these agencies act as policy entrepreneurs and shepherd the decision to adopt policies through state government. The key factor influencing these bureaucrats are the existing HCBS policies of the state. These leaders recognize the gaps, challenges, and opportunities with Medicaid HCBS policies in their state. They are able to couple these problems with solutions presented by the ACA HCBS initiatives and use their knowledge of HCBS policy and state government to convince others within state government, including the governor and legislature, of the benefits of pursuing new HCBS initiatives.

As in the preliminary conceptual framework, factors internal and external to the state may impact the decision making process. The revised conceptual framework acknowledges that the factors that influence adoption may vary by specific policy. In this case of interest groups, this variation is represented by the dashed line going from the interest groups to the Medicaid or disability agency box and the dashed line going from the interests groups to the elected officials' box. The results from this study suggest that interest groups were influential in the adoption

decisions of some of the programs but not all. In addition, interest groups may advocate directly with the state agency but also with elected officials, such as the governor and legislators, related to these programs.

Figure 8.1: Revised Conceptual Framework



ID/DD: intellectual disabilities/developmental disabilities, ACA: Affordable Care Act, HCBS: home and community-based services, CMS: Centers for Medicare and Medicaid Services

In pursuing new policies, state bureaucrats often need to convince elected officials to adopt these programs and may encounter both political and fiscal impediments depending on the specific policy. These potential impediments are indicated in the revised conceptual framework by the dashed line between state political ideology and economic factors and elected officials. Ideological opposition to specific legislation, such as the ACA, or general opposition to federal involvement in state policy can pose a barrier to adoption of some policies. In addition, states bureaucrats may desire to expand HCBS options but face fiscal barriers. When adding new Medicaid HCBS options, states need to come up with additional state funding to cover the state share of Medicaid spending. In addition, states have concerns about cost overruns especially with state plan options which do not allow states to implement waiting lists. Elected officials may fear political repercussions from the public if the state pursues unpopular programs and also must decide whether to make the resources available to the fund new programs. Both political and economic factors can make it more difficult for state bureaucrats to convince elected officials to pursue new policy opportunities

The impact of factors external to a state on policy adoption can also vary by program. The variation by programs is indicated by dashed lines between others states and federal policy, and state bureaucrats. State bureaucrats may discuss with and look at the policy experiences of other states to learn about what different states are doing in terms of policy adoption. Depending on the specific policy, states may look at neighboring states, as in the case of BIP and CFC, or broader interstate networks, as in the case of the 1915(i). In addition, information provided by CMS to states can also influence adoption; particularly the timing of adoption of some programs. The results indicated that some states were waiting for more information from CMS before deciding to move forward with the programs.

In conclusion, the revised conceptual framework highlights that state bureaucratic leaders within the Medicaid or disability services agencies are key to policy adoption. Within the states, existing HCBS programs are the primary factor influencing bureaucratic decision-making. Interest groups also play a role in the decision making process for some policies, and political and economic factors can pose as facilitators or impediments to adoption. Externally, states also look at the decisions of neighboring states and larger networks of states depending on the specific policy. Communication from CMS can influence state decision making particularly around the timing of policy adoption.

Policy Implementation

In addition to the adoption decision, this research examined the implementation process of the three ACA HCBS policies in Maryland and Texas. Based on the literature, Chapter 3 presented propositions of factors that may impact implementation. These propositions posited that clarity and flexibility from the federal government; buy-in among non-government stakeholders; minimal change; and sufficient staffing and financial resources are key to the implementation process. The findings from the case studies suggest that most of these factors facilitated implementation but that the amount of change from existing policies and financial resources can be both facilitators and barriers to implementation.

Communication and Flexibility from Federal Government

The findings from the case studies indicate that communication from CMS and their consultants influenced states' implementation of the ACA HCBS policies. Policy implementation literature from a top-down perspective highlights the importance of clear communication and objectives from the federal government while literature from a bottom-up perspective emphasizes the importance of flexibility and local control (Van Meter & Van Horn,

1975; Sabatier & Mazmanian, 1979; Berman, 1978; Hjern & Porter, 1981). The results from this study demonstrate the role of both top-down and bottom-up factors in facilitating policy implementation. Maryland's and Texas' experiences implementing BIP and the 1915(i) show the importance of clarity and flexibility in policy implementation.

When implementing BIP, CMS and their consultants, Mission Analytics Group, provided well-defined requirements for the three structural changes required: the No Wrong Door/Single Entry Point system, conflict-free case management, and the core standardized assessment. The BIP program manual and website provided states with specifics on CMS's expectations and examples of how to achieve these requirements. Moreover, CMS and Mission Analytics held monthly status meetings with state officials which helped states meet the program requirements. State officials felt that regular progress meetings with CMS and Mission Analytics facilitated their implementation of the program. Clear and frequent communication among states, CMS, and Mission Analytics helped states' implementation of BIP especially given the program's short duration.

CMS and Mission Analytics also sought to provide states with flexibility in meeting the BIP requirements based on each state's own interpretation of the legislation. In particular, with the core standardized assessment requirement, states could approach meeting this requirement in different ways, as Maryland and Texas did. To meet this requirement, Maryland adopted new assessment tools while Texas updated existing assessments to add new questions. With this flexibility, states could achieve the core standardized assessment requirement based on what worked best for their state. In contrast to BIP, with the 1915(i), CMS could not allow states flexibility with the income eligibility criteria. While Maryland repeatedly sought to serve children with income above 150 percent of the federal poverty level through the 1915(i), CMS's

interpretation of the 1915(i) authority did not allow Maryland to serve this population. Instead Maryland needed to pursue an alternative state plan amendment in addition to the 1915(i) due to CMS's inflexibility in this regard. The implementation of the BIP and the 1915(i) differed, in part, due to varying degree of flexibility afforded by CMS.

Involvement of Non-Governmental Stakeholders

The findings from this research are also consistent with bottom-up approaches to policymaking which emphasize the implementation process at the local level and the importance of communication among implementation partners (Berman, 1978; Thomas & Allen, 2016). The experiences implementing BIP, CFC, and the 1915(i) not only involved state-level bureaucrats within the Medicaid agency but also consumer advocates, provider representatives, Aging and Disability Resource Centers, Area Agencies on Aging, local ID/DD authorities in Texas, and behavioral health authorities in Maryland.

Across all three programs, interviewees conveyed that the implementation process could have gone smoother if state officials better engaged and communicated with stakeholders involved in implementation outside of state government. Consumer advocates in Texas suggested that they were not comfortable with the level 1 screening tool required by BIP; furthermore, entities responsible for administering the tool, including Aging and Disability Resource Centers and local authorities, were not involved in developing the questionnaire. In Maryland, mental health providers indicated that the training on the new BIP assessment tool for individuals with mental illness was inadequate. Thus, when implementing BIP, neither Texas nor Maryland sufficiently engaged and explained the changes made to individuals and organizations responsible for portions of the program's implementation. The rollout of new assessment and

screening tools may have gone smoother if external stakeholders were more engaged, had more input, and understood the rationale for the changes instituted by state officials.

States also experienced issues implementing the 1915(i) because of a lack engagement with local entities and providers. Local behavioral health authorities were responsible for administering the program in Maryland. In interviews, staff from the behavioral health authorities cited insufficient guidance and resources provided by the state to serve greater numbers of individuals with serious mental illness. Not only did Texas officials fail to provide clear guidance, according to interviewees, but changed instructions to providers during the implementation process. In addition, both states struggled with having enough providers who were willing and able to offer 1915(i) services. Overall, the findings suggest that greater engagement with potential 1915(i) providers earlier in the development process may have identified some of the barriers for providers such as low reimbursement rates and concerns about providing services to individuals with serious mental illness in the community.

Consistency with Existing Policies and Programs

Research suggests the implementation process is easier when new policies are consistent with existing policies and the amount of change is minimal (Van Meter & Van Horn, 1975). The findings of this study offer some support for this proposition but also identify ways in which existing policies complicate the implementation process. Maryland and Texas encountered difficulties implementing the 1915(i) because both states were serving individuals with serious mental illness-- a population that historically has been underserved by HCBS programs. Both states needed to recruit additional providers because the 1915(i) program differed from existing HCBS offerings. Implementation proved challenging as both states faced difficulties due to a lack of providers willing or able to offer these services.

Lack of consistency in financial eligibility for the 1915(i) and other Medicaid programs also proved problematic. As an example, Maryland's Medicaid program serves children and families with income up to 300% of Supplemental Security Income (\$2,250 per month in 2018); however, the 1915(i) authority caps income at 150% of the federal poverty level (\$1,517 per month in 2018). Given these differences, the state needed to develop processes to distinguish individuals specifically eligible for 1915(i) services. In addition, to provide services to children on Medicaid whose income was above 150% of the poverty level, Maryland chose to develop a second state plan amendment to offer case management services to individuals not financially eligible for the 1915(i). Together the findings suggest that the implementation process of the 1915(i) may have been easier if Maryland and Texas already had Medicaid providers who could offer these services and if anyone with Medicaid in their states could receive this benefit, as opposed to only those below 150% of federal poverty level.

On the other hand, existing HCBS programs presented both facilitators and barriers for states when implementing CFC. In Maryland and Texas, the CFC program was generally consistent with existing programs. Many of the individuals enrolled in CFC were already receiving services through waivers or the state plan personal care program and many of the providers were already Medicaid HCBS providers. Both states sought to make the transition as seamless as possible for enrollees and providers when moving to CFC. Leveraging existing provider networks facilitated the implementation process. Maryland and Texas, however, also experienced challenges implementing CFC because of the preexisting HCBS programs they were offering. One issue both states encountered when merging existing programs into CFC was disparities in rates paid to providers across programs which Maryland and Texas decided to equalize. In addition, Texas experienced an unexpected increase in waiver participants' service

plan costs when moving to CFC. Texas officials expected that waiver participants would receive the same amount of personal care and habilitation services through CFC as they were in the waiver—the only difference being the funding source. However, CFC lacked annual service plan limitations which existed in the waiver. In response to higher than expected costs, Texas stopped enrolling new participants in the waiver to bring costs down. Overall, Maryland and Texas' experiences with the CFC suggest that existing HCBS programs can facilitate the implementation of new HCBS programs in some respects but also complicate the implementation process in other ways.

Sufficient Staffing and Financial Resources for Implementation

The final propositions focused on the importance of resources in policy implementation. According to Van Meter and Van Horn (1975), implementation success is more likely when policies include financial resources and agencies implementing the policies have sufficient staff. The implementation of BIP and CFC suggest that additional federal revenue facilitated implementation but with BIP the limited duration of the enhanced revenue also posed challenges. For BIP, the additional federal revenue facilitated the implementation of new assessment tools in Maryland and a level one screening tool in Texas. In addition, Maryland utilized the BIP and CFC enhanced revenue to make enhancements to the state's information technology systems to allow for better coordination of the new CFC program. However, the experience with BIP suggests that temporary programs with additional federal revenue can also present challenges for states. When additional financial resources are time limited, as with BIP, states face increased pressure to implement changes before the enhanced funding ends or find alternative revenue sources which can be challenging given state budget constraints. Therefore, additional federal revenue has both benefits and drawbacks for states during the implementation process.

In addition to financial resources, policy implementation literature suggests that the competence and size of agency staff can facilitate the implementation process (Van Meter & Van Horn, 1975). This research provided support for the importance of sufficient and knowledgeable state level staff in implementation of the ACA's HCBS expansion programs. Both Maryland and Texas, for example, could have benefited from additional manpower; this is indicated by the need for state staff to defer other responsibilities when devoting time to implementing CFC. Due, in part, to staff and knowledge limitations, both states thus involved external university-based consultants during the 1915(i) implementation process. The findings from this study suggest that when implementing new policies, state governments faced impediments posed by not having sufficient numbers of knowledgeable staff to perform such activities as marketing new programs, providing training, recruiting providers, and developing materials. States can facilitate the implementation process by bringing in experts with experience specifically related to the program area being implemented.

Study Limitations

Quantitative Methods

This study contributes to our understanding of state policy adoption decisions and implementation processes surrounding new HCBS programs, but there are several limitations. One limitation of the quantitative analysis was the relatively short timeframe for this study. States could begin adopting these policies in 2010, for the 1915(i), and 2011, for BIP and CFC. The time period for studying adoption of the 1915(i) and CFC programs ended in 2015 due to available data on the independent variables. Therefore, the maximum number of years of observations in the quantitative models was six. At four years, the timeframe for studying BIP was even shorter because states were only eligible to apply for BIP between 2011 and 2014. The

short-time frame limited the number of observations. A small sample limits the statistical power of the models estimated reducing the probability of finding a statistically significant relationship. In addition, in the quantitative models, I needed to use a stepwise approach to identify the key predictors of adoption because there were many possible predictors but a limited number of observations. The number of states that adopted CFC and the 1915(i) during this period was particularly small. Just eight states adopted the CFC program between 2011 and 2015, while just 13 adopted the 1915(i) between 2010 and 2015. By contrast, 21 adopted BIP during 2011-2014. Relatively few adoptions served to limit the ability to detect statistically significant relationships, and there is also more likely to be bias in the maximum likelihood estimates of a logit coefficients with a smaller number of observations. In the multivariate models, several of the independent variables perfectly predicted adoption or non-adoption of CFC and were dropped from the models.

A second limitation was that I was not able to examine the influence of federal policy change in the quantitative models. I hypothesized that the issuance of the HCBS final rule would influence states' adoption of these programs. The variable measuring federal policy change was highly correlated with the year indicator variables in the models and therefore could not be included in the models. The qualitative results provide some evidence that communication and clarification from CMS on the requirements of the programs played a role in the adoption decisions; however, the qualitative findings do not suggest the HCBS final rule was important in adoption. Future research should consider alternative ways to operationalize the role that federal policies and guidance play in the state HCBS decision making process.

A third limitation is related to the operationalization of some variables. Many of the variables were proxy measures and may not adequately capture the concept being measured. For

example, the number of nursing facilities and percentage of elders in the population were proxy measures for the strength of the nursing facility and elder lobbies in each state but these variables could also measure supply of institutional care and demand for long-term services and supports. The disability measure was also based on the overall percentage of the population with a disability and did not differentiate among physical, intellectual or developmental, and mental health disabilities. Significant differences exist in providing HCBS services to these various populations which this measure did not capture. In addition, the variable measuring bureaucratic capacity was the number of full-time equivalent state employees per 1,000 population. This variable does not capture whether these state employees are within the Medicaid agency or other departments involved in HCBS policymaking. One measure of existing HCBS policies was the number of 1915(c) waivers a state operates. This variable; however, does not capture the size of each state's waivers and whether the waiver is designed to serve a small, targeted population or whether the state has a waiting list for its waivers. In addition, states can offer HCBS services outside of 1915(c) waivers including through 1115 demonstration waivers or managed care.

A fourth limitation related to states' adoption of the 1915(i) benefit. With the 1915(i) states can adopt multiple 1915(i) benefits to serve different populations. In the quantitative analysis, the dependent variable for the 1915(i) was based on the year each state first adopted this benefit and did not allow for the adoption of multiple 1915(i) benefits. A few states that adopted the 1915(i) between 2010 and 2015 adopted more than one benefit during this time frame. Future research should examine whether the adoption of one 1915(i) by a state increases or decreases the likelihood of adopting subsequent 1915(i) benefits.

Qualitative Methods

The qualitative methods also had several limitations. One limitation with the case studies was that potential interviewees were not found or were unable or willing to participate in this study. I sought to compile a comprehensive list of potential interviewees but could not identify all individuals involved in HCBS policy in the respective states and nationally. In addition, approximately half of the individuals contacted for an interview did not participate in this study. In particular, I was not able to interview any representatives of institutional providers such as nursing homes. These potential interviewees either declined to be interviewed because they were not familiar with the programs or did not respond to my request for an interview. Potential interviewees who were not identified or declined to participate may have been able to contribute additional insights into the adoption and implementation processes of these programs.

