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Edward Alan Miller

*University of Massachusetts Boston*, [edward.miller@umb.edu](mailto:edward.miller@umb.edu)

Divya Samuel

*University of Pennsylvania*, [divya.samuel@gmail.edu](mailto:divya.samuel@gmail.edu)

Susan Allen

*Brown University*, [susan\\_allen@brown.edu](mailto:susan_allen@brown.edu)

Amal Trivedi

*Brown University*, [amal\\_trivedi@brown.edu](mailto:amal_trivedi@brown.edu)

Vincent Mor

*Brown University*, [Vincent\\_Mor@brown.edu](mailto:Vincent_Mor@brown.edu)

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# **Implications of Rhode Island's Global Consumer Choice Compact Medicaid Waiver for Designing and Implementing State Health Reform<sup>1</sup>**

Edward Alan Miller, Ph.D., M.P.A.,<sup>1</sup>

Divya Samuel, A.B.<sup>2</sup>

Susan Allen, Ph.D.<sup>3</sup>

Amal Trivedi, M.D.,<sup>4</sup>

Vincent Mor, Ph.D.<sup>5</sup>

<sup>1</sup>Associate Professor of Gerontology and Public Policy, and Fellow, Gerontology Institute, John W. McCormack Graduate School of Policy and Global Studies, University of Massachusetts Boston, and Adjunct Associate Professor of Health Services, Policy and Practice, Brown University. Mail: Department of Gerontology, UMass-Boston, 100 Morrissey Blvd., Boston, MA 02125, Voice: 617-287-7313, Fax: 617 287 7080, Email: [edward.miller@umb.edu](mailto:edward.miller@umb.edu)

<sup>2</sup>Masters of Nursing Candidate, School of Nursing, University of Pennsylvania. Mail: University of Pennsylvania School of Nursing, 418 Curie Blvd., Philadelphia, PA 19104, Voice: (716) 200-9457, Fax: (215) 898-4043, E-mail: [divya.samuel@gmail.edu](mailto:divya.samuel@gmail.edu)

<sup>3</sup>Professor of Health Services, Policy and Practice, and Faculty, Center for Gerontology and Health Care Research, Brown University. Mail: Department of Health Services Policy and Practice, Brown University, 121 South Main Street, Providence, RI 02912, Voice: (401) 863-, Fax: (401) 863-3818, E-mail: [Susan\\_Allen@brown.edu](mailto:Susan_Allen@brown.edu)

<sup>4</sup>Assistant Professor of Health Services, Policy and Practice, and Faculty, Center for Gerontology and Health Care Research, Brown University. Mail: Department of Health Services Policy and Practice, Brown University, 121 South Main Street, Providence, RI 02912, Voice: (401) 863-9941, Fax: (401) 863-3713, E-mail: [Amal\\_Trivedi@brown.edu](mailto:Amal_Trivedi@brown.edu)

<sup>5</sup>Professor of Health Services, Policy and Practice, Brown University, and Faculty, Center for Gerontology and Health Care Research. Mail: Department of Health Services Policy and Practice, Brown University, 121 South Main Street, Providence, RI 02912, Voice: (401) 863-3172, Fax: (401) 863-3713, E-mail: [Vincent\\_Mor@Brown.edu](mailto:Vincent_Mor@Brown.edu)

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# **Implications of Rhode Island's Global Consumer Choice Compact Medicaid Waiver for Designing and Implementing State Health Reform**

## **Abstract**

Provisions in the Medicaid statute permit states to apply for waivers from traditional program requirements. On January 16, 2009, the federal government approved Rhode Island's Global Consumer Choice Compact Waiver. In exchange for a cap on combined federal and state spending of \$12.075 billion through 2013, Rhode Island received greater flexibility to adopt certain Medicaid program changes. This study analyzes the design and implementation of the Global Waiver to draw general lessons for health reform at the state-level, a key concern given ongoing state discretion to improve their health care systems under the Patient Protection and Affordable Care Act. Data derive from 325 archival sources and 26 semi-structured interviews. The Global Waiver would not have happened without political and ideological alignment between Rhode Island's Republican Governor and the Bush administration and the fractured nature of the waiver's opposition across provider and advocacy groups. The waiver was motivated largely by ongoing fiscal and programmatic pressures. Development was dominated by state officials, working over a short time period characterized by growing budgetary uncertainty. Dissatisfaction in the level of outside input contributed to distrust among stakeholder groups. Subsequent legislative constraints together with insufficient administrative personnel and antiquated information systems hampered implementation. So too did remaining divisions among those overseeing, advocating, and serving different beneficiary communities. Specific lessons include: ensuring sufficient levels of stakeholder input and transparency throughout the program design, approval, and implementation process; devoting adequate personnel and informational resources to program administration, including coordination across disparate elements of the state bureaucracy; and carefully considering the breadth and timing of the reform strategy pursued; factors that promote adoption, for example, may, in turn, impede implementation.

## Introduction

States administer Medicaid under specific authorities provided in Title XIX of the Social Security Act, which is consolidated into an agreement states enter into with the Federal government, called the state plan. This authority includes certain populations and services that states must cover if they are to receive federal funds. Most Medicaid spending, however, is on optional populations or services that states are not required to cover, but choose to do so anyway, both because it is politically desirable and because the Federal government picks up at least 50% of the tab (Lambrew 2005). No matter whether beneficiaries are mandatory or optional core program requirements include: comparability of benefits—states generally cannot provide services that differ in type or amount across beneficiary groups; free choice of providers by recipients; limits on cost-sharing; and bars on service rationing due to funding shortfalls—a state may alter eligibility or benefits as specified in the state plan, but cannot impose caps or waitlists. Although administered by the states, the Federal government matches state Medicaid spending at a rate determined by the Federal Medical Assistance Percentage (FMAP), which currently ranges from 50% to 73.4%, and is dependent on state per capita income (Snyder et al. November 2012).

States may also obtain federal waivers which “permit selective deviations from the law” (Thompson and Burke 2009). States seek out waivers so that they may gain the freedom to customize their Medicaid programs. In 1962, Congress enacted Section 1115 of the Social Security Act which permits the Federal government to offer states “research and demonstration” waivers. Although ostensibly requiring rigorous formal assessment, the evaluation function of these waivers has largely been neglected; instead, they have been used primarily for purposes of permitting states to engage in large scale program restructuring (Thompson and Burke 2007). In 1981, Congress promulgated Section 1915 which authorizes the Federal government to provide states with waivers that are limited in scope and not subject to evaluation (Thompson and Burke 2009). In allowing states to limit beneficiary freedom of choice and to use payment approaches other than fee-for-service, 1915(b) waivers permit states to enter into contracts with Medicaid managed care organizations. By contrast, 1915(c) waivers allow states to provide home- and community-based services (HCBS) not otherwise authorized by the state plan.