Another limitation of the qualitative portion of the study was that when the interviews were being conducted states were still working through some of the implementation issues with respect to CFC and the 1915(i). CMS approved Maryland's CFC and 1915(i) state plan amendments in 2014 and Texas' state plan amendments for both programs in 2015. For this study, the interviews with officials in both Maryland and Texas were conducted in 2017. Since both Maryland and Texas were still working on implementing these programs, there may be barriers or facilitators to implementation that the states experienced after I conducted this research. Moreover, the two states may have resolved some of the barriers they encountered early in the implementation process. Future research should examine the implementation of these programs after more time has passed.

A final limitation of the qualitative research is that this study only examined the policy adoption decisions of three states and policy implementation processes of two states. Each U.S.

state's governing structure, economic climate, interest group activity, and existing HCBS policies are unique; therefore, the factors identified in this study may not necessarily be applicable to other states. This research emphasized the important role of existing HCBS policies in future policy development. The findings from this study may be more transferable to other states with similar HCBS programs but less applicable to states that provide HCBS through alternative mechanisms such as 1115 demonstration waivers. In addition, the findings to the 1915(i) may be more transferable to states that are using the option to provide HCBS to individuals with serious mental illness and less applicable to states that are using this benefit to serve other populations. Future research should examine the policy adoption decisions and implementation processes in other states.

Conclusion

This research focused on the policy adoption decisions and policy implementation processes of three ACA HCBS programs. The findings related to policy adoption indicate that political ideology, existing HCBS programs, and state bureaucrats who acted as policy entrepreneurs were common factors in adoption of the ACA HCBS programs. These findings are consistent with literature on Medicaid policymaking that suggest state bureaucrats within the Medicaid agency are the key decision makers for Medicaid policy changes. In addition, this study supports literature that finds previously adopted Medicaid policies are important determinants in the adoption of future programs (Satterthwaite, 2002; Jacobs & Callaghan, 2013). The factors that affect policy adoption can vary by program, however. For some programs, interest groups and neighboring states influenced the adoption decision while for other policies studied these factors did not play a role.

The implementation results provide support for both top-down and bottom-up approaches to implementation. Factors at the federal level, including communication with state officials and flexibility from CMS, facilitated the implementation process. In addition, the results suggest the importance of close engagement with local organizations. Staffing resources can make it easier for states to implement new programs while financial resources and consistency with existing programs can be both facilitators and barriers. Overall, the findings from this study are consistent with factors identified in the policy adoption and implementation literatures and expand our understanding of HCBS policymaking.

CHAPTER 9

CONCLUSION

The Affordable Care Act (ACA) included several opportunities for states to expand Medicaid funded home and community-based services (HCBS). States could elect to participate in the Balancing Incentive Program (BIP), Community First Choice (CFC), or 1915(i) state plan benefit. Between 2010 and 2015, twenty-nine states adopted at least one of these programs while three states adopted all three. This study sought to understand the internal and external factors that influenced states' decisions whether to adopt these policies as well as the facilitators and barriers to implementation. Understanding the factors that influence HCBS policy adoption and implementation contributes to the literature in these areas and has implications for both federal and state officials interested in long-term services and supports (LTSS) policymaking. At the federal level, understanding factors influencing state level policy adoption and implementation of HCBS programs can inform future federal efforts that promote rebalancing LTSS. Within states, the policy adoption decisions and implementation processes can have important insights for other states considering the ACA HCBS expansion opportunities. This research also suggests several areas of future research, including evaluating the impact of these programs and examining why some states decide to un-adopt these programs. Overall, this study contributes to our understanding of state level adoption and implementation of HCBS programs and can inform future policy development.

This chapter provides an overview of this study's contributions to the literature, policy implications, and other areas of potential research. First, this chapter summarizes this study's research questions, methods, and main findings. The next section discusses the contributions to the literature on policy adoption, implementation, and the ACA. The third section examines the policy implications for adoption while the fourth section discusses the implications pertaining to policy implementation both at the federal and state level. The next section proposes areas of future research, and the final section is a conclusion.

Overview of Research Questions, Methods and Findings

This research sought to examine states' policy adoption decisions of three HCBS programs included in the ACA. BIP, CFC, and the 1915(i) HCBS state plan benefit were optional programs states could elect to adopt. The states that pursued these programs were diverse; therefore, the first research question was what factors influenced states' adoption of the HCBS opportunities in the ACA. This study proposed a preliminary conceptual framework identifying factors internal and external to the state that may influence policy adoption. The internal factors included political factors, governing capacity, interest groups, economic considerations, and existing HCBS and LTSS programs while the external factors included federal policy changes and the decisions of other states. The preliminary conceptual framework also posited that state bureaucrats were the key decision makers in state HCBS policy adoption.

This research used quantitative and qualitative methods to evaluate and test the hypotheses based on the preliminary conceptual framework. The quantitative methods utilized five different multivariate models to identify the factors influencing state policy adoption. The first four models modeled the adoption of BIP, CFC, the 1915(i), and any of the three programs. In these models, the data was longitudinal and the unit of observation was the state-year. The

final model was cross-sectional, and the dependent variable was the proportion of eligible policies each state adopted as of 2015. The independent variables were factors that may influence state policy adoption based on the preliminary conceptual framework and hypotheses. The qualitative portion of this research utilized comparative case studies to examine the policy adoption decisions of three states. Maryland and Texas adopted all three of the ACA HCBS programs while Oklahoma pursued none of these programs. Interviews with national and state level government officials, consumer advocates, provider representatives, and consultants identified factors which influenced states' adoption decisions.

Common factors that affected adoption across more than one program were political ideology and states' existing HCBS programs. More specifically, state with liberal political ideology, more 1915(c) waivers, and a lower percentage of Medicaid LTSS spending devoted to HCBS were more likely to adopt these programs. The qualitative analysis also indicated that states adopted the ACA HCBS programs because they were consistent with existing HCBS programs or goals of the state. In addition, the case studies highlighted that a leader within the state Medicaid agency or disability services agencies was important in the policy adoption decision. Based on these findings, this study proposed a refined conceptual framework to highlight the important role that state bureaucrats played as policy entrepreneurs in the adoption decision. In addition, the revised conceptual framework identified the factors that influenced adoption across all three programs and other factors that played a role in the adoption of some programs, but not others.

This research also examined the policy implementation process. After deciding to pursue each program, states needed to receive approval from the Centers for Medicare and Medicaid Services (CMS) and implement the program. The second research question was thus what factors

were facilitators or barriers to implementation of the three ACA HCBS programs. Based on policy implementation literature, this research identified potential factors that may influence the implementation process, including communication from the federal government; staffing and financial resources; the amount of change required; and engagement with external stakeholders. Case studies of Maryland and Texas identified the barriers and facilitators of implementing BIP, CFC, and the 1915(i) state plan benefit.

This research identified common facilitators and barriers to policy implementation across the ACA HCBS programs and facilitators and barriers to specific programs. Common facilitators to implementing BIP and CFC were frequent communication with CMS, additional financial resources through enhanced federal matching revenue, and leveraging existing HCBS programs and infrastructure. Barriers to implementation included insufficient staffing, aggressive timeframes, and communication with external stakeholders. States also encountered challenges implementing some of these programs due to unexpected impacts on existing programs, lack of available providers, and lower than expected numbers of enrollees.

Contributions of this Research

This research contributes to literature on HCBS policy adoption, policy implementation, and the ACA. The state policy adoption and diffusion literature has identified many factors that may influence policy adoption across a variety of policies (Walker, 1969; Berry and Berry, 1990); however, the number of studies focused on state policy adoption of Medicaid HCBS options is limited. Most research on state variation in HCBS policy focuses on variation in spending levels or participants rather than HCBS adoption decisions specifically (Kane, Kane, Ladd, & Veazie, 1998; Miller et al. 2001; Miller, Rubin, Elder, Kitchener, & Harrington, 2006). Some studies have examined the factors influencing adoption of 1915(c) waivers or state plan

personal care benefits (Nelson, 2007; Miller, Elder, Kitchener, Kang, & Harrington, 2008; Merryman et al. 2015). The HCBS opportunities in the ACA may be the most substantial expansion of Medicaid HCBS options for states since the authorization of 1915(c) waivers in the Omnibus Budget Reconciliation Act of 1981. Therefore, understanding the factors that influence state adoption of these policies has important contributions to the HCBS policy adoption literature.

This study also expands the HCBS policy adoption literature by identifying the factors that influenced policy adoption of all the Medicaid HCBS opportunities in the ACA. Most existing studies on HCBS policy adoption examine the adoption of one program while this study examined three different policies. By examining multiple policies, this research could identify factors that were influential in adoption across programs and identify factors that played a role in each program, specifically. This research found that one of the most important factors in HCBS policy adoption across all three programs was a state's existing HCBS policies and programs. Many states pursued the ACA HCBS programs because these opportunities substituted for or complemented existing HCBS offerings. This study also confirmed the important role that state bureaucrats in the Medicaid or disability services agencies play as policy entrepreneurs in Medicaid HCBS policymaking. Based on these findings, the revised conceptual framework contributes to our knowledge about the key factors influencing state HCBS policymaking, including state bureaucratic leaders and existing HCBS policies. The revised conceptual framework also identifies other factors that may influence the adoption of some, but not all, HCBS programs such as interest groups, political ideology, and the decisions of other states.

This study also examined the implementation of each of the three ACA HCBS programs and contributes to policy implementation research in general and HCBS implementation research

specifically. The findings from this study underscore the role of elements identified in both top-down and bottom up approaches to implementation. Clear and frequent communication from CMS to states facilitated implementation as did input and engagement with local stakeholders who were involved in implementation. This research also identified that some factors, such as financial resources and consistency with existing programs, can be both barriers and facilitators to HCBS policy implementation. Literature examining the implementation of HCBS programs is somewhat limited and tends to focus on the implementation of policy in a single state or implementation of a single policy broadly across many states (Miller, 2014; Friss Feinberg & Newman, 2004; Friss-Feinberg & Newman, 2006; Thomas & Allen, 2016). This study pursued a middle approach and compared the implementation of three programs in two different states. By examining the policy implementation of three separate policies, this research identified common barriers and facilitators of implementation across programs as well as barriers and facilitators specific to each program.

Lastly, this research contributes to literature on the ACA. Most research on the ACA focuses on the health insurance and exchange aspects of the legislation. While some studies and reports have examined the HCBS opportunities in the ACA, this research expands upon that research in several ways (GAO, 2012; CMS, 2015; Karon et al. 2015; Dorn et al. 2016). First, some studies of the ACA HCBS programs were conducted soon after states had the opportunity to pursue these options (GAO, 2012). At that time, many states were still evaluating whether to adopt these policies and had not made a decision. This research's timeframe was longer and focused on the five years after these policies became available to states. Second, several studies explored the adoption of these policies through interviews with state officials or others involved in state decision making (GAO, 2012; Dorn et al. 2016). This research utilized both quantitative

and qualitative methods. When the quantitative and qualitative results were consistent, there is more confidence in the findings. Third, most research only examines the policy adoption decision or implementation process while this research examined both policy adoption and implementation. Lastly, some studies only examine one of the ACA HCBS policies while this research examined all three programs (CMS, 2015; Karon et al. 2015; Dorn et al. 2016). By examining multiple programs simultaneously, this research could identify common factors that influenced adoption and implementation across more than one program while also identifying factors that only influenced adoption and implementation of a single program.

Implications for Policy Adoption

This research has implications for adoption of HCBS policies at both the federal and state level. For optional HCBS programs, like those included in the ACA, many aspects of the programs decided at the federal level can influence policy adoption within the states. In the future, federal policymaking should consider ways to overcome barriers to make the adoption of HCBS programs more attractive for states. At the state level, bureaucrats within the Medicaid and disability services agency were important for state adoption of these policies. To expand HCBS options within states, bureaucratic leaders must be committed to HCBS programs and be willing and able to spend time and resources convincing others within state government to pursue new policy initiatives. In addition, states should take an inventory of their existing HCBS programs to identify issues and gaps. States that successfully pursued these policies were able to recognize how the ACA HCBS opportunities complemented or substituted for existing HCBS programs.

Federal Policy Implications

The inclusion of HCBS programs within the larger ACA legislation deterred some states from adopting these policies for political or ideological reasons. The quantitative and qualitative results suggest that political ideology and opposition to the ACA played a role in the adoption decisions of some states. Including new optional HCBS benefits within a larger piece of controversial legislation may discourage some states from pursuing these options. In general, Democrats and Republicans are both supportive of HCBS programs. Interviewees indicated that HCBS rebalancing is generally not a partisan issue. However, the ACA was and continues to be a highly partisan piece of legislation with strong opposition from many Republican leaders at both the state and national level. Future federal policy initiatives should consider whether the benefits of including HCBS policies within larger controversial pieces of legislation outweigh the drawbacks. On the one hand, policymakers often need to add HCBS initiatives to larger pieces of legislation simply to pass legislation and get programs enacted. On the other hand, attaching HCBS policies to controversial legislation may dissuade some states from adopting policies they might otherwise be interested in pursuing.

The inclusion of multiple HCBS opportunities for states within one piece of legislation also may discourage adoption. In the quantitative findings, states that adopted an ACA policy in the previous year were much less likely to adopt a different policy the following year. In addition, the qualitative results suggest that competing priorities in some states were an impediment to adopting these policies, especially BIP. When multiple HCBS initiatives are included within one piece of legislation, states may not be able to pursue all of the opportunities because of competing priorities. The amount of staff resources to develop a state plan amendment, obtain approval from CMS, and implement an HCBS program may limit the pursuit

of other HCBS opportunities. The qualitative interviews indicated that the state bureaucrats responsible for the adoption decision and writing the state plan amendment were often the same individuals responsible for implementation. To encourage policy adoption, future federal policy initiatives should consider state staffing bandwidth especially with time limited programs like BIP. States could only participate in BIP between 2011 and 2015. More states may have pursued BIP, not only if the timeframe was longer, but if they were less focused on other priorities related to the ACA or HCBS programs during the BIP period.

To encourage state adoption of new policy initiatives, federal officials should also make clear guidance about program requirements available for states. The qualitative findings suggest that some states waited to apply for BIP and CFC because they wanted more clarification from CMS on the expectations and requirements of each program. With CFC, interviewees indicated that CMS initially lacked a manual or guide for states interested in this program. According to state bureaucrats in Maryland and Texas, there was also confusion with CMS around what services were allowable and the eligibility criteria for the program. To encourage state adoption, CMS should have guidance prepared for states about the specific requirements of the program. Obviously one challenge is federal officials may not have sufficient time between the passage of legislation and making the program available to specify all of the requirements. With BIP and CFC, CMS did develop manuals and guidance for states; nevertheless, providing direction earlier can facilitate and promote state policy adoption.

Future federal HCBS policy opportunities should also consider the fiscal implications of adopting new HCBS programs at the state level. Interviewees identified cost concerns as one barrier to adopting CFC and the 1915(i) because both options are state plan benefits. States face challenges coming up with the state share of Medicaid HCBS spending. State officials in

Oklahoma cited the additional state spending as one barrier to adopting these programs. To promote adoption of HCBS programs, federal policy could address the state cost of new programs in several ways. Additional federal revenue, through a higher federal match, can make adopting new optional Medicaid HCBS policies more attractive to states by reducing the state share of Medicaid spending as with BIP and CFC. Alternatively, many states desire to grow HCBS programs slowly and manage enrollment rather than have open-ended Medicaid entitlements. When considering CFC and the 1915(i), many states were cautious about the added state cost of an entitlement benefit.

States adopted the ACA's HCBS policies because these initiatives were consistent with existing programs or goals of the state. Both the quantitative and qualitative results suggest that states pursued many of these policies because they were already providing similar benefits or wished to address gaps in HCBS. Future federal efforts to promote HCBS programs may need to consider additional incentives for states that have limited HCBS programs and lack a commitment to expanding HCBS options. The disparities in HCBS programs across states could increase if only states with robust HCBS systems and a commitment to rebalancing pursue new HCBS opportunities. BIP sought to address state variation in HCBS rebalancing by only allowing states to participate if they spent less than 50% of Medicaid LTSS spending on HCBS and by providing states spending less than 25% with a higher match rate. Other federal policy initiatives may need to consider additional incentives to encourage adoption in states without as strong a commitment to expanding HCBS programs.