Specific reasons why states apply for federal waivers include obtaining increased flexibility to innovate, expand coverage, control costs, and provide consumer-driven care. The pace with which the Federal government granted waivers increased considerably under the Presidential administrations of Bill Clinton and George W. Bush, both of whom, as former governors, proved sympathetic to state calls for increased flexibility in administering Medicaid (Thompson 2012). Although not required by law, the federal government requires states to demonstrate budget neutrality with their 1115 “research and demonstration” applications—that the federal government would not spend more than it would have spent without the waiver. It is important to note that these projections provide for a per-capita cap, but NOT an overall cap on federal spending (Atiga 2009; Shirk 2009). Federal spending per enrollee may be fixed under such a waiver, but the number of enrollees served is unrestricted so that the federal government will continue to match spending increases caused by enrollment growth.

In Fiscal Year (FY) Medicaid constituted about \$800 million or approximately one-quarter of the Rhode Island (RI) state budget (Executive Office of Health and Human Services [EOHHS] October 2007). Given that the state projected a structural deficit of more than \$350 million over 5 years and that Medicaid spending growth had far exceeded general revenue growth, Medicaid stood at the forefront of state budget discussions. A subsequent 2007 report by then Governor Donald Carcieri, *The Future of Medicaid*, contained recommendations on how to

better coordinate Medicaid's financing and administration, make the program more consumer-centered, and contain costs (EOHHS October 2007). Another significant focus was rebalancing the long-term care system. While RI has been a leader in some areas—for example, providing access to high quality care through RItE Care, the state's managed care program for low income children and families, just 11% of Medicaid long-term care expenditures in 2006 were directed toward HCBS and 89% toward nursing homes, far below the national totals (AARP 2009). This despite ongoing initiatives such as two federal Real Choices Systems Change grants and the state's Perry-Sullivan Long-Term Care Service and Finance Reform Act of 2006, which established a mandate to achieve a 50-50 spending split between Medicaid institutional care and HCBS and to reinvest savings from reduced nursing home use into HCBS.

In January 2008 Governor Carcieri announced plans to pursue a broad-based waiver from traditional Medicaid rules, claiming \$67 million in potential first year savings (Peoples May 23 2008). A month later the Governor proposed "The Medicaid Reform Act of 2008" which was approved on June 26 by the State Legislature as part of the FY 2009 budget with the stated intent of ensuring that "Medicaid shall be a sustainable, cost-effective, person-centered and opportunity-driven program" and authorizing the pursuit of "any necessary waiver(s) and/or state plan amendments" to achieve these objectives. On July 29, 2008 the Governor made his administration's waiver application public; on August 8, 2008, it was submitted to the Centers for Medicaid and Medicare Services (CMS), the federal agency responsible for administering Medicaid for approval.

The state requested substantial flexibility administering Medicaid in exchange for accepting a limit on the federal contribution. In particular, it asked for the provision of a fixed, upfront federal allotment or block grant that would no longer require a state match. It instead proposed the state maintain its funding effort at 23% of the general revenue budget. On December 19, 2008, CMS gave provisional approval to RI's Global Consumer Choice Compact Waiver, subject to a 30 day review period by the state's Democratic party-dominated General Assembly as stipulated in the 2008 Medicaid Reform Act. If the Assembly wished it could have voted to block the waiver; since it chose not to do so, CMS gave its official approval on January 16, 2009. Rhode Island became the first state granted permission from the Federal government to operate its entire Medicaid program (excepting disproportionate share hospital payments and local education agency funding) under the state plan and a single 1115 waiver; prior to the Global Waiver, the program operated under the state plan and eleven waiver authorities, including: a 1115 RItE Care waiver; a 1915(b) Dental waiver; and nine 1915(c) waivers.

The final version of the Global Waiver did not include the block grant structure. It instead set a cap whereby the state agreed to limit federal fiscal participation to a level no higher than the federal share of total state and federal spending of \$12.075 billion over five years in exchange for the ability to make certain program changes. This five year budget was based on historical caseload and health utilization trends, accounting for a 7.8% rate of program growth. This kept Medicaid's traditional funding structure intact, with the state having to spend a dollar first in order to receive the federal match. Rhode Island began implementing the Global Waiver on July 1, 2009, the same day that the 2008 Medicaid Reform Act was amended to legally require legislative oversight, to establish a process for community input, and to make other program changes. The Global Waiver is set to expire December 31, 2013 unless it is renewed for another five years. Figure 1 provides a timeline of key Global Waiver-related events. The purpose of this study is to analyze the design and implementation of the Global Waiver to draw lessons for health reform at the state-level, a key concern given ongoing state discretion for states to mold

Medicaid under the Patient Protection and Affordable Care Act of 2010. Before describing our methods and results, we outline the major provisions of the Global Waiver.

[Figure 1 about Here]

### **The Global Waiver: A Primer**

Pursuit of the Global Waiver was largely driven by state fiscal pressures deriving from the rapidly deteriorating economy and disproportionate proportion of the state budget devoted to Medicaid. The early 2000s saw comparatively high Medicaid expenditure growth in the state—an average of 11.6% per year—higher than the national average of 9.4% (Carcieri 2004; EOHHS October 2007). Although cost control measures were instated at that time to curb enrollment, contain costs, and improve efficiency, Medicaid’s contribution to the state’s growing budget crisis was expected to intensify. Without reform, state officials asserted, Medicaid spending would prove unsustainable, necessitating removal of tens of thousands of beneficiaries from the program’s rolls (Davis November 11, 2008; EOHHS October 2007, August 7, 2008; Peoples May 23, 2008). In a December 19, 2008 press release touting the waiver agreement with the federal government, Governor Carcieri observed that “Medicaid spending has increased drastically and the current funding structure is forcing states to cut other critical programs... This agreement will put us on a sustainable path for growth in Medicaid, while also maintaining services for those most in need” (Office of the Governor 2008).

In addition to fiscal issues, pursuit of the Global Waiver was motivated by specific programmatic goals, both with the aim of improving patient care and reducing program costs. Thus, in addition to cost containment, state officials sought to ensure that program beneficiaries were “provided the right level and kind of services in the most appropriate setting” (EOHHS October 2007). Specific goals included: (1) improving cooperation across the state agencies responsible for administering Medicaid; (2) rebalancing the publicly-funded long-term care system to increase access to HCBS and to decrease reliance on institutional stays; (3) ensuring all Medicaid beneficiaries have access to care management whereby primary and acute care is managed and coordinated with other services and supports; and (4) procuring Medicaid-funded services through cost-effective payment and purchasing strategies that align with programmatic goals. The Federal government also authorized the state to receive federal matching funds for populations and services previously covered by state-only funded programs through the Global Waiver’s Cost Not Otherwise Matchable (CNOM) provision. The level of federal scrutiny was made more commensurate with the scope of future program changes as well.