State Policy Implications

The findings from this study suggest that at the state level, a leader within the Medicaid agency or disability services agencies is an important factor in policy adoption. In both Maryland

and Texas, bureaucratic leaders within state government were necessary for each state to pursue the ACA's HCBS expansion initiatives. In Texas, the state Medicaid director was able to overcome opposition to the ACA and convince the governor and legislature of the value of pursuing these programs. To promote expansion of HCBS policies, state agency leaders must be able and willing to advocate for new opportunities. Those leaders must act as policy entrepreneurs and couple HCBS policy opportunities with problems within their states. States without a bureaucratic leader who understands Medicaid HCBS policymaking may be unlikely to pursue new HCBS opportunities.

To act as policy entrepreneurs, state bureaucratic leaders must have knowledge about HCBS challenges, gaps, and goals within their respective states. Policy change can occur when policy entrepreneurs are able to couple solutions, such as new program opportunities, with existing problems. To promote adoption of HCBS programs, states should carefully evaluate the gaps and issues within their HCBS systems so they can recognize how federal opportunities can address these issues. State officials in Maryland recognized inequities in existing waiver and personal care programs and realized that CFC could address some of these issues. In addition, officials in both Maryland and Texas understood the lack of HCBS programs for individuals with serious mental illness and perceived the 1915(i) state plan benefit as a solution to this problem. To be able to couple the solution with problems, state bureaucratic leaders must have a comprehensive understanding of the existing HCBS system and the challenges and gaps.

Implications for Policy Implementation

This research also explored Maryland's and Texas' experiences implementing the BIP, CFC, and 1915(i) state plan benefit. Decisions made at both the federal and state levels influenced the implementation process. The design of HCBS programs, including the timeframe,

consistency with existing HCBS programs, and enhanced revenue, can facilitate or impede implementation. In addition, the implementation of HCBS programs often involves stakeholders at all levels of government, including federal, state, and local officials, and stakeholders outside of government, including advocates, providers, and consumers. The implementation process can go smoother when there is frequent and clear communication among all involved. The experiences implementing these three programs can provide lessons learned to inform the implementation of future policies.

Federal Policy Implications

When implementing the ACA HCBS programs, states faced aggressive timeframes especially for BIP. Implementing BIP was challenging for states because this program only ran from 2011 to 2015, and states needed to meet several requirements by the end of this time period. Interviewees in Maryland and Texas indicated that they needed to scale back some of their aspirations with BIP because of the timeframe and delays related to state contracting requirements. If BIP was available for a longer time, states may have achieved additional improvements to their LTSS systems. Future federal grant opportunities should carefully consider the program timeframe given state processes around procurement and contracting because states may not be able to achieve the objectives of federal initiatives if the timeframe is too short.

In addition, states faced challenges implementing these programs because some eligibility requirements for the ACA HCBS programs differed from eligibility for other Medicaid programs. When HCBS programs have financial eligibility criteria that differs from Medicaid eligibility or from other HCBS programs, this places administrative burdens on states to ensure that only individuals who meet specific eligibility criteria can enroll. With CFC, some states also

needed to create workarounds to ensure that individuals did not lose Medicaid coverage when their services moved from waivers to CFC. Policy implementation can be easier when there is greater consistency in the eligibility and requirements of new and existing HCBS programs. Federal policymakers should thus consider aligning eligibility requirements across HCBS or Medicaid policies to ensure consistency and reduce administrative burdens on states tracking different eligibility criteria. Federal initiatives could also allow states more flexibility in determining the clinical and financial eligibility for new Medicaid HCBS programs. With greater flexibility, states could align the eligibility criteria of new HCBS programs with the state's Medicaid eligibility or eligibility for other HCBS programs.

One facilitator when implementing these policies was frequent communication among federal officials, consultants, and state officials. With BIP, state bureaucrats indicated that monthly calls with CMS and their contractors, Mission Analytics, were very helpful and kept them accountable for the program requirements. In addition, close collaboration between CMS and state officials facilitated the development of states' CFC state plan amendments. Future federal programs should include close engagement with state participants. When federal and state officials communicate frequently, they can ensure that the states are aligned with federal requirements. In addition, federal consultants can be beneficial to the implementation process by providing additional staff and expertise to support states.

Another factor that can facilitate policy implementation is the provision of additional federal revenue for states. Enhanced federal medical assistance percentage money can help offset the state costs of implementing a new program. With both BIP and CFC, state officials recognized the value of the additional federal revenue. In addition, enhanced federal revenue can have spillover effects on other programs. As an example, states utilized the enhanced revenue

from BIP to develop other HCBS programs such as CFC. These findings suggest that federal officials should consider providing additional federal revenue for HCBS programs both to encourage state adoption and to facilitate implementation. However, with temporary enhanced revenue programs, such as BIP, federal officials need to ensure that states have sustainability plans. With BIP, states faced challenges determining how to spend the additional federal revenue in a way that was sustainable after the enhanced match ended. When the period of the enhanced federal match ends, states need to have another funding source. New federal money facilitates the implementation process but it can also pose challenges for states when the additional federal revenue expires.

State Policy Implications

State bureaucrats should actively engage interest groups involved in HCBS policies, including consumer advocates, provider representatives, and regional organizations such as Aging and Disability Resource Centers. When implementing all three ACA HCBS programs, external stakeholders in Maryland and Texas indicated that state officials were not always receptive to their feedback, did not provide sufficient training, and could have communicated better about changes due to the new programs. Individuals and organizations outside of state government often play a crucial role in HCBS programs and can be responsible for eligibility determinations, case management, and service provision. To facilitate implementation, states should communicate clearly and collaborate with these external stakeholders because they may have a different perspective from state bureaucrats.

During the implementation process, states should ensure that they have sufficient staffing. Maryland's and Texas' experiences implementing the ACA HCBS programs indicated that both states faced staff shortages. When implementing these policies, both states needed to

hire additional staff or redirect staff from their ongoing responsibilities to focus all of their time and energy on the implementation of these programs. To compensate for these issues, states could consider contracting with consultants such as local universities to assist in the implementation process. Consultants may bring additional resources and skill sets to the implementation process. Both Maryland and Texas hired external consultants to assist with 1915(i) development, and several interviewees noted the benefits and additional skills consultants could contribute to the process.

In addition to state staff, states should ensure they have enough providers to offer services when pursuing new programs. One challenge Maryland and Texas encountered when implementing the 1915(i) was an insufficient number of providers who were willing or able to offer the services included in the state plan amendment. Prior to proposing services, states should consider available provider networks and ensure that there are providers within the state that can offer the services. Without a sufficient number of providers, states may struggle to implement new programs.

State officials should also carefully consider the potential impact of pursuing new policies on existing HCBS programs. Adopting new HCBS programs can have unintended consequences for existing programs, budgets, and participants. When planning for implementation, states should evaluate all aspects of existing programs that would be affected by the new program. For example, when implementing the CFC, states needed to consider the impact of transitioning 1915(c) waiver enrollees who qualified under the special income rule; otherwise these individuals could risk losing their Medicaid coverage and HCBS. In addition, Texas faced the potential of cost overruns in one waiver program because state officials did not consider individuals already receiving HCBS would get more services under the CFC. Adding

new programs can have unforeseen impacts on existing programs and participants, and states should seek to mitigate these negative impacts to the extent possible.

Areas of Future Research

Based on the findings from this study, there are several areas of future research related to the adoption and implementation of the three ACA HCBS expansion opportunities. One area of research is looking at states that almost adopted these policies but ultimately decided not to pursue these options. Although this research examined why Oklahoma has not pursued these options, the state never seriously evaluated or considered adopting any of the policies. In contrast, other states have carefully examined pursuing these options but have, thus far, not developed or submitted a state plan amendment to CMS. As an example, Colorado conducted several studies examining the impact of the CFC and established a CFC Development and Implementation Council to determine the feasibility of adopting this program within the state. Future research looking at states that invest time and resources exploring these policy options may uncover additional barriers to pursuing these policies. In addition, other states wrote state plan amendments and submitted them to CMS but decided not to pursue the program. States' rationales for abandoning a state plan amendment prior to approval from CMS likely vary and may include political turnover or a changing fiscal environment in the state. States may also face challenges obtaining CMS approval of their state plan amendment. Therefore, future research could examine the barriers to adoption once a state has developed and submitted a state plan amendment to CMS but failed to adopt the program.

Another area of future research is to examine the reasons why some states decide to eliminate the ACA HCBS options from their state plan offerings. This research focused on the adoption decision and implementation process; however, some states after adopting and

implementing the programs decide to no longer offer the benefit. For example, Florida terminated its 1915(i) HCBS state plan benefit in 2015. Many factors could contribute to states' decisions to eliminate optional Medicaid HCBS benefits such as higher than expected program expenditures or the adoption of other HCBS programs that meet the same needs. Understanding the factors that contribute to states electing to no longer offer services has important implications for HCBS policy development.

Additional research could also examine the HCBS policy adoption and implementation processes in other states. The qualitative portion of this study focused on the policy adoption decisions in three states and the policy implementation process in two states. Each state is unique in the design of HCBS program and policies. States use different options to provide HCBS and also serve different populations needing LTSS. More specifically, the 1915(i) portions of this research focused on states that are using this option to provide mental health services. While many states are utilizing this option to meet these needs; other states serve different populations under the 1915(i). Connecticut's 1915(i) benefit provides services to individuals age 65 and older with specific activities of daily living or instrumental activities of daily living impairments. Delaware's program provides employment supports to individuals who are visually impaired; with physical disabilities; or with intellectual disabilities, Autism Spectrum Disorders or Asperger's Syndrome. The factors that influence adoption and implementation of this benefit may vary depending on what populations the state is targeting.

Another avenue to explore is to evaluate the impact of these programs on state HCBS systems and on the individuals enrolled in the programs. States rationales for adopting these programs included rebalancing LTSS, streamlining HCBS programs, and transitioning to managed care. Future research could examine whether the adoption and implementation of these

programs are meeting states' goals. In addition, states pursued these policies to expand options for individuals needing LTSS and fill gaps in Medicaid funded HCBS. Future research should examine whether these policies meet the LTSS needs of individuals living in the community. Beneficiaries participating in these programs may have very different experiences than what decision makers within the state capital, advocates, or providers expect. Interviewing enrollees could contribute to an evaluation of these programs.

Conclusion

This study sought to understand state processes related to the adoption and implementation of three HCBS programs within the ACA. The two research questions were: what factors contribute to state adoption of BIP, CFC, and the 1915(i) and what facilitates or impedes implementation of these programs. To answer these questions, this study utilized multivariate regression models and comparative case studies. The quantitative results indicated more liberal political ideology, more 1915(c) waivers, and a lower percentage of Medicaid LTSS spending on HCBS increases the likelihood of adopting these policies. The qualitative findings identified the importance of state leaders in the Medicaid or disability services agencies and existing HCBS programs in the adoption decision. When implementing these programs, communication with federal officials, leveraging existing programs, and additional financial resources facilitated the implementation process while aggressive timelines, insufficient staffing, and limited engagement with external stakeholders posed barriers. This research contributes to our understanding of policy adoption, implementation, and the ACA. These findings also have implications for federal and state policymakers interested in HCBS policy development and implementation.

APPENDIX A: RECRUITMENT LETTER TO POTENTIAL INTERVIEW PARTICIPANTS IN PARTICIPATING STATES

Dear _____:

As a result of your involvement in home- and community-based policies and programs, I would like to interview you as part of a research study I am conducting as a doctoral student in the Department of Public Policy at the University of Massachusetts Boston. This study aims to understand the factors that influenced states' adoption and implementation of several of the home- and community-based programs included in the Patient Protection and Affordable Care Act of 2010. This research is specifically focused on the Balancing Incentive Program (BIP), 1915(k) Community First Choice personal care benefit, and 1915(i) state plan benefit. The goal of this research is to better understand state policymaking around home- and community-based services to inform the development of future policies.

Should you choose to participate, the interview will be conducted by telephone and last approximately sixty (60) minutes. The interview will be scheduled at a time convenient for you and will be audio recorded, with your permission, for future transcription and analysis. The interview will be confidential and you will not be identified by name or title in the transcript, analysis, or report. If you are interested, I will provide you with a copy of the final study report.

The decision whether or not to take part in this research study is voluntary. There is no penalty for refusing or terminating participation. In the next few days, I will contact you by telephone or email about your willingness to participate in this study. If you have any questions before then, I can be reached at Lisa.Kalimon001@umb.edu or 978-766-0493.

Thank you for your consideration.

Sincerely,

Lisa Kalimon Beauregard
University of Massachusetts – Boston

APPENDIX B: RECRUITMENT LETTER TO POTENTIAL INTERVIEW PARTICIPANTS IN NON-PARTICIPATING STATES

Dear _____:

As a result of your involvement in home- and community-based policies and programs, I would like to interview you as part of a research study I am conducting as a doctoral student in the Department of Public Policy at the University of Massachusetts Boston. This study aims to understand the factors that influenced states' adoption of several of the home- and community-based programs included in the Patient Protection and Affordable Care Act of 2010. This research is specifically focused on the Balancing Incentive Program (BIP), 1915(k) Community First Choice personal care benefit, and 1915(i) state plan benefit. The goal of this research is to better understand state policymaking around home- and community-based services to inform the development of future policies.

Should you choose to participate, the interview will be conducted by telephone and last approximately sixty (60) minutes. The interview will be scheduled at a time convenient for you and will be audio recorded, with your permission, for future transcription and analysis. The interview will be confidential and you will not be identified by name or title in the transcript, analysis, or report. If you are interested, I will provide you with a copy of the final study report.

The decision whether or not to take part in this research study is voluntary. There is no penalty for refusing or terminating participation. In the next few days, I will contact you by telephone or email about your willingness to participate in this study. If you have any questions before then, I can be reached at Lisa.Kalimon001@umb.edu or 978-766-0493.

Thank you for your consideration.

Sincerely,

Lisa Kalimon Beauregard
University of Massachusetts – Boston

APPENDIX C: CONSENT FORM FOR INTERVIEW PARTICIPANTS

Lisa Kalimon Beauregard
University of Massachusetts Boston
Department of Public Policy
100 Morrissey Boulevard
Boston, MA. 02125-3393

Study: Factors Impacting States' Pursuit of ACA's Home- and Community-based Programs

Researcher: Lisa Kalimon Beauregard

Introduction and Contact Information

You are asked to take part in a research study to understand the adoption and implementation of several of the Patient Protection and Affordable Care Act's (ACA) home- and community-based policies. The principal researcher is Lisa Kalimon Beauregard. If you have any questions about this study, she is available to discuss them at Lisa.Kalimon001@umb.edu or 978-766-0493.

If you have any questions or concerns about your rights as a research participant, please contact a representative of the Institutional Review Board (IRB), at the University of Massachusetts Boston, which oversees research involving human participants. The Institutional Review Board may be reached at the following address: IRB, Quinn Administration Building-2-080, University of Massachusetts Boston, 100 Morrissey Boulevard, Boston, MA 02125-3393. You can also contact the Board by telephone or e-mail at 617-287-5374 or at human.subjects@umb.edu.

Description of the Project:

This study aims to understand the factors that influenced states' adoption of several of the ACA's home- and community-based programs. This research is specifically focused on the Balancing Incentive Program (BIP), 1915(k) Community First Choice personal care benefit, and 1915(i) state plan benefit. A secondary aim of this research project is to understand how states implemented these policies and what, if any, challenges, were encountered. The goal of this research is to better elucidate state policymaking around home- and community-based services to inform the development of future policies.

Participation:

Participation in this research involves a telephone or in-person interview lasting approximately sixty to ninety (60-90) minutes. The interview will be scheduled at a time and location convenient for you. With your permission, the interview will be audio recorded for future transcription and analysis. The interviewer may also take notes during the interview. All interviews will be conducted by the principal researcher, Lisa Kalimon Beauregard. There is no compensation for this research.

Confidentiality:

Your part in this research is confidential. You will be identified by a number code in interview transcripts and interview notes. Only the principal researcher will have access to the code key, and the file will be password protected. Transcripts, notes, and analyses gathered for this project will be stored in a locked file cabinet or in a password protected electronic file and only the principal researcher will have access to the data.

The analysis of interviews may be disseminated through publications or presentations. You will not be identified by name or title. If you are concerned the information you provide during the interview could easily identify you, please let the principal researcher know, and she will take any necessary steps to ensure your identity remains confidential.

Risks or Discomforts:

Although all efforts will be made to ensure confidentiality, the possibility exists that information appearing in the final report could cause controversy or discomfort for you professionally. If this occurs or you anticipate this occurring, please contact the researcher. The researcher will take all necessary steps to ensure that the information you provide does not create problems for you in the reporting of the data. The other inconvenience is your time in conducting the interview. To minimize this inconvenience, the interview will be scheduled at a time convenient for you.

Voluntary Participation:

The decision whether or not to take part in this research study is voluntary. If you do decide to take part in this study, you may terminate participation at any time without consequence. You may also refuse to answer any questions. There is no penalty for refusing or terminating participation.

Audiotaping & Transcription

With your permissions, the interview will be audio taped and transcribed. Neither your name nor any other identifying information will be associated with the audiotape or the transcript. Only the researcher will be able to listen to the tapes. The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice or picture) will be used in presentations or in written products resulting from the study. Immediately following the interview, you will be given the opportunity to have the tape erased if you wish to withdraw your consent to taping or participation in this study.

Rights:

You have the right to ask questions about this research at any time during the study. You also have the right to participate or withdraw from participation at any time.

APPENDIX D: INTRODUCTORY SCRIPT

Thank you for taking the time to speak with me today. As background, I am interviewing people involved in Medicaid long-term services and supports policy. This interview will consist of open-ended questions about the Balancing Incentive Program, 1915(i) state plan benefit and 1915(k) Community First Choice personal care benefit. All of your answers will be kept confidential and your name or title will not appear in any publications or reports. You can terminate participation at any time without consequence and also refuse to answer any questions. With your permission, I would like to record this interview. Doing so will allow me to focus on the information you provide and facilitate analysis at a later date. Do I have your permission to record?

Do you have any questions before we begin?

APPENDIX E: INTERVIEW PROTOCOL

Government Official (Participating States)

1. First, I would like to start by learning more about you and your agency.
 - a. Tell me about your agency and your role within the agency.
 - b. What are your major responsibilities?
 - c. How long have you been in this position?
 - d. What role does your agency play in long-term services and supports (LTSS) policies and programs?
2. Please describe your state's approach to LTSS and the main factors affecting LTSS policy.
 - a. How important do you think rebalancing LTSS is? Why?
 - b. How focused is your state on rebalancing? Why?

Balancing Incentive Program:

3. Turning to the Affordable Care Act's LTSS policies and focusing first on the Balancing Incentive Program (BIP),
 - a. What is your perception of BIP?
 - b. What was your agency's position on applying for BIP?
 - c. Did your agency make its position known to state decision-makers? If so, which ones and how?
 - d. What role, if any, did you or your agency play in the decision to apply for BIP?
4. Do you have any insights into what prompted your agency/state to apply for BIP?
 - a. Did the political environment have any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - i. How important was the additional 2% [5%] Federal Matching Assistance Percentage (FMAP) in the decision?
 - c. From your perspective, prior to BIP was rebalancing LTSS spending something your state was already committed to?
 - d. Were the structural requirements of BIP (i.e., the No Wrong Door/Single Entry Point system, the core standardized assessment, conflict free case management) things your state had already attained or were planning on doing?
5. Do you know who was involved in the decision to apply for BIP?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did the governor's office staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?

- i. Did other states influence the decision to submit an application for BIP? If so, which states?
 - j. Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule or BIP Manual, influence the decision?
- 6. Please tell me about the decision-making process,
 - a. What were the factors cited in favor of participating in BIP?
 - b. What, if any, were the factors mentioned against applying?
 - c. Was there consensus among those involved about the decision to apply or were some initially opposed or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision about applying?
- 7. Was there anything else that had an influence on the decision to apply for BIP that we have not already discussed?
- 8. After the decision was made to apply, how did the BIP application process unfold?
 - a. Who was involved in writing the application?
 - i. What role, if any, did the governor's office, legislature, or other agencies within government play?
 - ii. Did advocates for the elderly, physically disabled, intellectually and developmentally disabled or home- and community-based services providers have any input? Did others advocates and/or provider representatives play a role?
 - iii. Were outside consultants used in the application process? Did you have discussions with the Centers of Medicare and Medicaid Services (CMS) during the application process?
- 9. Tell me about what happened after the application was submitted.
 - a. How long between when the application was submitted until when it was approved?
 - b. What happened during that time? Were there discussions with CMS and/or changes to the application? What types of changes?
- 10. After approval from CMS, what happened next?
 - a. Who was involved in implementing BIP?
 - i. What role did agency staff play?
 - ii. Were other state agencies involved? If so, in what way? Were the governor's staff or legislative staff involved? In so, how?
 - iii. Did consumer advocacy organizations have input? If so, which ones and what was their role?
 - iv. Were provider organizations involved? If so, which organizations and what was their involvement?
 - v. Were outside consultants hired?

- b. How did those involved approach, participate, and/or influence implementing the structural changes and rebalancing requirements of BIP?
- 11. From your perspective, were there things that your agency or state did that facilitated the implementation of BIP?
 - a. How did your agency or state address the need for staffing and other resources (e.g., IT) due to BIP?
 - b. Did you or your state consult with other BIP states? If so, which states?
 - c. Did you or your state utilize the technical assistance provided by Mission Analytics?
- 12. Did your agency/state encounter any challenges or setbacks getting the program going? If so, what were these challenges?
 - a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to implementing any of the structural changes including the:
 - i. No Wrong Door/Single Entry Point System?
 - ii. Conflict Free Case Management?
 - iii. Core Standardized Assessment?
 - iv. If so, were they overcome and how?
 - c. Were there concerns about achieving the 25% [50%] spending on home- and community-based services before the end of BIP? Why or why not?
 - d. Were there concerns about sustaining these changes after the enhanced FMAP ended? Why or why not? If so, how were these concerns addressed?
 - e. In your opinion, what were the biggest challenges in implementing BIP and how were those challenges overcome?
- 13. Looking back, is there anything you think should have been done differently in implementing BIP?
- 14. Now that BIP has been in effect for __ years, what impact do you think it has had on long-term services and supports in your state? And how successful do you think BIP has been at rebalancing LTSS?
- 15. Is there anything we have not already discussed about BIP that you think I should know?

1915(i) State Plan Benefit:

- 16. Turning to the 1915(i) state plan benefit,
 - a. What is your perception of the 1915(i) HCBS state plan benefit?
 - b. What was your agency's position on adopting this state plan option?
 - c. Did your agency make its position known to state decision-makers? If so, which ones and how?
 - d. What role, if any, did you or your agency play in the decision to adopt the 1915(i)?

17. Prior to the ACA, did your state considering pursuing the 1915(i) state plan benefit?
 - a. If so, why did your state decide against it?
 - b. If not, why was it not considered?
18. After the ACA, do you have any insights into what prompted your agency to submit a 1915(i) state plan amendment?
 - a. Did the political environment have any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Was your state already offering a similar program or services for these individuals? If so, why did your state decide to adopt the 1915(i)? If not, why did your state decide to begin offering these services/this program?
19. Do you know who was involved in the decision to apply for the 1915(i)?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did the governor's office staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?
 - i. Did other states influence the decision to submit a 1915(i) state plan amendment? If so, which states?
 - j. Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
20. In making the decision to submit a 1915(i) state plan amendment,
 - a. What were the factors cited in favor of submitting an amendment?
 - b. What, if any, were reasons against submitting the amendment?
 - c. Was there consensus among those involved about the decision or were some initially opposed or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
21. Was there anything else that had an influence on the decision to adopt the 1915(i) that we have not already discussed?
22. After the decision was made to apply, how did the 1915(i) application process unfold?
 - a. Who was involved in writing the state plan amendment?
 - i. What role, if any, did the governor's office, legislature, or other agencies within government play?
 - ii. Did advocates for the elderly, physically disabled, intellectually or developmentally disabled, or home- and community-based services providers have any input? Others advocates and/or provider representatives?

- iii. Were outside consultants used in the application process?
23. Tell me about what happened after the amendment was submitted.
- a. How long between when the amendment was submitted until when it was approved?
 - b. What happened during that time? Were there discussions with CMS and/or changes to amendment? What types of changes?
24. After approval from CMS, what happened next?
- a. Who was involved in implementing the 1915(i) program?
 - i. What role did agency staff play?
 - ii. Were other state agencies involved? Were the governor's staff or legislative staff involved? In so, how?
 - iii. Did consumer advocacy organizations for the elderly, physically disabled, and/or intellectually or developmentally disabled have input?
 - iv. Were provider organizations involved? If so, which organizations and what was their involvement?
 - v. Were external consultants hired?
 - b. How did those involved approach, participate in, and/or influence implementing the 1915(i) benefit?
25. From your perspective, were there things that your agency or state did that facilitated the implementation of the 1915(i)?
- a. How did your agency or state address the need for staffing and other resources (e.g., IT) due to this program?
 - b. Did you or others from your state talk with other states that had already implemented 1915(i) programs?
26. Did your state encounter any challenges or setbacks getting the program going? If so, what were these challenges?
- a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to enrolling individuals? Was the number of people enrolled less than, consistent with, or greater than the original estimates?
 - c. Did the program expenditures exceed projections?
 - d. Was there sufficient provider capacity?
 - e. In your opinion, what were the biggest challenges in implementing 1915(i) and how were those challenges overcome?
27. Looking back, is there anything you think should have been done differently in implementing the 1915(i) state plan amendment?
28. Now that the 1915(i) has been in effect for __ years, what impact do you think it has had on long-term services and supports in your state? And how successful do you think the 1915(i) has been at rebalancing LTSS?

29. Is there anything we have not already discussed about the 1915(i) that you think I should know?

1915(k) Community First Choice personal care benefit

30. Turning to the 1915(k) personal care benefit,
- What is your perception of the 1915(k) Community First Choice personal care benefit?
 - What was your agency's position on adopting this state plan option?
 - Did your agency make its position known to decision-makers? If so, which ones and how?
 - What role, if any, did you or your agency play in the decision to adopt the 1915(k)?
31. Do you have any insights into what prompted your agency to submit a 1915(k) state plan amendment?
- Did the political environment have any impact?
 - What, if any, role did the state's economic and fiscal situation play?
 - How important was the additional 6% Federal Medical Assistance Percentage (FMAP) in the decision?
 - Was your state already offering personal care services for these individuals? If so, why did your state decide to adopt the 1915(k)? If not, why did your state decide to begin offering these services?
32. Do you know who was involved in the decision to apply for the 1915(k)?
- Which state agencies were involved? And what role did they play?
 - Did state legislators and/or legislative staff play a role? If so, what role?
 - Did the governor's office staff play a role? If so, what role?
 - How involved were advocates for the elderly?
 - Did advocates for the physically disabled play a role?
 - What about advocates for the intellectually or developmentally disabled?
 - Did home health agencies or the home care industry have any input?
 - What role, if any, did the nursing facility industry play?
 - Did other states influence the decision to submit a 1915(i) state plan amendment? If so, which states?
 - Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
33. In making the decision to submit a 1915(k) state plan amendment,
- What were the factors cited in favor of submitting an amendment?
 - What, if any, were the factors mentioned against submitting the amendment?
 - Was there consensus among those involved about the decision or were some initially opposed? If there was not consensus, how was this overcome?
 - Do you know who made the final decision?

34. Was there anything else that had an influence on the decision to adopt the 1915(k) that we have not already discussed?
35. After the decision was made to apply, how did the 1915(k) application process unfold?
- Who was involved in writing the state plan amendment?
 - What role, if any, did the governor's office, legislature, or other agencies within government play?
 - Did advocates for the elderly, disabled, or home- and community-based services providers have any input?
 - Were outside consultants used in the application process?
36. Tell me about what happened after the amendment was submitted.
- How long between when the amendment was submitted until when it was approved?
 - What happened during that time were there discussions with CMS and/or changes to amendment? What types of changes?
37. After approval from CMS, what happened next?
- Who was involved in implementing the 1915(k) program?
 - What role did agency staff play?
 - Were other state agencies involved? Were the governor's staff or legislative staff involved? In so, how?
 - Did consumer advocacy organizations for the elderly, physically disabled, and/or intellectually or developmentally disabled have input?
 - Were provider organizations involved?
 - Were outside consultants hired?
 - How did those involved approach, participate in, and/or influence implementing this program?
38. Were there things that your agency or state did that facilitated the implementation of the 1915(k)?
- How did your agency or state address the need for staffing and other resources (e.g., IT) due to this program?
 - Did you or others from your state talk with other states that had already implemented 1915(k) services?
39. Did your agency/state encounter any challenges or setbacks getting the program going? If so, what were these challenges?
- Were there sufficient staff and resources to implement the program?
 - Were there challenges related to enrolling individuals? Was the number of people enrolled less than, consistent with, or greater than the original estimates?
 - Did the program expenditures exceed projections?
 - Was there sufficient provider capacity?
 - In your opinion, what were the biggest challenges in implementing 1915(k) services and how were those challenges overcome?

40. Looking back, is there anything you think should have been done differently in implementing the 1915(k) state plan amendment?
41. Now that the 1915(k) has been in effect for ___ years, what impact do you think it has had on long-term services and supports in your state? And how successful do you think the 1915(k) has been at rebalancing LTSS?
42. Is there anything we have not already discussed about the 1915(k) that you think I should know?

Conclusion

43. Before concluding, is there anything else that you think is important about any of these programs that you would like to share?
44. Do you have any reports, issue briefs, presentations, or other documents that might inform my study? Would you be willing to share them with me?
45. Could you suggest any other individuals who played a role in these programs that you think I should also interview?

Thank you again for sharing your time and knowledge with me.

Stakeholders – Participating States

1. First, I would like to start by learning more about you and your organization.
 - a. Tell me about your organization and your role within the organization.
 - b. What are your major responsibilities?
 - c. How long have you been in this position?
 - d. What role does your organization play in long-term services and supports (LTSS) policies and programs?
2. Please describe your state's approach to LTSS and the main factors affecting LTSS policy.
 - a. How important do you think rebalancing LTSS is? Why?
 - b. From your perspective, how focused is your state on rebalancing?

Balancing Incentive Program:

3. Turning to the Affordable Care Act's LTSS policies and focusing first on the Balancing Incentive Program (BIP),
 - a. What is your perception of BIP?
 - b. What was your organization's position on applying for BIP?
 - c. Did your organization make its position known to state decision-makers? If so, which ones and how?
 - d. What role, if any, did you or your organization play in the decision to apply for BIP?
4. Do you have any insights into what prompted your state to apply for BIP?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - i. From your perspective, how important was the additional 2% [5%] Federal Matching Assistance Percentage (FMAP) in the decision?
 - c. Do you think rebalancing LTSS spending something your state was already committed to doing before BIP?
 - d. Were the structural requirements of BIP (i.e. the No Wrong Door/Single Entry Point system, the core standardized assessment, and conflict free case management) things your state had already attained or were planning on doing?
5. Do you know who was involved in the decision to apply for BIP?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did the governor's office staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?