### **Interagency Coordination**

Rhode Island’s Medicaid program is operated within the Executive Office of Health and Human Services (EOHHS). In 2006, all five of the state’s health and human service departments were consolidated within the secretariat, including the Department of Human Services (DHS) (designated the single state Medicaid agency), the Department of Health (DOH), the Department of Children, Youth and Families (DCYF), the Department of Elderly Affairs (DEA), and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). Medicaid spending is divided across these departments, with the vast majority of expenditures in SY 2010, for example, being managed by DHS (75%) and BHDDH (22%) (EOHHS June 2011).

Prior to the creation of EOHHS, there was little to no policy connection between the five departments, resulting in, for example, conflicting budget requests over which DHS, as the single state Medicaid agency, may or may not have been aware or have any sort of oversight over. Indeed, a “fiscal fitness” audit conducted in 2003-2004 found Medicaid’s programmatic and operational responsibilities were highly fragmented and prone to inefficiency in both

organization and financing (Carceri 2004). The purpose of the consolidation, therefore, was to facilitate cooperation across the five departments that administer the state's health and human services programs, including streamlining administration, in part, by centralizing common functions such as finance, human resources, and legal services.

Still, responsibility for administering Medicaid funded services continues to be distributed across the separate departments, each with its own priorities, constituencies, policies and staff, and director who reports independently to the Governor rather than to the state's EOHHS Secretary. Moreover, having multiple 1915(c) waivers administered by different agencies for different populations had resulted in administrative burdens for the state and confusion for providers and beneficiaries. Thus, one goal of the Global Waiver was to improve coordination across the various state entities receiving Medicaid funding (EOHHS August 7, 2008; Alexander 2011). By reducing the number of silos under which the Medicaid program operated, the intention was to improve operational efficiency and to ensure beneficiaries received services based on their level of function, not label, with their needs being met more seamlessly, though in different ways at different times in their disability or aging.

### **Long-Term Care Rebalancing**

Foremost among the waiver's goals was a desire to bolster the state's long-term care system. Government officials recognized the desirability of aligning Medicaid long-term care with consumer preferences for non-institutional options to nursing home placement (EOHHS October 2007, August 7, 2008). They also recognized that on a per unit basis HCBS is significantly less expensive to provide than institutional care. Shifting the locus of service provision to favor more HCBS thus represents a potential source of savings for both the state and Federal governments, as well as taxpayers. Thus, according to then DHS director Gary Alexander "rebalancing will give beneficiaries the care they prefer while saving the tax payers millions" (Office of the Governor 2008).

The most prominent waiver-specific rebalancing task has been the adoption of a three-tier level of care determination process for eligibility for Medicaid long-term care: "highest," "high," and "preventive." Previously, there had been only one basic level of eligibility, with all those meeting the state's clinical eligibility requirements being eligible to receive nursing home care or to participate in one of the state's HCBS waiver programs if a slot was available. Now only those deemed "highest" need have an entitlement to nursing home care, though they may also choose a home- and community-based placement. Those deemed "high" are eligible for HCBS only and those deemed "preventive" to a restricted package of home care benefits.

The state also developed and implemented a so-called Assessment and Coordination Organization to better promote uniformity in the administration of Medicaid-funded long-term services, including with respect to information and referral, eligibility and referral, and care planning and care management. Here, the goal has been to create a central inter-agency mechanism for making level of care determinations, supporting community-based placements, implementing consistent case management practices, and conducting high cost case reviews. In doing so, the state removed delegated authority from discharge planners to make most leveling decisions. Efforts have been made to better educate discharge planners and other referral sources about the services and housing options available. The same is true for patients and families.

The state has also designed and implemented nursing home diversion and transition projects. In addition to better education, the states diversion strategy has involved tasking an on-site registered nurse at Rhode Island Hospital, in collaboration with hospital social workers, to identify Medicaid beneficiaries who might be discharge safely back into the community. The

state's transition program was initially operated by an outside vendor. It involves identifying persons who are both willing and able to be move safely back into the community, though individuals and families may also self-refer. The state has since taken over this function.

Efforts have also been made to expand access to and the availability of shared living, home health, assisted living, adult day, and preventive services. Effective July 1, 2010, the state negotiated a rate increase for assisted living facilities, from \$36.32 to \$42.16. It also developed and implemented new criteria for Medicaid home health agencies, including those participating in the state's "Enhanced Reimbursement Program" whereby agencies can earn additional reimbursement by meeting standards beyond minimal licensing requirements. Prior to the Global Waiver, the state had implemented a 10% increase in homemaker, personal care, home health aide, and adult day care reimbursement effective July 1, 2008.

### **Care Management**

State officials believed that greater care management could help control costs and improve quality of care for high cost aged and disabled individuals (EOHHS October 2007, August 7, 2008). It was also felt that care management enrollment would better ensure that disabled beneficiaries received services in the most appropriate settings possible since they have been excluded from such initiatives in the past. Thus, a major waiver-related task has been to implement mandatory enrollment in Medicaid managed care for all those without third-party medical coverage. Previously, children and families on Medicaid were enrolled in managed care through the state's RItE Care program. By contrast, enrollment in the state's managed care program for adults, Rhody Health Partners, was optional. This was also true of children with special health care needs but with respect to RItE Care. Beginning in July 1, 2009, Medicaid eligible adults with no health insurance coverage other than Medicaid were required to enroll in either Rhody Health Partners or primary care case management via Connect Care Choice, while children with special health care needs were required to enroll in RItE Care.

Connect Care Choice includes 17 participating practices where physicians partner with an onsite nurse care manager to create a medical home for patients to better ensure all necessary services are effectively managed and coordinated. Participating practices must also coordinate with behavioral health providers if necessary and adopt e-prescribing, e-billing, and computerized decision guidelines. Rhody Health Partners consists of two participating plans where care management is provided by interdisciplinary teams. Mandatory enrollment was phased in, with clients being permitted to switch between Connect Care Choice and Rhody Health Partners up to December 31, 2009, after which they were locked in until the next open enrollment period. In addition to mandatory managed care enrollment, there have been related efforts to develop medical home standards and to expand managed long-term care, both of which are still in process.

### **Smart Purchasing**

The 2007 *Future of Medicaid* report concluded that RI could benefit from updating its provider payment methodologies (EOHHS October 2007). It was felt that further reductions in provider reimbursement were unlikely to generate significant additional savings given the state's already low reimbursement rates. What could be done was to create "smarter" payment methodologies and purchasing mechanisms that incentivized quality and cost improvements to enhance value for money (EOHHS October 2007, August 7, 2008). This included using selective contracting to take advantage of the state's leverage and purchasing power to ensure payment for high quality, cost-effective services. It is also included adoption of more uniform payment structures that eschew paying varying rates for the same services offered by different providers.



Selective contracting has been pursued in three areas: durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); shared living; and managed care.

The state's "smart" purchasing strategy has also involved nursing facility and hospital reimbursement reform. In both cases the state sought to replace the prevailing cost-based system with a price-based system grounded in average nursing costs in the case of nursing homes, adjusted for resident acuity, and diagnostic related groups in the case of inpatient hospital care. Implementation of both took place in 2010. The state also intended to increase cost-sharing to enhance personal responsibility, encourage cost-effective service use, deter crowd-out, and reward healthy choices. These efforts, however, were eventually blocked by CMS due to maintenance of effort requirements included in the federal health reform law.

### **Costs Not Otherwise Matchable**

CMS granted RI the authority to obtain federal matching funds for populations and services previously covered only by the state. The purpose was to determine if such a strategy was cost-effective over the long run by slowing down or preventing the trajectory towards full Medicaid eligibility. These are known as CNOMs or Costs Not Otherwise Matchable. Each EOHHS Department has benefited from CNOM dollars. BHDDH is the largest recipient, as CNOM money covers all of the Department's outpatient substance abuse, partial hospitalization, and intensive outpatient programs. Another noteworthy CNOM initiative is the DEA's Co-Pay Program which previously relied entirely on state dollars and beneficiary cost-sharing to fund home health, adult day, and case management services for low income people aged 65 years with incomes too high to qualify for Medicaid but in need of supportive services. In all, RI received \$16,834,550 and \$19,502,121 respectively, in federal matching dollars during state FY 2010 and FY 2011, for state expenditures of \$15,414,550 and \$17,335,506 on programs that had been "CNOM'ed" (DHS 2010-2012).

### **Federal and State Oversight**

The RI General Assembly passed a July 1, 2009 oversight bill which requires that certain categories of Medicaid program changes be approved by the state legislature first before DHS/EOHHS could seek permission from CMS to implement those change. These categories, termed I, II, and III and defined by CMS when it authorized the waiver, were designed for purposes of establishing federal oversight protocols and to make federal review more commensurate with the scope of changes proposed. Category I, II, and III changes and associated federal and state oversight requirements are described in Table 1. Between July 2009 and August 2011, the state made eight Category I requests, seven Category II requests, one Category III request, and four amendments to the state plan. Most were approved by CMS; however, some such as proposed limits on the number of emergency department visits (a Category II request) and proposed increases in RIte Care Premium Cost Sharing (a Category I request) were denied.

[Table 1 about Here]

### **Methods**

This study relies on two primary sources of data: archival documents and in-depth open-ended interviews with key stakeholders. The interviews were undertaken with people chosen through a combination of purposive and snowball sampling (Patton 2002). Thus, selection of subjects was initially based on our own knowledge about RI and the Medicaid program but later on information provided by our respondents regarding additional actors who should be interviewed about the design and implementation of the Global Waiver. Twenty-six semi-structured interviews were conducted with 30 individuals from March 17, 2010 through May 28, 2010. Two interviews included two subjects each (two consumer advocates; two executive

branch officials); one interview included three subjects (three state officials). Interviews were about one hour long. Interview subjects included: legislative staff (2 individuals); current and former officials within the pertinent executive/administrative agencies (7 individuals); consumer advocates representing different populations (e.g., the elderly, developmentally disabled, mentally ill, physically disabled, children and families) (10 individuals); provider representatives representing different service modalities (e.g., nursing homes, home care, managed care, shared living, community providers) (8 individuals); and other knowledgeable observers (3 individuals) (i.e., consultant, other executive branch officials).

Stakeholders representing different backgrounds were recruited as interview subjects to ensure representation of varying points of view about Medicaid and the Global Waiver (Glaser and Strauss 1967). Use of a diverse sample is important because the greater the degree to which the perceptions of people about a particular phenomenon converge, the more likely that they provide a reasonably accurate portrayal of the process studied (Jick 1979). Use of a diverse sample also is important because employing multiple types of informants minimizes the threat of single-source information bias while maximizing the breadth of the information consulted (Pothas and de Wet 2000).

Through our interviews we sought to identify what factors contributed to the design of the Global Waiver. This includes the purpose of the waiver, the contours of the drafting process, and the reactions and/or involvement of government officials and other interested actors. We also sought to understand factors influencing subsequent approval and oversight of the Global Waiver by the Federal government and state legislature. This includes negotiations between state and federal officials and changes to the state's waiver application resulting from those negotiations. It also includes the timing of legislative approval and the enactment of legislation formalizing the legislature's oversight role. The reactions and/or involvement of key stakeholders in each of these areas were examined as well.

We further sought to understand factors facilitating and/or impeding implementation of the Global Waiver by EOHSS and its constituent agencies. This includes identifying and exploring the effectiveness of processes put into place to implement the Global Waiver (e.g., the Global Waiver Implementation Task Force, internal state work groups) and the involvement and/or reactions of key stakeholders to these endeavors. It also includes identifying how much progress had been made in implementing the Global Waiver and the role of the economic recession, state budget crisis, federal stimulus package, state administrative capacity, provider capacity, and other factors in this regard.

All interviews were recorded and transcribed. Each transcript was coded to identify recurring themes and patterns in responses (Miles and Huberman 1994). This was an emergent process to the extent that we formulated new categories and revised old ones as we read the transcripts. Once a full set of codes were developed, we went back and recoded all transcripts using the common set of themes developed. Quotes illustrative of each of four major topic areas—waiver design and development; federal approval and legislative oversight; implementation and the external environment; and implementation and the internal environment—were excerpted (See Table 2).

[Table 2 about Here]

In addition to analyzing interview transcripts, more than 325 archival sources published between 2007 and 2012 were reviewed. Pertinent statutes and regulations about Medicaid and the Global Waiver were identified and collected; so too were relevant government reports, press releases, letters, and other documents. Information was collected from consumer advocacy

groups, provider organizations, and other non-governmental entities, in addition to articles published in the *Providence Journal* and other news sources. This information was used to cross-validate the descriptions and perspectives of key informants (Jick 1979), corroborating accounts given by interviewees through independent verification in alternative sources. They also provided historical background on RI's Medicaid program and the Global Waiver.

## **Findings**

### **Topic 1: Waiver Design & Development**

This section examines political and ideological factors motivating administration officials to address prevailing fiscal and programmatic concerns through the Global Waiver. It also examines key personnel involved in the design of the waiver while reviewing the extent of community input in this area. Stakeholder concerns about the Global Waiver and its development are discussed as well.