- i. Did other states influence the decision to submit an application for BIP? If so, which states?
 - j. Did federal officials play a role? If so, from which federal agencies? Do you think federal regulations or publications, such as the home and community-based services final rule or BIP Manual, influenced the decision?
- 6. In making the decision to apply for BIP,
 - a. Do you know what were the factors cited in favor of participating?
 - b. What, if any, were the factors mentioned against applying?
 - c. Was there consensus among those involved about the decision to apply or were some initially opposed or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision about applying?
- 7. Was there anything else that had an influence on the decision to pursue BIP that we have not already discussed?
- 8. After the decision was made to apply, how did the BIP application process unfold?
 - a. Were you or your agency involved in writing the BIP application? If so, what role did you play?
 - b. Who else was involved in writing the application?
 - i. What role, if any, did the governor's office, legislature, or other agencies within government play?
 - ii. Did advocates for the elderly, physically disabled, intellectually and developmentally disabled or home- and community-based services providers have any input? Did others advocates and/or provider representatives play a role?
 - iii. Were outside consultants used in the application process? Did you have discussions with the Centers of Medicare and Medicaid Services (CMS) during the application process?
- 9. Tell me about what happened after the application was submitted.
 - a. How long between when the application was submitted until when it was approved?
 - b. Do you know what happened during that time? Were there discussions with CMS and/or changes to application? What types of changes?
- 10. After approval from CMS, what happened next?
 - a. Were you or your organization involved in implementing BIP? If so, what was your involvement?
 - b. Who else was involved in implementing BIP?
 - i. What role did state agency staff play?
 - ii. Were the governor's staff or legislative staff involved? In so, how?
 - iii. Did consumer advocacy organizations have input? If so, which ones and what was their role?

- iv. Were provider organizations involved? If so, which organizations and what was their involvement?
 - v. Were outside consultants hired?
 - c. How did those involved approach, participate and/or influence implementing the structural changes and rebalancing requirements of BIP?
11. From your perspective, were there things that your state did that facilitated the implementation of BIP?
- a. How did your state address the need for staffing and other resources (e.g. IT) due to BIP?
 - b. Did [state] talk with other states that had already implemented BIP? If so, which states?
 - c. Do you know if your state utilized the technical assistance provided by Mission Analytics?
12. Did [state] encounter any challenges or setbacks getting the program going? If so, what were these challenges?
- a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to implementing any of the structural changes including the:
 - a. No Wrong Door/Single Entry Point System
 - b. Conflict Free Case Management
 - c. Core Standardized Assessment?
 - d. If so, were they overcome and how?
 - c. Were there concerns about achieving the 25% [50%] spending on home- and community-based services before the end of BIP? Why or why not?
 - d. Were their concerns about sustaining these changes after the enhanced FMAP ended? Why or why not? If so, how were these concerns addressed?
 - e. In your opinion, what were the biggest challenges in implementing BIP and how were those challenges overcome?
13. Looking back, is there anything you think should have been done differently in implementing BIP?
14. Now that BIP has been in effect for __ years, what impact do you think it has had on long-term services and supports in your state? And how successful do you think BIP has been at rebalancing LTSS?
15. Is there anything we have not already discussed about BIP that you think I should know?

1915(i) State Plan Benefit:

16. Turning next to the 1915(i) home- and community-based services state plan benefit,
- a. What is your perception of the 1915(i) HCBS state plan benefit?
 - b. What, if any, was your organization's position on submitting the amendment?

- c. Did your organization make its position known to state decision-makers? If so, which ones and how?
 - d. What role, if any, did you or your organization play in the decision to submit the 1915(i) amendment?
- 17. Prior to the ACA, did your state considering pursuing the 1915(i) state plan benefit?
 - a. If so, why did your state decide against it?
 - b. If not, why was it not considered?
- 18. After the ACA, do you have any insights into what prompted your state to submit a 1915(i) state plan amendment?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Was your state already offering a similar program or services for these individuals? If so, why did your state decide to adopt the 1915(i)? If not, why did your state decide to begin offering these services?
- 19. Do you know who was involved in the decision?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did the governor's office staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?
 - i. Did other states influence the decision to submit a 1915(i) state plan amendment? If so, which states?
 - j. Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
- 20. In making the decision to submit the state plan amendment,
 - a. Do you know what were the factors cited in favor of participating?
 - b. What, if any, were the factors mentioned against applying?
 - c. Was there consensus among those involved about the decision to apply or were some initially opposed? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
- 21. Was there anything else that had an influence on the decision to pursue a 1915(i) state plan amendment that we have not already discussed?
- 22. After the decision was made to apply, how did the 1915(i) application process unfold?
 - a. Were you or your organization involved in writing the 1915(i) amendment? If so, what role did you play?
 - b. Who else was involved in writing the state plan amendment?

- i. What role, if any, did the governor's office, legislature, or state agencies within government play?
 - i. Did advocates for the elderly, physically disabled, intellectually or developmentally disabled, or home- and community-based services providers have any input? Others advocates and/or provider representatives?
 - ii. Were outside consultants used in the application process?
- 23. Tell me about what happened after the amendment was submitted.
 - a. How long between when the amendment was submitted until when it was approved?
 - b. Do you know what happened during that time? Were there discussions with CMS and/or changes to amendment? What types of changes?
- 24. After approval from CMS, what happened next?
 - a. Were you or your organization involved in implementing the 1915(i) program? If so, what was your involvement?
 - b. What role did state agency staff play?
 - c. Were the governor's staff or legislative staff involved? In so, how?
 - d. Did consumer advocacy organizations for the elderly, physically disabled, and/or intellectually or developmentally disabled have input?
 - e. Were provider organizations involved? If so, which organizations and what was their involvement?
 - f. Were external consultants hired?
 - g. How did those involved approach, participate in, and/or influence implementing the 1915(i) benefit?
- 25. From your perspective, were there things that your state did that facilitated the implementation of the 1915(i)?
 - a. How did your state address the need for staffing or other resources (e.g. IT) due to this state plan amendment?
 - b. Did [state] talk with other states that had already implemented 1915(i) programs? If so, which states?
- 26. Did your [state] encounter any challenges or setbacks getting the program going? If so, what were these challenges?
 - a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to enrolling individuals? Was the number of people enrolled less than, consistent with, or greater than the original estimates?
 - c. Did the program expenditures exceed projections?
 - d. Was there sufficient provider capacity?
 - e. In your opinion, what were the biggest challenges in implementing 1915(i) and how were those challenges overcome?
- 27. Looking back, is there anything you think should have been done differently in implementing the 1915(i)?

28. Now that the 1915(i) has been effect for __ years, what impact do you think it has had on long-term services and supports in your state? And how successful do you think it has been at rebalancing LTSS?

29. Is there anything we have not already discussed about the 1915(i) that you think I should know?

1915(k) Community First Choice personal care benefit

30. Turning lastly to the 1915(k) Community First Choice personal care benefit,

- a. What is your perception of the 1915(k) Community First Choice personal care benefit?
- b. What, if any, was your organization's position on submitting the amendment?
- c. Did your organization make its position known to state decision-makers? If so, which ones and how?
- d. What role, if any, did you or your organization play in decision to submit the 1915(k) amendment?

31. Do you have any insights into what prompted your state to submit a 1915(k) state plan amendment?

- a. Do you think the political environment had any impact?
- b. What, if any, role did the state's economic and fiscal situation play?
 - i. In your opinion, how important was the additional 6% Federal Medical Assistance Percentage (FMAP) in the decision?
- c. Was your state already offering a similar program or services for these individuals? If so, why did your state decide to adopt the 1915(k)? If not, why did your state decide to begin offering these services?

32. Do you know who was involved in the decision?

- a. Which state agencies were involved? And what role did they play?
- b. Did state legislators and/or legislative staff play a role? If so, what role?
- c. Did the governor's office staff play a role? If so, what role?
- d. How involved were advocates for the elderly?
- e. Did advocates for the physically disabled play a role?
- f. What about advocates for the intellectually or developmentally disabled?
- g. Did home health agencies or the home care industry have any input?
- h. What role, if any, did the nursing facility industry play?
- i. Did other states influence the decision to submit the state plan amendment? If so, which states?
- j. Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?

33. In making the decision to submit the state plan amendment,

- a. Do you know what were the factors cited in favor of participating?

- b. What, if any, were the factors mentioned against applying?
 - c. Was there consensus among those involved about the decision to apply or were some initially opposed? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
- 34. Was there anything else that had an influence on the decision to pursue a 1915(k) state plan amendment that we have not already discussed?
- 35. After the decision was made to apply, how did the 1915(k) application process unfold?
 - a. Were you or your organization involved in writing the 1915(k) amendment? If so, what role did you play?
 - b. Who else was involved in writing the state plan amendment?
 - i. What role, if any, did the governor's office, legislature, or other agencies within government play?
 - ii. Did advocates for the elderly, disabled, or home- and community-based services providers have any input?
 - iii. Were outside consultants used in the application process?
- 36. Tell me about what happened after the amendment was submitted.
 - a. How long between when the amendment was submitted until when it was approved?
 - b. Do you know what happened during that time were there discussions with CMS and/or changes to amendment? What types of changes?
- 37. After approval from CMS, what happened next?
 - a. Were you or your organization involved in implementing the 1915(k) program? If so, what was your involvement?
 - b. Who else was involved in implementing the 1915(k) program?
 - i. What role did state agency staff play? Were the governor's staff or legislative staff involved? In so, how?
 - ii. Did consumer advocacy organizations for the elderly, physically disabled, and/or intellectually or developmentally disabled have input?
 - iii. Were provider organizations involved?
 - iv. Were outside consultants hired?
 - c. How did those involved approach, participate in, and/or influence implementing this program?
- 38. Were there things that your state did that facilitated the implementation of the 1915(k)?
 - a. How did your state address the need for staffing and other resources (e.g. IT) due to this state plan amendment?
 - b. Did [state] talk with other states that had already implemented 1915(k) programs?
- 39. Did your [state] encounter any challenges or setbacks getting the program going? If so, what were these challenges?
 - a. Were there sufficient staff and resources to implement the program?

- b. Were there challenges related to enrolling individuals? Was the number of people enrolled less than, consistent with, or greater than the original estimates?
 - c. Did the program expenditures exceed projections?
 - d. Was there sufficient provider capacity?
 - e. In your opinion, what were the biggest challenges in implementing 1915(k) services and how were those challenges overcome?
40. Looking back, is there anything you think should have been done differently in implementing the 1915(k)?
41. Now that the 1915(k) has been effect for __ years, what impact do you think it has had on long-term services and supports in your state? And how successful do you think it has been at rebalancing LTSS?
42. Is there anything we have not already discussed about the 1915(k) that you think I should know?

Conclusion

43. Before concluding, is there anything else that you think is important about any of these programs that you would like to share?
44. Do you have any reports, issue briefs, presentations, or other documents that might inform my study? Would you be willing to share them with me?
45. Could you suggest any other individuals who played a role in these programs that you think I should also interview?

Thank you again for sharing your time and knowledge with me.

Government Officials – Non-Implementing State

1. First, I would like to start by learning more about you and your agency.
 - a. Tell me about your agency and your role within the agency.
 - b. What are your major responsibilities?
 - c. How long have you been in this position?
 - d. What role does your agency play in long-term services and supports (LTSS) policies and programs?
2. Please describe your state's approach to LTSS and the main factors affecting LTSS policy.
 - a. How important do you think rebalancing LTSS is? Why?
 - b. How focused is your state on rebalancing? Why?

Balancing Incentive Program:

3. Turning to the Affordable Care Act's LTSS policies and focusing first on the Balancing Incentive Program (BIP),
 - a. What was your perception of BIP?
 - b. What, if any, was your agency's position on applying for BIP?
 - c. Did your agency make its position known to state decision-makers? If so, which ones and how?
 - d. Did your state consider adopting BIP?
 - e. What role, if any, did you or your agency play in the decision to not apply for BIP?
4. When making the decision not to participate in BIP, what were the main factors affecting the decision not to participate?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Did the specific requirements of BIP, including the rebalancing percentage and structural changes (i.e. the No Wrong Door/Single Entry Point, conflict free case management, and core standardized assessment) discourage your state from participating? If so, which requirements?
5. Do you know who was involved in the decision not to apply for BIP? Were they advocating for or against participating in BIP?
 - a. Other state agencies?
 - b. State legislators or their staff?
 - c. The governor's office staff?
 - d. Advocates for the elderly?
 - e. Advocates for the physically disabled?
 - f. Advocates for the intellectually or developmentally disabled?
 - g. Provider organizations such as home health agencies, home care providers or nursing homes?

- h. Did you or your agency look at what other states were doing? If so, which states and how did this influence your decision-making?
 - i. Did you or your agency have any discussions with federal officials? If so, with whom and how did that shape the decision? Did federal regulations or publications, such as the home and community-based services final rule or BIP Manuel, influence the decision?
6. In making the decision not to apply for BIP,
 - a. What, if any, factors were cited in favor of participating?
 - b. What, if any, factors were mentioned against applying?
 - c. Was there consensus among those involved about the decision not to apply or were some initially in favor of participating or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
 7. Would there have been any conditions or instances in which your state would have participated in BIP?
 8. Looking back, do you think your state made the right decision in not participating in BIP?
 9. Is there anything we have not already discussed about BIP that you think I should know?

1915(i) state plan benefit:

10. Turning next to the 1915(i) state plan benefit,
 - a. What was your perception of the ACA's revised 1915(i) state plan benefit?
 - b. What, if any, was your agency's position on adopting this state plan option?
 - c. Did your agency make its position known to state decision-makers? If so, which ones and how?
 - d. Did your state consider adopting the 1915(i) state plan benefit?
 - e. What role, if any, did you or your agency play in the decision not to adopt the 1915(i)?
11. When making the decision not to adopt the 1915(i), what were the main factors affecting the decision not to participate?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Did specific requirements or conditions of the 1915(i) discourage your state from participating? If so, what aspects?
12. Do you know who was involved in the decision not to apply for the 1915(i)? Were they advocating for or against adopting?
 - i. Other agencies?
 - ii. State legislators or their staff?
 - iii. The governor's office?
 - iv. Advocates for the elderly?
 - v. Advocates for the physically disabled?

- vi. Advocates for the intellectually or developmentally disabled?
 - vii. Provider organizations such as home health agencies, home care providers or nursing homes?
 - viii. Did you or your agency look at what other states were doing? If so, which states and how did this influence your decision-making?
 - ix. Did you or your agency have any discussions with federal officials? If so, with whom and how did that shape the decision? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
13. In making the decision not to submit a 1915(i) state plan amendment,
- a. What, if any, factors were cited in favor of participating?
 - b. What, if any, factors were mentioned against applying?
 - c. Was there consensus among those involved about the decision not to apply or were some initially in favor of participating or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
14. Do you think your state made the right decision not to add a 1915(i) state plan amendment?
15. In the future, would your state consider adopting the 1915(i) state plan amendment? If so, under what conditions?
16. Is there anything we have not already discussed about the 1915(i) that you think I should know?

1915(k) Community First Choice personal care benefit:

17. Lastly turning to the 1915(k) personal care benefit,
- a. What was your perception of the 1915(k) Community First Choice personal care benefit?
 - b. What, if any, was your agency's position on adopting this state plan option?
 - c. Did your agency make its position known to state decision-makers? If so, which ones and how?
 - d. Did your state consider adopting the 1915(k) state plan benefit?
 - e. What role, if any, did you or your agency play in the decision not to adopt the 1915(k)?
18. When making the decision not to adopt the 1915(k), what were the main factors affecting the decision not to participate?
- a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Did specific requirements or conditions of the 1915(k) discourage your state from participating? If so, what aspects?

19. Do you know who was involved in the decision not to apply for the 1915(k)? Were they advocating for or against adopting?
- Other state agencies?
 - State legislators or their staff?
 - The governor's office?
 - Advocates for the elderly?
 - Advocates for the physically disabled?
 - Advocates for the intellectually or developmentally disabled?
 - Provider organizations such as home health agencies, home care providers or nursing homes?
 - Did you or your agency look at what other states were doing? If so, which states and how did this influence your decision-making?
 - Did you or your agency have any discussions with federal officials? If so, with whom and how did that shape the decision? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
20. In making the decision not to submit a 1915(k) state plan amendment,
- What, if any, factors were cited in favor of participating?
 - What, if any, factors were mentioned against applying?
 - Was there consensus among those involved about the decision not to apply or were some initially in favor of participating or neutral? If there was not consensus, how was this overcome?
 - Do you know who made the final decision?
21. Do you think your state made the right decision not to add a 1915(k) state plan amendment?
22. In the future, would your state consider adopting the 1915(k) state plan amendment? If so, under what conditions?
23. Is there anything we have not already discussed about the 1915(k) that you think I should know?