#### ***1.a. Waiver Politically and Ideologically Motivated***

Rhode Island would have been unlikely to propose the Global Waiver without federal encouragement. On January 31, 2003, the Bush administration unveiled a proposal through which states could block grant Medicaid (Lambrew 2005; Holahan and Weil 2003; Guyer 2003; Thompson 2012). Unable to convince Congress to give them the authority, the administration sought to demonstrate the effectiveness of the general approach by recruiting states willing to place an overall cap on federal contributions. Rhode Island proved to be the only volunteer, though Vermont had previously received two 1115 waivers with separate caps for acute and long-term care. As a small state, state officials believed that RI was in an excellent position to test Medicaid reform models such as this (EOHHS August 7, 2008).

The political alignment of the state's Republican governor and Bush administration proved critical. Interviewees felt that the waiver was ideologically motivated, spurred on by federal and state Republican administrations focused more on restraining spending and delegating further responsibilities to states than on improving beneficiary access and quality. The delayed waiver application—it was not submitted until August 8, 2008 although it was first proposed in January—made it uncertain whether it would be approved and implemented by October 1, 2008, as originally proposed. Lacking confidence that the waiver would be received favorably by the next administration (Solomon 2009), subsequent negotiations between the state and Federal governments were accelerated so approval would take place before President Bush left office. Indeed, Gary Alexander, then Director of DHS, was quoted as saying that the “Bush Administration has a number of waivers that they want to take care of before they leave and this is one of them” (Davis November 11, 2008). This accelerated process received considerable criticism given expectations of federal financial relief in light of the cratering economy.

#### ***1.b. Waiver Developed by State Officials and Consultants with Lack of Public Input***

State officials in all EOHHS departments informed the general conceptual outlines of the Global Waiver although most state officials interviewed agreed that it was high level staff within DHS who drafted the state's waiver application and led subsequent negotiations with the Federal government. There was heavy reliance on at least one additional external consultancy, although their role was initially downplayed or denied to the chagrin of outside observers who were told that their services were voluntary but ultimately cost \$370,000 (Gregg January 9, 2009; Peoples March 3, 2009). Moreover, this firm took credit for negotiating federal approval, thereby undermining the Carcieri administration's contention that DHS Director Alexander and his team of senior level staffers were primarily responsible for this success (RI Government February 26, 2009; Gregg June 9, 2009). Uncertainty about the firm's role contributed to prevailing distrust

regarding the administration's intentions, making general acceptance of the Global Waiver even more challenging than it already was.

Lack of public input into the waiver development process was an ongoing concern among both elected officials and community stakeholders. Most stakeholders reported few, if any opportunities for provider representatives, consumer advocates, and the general public to comment on and influence the waiver's design and direction (Reichard September 15, 2008; Reed and Whitehouse September 23, 2008; Katz November 4, 2008; Trapp November 17 2008). This lack of participation helped sow the seeds of distrust between the administration and other parties. Most interviewees felt that there was not a real attempt to reach out and have sustained conversations with communities of interest. Although some meetings with state officials did in fact take place, such interactions were less about acquiring public input than about reporting what that state had done. The need to develop the waiver quickly in light of prevailing fiscal imperatives and the timing of the state's budget process was the primary reason given for the lack of discussion and openness. That the approach taken contrasted markedly with the much more collaborative approach that normally characterized the way the state did business with respect to RItE Care and other programs further contributed to stakeholder distrust regarding DHS/EOHHS' intentions in this particular instance.

#### ***1.c. Limited Details Released to the General Public During Waiver Program Development***

A number of interviewee reported that for a long time all the Global Waiver seemed to consist of were a series of short PowerPoint presentations with uncontroversial generalities that no one could disagree with; for example, ensuring that beneficiaries receive "the right services at the right time in the right setting." Although advocates and policymakers had been rallying around such goals for years, there was little specificity about how the Global Waiver would, in fact, enable the state to get from point A to point B, say, with respect to making long-term care more home- and community-based. It was felt that even at well over 100 pages the final waiver application lacked specifics—it proposed giving state officials the power to make changes but offered few details about the particular changes they intended to make (Peoples July 30, 2008).

The lack of specifics regarding the state's intentions made it difficult for outside observers to provide feedback on what was being proposed and to understand why the Global Waiver should be preferred over other potential strategies for achieving the same goals. State officials generally admitted that the waiver lacked details because what they were proposing was an overall framework more than anything else; that in exchange for limiting federal fiscal contributions, the state would receive greater administrative flexibility with which to achieve the general goals outlined in the waiver application (Peoples July 30, 2008). The result was few, if any definitive answers to stakeholders' questions about what was going to happen if the waiver went into effect. The absence of specifics, however, only fed stakeholder suspicion that there were details being locked in behind closed doors without their consultation.

Lack of details combined with the proposed block grant structure of the proposed waiver, generated high levels of distrust and concern among outside groups (Peoples July 30, 2008; Alker August 5, 2008; Byrant August 5, 2008; Solomon September 4, 2008; Reed and Whitehouse September 23, 2008; Katz November 4, 2008; Davis December 1, 2008). What was clear was that the state could acquire additional flexibility to shape Medicaid, possibly under more limited state and federal funding authority. What was unclear was what the state would use that additional flexibility for in an era of increasing fiscal scarcity, particularly given the Governor's stated desire to protect the mandatory but not optional eligibility groups on which

most Medicaid spending is made (Alker August 15, 2008; Bryant August 5, 2008; The Poverty Institute August 15, 2008; Beckwith September 15, 2008; Davis December 1, 2008).

## **Topic 2: Federal Approval & Legislative Oversight**

This section examines how the federal approval process unfolded. It also examines the state legislative role. This includes considerations informing the General Assembly's approval of the Global Waiver. It also includes mechanisms through which the state legislature has both overseen implementation of the Global Waiver by DHS/EOHHS and addressed stakeholder concerns about the level of community input.

### ***2.a. Lack of Transparency in the Federal Approval Process***

Together the lack of detail and transparency during the waiver development process contributed to distrust on the part of key stakeholders who feared programmatic cutbacks that would, for example, adversely impact successful programs such as RIte Care. This distrust was further exacerbated by the opaqueness of the state's negotiations with the federal government (Baucus, et al. June 19, 2008; Alker August 5, 2008; Dingell, et al. August 21, 2008; Katz November 4, 2008). Thus, consistent with criticisms routinely expressed about the federal approval process (Alker 2012; U.S. General Accountability Office 2007, 2012), most community stakeholders in RI reported challenges acquiring information on the status of the state's negotiations with CMS.

### ***2.b. Congressional Delegation as a Conduit for Information about Federal Approval Process***

Letters written to CMS were one avenue through which key stakeholders expressed their qualms about the Global Waiver. The state's Congressional delegation was another. Through monthly phone calls and other contacts the state's two Democratic Senators and two Congressmen learned about stakeholder concerns. This communication, in turn, spurred letters to the Governor, CMS Director, and U.S. Department of Health and Human Services Secretary whereby members of the delegation and Chairmen of the pertinent House and Senate Committees articulated the reservations of consumer advocates and other stakeholders with whom they consulted, including regarding the lack of transparency, opportunity for public comment, and block grant structure of the original proposal (Baucus, et al. June 19, 2008; Dingell, et al. August 21, 2008; Reed and Whitehouse September 23, 2008; Reed, et al. January 13, 2009). It also led the delegation to serve as kind of a clearinghouse for the limited amount of information available on the state's negotiations with federal officials. It was recognized that while the Congressional delegation was supportive of community stakeholders, and took some positive actions, they could, in actuality, exert very little influence over the process.

### ***2.c. A Tight Time Framed Colored by Promised Savings Led to State Legislative Approval***

After federal approval the state legislature had an opportunity to prevent implementation of the Global Waiver. Because the legislature had previously adopted a 30 day time frame, it had limited time to review the agreement. Initial federal approval was granted on December 19, 2008 and the General Assembly did not convene again until after the Christmas and New Year's holidays (Needham and Gregg January 10, 2009; Needham January 13, 2009). Although characterized as "reluctant participants," and generally distrustful of the state's Republican governor, state legislators recognized that, at a minimum, new federal money would come into the state in the form of the CNOM programs (Needham and Gregg January 10, 2009). They also appreciated safeguards imposed by CMS—that state officials would not have unlimited flexibility but were bound by the waiver's "Special Terms and Conditions" and three-tier system of federal review (Weens January 16, 2009). But the decisive factor underlying the General Assembly's decision not block the waiver was \$67 million in promised first year waiver-derived

savings built into the state's FY '09 budget (Anonymous July 29, 2008; Needham and Gregg December 23, 2009; Peoples January 14, 2009; Peoples and Needham January 15, 2009). At the time, the state was facing a current year deficit of \$357 million (Gregg January 7, 2009). If the state legislature did not approve the waiver, it would have needed to find those savings someplace else, a daunting task given the state's desperate fiscal outlook.

#### ***2.d. An Increased Oversight Role for the State Legislature in State Medicaid Decision Making***

Once approved, the General Assembly used both existing and newly established mechanisms to oversee implementation. Existing mechanisms have included the state budget process, periodic hearings, and routine communication between the legislative and executive branches of government. In response to continued trepidation on the part of providers and advocates, however, the General Assembly eventually passed legislation putting into place additional safeguards and providing itself with a more formal oversight role in implementing the Global Waiver. This legislation was largely drafted by the Coalition for Responsible Medicaid Reform, an organization that grew out of advocates and providers' concerns about the state's waiver application (Katz January 20, 21 2009). This legislation, which was enacted on July 1, 2009, grandfathered current nursing home residents, in part, from the state's new level of care requirements. This provision stemmed largely from concern that state officials could have the power to remove people from nursing homes who moved in under the old level of care criteria, or to not allow them to move back into the nursing home if they had transferred out, if they were classified as "high" rather than "highest" under the new criteria established under the Global Waiver (Coffey 2009; Needham 2009; Peoples May 29, 2009).

The oversight legislation also includes a Global Waiver Implementation Task Force through which DHS/EOHHS is directed to seek out and incorporate input from the stakeholder community. Knowing that legislation was pending and community support for the waiver lacking DHS/EOHHS established the Task Force several months before the legislation passed, with the first session taking place May 12, 2009 (RI Government March 9, 2009; EOHHS May 12, 2009). It originally included 60 members (from more than 200 applicants) and was slated to meet quarterly. The oversight legislation, however, required just 45 members and more frequent monthly meetings. Rather than removing members who had already been recruited, DHS/EOHHS decided to rely on attrition to reduce the size of the Task Force to meet statutory specifications; monthly meetings began July 2009 and have continued to the present day.

The oversight legislation also authorized a 12 member Joint House-Senate Legislative Committee specifically charged with overseeing Medicaid and the Global Waiver. This Committee never met, although members were appointed, at least on the Senate side. The legislation also put into place CMS' three category system of federal review at the state-level. Consequently, all but simple administrative changes must be reviewed by the state legislature before DHS/EOHHS can seek federal approval (Peoples February 4, 2009). The implication is that the state legislature would now participate in Category II changes, an area it had previously left up to the administration. The state legislature would also play a more formalized role vis-à-vis Category III changes, an area in which it had already exercised authority under state statute.

The requirement for prior legislative approval has clearly limited state administrative flexibility. A particular challenge for state officials, however, has been the absence of clear mechanisms through which legislative review and approval for specific changes might be made, particularly since the joint oversight committee was never formally established. The result is that state officials now need to plan well in advance to make sure that there is either legislation or a budget article in place before they can go forward with either a Category II or III change.

Because the state legislature now involves itself in decisions it previously was not involved in, the result has been a somewhat more burdensome process; certainly more extensive than originally envisioned and, in some ways, greater than if the Global Waiver had not been pursued.

### **Topic 3: External Influence on Global Waiver Implementation**

This section examines external factors influencing implementation of the Global Waiver. It starts with the Global Waiver Implementation Task Force authorized by the General Assembly and administered by DHS/EOHHS. Next, it examines the implications of the Global Waiver for increasing cooperation among key stakeholder groups representing different populations and service modalities. It concludes by examining fiscal and budgetary pressures that have influenced the way in which the Global Waiver has been implemented.

#### ***3.a. The Global Waiver Task Force Has Been Heavily State Directed***

There is general dissatisfaction with the way the Global Waiver Implementation Task Force has been administered. Indeed, most interviewees felt that the Task Force has not had much influence on state implementation despite state lawmakers' intentions in this respect. One frequently cited criticism is the lack of productive dialogue. Communication has tended to be one-way. The agenda has been set by the state with meetings consisting largely of state officials informing Task Force members about progress and activities administering the waiver. Part of the challenge has been varying interpretations of the Task Force's mission. Some felt that Task Force members should get involved in the "nitty-gritty of implementing the program" since, well, "it's called an Implementation Task Force." Others felt that too much stakeholder involvement would result in an unwieldy process that could slow down and inhibit progress.