Conclusion

24. Before concluding, is there anything else that you think is important about any of these programs that you would like to share?
25. Do you have any reports, issue briefs, presentations, or other documents that might inform my study? Would you be willing to share them with me?
26. Could you suggest any other individuals who played a role in these programs that you think I should also interview?

Thank you again for sharing your time and knowledge with me.

Stakeholders – Non-Implementing State

1. First, I would like to start by learning more about you and your organization.
 - a. Tell me about your organization and your role within the organization.
 - b. What are your major responsibilities?
 - c. How long have you been in this position?
 - d. What role does your organization play in long-term services and supports (LTSS) policies and programs?
2. Please describe your state's approach to LTSS and the main factors affecting LTSS policy.
 - a. How important do you think rebalancing LTSS is? Why?
 - b. From your perspective, how focused is your state on rebalancing?

Balancing Incentive Program:

3. Turning to the Affordable Care Act's LTSS programs and focusing first on the Balancing Incentive Program (BIP)
 - a. What is your perception of BIP?
 - b. What, if any, was your organization's position on adopting BIP?
 - c. Did your organization make its position known to state decision-makers? If so, which ones? And how?
 - d. What role, if any, did you or your agency play in the decision not to apply for BIP?
4. When making the decision not to participate in BIP, what do you think were the main factors affecting the decision not to participate?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Do you think the specific requirements of BIP, including the rebalancing percentage and structural requirements (i.e. No Wrong Door/Single Entry Point system, the core standardized assessment, and conflict free case management) discouraged your state from participating? If so, what aspects?
5. Do you know who was involved in the decision not to apply for BIP? Were these individuals or groups advocating for or against adopting BIP?
 - a. State agency staff?
 - b. State legislators or their staff?
 - c. The governor's office?
 - d. Advocates for the elderly?
 - e. Advocates for the physically disabled?
 - f. Advocates for the intellectually or developmentally disabled?
 - g. Provider organizations such as home health agencies, home care providers or nursing homes?

- h. Do you know if state officials looked at what other states were doing? If so, which states and how did this influence the decision-making process?
 - i. Were there discussions with federal officials? If so, with whom and how did that shape the decision? Did federal regulations or publications, such as the home and community-based services final rule or BIP Manual, influence the decision?
6. In deciding not to apply for BIP,
 - a. What, if any, factors were cited in favor of participating?
 - b. What, if any, factors were mentioned against applying?
 - c. Was there consensus among those involved about the decision not to apply or were some initially in favor or neutral? If there was not consensus, do you know how this was overcome?
 - d. Do you know who made the final decision to not apply?
 7. Do you think there would have been any conditions or instances where your state would have participated in BIP?
 8. Looking back, do you think your state made the right decision in not participating in BIP?
 9. Is there anything we have not already discussed about BIP that you think I should know?

1915(i) state plan benefit:

10. Next turning to the 1915(i) state plan benefit,
 - a. What is your perception of the 1915(i) HCBS state plan benefit?
 - b. What, if any, was your organization's position on pursuing the 1915(i)?
 - c. Did your organization make its position known to state decision-makers? If so, which ones? And how?
 - d. What role, if any, did you or your organization play in the decision not to adopt the 1915(i)?
11. When making the decision not to adopt the 1915(i), what do you think were the main factors affecting the decision not to participate?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Do you know, did specific requirements or conditions of the 1915(i) discourage your state from participating? If so, what aspects?
12. Do you know who was involved in the decision? Were these individuals or groups advocating for or against adopting the 1915(i)?
 - a. State agency staff?
 - b. State legislators or their staff?
 - c. The governor's office?
 - d. Advocates for the elderly?
 - e. Advocates for the physically disabled?
 - f. Advocates for the intellectually or developmentally disabled?

- g. Provider organizations such as home health agencies, home care providers or nursing homes?
 - h. Do you know if state officials looked at what other states were doing? If so, which states and how did this influence the decision-making process?
 - i. Were there discussions with federal officials? If so, with whom and how did that shape the decision? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
13. In making the decision not to submit a 1915(i) state plan amendment,
- a. What, if any, factors were cited in favor of participating?
 - b. What, if any, factors were mentioned against applying?
 - c. Was there consensus among those involved about the decision not to apply or were some initially in favor or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
14. Looking back, do you think your state made the right decision not to add a 1915(i) state plan amendment?
15. In the future, do you think your state would consider adopting the 1915(i) state plan amendment? If so, under what conditions?
16. Is there anything we have not already discussed about the 1915(i) that you think I should know?

1915(k) Community First Choice personal care benefit:

17. Lastly turning to the 1915(k) personal care benefit,
- a. What is your perception of the 1915(k) Community First Choice personal care benefit?
 - b. What, if any, was your organization's position on pursuing the 1915(k)?
 - c. Did your organization make its position known to state decision-makers? If so, which ones? And how?
 - d. What role, if any, did you or your agency play in the decision not to adopt the 1915(k)?
18. When making the decision not to adopt the 1915(k), what do you think were the main factors affecting the decision not to participate?
- a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - c. Do you know, did specific requirements or conditions of the 1915(k) discourage your state from participating? If so, what aspects?
19. Do you know who was involved in the decision to apply for the 1915(k)? Were these individuals or groups advocating for or against adopting the 1915(k)?

- a. State agency staff?
 - b. State legislators or their staff?
 - c. The governor's office?
 - d. Advocates for the elderly?
 - e. Advocates for the physically disabled?
 - f. Advocates for the intellectually or developmentally disabled?
 - g. Provider organizations such as home health agencies, home care providers or nursing homes?
 - h. Do you know if state officials looked at what other states were doing? If so, which states and how did this influence the decision-making process?
 - i. Were there discussions with federal officials? If so, with whom and how did that shape the decision? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
20. In making the decision not to submit a 1915(k) state plan amendment,
- a. What, if any, factors were cited in favor of participating?
 - b. What, if any, factors were mentioned against applying?
 - c. Was there consensus among those involved about the decision not to apply or were some initially in favor or neutral? If there was not consensus, how was this overcome?
 - d. Do you know who made the final decision?
21. Looking back, do you think your state made the right decision not to add a 1915(k) state plan amendment?
22. In the future, do you think your state would consider adopting the 1915(k) state plan amendment? If so, under what conditions?
23. Is there anything we have not already discussed about the 1915(k) that you think I should know?

Conclusion

24. Before concluding, is there anything else that you think is important about any of these programs that you would like to share?
25. Do you have any reports, issue briefs, presentations, or other documents that might inform my study? Would you be willing to share them with me?
26. Could you suggest any other individuals who played a role in these programs that you think I should also interview?

Thank you again for sharing your time and knowledge with me.

National Officials / Stakeholders / Policy Experts

1. First, I would like to start by learning more about you and your organization.
 - a. Tell me about your organization and your role within the organization.
 - b. What are your major responsibilities?
 - c. How long have you been in this position?
 - d. What role does your organization play in long-term services and supports (LTSS) policies and programs?
2. From your perspective, what are the main factors affecting LTSS policy at the state level.
 - a. How important do you think rebalancing LTSS is? Why?
 - b. Overall, how focused do you think states are on rebalancing Medicaid-funded LTSS?

Balancing Incentive Program:

3. Turning to the Affordable Care Act's LTSS policies and focusing first on the Balancing Incentive Program (BIP),
 - a. What is your perception of BIP?
 - b. What, if any, was your organization's position on BIP?
 - c. What, if any, was you or your organization's involvement in BIP at the federal and/or state level?
4. Do you have any insights into what prompted states to apply or not apply for BIP?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did states' economic and fiscal situations play?
 - i. From your perspective, how important was the additional 2% or 5% Federal Matching Assistance Percentage (FMAP) in states' decisions?
 - c. Do you think rebalancing LTSS spending was something participating states were already committed to doing before BIP?
 - d. Do you think the structural requirements (i.e. the No Wrong Door/Single Entry Point system, the core standardized assessment, and conflict free case management) discouraged or encouraged states to pursue BIP?
5. At the state level, do you know who has been involved in the decision about whether to apply for BIP?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did governor's offices' staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?
 - i. Did other states influence states' decisions to submit an application for BIP?

- j. Did federal officials play a role? If so, from which federal agencies? Do you think federal regulations or publications, such as the home and community-based services final rule or BIP Manual, influenced states' decisions?
- 6. In making the decision about applying for BIP,
 - a. Do you know what were the factors cited in favor of participating?
 - b. What, if any, were the factors mentioned against applying?
 - c. Who typically made the final decision in states?
- 7. Was there anything else that had an influence on states' decisions to pursue or not pursue BIP that we have not already discussed?
- 8. After deciding to apply for BIP, do you know how states approached the application?
 - a. Do you know who was typically involved in writing the application?
 - i. What role, if any, did governor's offices, legislatures, or other agencies within government play?
 - ii. Did advocates for the elderly, physically disabled, intellectually and developmentally disabled or home- and community-based services providers have any input? Did others advocates and/or provider representatives play a role?
 - iii. Were outside consultants used in the application process? Did state officials have discussions with the Centers of Medicare and Medicaid Services (CMS) during the application process?
- 9. Tell me about what usually happened after the application was submitted.
 - a. Do you know the average time between when an application was submitted until when it was approved?
 - b. What happened during that time? Did states have discussions with CMS and/or make changes to their application? What types of changes?
- 10. After approval from CMS, how did states approach implementing BIP?
 - a. Were you or your organization involved in implementing BIP? If so, in which states and what was your involvement?
 - b. Who else was involved in implementing BIP in participating states?
 - i. What role did state agency staff play?
 - ii. Were governors' staff or legislative staff involved? In so, how?
 - iii. Did consumer advocacy organizations have input? If so, which ones and what was their role?
 - iv. Were provider organizations involved? If so, which organizations and what was their involvement?
 - v. Were outside consultants hired?
 - c. How did those involved approach, participate and/or influence implementing the structural changes and rebalancing requirements of BIP?
- 11. From your perspective, were there things that states did that facilitated the implementation of BIP?

- a. How did states address the need for staffing and other resources (e.g. IT) due to BIP?
 - b. Did states talk with other states that had already implemented BIP?
 - c. Do you know if most states utilized the technical assistance provided by Mission Analytics?
 - d. Is there any specific state or states that were very successfully implementing BIP? Why was this state so successful?
12. What, if any, challenges or setbacks did states face getting the program going?
- a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to implementing any of the structural changes including the:
 - a. No Wrong Door/Single Entry Point System
 - b. Conflict Free Case Management
 - c. Core Standardized Assessment?
 - d. If so, were they overcome and how?
 - c. Were there concerns about achieving the 25% or 50% spending on home- and community-based services before the end of BIP? Why or why not?
 - d. Were their concerns about sustaining these changes after the enhanced FMAP ended? Why or why not? If so, how were these concerns addressed?
 - e. In your opinion, what were the biggest challenges for states in implementing BIP and how were those challenges overcome?
 - f. Is there any specific state or states that face significant challenges implementing BIP? What were these challenges?
13. Looking back, is there anything you think states should have been done differently while implementing BIP?
14. Now that BIP has been in effect for ___ years, what impact do you think it has had on long-term services and supports in BIP states? And how successful do you think BIP has been at rebalancing LTSS?
15. Is there anything we have not already discussed about BIP that you think I should know?

1915(i) State Plan Benefit:

16. Turning next to the 1915(i) home- and community-based services state plan benefit,
- a. What is your perception of the 1915(i) HCBS state plan benefit?
 - b. What, if any, was your organization's position on the 1915(i)?
 - c. What, if any, was your or your organization's involvement in the 1915(i) at the federal and/or state level?
17. From your perspective, prior to the ACA, why did only a few states adopt the 1915(i) state plan option?

18. After the ACA, do you have any insights into what prompted states to pursue or not pursue a 1915(i) state plan amendment?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did states' economic and fiscal situations play?
 - c. Were states that adopted the 1915(i) already offering a similar program or services for these individuals or was the adoption of the 1915(i) an expansion of services?
19. At the state level, do you know who was involved in the decision?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did governor's office's staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?
 - i. Did other states influence states' decisions to submit a 1915(i) state plan amendment?
 - j. Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule, influence states' decisions?
20. In making the decision to submit or not submit the state plan amendment,
 - a. Do you know what were the factors cited in favor of participating?
 - b. What, if any, were the factors mentioned against applying?
 - c. Who typically made the final decision in states?
21. Was there anything else that had an influence on states' decision to pursue or not pursue a 1915(i) state plan amendment that we have not already discussed?
22. After the decision was made to apply, how did states typically approach did the 1915(i) state plan application?
 - a. Do you know who was involved in writing the application?
 - i. What role, if any, did governor's offices, legislatures, or state agencies within government play?
 - ii. Did advocates for the elderly, physically disabled, intellectually or developmentally disabled, or home- and community-based services providers have any input? Others advocates and/or provider representatives?
 - iii. Were outside consultants used in the application process?
23. Tell me about what usually happened after a state submitted the state plan amendment.
 - a. Do you know what the average time between when amendment was submitted until when it was approved?

- b. What happened during that time? Did states have discussions with CMS and/or make changes to amendment? What types of changes?
- 24. After approval from CMS, how did states approach implementing the 1915(i)?
 - a. Were you or your organization involved in implementing the 1915(i)? If so, in which states and what was your involvement?
 - b. Who else was involved implementing the 1915(i) in states?
 - i. What role did state agency staff play?
 - ii. Were governors' staff or legislative staff involved? In so, how?
 - iii. Did consumer advocacy organizations for the elderly, physically disabled, and/or intellectually or developmentally disabled have input?
 - iv. Were provider organizations involved? If so, which organizations and what was their involvement?
 - v. Were external consultants hired?
 - c. How did those involved approach, participate in, and/or influence implementing the 1915(i) benefit?
- 25. From your perspective, were there things that states did that facilitated the implementation of the 1915(i)?
 - a. How did states address the need for staffing or other resources (e.g. IT) due to this state plan amendment?
 - b. Did states talk with other states that had already implemented 1915(i) programs?
 - c. Is there any specific state or states that were very successfully implementing this state plan amendment?
- 26. What, if any, challenges or setbacks did states face getting the program going?
 - a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to enrolling individuals? Was the number of people enrolled generally less than, consistent with, or greater than the original estimates?
 - c. Did the program often expenditures exceed projections?
 - d. Did states have sufficient provider capacity?
 - e. In your opinion, what were the biggest challenges in implementing 1915(i) and how were those challenges overcome?
 - f. Is there any specific state or states that face significant challenges implementing this state plan amendment?
- 27. Looking back, is there anything you think states should have been done differently in implementing the 1915(i)?
- 28. Now that the revised 1915(i) has been available for __ years, what impact do you think it has had on long-term services and supports in states that have adopted it? And how successful do you think it has been at rebalancing LTSS?
- 29. Is there anything we have not already discussed about the 1915(i) that you think I should know?

1915(k) Community First Choice personal care benefit

30. Turning lastly to the 1915(k) Community First Choice personal care benefit,
 - a. What is your perception of the 1915(k) Community First Choice personal care benefit?
 - b. What, if any, was your organization's position on the 1915(k) Community First Choice personal care benefit?
 - c. What, if any, was your or your organization's involvement in the 1915(k) at the federal and/or state level?
31. Do you have any insights into what prompted states to submit or not submit a 1915(k) state plan amendment?
 - a. Do you think the political environment had any impact?
 - b. What, if any, role did the state's economic and fiscal situation play?
 - i. In your opinion, how important was the additional 6% Federal Medical Assistance Percentage (FMAP) in states' decision?
 - c. Were states that adopted the 1915(k) already offering a similar program or services for these individuals or was the adoption of the 1915(k) an expansion of services?
32. At the state level, do you know who was involved in the decision?
 - a. Which state agencies were involved? And what role did they play?
 - b. Did state legislators and/or legislative staff play a role? If so, what role?
 - c. Did governor's office's staff play a role? If so, what role?
 - d. How involved were advocates for the elderly?
 - e. Did advocates for the physically disabled play a role?
 - f. What about advocates for the intellectually or developmentally disabled?
 - g. Did home health agencies or the home care industry have any input?
 - h. What role, if any, did the nursing facility industry play?
 - i. Did other states influence the decision to submit the state plan amendment? If so, which states?
 - j. Did federal officials play a role? If so, from which federal agencies? Did federal regulations or publications, such as the home and community-based services final rule, influence the decision?
33. In making the decision to submit the state plan amendment,
 - a. Do you know what were the factors cited in favor of participating?
 - b. What, if any, were the factors mentioned against applying?
 - c. Who typically made the final decision in states?
34. Was there anything else that had an influence on states' decisions to pursue or not pursue a 1915(k) state plan amendment that we have not already discussed?
35. After states decided to apply for the 1915(k), do you know how states approached the application?