Both state officials and their community partners believed the Task Force is too large and cumbersome. The inclusion of 60 people representing a diverse array of interests has served both to limit the amount of influence that could be exerted by any one Task Force member and to complicate the incorporation of whatever input that might be provided into the state's implementation efforts. Community-leadership has also been absent. The oversight bill required the appointment of both administrative and community co-chairs. While Ann Martino, now Deputy Secretary for Policy at EOHHS, was appointed administrative co-chair when the Task Force was first established, a community co-chair was not appointed until October 2011, nearly two and a half years after the Task Force began meeting.

#### ***3.b. There Has Been a Lack of State Responsiveness to Task Force Recommendations***

The lack of effective dialogue between DHS/EOHHS and the stakeholder community was widely noted. The most frequently cited example was state unresponsiveness to recommendations developed by the Task Force's work groups. State officials directed the Task Force's work groups with developing specific recommendations that could be pursued as budget articles, waiver changes, legislative proposals, or rule changes. Beyond this general instruction, however, there was very little charge. There was also tension between what members viewed as the state's imperative and, perhaps, even charge that the Task Force and its Work Groups focus on achieving reductions in costs, and members' desire to enact longer term changes that might improve care quality and program efficiency (EOHHS May 12, 2009). Task Force members also expressed frustration with the lack of discussion, both with regard to the work group concept itself and with regard to the recommendations that were ultimately produced. They were especially frustrated that their work group efforts seem to have been for naught.

#### ***3.c. Greater Integration with State Efforts Is Necessary for Task Force Success***

It was felt that community input would have been more productively translated into policy if the Task Force's work groups had been better supported by state personnel. It was also

felt that the Task Force's work groups would have worked better if there was greater interaction with the state's own internal work groups; that there has not been enough cross communication between the internal groups and the external groups. Some simply wished to be kept informed of the state's internal activities—they felt it was part of their charge. Others felt that that greater collaboration with community stakeholders was the key to successful implementation of the Global Waiver's provisions, particularly since the state did not have enough of its own staff to accomplish what needed to be done.

Indeed, there was some recognition that managing the Task Force has been burdensome for state officials. This is due, in part, to distrust that arose during the waiver development and approval process has continued through implementation even though those state officials working directly with Task Force members were not necessarily the same as those who designed the Global Waiver. State personnel were also, in some ways, living with the sins of the present to the extent that they are blamed for decisions made, say, by the Governor or state budget office not to pursue certain Task Force recommendations, over which they have no control. There are also challenges that have arisen because state agencies can only do so much given the amount of time, energy, skills, and staff available to get things done (EOHHS June 28, 2010). Despite widespread criticism, some believe that DHS/EOHHS had done a good job canvassing stakeholder input given the circumstances, both at Task Force meetings and other venues

### ***3.d. Mixed Assessment of Relationships among Population Sectors/Systems***

Several different populations can qualify for public assistance, including children, the elderly, physically disabled adults, the developmentally disabled, and mentally ill. These populations have typically been cared for by separate systems and, as such, have developed very different traditions about how they have been funded and served. Not surprisingly, therefore, advocates and providers networks representing different populations have focused on their own particular interests as they compete for scarce resources. Some observers believe that these silos have largely remained intact since implementation on the Global Waiver began.

Some interviewees, however, perceived greater cooperation among provider and advocacy groups representing different populations and service modalities. This has been driven, in part, by the changing needs of the populations served; a prime example being the developmentally disabled population which, because they are starting to live longer, is increasingly requiring aging-related services. It has also been driven by the program-wide scope of the Global Waiver. Through participation on the Global Waiver Implementation Task Force, individuals representing different groups have joined together and, in so doing, acquired a broader perspective than if the conversation focused exclusively on their own populations. A broader perspective has also arisen due to participation in the Coalition for Responsible Medicaid Reform, a largely informal group which has served as a clearinghouse for information and grievances and convener where providers and advocates impacted by the waiver have come together to analyze information coming out of the departments and develop strategies with which to influence state policy in this area.

### ***3.e. Waiver Implementation Driven Primarily by Fiscal and Budgetary Environment***

There is general agreement that decisions made under the Global Waiver have been driven by the adverse fiscal and budgetary environment facing the state. Indeed, a dominant and recurring theme was the effect of the fiscal crisis on Medicaid, which has enhanced the focus on cost control, limited the amount of state dollars available for the program, and made it difficult to distinguish waiver-driven changes from budget-driven changes. Indeed, most provider representatives and consumer advocates interviewed concluded that decisions made under the



Global Waiver have been weighted more heavily toward cutting costs than on achieving savings and improving care through programmatic improvements such as rebalancing.

Examples include proposals to substantially reduce reimbursement for certain hospitals and to lower overall funding for the nursing home sector while adopting a new methodology for paying providers. Examples also include forgoing a planned \$400 increase in the amount of monthly income beneficiaries could keep to help pay for the housing, transportation, and other costs necessary to remain in the community, a prime example of what many perceived to be a small short-term investment that could have considerable long-term consequences for reducing nursing use but was not implemented due to the absence of funds. Still other examples include proposals to generate savings by re-procuring all managed care contracts; reducing dental coverage; adopting a generics first pharmaceutical benefit policy; reducing spending on behavioral health services; redesigning the state's developmental disability system; restricting the number of emergency room visits; increasing beneficiary cost-sharing; and rolling back parent eligibility under RItE Care (Peoples March 20, 2009; EOHHS December 21, 2009; DHS 2010; Liberman June 2010; EOHHS June 28, 2010; Greg and Marcelo June 7, 2011; Marcelo August 26, 2011).

### ***3.f. Stakeholder Concerns Ameliorated by Federal Stimulus, Funding Cap, and CNOM***

Despite the emphasis on cost containment, there is general recognition that provision of hundreds of millions of dollars in federal stimulus money with the American Recovery and Reimbursement Act of 2009 helped the state support caseload increases resulting from rising unemployment while softening the state's emphasis on reducing spending. That the state had to maintain eligibility at July 1, 2008 levels to qualify for federal stimulus support, a provision since extended by the federal health reform law, has also helped to ameliorate stakeholder concern regarding the waiver's impact. So too has been recognition that the state would not come close to losing its federal match as a result of exceeding the funding cap agreed upon with the federal government. This was both because of the generosity of the funding cap itself and because the level of state appropriations and spending were simply not high enough in the prevailing fiscal climate to draw in sufficient federal dollars to exceed cap. The state has also been successful in using its CNOM authority to obtain additional federal dollars for services and populations that do not typically qualify for the federal Medicaid match. This has provided the state with much needed fiscal relief, thereby helping to maintain benefits at levels that otherwise would have been reduced or eliminated due to prevailing budgetary difficulties.