- a. Do you know who was involved in writing the application?
 - i. What role, if any, did governor's offices, legislature, or other agencies within government play?
 - ii. Did advocates for the elderly, disabled, or home- and community-based services providers have any input?
 - iii. Were outside consultants used in the application process? Did state officials have discussions with CMS during the application process?
36. Tell me about what usually happened after the application was submitted.
- a. Do you know the average time between when an application was submitted until when it was approved?
 - b. What happened during that time? Did states have discussions with CMS and/or make changes to their application? What types of changes?
37. After approval from CMS, how did states approach implementing the 1915(k)?
- a. Were you or your organization involved in implementing the 1915(k) program in any states? If so, in what states and what was your involvement?
 - b. Who else was involved in implementing the 1915(k) within participating states?
 - i. What role did state agency staff play?
 - ii. Were governors' staff or legislative staff involved? In so, how?
 - iii. Did consumer advocacy organizations for the elderly, physically disabled, and/or intellectually or developmentally disabled have input?
 - iv. Were provider organizations involved?
 - v. Were outside consultants hired?
 - c. How did those involved approach, participate in, and/or influence implementing this program?
38. From your perspective, were there things that states did that facilitated the implementation of the 1915(k)?
- a. How did states address the need for staffing and other resources (e.g. IT) due to this state plan amendment?
 - b. Did states talk with other states that had already implemented 1915(k) programs?
 - c. Is there any specific state or states that were very successfully implementing this state plan amendment?
39. What, if any, challenges or setback did states face getting the program going?
- a. Were there sufficient staff and resources to implement the program?
 - b. Were there challenges related to enrolling individuals? Was the number of people enrolled generally less than, consistent with, or greater than the original estimates?
 - c. Did the program expenditures often exceed projections?
 - d. Was there sufficient provider capacity?
 - e. In your opinion, what were the biggest challenges in implementing 1915(k) services and how were those challenges overcome?
 - f. Is there any specific state or states that face significant challenges implementing this state plan amendment?

40. Looking back, is there anything you think states should have been done differently in implementing the 1915(k)?
41. Now that the 1915(k) has been available for ___ years, what impact do you think it has had on long-term services and supports in participating state? And how successful do you think it has been at rebalancing LTSS?
42. Is there anything we have not already discussed about the 1915(k) that you think I should know?

Conclusion

43. Before concluding, what do you see as barriers and facilitators to states' rebalancing efforts in general?
44. Is there anything else that you think is important about any of these programs that you would like to share?
45. Do you have any reports, issue briefs, presentations, or other documents that might inform my study? Would you be willing to share them with me?
46. Could you suggest any other individuals who played a role or could comment informatively on these programs that you think I should also interview?

Thank you again for sharing your time and knowledge with me.

APPENDIX F: A PRIORI THEMES, CATEGORIES AND RELATED CODES

Theme	Categories	Related Codes
Political and ideological factors	Elected officials support	Gubernatorial support Legislative support
	Ideology	Liberal ideology Conservative ideology
	Political party	Democrat Republican
	Position on ACA	Health insurance exchanges Medicaid expansion National Federation of Independent Business v. Sebelius
Interest groups	Consumer advocates	Older adults advocacy Physically disabled advocacy Developmentally or intellectually disabled advocacy
		Home care providers Certified home health agencies Nursing home industry For-profit nursing homes
	Lobbying	Bureaucratic lobbying

Theme	Categories	Related Codes
		Legislative branch lobbying
Economic/Fiscal Considerations	New revenue	Revenue maximization Federal Medical Assistance Percentage (FMAP)
	Cost concerns	Sustainability Financial exposure
	State spending	State budget State share of Medicaid Total state Medicaid spending
	Economic climate	Recession
Existing LTSS Policies	HCBS policies	LTSS state plan services HCBS waiver Money Follows the Person State-funded home care programs
	LTSS policy goals	Rebalancing Managed care
	LTSS demand	Waiting list
	LTSS supply	Provider capacity Certificate of need – HHA Certificate of need – nursing facility

Theme	Categories	Related Codes
	Impact on other policies	Complementing policy Substituting policy
Governing Capacity	Power Separation of Powers/ Partisanship Policy Constraints	Gubernatorial power Bureaucratic autonomy Unified government Divided government Unified legislature Divided legislature Agency Personnel – Lack of Knowledge Agency Personnel – Insufficient staffing Legislative approval Other entity approval
External Factors	Federal government Other states	Centers for Medicare and Medicaid Services Administration for Community Living HCBS Final Regulations Federal programmatic requirements Neighboring states Other states' applications and/or state plan amendments

APPENDIX G: FINAL CODING MATRIX WITH EXAMPLE QUOTES

Theme	Categories	Related Codes	Examples
Political and ideological factors	Elected officials support	Gubernatorial / legislative support	<p>“Extra money was a huge thing but that was another thing that we did have to get special permission from the Governor to apply for.”</p> <p>“State leadership, including the legislature and the governor have made it very clear that they want to support people in community-based residential settings rather than institutional-based settings.”</p> <p>“That fact [is] that the administrative branches of government can get their act together and want to do something but is not supported by the executive, the Governor and the legislature.”</p>
	Ideology	Conservative ideology	<p>“It's [Texas] a very, very, very conservative state...while we didn't do the Medicaid expansion piece, we certainly availed [in] other cases, to the Affordable Care Act for example, the Balancing Incentive Program, the extension of Money Follows the Person”</p>
	Political party	Republican	<p>“There were some in favor [of pursuing BIP]. It was pretty much along policy ... a party line and the Republicans have that in control for a long time, and it wasn't what's going to happen.”</p>
	Position on ACA	Opposition to ACA	<p>“It [BIP] was . . . political toxic because it was associated with the ACA”</p> <p>“There was probably some pause just with the fact that CFC was a part of</p>

			<p>the Affordable Care Act. There were questions”</p> <p>“If there was a strong association with the Affordable Care Act, it [the 1915(i)] certainly wouldn't have made it very far in the budget process, so it probably kind of slipped under the radar with many high-level decision makers in the state.”</p>
Interest groups	Consumer advocates	Older adults/physical disabled advocacy	<p>“There isn't a really strong place in advocacy around the aging and aged and physically disabled population. They are populations that are ... don't really have good advocacy at the legislature or often within the government.”</p>
		Developmentally or intellectually disabled advocacy	<p>“There was a lot of support to provide the service [CFC] among the IDD [intellectual/development disability] advocate community because people were waiting 10, 12 years”</p> <p>“Advocates were glad too that this [CFC] might help alleviate some of the pressure on people and families who are on the interest lists.”</p>
		Mental illness advocacy	<p>“We have a very strong advocacy organization that represents the family members of kids with mental health disorders. They're called the Maryland Coalition of Families, MCF... and the advocacy community wanted a replacement.”</p>
	Provider organizations	Nursing home industry	<p>“Not in every state, but I think the nursing home industry certainly has a financial incentive and their own business reasons for not being behind these. Again, it's not in every state, but in some states, they're a strong lobby.”</p>

		Intermediate Care Facilities	<p>“We have a large nursing home industry, which is relatively influential in the state.”</p> <p>“Legislators who have an SSLC, a state supported living center, in their district are very unlikely to prioritize community based options over institutional because SSLCs are large employers in their districts and they have constituents who are very invested in that system.”</p> <p>“They are very protected by the legislators in which these institutions are located, mainly because these are state jobs, often into small communities.”</p>
		Mental health providers	<p>“There was a lot of resistance from the mental health providers to asking those questions, because the individuals they serve, by and large, don't have ADL issues”</p>
Economic/Fiscal factors	New revenue	Revenue maximization	<p>“There were a number of states that were kind of on a trajectory already to surpass the 50% threshold but found a way in BIP to just reduce the cost of doing that”</p> <p>“We just got extra money for doing what we were already doing. Which was great, and we were able to expand the program.”</p> <p>“I think it's the motivating factor for states to pursue it [CFC], in the hopes that they could get additional resources for something they're already doing”</p>

	Cost concerns	Enhanced match	<p>“So being able to offer additional services and being able to get that enhanced match was a big deal”</p> <p>“It [the 6% additional match for CFC] was very important. No question about it. Very important.”</p> <p>“The state was interested in the six percent enhanced match”</p>
		Refinance existing benefit	<p>“I think the fact that it gave them an opportunity to, I don't know how to put, refinance part of the waivers.”</p> <p>“There are some option to refinance what they're already providing.”</p>
		Sustainability	<p>“You have to sustain what you've done ... I mean you hope that you're going in that direction anyway, but yes sustainability is always an issue.”</p> <p>“I think there was a lot of concern, primarily among legislators who were concerned that it would create services that would not be sustainable after BIP went away.”</p>
		Financial exposure	<p>“We were worried about the financial impact of not being able to cap the [1915(i) program]”</p> <p>“I think that there were concerns that it could be a really expensive program”</p> <p>“I think a challenge for states that are seeing their expenditures beyond expectation.”</p>

		Cost-benefit analysis	<p>“Discussions [are] going on in other states about whether the cost is, they're looking at the cost benefit ratio and figuring out if it's [CFC's] worth it to do, to take it on”</p> <p>“They get this extra money, but they have to figure ... because it's [CFC] a state plan, they have to serve everyone who's eligible. They can't have a waiting list. They can't have a cap. They have to do some calculations and figure out is this a good deal?”</p>
	State spending	State budget	<p>“State budgets are a driving factor”</p> <p>“State budget situation is always a factor. There's never enough money, but unfortunately, when there's budget crunches, like the recession, the first thing that gets cut is home and community-based services because they're optional.”</p> <p>“So I think that would be the number one challenge for developing policy or new initiatives in long term care services, is the lack of available money”</p>
		State share of Medicaid	<p>“There's still only a certain number of state dollars, you know, for the match.”</p> <p>“The reason why we haven't seen more than what we have today. In a large extent, in addition to the coming up with their own state funding that I mentioned earlier, the state match.”</p>
	Economic climate	Recession	<p>“The states at the time were still really reeling from the great recession, so</p>

			there were fewer resources than states typically have.”
Existing LTSS Policies	HCBS policies	<p>Aging and Disability Resource Centers (ADRCs)</p> <p>Department of Labor overtime</p> <p>HCBS waiver</p>	<p>“Texas used its BIP money to build out its ADRC system and that was fine, that was perfectly acceptable, because the ADRC system serves Medicaid eligible individuals”</p> <p>“We were early adopters in the ADRC program, and so we were already in the process of really trying to stand those up before the BIP project funding”</p> <p>“We ended up having issues with Department of labor laws, which had requirements on paying for overtime, and transportation.”</p> <p>“The state realized probably a year and a half ago that they could not see a way to relieve themselves of any employer responsibility, so what they did is said "Okay so everybody who's on a self-directed plan has to go, has to have all their employees work for an agency, a provider." So essentially we have an agency-provider system now”</p> <p>“Maryland decided to merge two waivers, a waiver for older adults that served folks 50 and up and then the waiver for folks with physical disabilities from 18 to 64. We merged those two waivers so it just became 18 and up with disabilities and we carved out all the services that were eligible under CFC and so waiver folks would be eligible for the services of state plan services”</p>

			<p>“We have four waivers that serve people with IDD and so we took the habilitation service that was through their waiver program and kind of ... With one program swapped out one for one with CFC on June 1st”</p>
		LTSS state plan services	<p>“We already had a state plan benefit available to people with physical disabilities called Personal Assistance Services. Someone who was not in a waiver but had a functional, a physical, functional need for attendant care, could already get that through the state plan.”</p> <p>“My understanding is that the states that have adopted it [CFC] already had personal care in their state plan and so that part of it, at least, was not a heavy lift, cost-wise.”</p>
		Mental health exclusion	<p>“Traditionally, people who have a disability from mental illness have generally been in many ways excluded from Medicaid, long term care.”</p> <p>“The federal government doesn't fund a lot of services for institutional care that can be brought out into the community because of the IMD [institutes for mental disease] exclusion”</p>
		Money Follows the Person	<p>“All the states that had BIP also had a MFP program, so there's that synergy there, too.”</p> <p>“In a number of cases, the projects director for Money follows the Person was also the project director for BIP”</p>

	LTSS policy goals	Olmstead decision	“Another big driver and then we also have issues around litigation. There's a Supreme Court decision you're probably familiar with called the Olmstead Decision in 1999. Which affirms the rights of individuals to receive services in the most integrated setting appropriate to their needs.”
		PRTF [Psychiatric Residential Treatment Facilities] demonstration grant	“The federal government, the CMS did an alternatives to psychiatric residential treatment demonstration program a few years ago. And that whole demonstration project came out of an earlier action by our state to request the 1915(c) waiver for kids with serious emotional disturbances who met the level of care of psychiatric residential treatment.”
		State-funded home care programs	“There definitely was interest with states in securing some federal match to a program that was previously state only funded”
		Grow programs slowly	<p>“States need to take things up that they can manage. They're not likely to undertake a large entitlement without understanding how they can grow it responsibly and in a way that they can sustain”</p> <p>“I could see where that [the 1915(i)] was an attractive option. Like we could start a program small, grow it bigger over time”</p>
		Managed care	“It [CFC] has done what it was intended to do, which is to prepare the system to move into a managed care business model, and so with CFC you can say that more and more of the

			<p>system is being served in a managed care environment”</p>
		Rebalancing	<p>“I think most of the states are on board with the idea that they should be rebalancing towards greater reliance on HCBS, and we see that's a general trend. Some states are doing that faster and better than others.”</p> <p>“Anything that would bring in additional resources and help us rebalance at the same time was seen as a net positive.”</p>
	LTSS demand	Waiting list/interest list	<p>“[We have] a never-ending number of people on the interest lists waiting for services, and had to wait 10, 12 years for any type of service whatsoever. And the idea was, at least perhaps we could give a basic service.”</p> <p>“Community First Choice, I think that did create some service for folks who had been languishing on interest lists for years and years.”</p> <p>“The real goal with CFC for Texas was to allow for something that could be provided to people with IDD who sometimes wait longer than 10 years for a waiver slot to get them a state plan benefit, to help them in the meantime”</p>
	LTSS supply	Provider capacity	<p>“We've had problems with recruiting those kind of non-traditional providers for a number of reasons”</p> <p>“One of our current problems is in Travis County ... We have no program</p>

	Impact on other policies	Address existing problem	<p>providers at this point because no one has decided to take it on”</p> <p>“Some of the hurdles that we had been facing with the previous state plan personal care program, that was built to the best of their abilities, but it had a lot of shortcomings. So, this was kind of a good opportunity to move personal assistance into the state plan totally, and not piecemeal it together, some through the waiver, some on the state plan”</p> <p>“Some states have used it [the 1915(i)] to fix other problems in their system”</p>
		Complementing policy	<p>“for Maryland, it [BIP} lined up so well with our vision for where we wanna take home- and community-based services, and so why not do it”</p> <p>“I think it was a very natural fit for us to pursue a Balancing Incentive Program, just because a lot of the requirements were already things that we were working on in one way or another.”</p> <p>“It [the 1915(i) was, right place, right time kind of thing. We were already in the process of trying to do something on the mental health side, and specifically addressing people who were churning in and out of state hospital facilities”</p>
		Substituting policy	<p>“They've shifted things around, and we knew that was going to happen, but they'll move services over from the waiver to Community First Choice to get that extra 6%”</p>

			“They did flip people who were in existing services into CFC”
Governing Capacity	Governmental Actors	Governor	“The governor's office, to some extent, is always the one that says, "Yes," or "No.””
		Leader	<p>“We are very lucky to have extremely strong leadership and rational leadership in Maryland's Medicaid department in general, and especially on the long-term care side.”</p> <p>“Just it takes good leadership”</p>
		Legislators	<p>“I would venture to say that many of our legislators had no idea what percentage of money is going to spend to support the relatively-small number of people of institutions versus supporting a much larger number in the community”</p> <p>“There were a couple of legislators that were certainly key involved. The two that come to mind are Senator Jane Nelson and Representative Richard Raymond were very key involved.”</p>
		Local authority	“I think there was a lot of concern that the tool was to be used by Aging and Disability Resource Centers and local authorities. They were not involved in developing the tool, nor were any consumers involved in developing the tool.”
		Medicaid director	“He made himself available and listened to the feedback, but also was ... He just was a really good leader at that time. He believed in what we were doing and he stood behind it and

			<p>he gave us, internally, the resources that we needed to fix what wasn't working so well and make things happen.”</p> <p>“Coming from a state Medicaid director that was interested and wanted to do long term care reform after seeing our system, and seeing the recommendations, we wanted to do something.”</p> <p>State agency</p> <p>“So our state Medicaid agency and our state behavioral health, or at that time, mental health agency came to the decision to apply”</p> <p>“it [BIP] was definitely a DADS [Department of Aging and Disability Services] initiative certainly because HHSC [Health and Human Services Commission] was a state Medicaid agency. It had to be involved but it was definitely delegated to DADS to do the application and plan for it and all of that.</p> <p>Bureaucrats</p> <p>“I'd say it was generally savvy folks who had worked for years in LTSS and recognized BIP as an opportunity to do work that they were already doing or wanted to do but couldn't pay for, and they knew how to make the pitch to their leadership and ultimately to either the governor or the legislature or both.”</p> <p>“I think that there have always been people at the Medicaid level in Maryland. Who believe in folks getting out. And getting back to the community.”</p>
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	Policy Constraints	<p>Bureaucratic autonomy</p> <p>Agency Personnel – Lack of Knowledge</p> <p>Agency Personnel – Insufficient staffing</p> <p>Legislative approval</p>	<p>“Mostly it was folks taking on additional responsibilities. People who were already state employees and working in LTSS who took on BIP.”</p> <p>“So a lot depended on how much autonomy folks were given. In states where staff had a fair amount of autonomy to do things, they moved quickly and got a lot done in a relatively short period of time. In states where the staff didn't have a lot of autonomy and had to vet every decision through two or three layers”</p> <p>“There's been that much turnover in the Texas state government in the last couple that you've lost a lot of ... institutional knowledge.”</p> <p>“Probably could have used a little more staff at the time for overall implementation. And it would've been helpful to have had some additional, at least a dedicated person in our budget office looking at the sources of income and dividing that apart.”</p> <p>“States alternately do have a limited number of staff positions that they can use to run the Medicaid program. You do kind of just run out of FTE's to apply for and manage all of these different projects.”</p> <p>“We had to get legislative approval and then everything had to be sort of run by HHSC. Both of those approvals were necessary but pretty easy to get from my perspective. I wasn't involved in the conversations but I</p>
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			don't think that we had any trouble convincing anyone to do it.”
External Factors	Federal government	Centers for Medicare and Medicaid Services	<p>“CMS was really not 100% clear, we were trying to explore with them what the possibilities were, which they ... at that time, weren't crystal clear on”</p> <p>“CMS has not issued any additional guidance about 1915(k). There's the rule, but the rule itself is pretty under specified.”</p>
		HCBS Final Regulations	<p>“I think some states took the proposed rule pretty well on it's face, and moved forward. I think we tell saw some steady movement leading up to the final rule. But I do think the states aren't often in the gambling game, they like to understand what rules they'll be playing by before they make the commitment.”</p> <p>“One of the biggest things driving Medicaid long term services and supports policy right now is a regulation that was published nearly three years ago at the beginning of 2014.”</p>
	Other states	Other states' applications and/or state plan amendments	<p>“States that are thinking about it [the 1915(i)] are looking at the states that have adopted it”</p>
		Consultants	<p>“I think that was really helpful in terms of having that outside consultant do this because resources were limited, and especially in IT. And I think it was important to have a third party look at the system versus those who are internal and have their own best interests.”</p>

			<p>“A lot of states have hired consultants to come in and look at their data, run the numbers, figure it out.”</p> <p>“Mission Analytics were very, very helpful. Wish I could remember her name who was really helpful there. She was amazing.”</p>
Policies and Programs	Policy/program characteristics	<p>Ability to target</p> <p>Clinical eligibility</p> <p>Entitlement</p> <p>Financial eligibility</p>	<p>“We can be innovative and we can target to particular populations, very narrowly defined, who don't meet institutional level of care”</p> <p>“We were worried about the financial impact of not being able to cap the program. So we set really incredibly high clinical criteria, which required an enrollee to have within the prior 12 months, three psychiatric hospitalizations.”</p> <p>“Part of the reason why the eligibility criteria was made so restrictive was specifically a concern about how much this program was going to cost.”</p> <p>“States are leery of doing Community First Choice because it does open it up to be an entitlement”</p> <p>“It costs every state to adopt CFC because it is entitlement”</p> <p>“The financial eligibility ended up being 150% of the federal poverty level and that's below who we allow other Medicaid services”</p> <p>“I think the overall service package is outstanding. I think that where we have challenges is it is capped at</p>

			<p>150% of federal poverty, which is pretty low”</p> <p>“I think the 150% ceiling, even for populations who might meet those other criteria, creates an addition barrier”</p>
		Program flexibility	<p>“Allowing some more flexibility around the services that can be included within the 1915I as well as some flexibility around developing programs that were specifically targeted to different populations.”</p> <p>“It [the 1915(i)] can be used in really innovative ways to serve individuals who previously were underserved. And I think that's the attraction, too, for a lot of states. They have a lot more freedom than they have with, say, 1915(k).”</p>
		Provider Rates	<p>“I think there's three different levels maybe. So all of those were standardized to an agency based rate or sort of self-directed rate with a floor and a ceiling that the CFC participant could choose. So some people, depending on what program they were in, were now going to be getting a higher rate and there were some people that saw a rate cut”</p> <p>“It represented for the IDD service providers, it represented a much less reimbursement rate than the traditional waiver reimbursement. And then that creates a problems”</p>
		Timeframe	<p>“BIP wasn't enough time to really do this well. And I think that was probably the ultimate lesson learned.”</p>

		<p>Program requirements</p> <p>Services</p>	<p>“Challenges, we were running on a tight timeline, we were trying to do a bunch of things at once”</p> <p>“I mean, the assessment piece, for the most part, we had already met all those requirements. The Conflict free Case Management I was able to demonstrate that we had, really for the most part, had met those requirements. I mean, we had a lot of those issues already in play. The No Wrong Door, again, wasn't really going to be too much of a problem”</p> <p>“Federal rules and requirements impact state decisions on LTSS”</p> <p>“One [issue with the 1915(i)] was that they weren't able to indicate other services that states can include in 1915C waivers. So, they could only include a specific set of services that are enumerated in 1915C statute. And not those other services.”</p> <p>“1915(i) didn't initially have the quote, unquote, "other service category" in it and other services really do represent a lot of the flexibility you see in the Medicaid home and community-based services program.”</p>
	Policy implementation	Communication	<p>“Better communication and better marketing of the program. I still think they're not doing a great job in terms of explaining to each of the players how to cooperate with each other.”</p> <p>“The idea of getting this service [CFC] suddenly seems too good to be</p>

			<p>true and we had a lot of people who just declined to be assessed for the service overall. I think a more targeted communication plan would have been helpful for that.”</p> <p>“There's whole parts of the state that don't even know about it and don't enroll kids”</p>
		Enrollment	<p>“I know that we've had a lot of difficulty with getting people enrolled in the program that were not already receiving some kind of service”</p>
		Input	<p>“I think it [CFC] hasn't ended up being quite what we hoped it would be. And it's changed some in what we thought. We've had a really difficult time getting Medicaid to do what we think is right and taking our input.”</p> <p>“They do ask very frequently for stakeholder input on things. But it's usually after the majority of it's already kind of internally been determined. And so you kind of get the peripheral stuff at that point.”</p> <p>“Opportunities for meaningful stakeholder input, emphasis on meaningful but probably limited.”</p>
		Procurement	<p>“I'd say the biggest delay in anything was just working our way through the procurement process”</p> <p>“So some states actually experienced delays in their contracting process.”</p>
		Publicize	<p>“They really focused primarily on the IDD interest list for approaching</p>

			<p>people to get enrolled into the program [CFC] and wasn't like a widespread you just heard about it everywhere type of campaign by any means”</p>
		Lack of understanding	<p>“I think a lot of people that were getting offered the service didn't really understand that they could remain on an interest list for other services if they accepted it [CFC]”</p>
		Uncertainty	<p>“CMS was really not 100% clear, we were trying to explore with them what the possibilities were, which they didn't, at that time, weren't crystal clear on”</p>
		Reluctance	<p>“Some providers who were a little resistant to changing their instruments.”</p> <p>“And so some people that were really interested in stepping into the field were a little hesitant because of the administrative overhead to first step into it”</p>
		Multiple players	<p>“Sometimes it's because you're dealing with multiple levels of government, and that's one thing that's not terribly well understood is that in a lot of states, the state government, per se, has delegated a lot of things to counties or other regional entities. You have a lot of players, and the state doesn't necessarily have total control over them. Some of them are more on board than others, and some of them are more competent than others. It can be a little difficult, and it can just take</p>

			<p>longer to get something implemented because of that.”</p> <p>“There's been challenges with getting to know one another and getting to understand one another on the provider side and managed care side.”</p>
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APPENDIX H: CORRELATION MATRIX OF INDEPENDENT VARIABLES

	Democratic Governor	% of Legislature Democratic	ADA Ideology Index	FTE state employees per 1,000	Gubernatorial power index	Average state legislative salary	Partisan control indicator	NF beds per 1,000 age 65+	% of NF beds for profit	HHA per 100,000	% of the population 65+	% of population with disability	% of the population cognitive disability	Per capita income (t-1)
Democratic Governor	1.00													
% of Legislature Democratic	0.60	1.00												
ADA Ideology Index	0.56	0.82	1.00											
FTE state employees per 1,000	0.15	0.00	0.13	1.00										
Gubernatorial power index	0.13	0.26	0.33	0.04	1.00									
Average state legislative salary	0.21	0.34	0.22	-0.42	0.43	1.00								
Partisan control indicator	-0.13	-0.11	-0.13	-0.04	0.27	0.24	1.00							
NF beds per 1,000 age 65+	0.00	-0.08	-0.13	0.14	0.10	0.09	0.02	1.00						
% of NF beds for profit	0.06	0.20	-0.04	-0.24	-0.35	0.02	-0.01	-0.36	1.00					
HHA per 100,000	-0.27	-0.28	-0.36	-0.18	-0.14	0.01	0.09	0.27	0.12	1.00				
% of the population 65+	0.10	0.21	0.29	0.15	-0.03	0.00	-0.13	0.03	-0.12	-0.07	1.00			
% of population with disability	-0.05	-0.04	-0.23	0.25	-0.36	-0.29	-0.06	-0.01	0.31	0.05	0.49	1.00		
% of the population with cognitive disability	-0.03	0.02	-0.14	0.21	-0.32	-0.23	-0.01	-0.07	0.34	-0.02	0.43	0.96	1.00	
Per capita income (t-1)	0.15	0.09	0.24	0.15	0.48	0.16	0.13	0.55	-0.52	0.02	0.00	-0.47	-0.50	1.00
GDP (t-1)	0.32	0.30	0.44	0.12	0.58	0.36	0.13	0.22	-0.35	-0.11	-0.22	-0.67	-0.65	0.78
Unemployment rate (t-1)	0.04	0.35	0.08	-0.43	-0.16	0.27	-0.07	-0.36	0.54	-0.14	-0.07	0.14	0.16	-0.45
# of 1915(c) waivers (t-1)	0.02	-0.11	-0.18	-0.38	0.10	0.37	0.08	0.17	-0.01	0.21	-0.13	-0.21	-0.22	0.18
Medicaid state plan personal care program (t-1)	0.03	-0.03	0.09	-0.03	-0.17	-0.02	-0.14	-0.27	-0.05	-0.05	0.02	-0.05	-0.03	-0.14
% of Medicaid LTSS spending on HCBS (t-1)	0.29	0.27	0.45	0.03	0.00	-0.08	-0.16	-0.39	0.03	-0.17	-0.02	-0.13	-0.05	-0.10

	Democratic Governor	% of Legislature Democratic	ADA Ideology Index	FTE state employees per 1,000	Gubernatorial power index	Average state legislative salary	Partisan control indicator	NF beds per 1,000 age 65+	% of NF beds for profit	HHA per 100,000	% of the population 65+	% of population with disability	% of the population cognitive disability	Per capita income (t-1)
Medicaid HCBS spending per capita (t-1)	0.49	0.49	0.55	0.09	0.22	0.21	-0.02	0.20	-0.31	-0.27	0.28	-0.09	-0.03	0.38
NF certificate of need program (t-1)	0.20	0.32	0.16	-0.02	-0.16	0.05	-0.21	0.00	0.30	-0.17	0.35	0.40	0.38	-0.21
HHA certificate of need program (t-1)	0.26	0.26	0.09	0.21	-0.07	-0.14	-0.09	-0.05	0.17	-0.43	0.08	0.34	0.32	-0.18
Medically needy program (t-1)	0.27	0.30	0.26	-0.06	0.27	0.26	-0.04	0.15	-0.21	-0.18	0.10	-0.16	-0.10	0.26
Prior year ACA HCBS policy (t-1)	0.09	0.05	0.01	-0.09	-0.10	0.06	-0.11	0.14	0.08	0.04	0.03	0.06	0.06	-0.03
HCBS Final Rule issuance	0.02	0.01	-0.01	-0.01	0.01	-0.01	0.03	0.01	0.04	0.02	0.18	0.06	0.06	0.01
% of neighboring states adopting BIP (t-1)	-0.03	0.13	0.07	0.03	-0.06	0.04	0.04	0.20	0.11	0.12	0.41	0.38	0.41	-0.05
% of neighboring states adopting CFC (t-1)	0.12	0.15	0.17	-0.03	0.09	0.09	-0.01	-0.34	0.12	-0.19	0.05	-0.08	-0.07	0.00
% of neighboring states adopting 1915(i) (t-1)	0.10	0.04	-0.04	-0.04	0.13	0.03	0.14	-0.10	0.08	0.01	-0.23	-0.03	-0.03	-0.03
% of neighboring states adopting any policy (t-1)	0.00	0.08	0.02	-0.01	-0.03	0.00	0.08	-0.04	0.14	0.05	0.23	0.31	0.32	-0.13

	GDP (t-1)	-0.14	-0.12	0.00	-0.05	-0.12	0.16	0.29	0.00	0.12	0.04	0.39	1.00	% of neighboring states adopting BIP (t-1)	% of neighboring states adopting 1915(i) (t-1)	% of neighboring states adopting any policy (t-1)
% of neighboring states adopting BIP (t-1)		0.18	0.05	-0.18	0.17	0.22	0.02	-0.09	-0.07	-0.10	-0.17	0.31	-0.08	1.00		
% of neighboring states adopting CFC (t-1)		0.09	0.14	-0.01	-0.01	0.10	0.00	0.03	0.19	-0.06	0.05	0.14	-0.06	0.37	1.00	
% of neighboring states adopting 1915(i) (t-1)		-0.09	-0.01	-0.04	0.04	0.05	0.08	0.23	0.04	-0.02	0.02	0.39	0.75	0.30	0.53	1.00
% of neighboring states adopting any policy (t-1)																

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