## **Topic 4: Internal Influences on Global Waiver Implementation**

This section examines internal factors that have influenced the implementation of the Global Waiver. This includes the state's capacity to successfully administer the waiver, both due to the number of experienced administrative personnel and due to the presence of the requisite data and informational architecture. It is also with respect to amount of coordination that has taken place across state administrative agencies.

### ***4.a. Inadequate Numbers of State Personnel to Administer the Global Waiver***

Between July 1 and December 31, 2008, DHS lost 101 workers, or 11% of its employees; BHDDH, 209 workers (14.4%); DEA 10 workers (30%); DCYF, 63 workers (8.8%); and DOH, 43 workers (10.5%) (Peoples February 2, 2009). Reductions have impacted both central administrative personnel and frontline staff who interface with individual beneficiaries and providers, including trained nurses and social workers capable of handling eligibility assessment, case management, and other functions. These reductions were largely due to changes in the state's retirement system adopted with the expressed aim of reducing the size of the state's

workforce (Gregg October 1, 2008), a decision driven both by the Governor's ideological belief in smaller state government and by the exigencies of the state's budget crisis. The result was widespread concern that RI did not have sufficient numbers of experienced state administrative personnel to properly implement the Global Waiver (Trapp 2008; The Lewin Group 2008; Needham and Gregg December 23, 2008; Anonymous February 18, 2009; Reed, et al. 2009; Peoples February 2, 2009, February 4, 2009, March 3, 2009; McKay and Nyberg 2009; Woodcock 2010). The extant shortage in state staff has been exacerbated by prevailing fiscal and budgetary conditions with rising caseloads stretching existing resources and revenue reductions slowing down the rate of new hires, which have not kept up with projections (Peoples February 2, 2009).

The prevailing lack of state administrative personnel has been reinforced by heavy reliance on consulting firms that provide expertise that does not exist within the state's administrative apparatus and that help manage programs such as RIte Care. Some felt that both EOHHS and its departments had become so reliant on consultants that they lacked the staff and expertise necessary to perform certain critical functions on their own. While increased demand for Medicaid has placed greater burdens on existing resources, there has been reluctance to spend limited state dollars on additional personnel. The result has been challenges filling both the old and new positions necessary to implement the Global Waiver (Peoples February 2, 2009). The result has been significant levels of stress when performing day-to-day functions, let alone the added burdens associated with administering the Global Waiver.

#### ***4.b. Insufficiently Experienced Leadership within the State Has Hampered Implementation***

Some interviewees expressed concern that while prior state agency leadership had significant experience with Medicaid, and a long history of working with provider and advocacy organizations, some—though not all—of the new leadership had little experience, both with the populations served by Medicaid and in working in partnership with the community that represents/serves them. Because large numbers of long time senior administrators had left, a major concern was how could significant changes reconfiguring the way Medicaid is operated be proposed without the leadership necessary to implement those changes. Rhode Island's Acting Medicaid director retired in 2008 in the midst of the waiver application process. It was a year before the position was once again filled. In the meantime, leadership at EOHHS and DHS was shifting. Temporary deputy directors were appointed whose experience and qualifications with Medicaid populations were questioned. Moreover, the new head of EOHHS did not have a background in Medicaid. Especially troubling was the belief that some of the senior staff put in charge of the process did not work collaboratively with providers and advocates. Indeed, it seemed that stakeholder perceptions that agency leadership had taken a top-down strategy to designing and implementing the Global Waiver did more than anything to alienate potential allies and to engender opposition among community stakeholders.

#### ***4.c. Mixed Assessment of the Global Waivers Impact on Interagency Coordination***

Most observers identify continuing organizational challenges associated with developing and implementing a uniform, coherent policy affecting Medicaid across separate EOHHS departments. (The Lewin Group 2008; Woodcock, et al. 2010). Thus, while departmental directors have certainly been interested in receiving additional federal funding through the state's CNOM authority, they resist having their policies and budgets changed under the waiver's provisions. A continuing lack of clarity regarding the role of EOHHS remains the primary obstacle to greater interdepartmental coordination. This is especially true of Medicaid which while formally sitting in DHS, funds programs in other departments. It was pointed out, for

example, that in situations where a director wanted to move their department in a direction contrary to the goals of the Global Waiver there would be little, if any recourse for the Secretary's of EOHHS to move them in a different direction. Thus, although the goals of the Global Waiver have tended to align with the goals of most directors, particularly with regard to providing care in the least restrictive settings, such alignment need not be the case.

There is some evidence to suggest that the Global Waiver has helped promote greater communication, collaboration, and understanding across departments despite persistent challenges posed by bureaucratic divisions. Thus, some believe that placing all money in one pool under a single waiver has helped break down the prevailing silo mentality. Instead of protecting one's own budget there has been increased emphasis on meeting beneficiaries' cross-departmental needs. Several examples were provided. One has been a move to develop a better coordinated, consolidated transportation system for all clients rather than separate systems for, say, populations served by DHS versus BHDDH. Another is collaboration between DHS and DCYF to interpret the language of the waiver's Special Terms and Conditions for children and families because it is largely oriented toward the adult disabled and elderly population. Still another is increased collaboration between DHS and DEA in administering HCBS for elderly and disabled people. At a minimum, it seems as if the state's internal work groups have provided health and human services personnel with opportunities to get to know one another and the respective missions of their departments of origin.

#### ***4.d. Lack of Data and Information Resources Has Posed Implementation Challenges***

Although the state tracks a variety of key data elements across a number of different information systems, most felt it lacked the requisite information processing capacity to effectively administer the Global Waiver. Instead, the state relies heavily on antiquated technology that requires considerable resources to maintain and prevents timely access to the data needed to track and evaluate progress. It was pointed out that government has gotten increasingly complicated over the last 25 years but that the state's information, human resource, and other systems has not kept up with this complexity. Thus, the state continues to rely on technology which requires substantial time, energy, and money to maintain, and precludes timely access to the key data points necessary to track and evaluate progress, either because the various data elements needed were not integrated or readily accessible. This has proven frustrating not only for state officials but for outside stakeholders.

Recognizing prevailing challenges, the state has sought to modernize its information technology architecture as part of its Global Waiver implementation strategy (Alexander 2010; EOHHS October 7, 2009, December 2, 2009). General needs identified included updating network, hardware and software resources, instituting data sharing across agencies, implementing centralized monitoring and reducing redundancy, and adopting a centralized portal for all EOHHS programs (Alexander 2010). Specific tasks include updates, both to the state's eligibility determination/redetermination system and to the state's Medicaid management information and claims processing systems. They also include development of a data warehouse for comprehensive real time data reporting and a new system for managing long-term care application and care management functions.

#### ***4.e. Need to Incorporate Additional Information into States' Monitoring/Evaluation Activities***

A recurring theme was the need to collect and report certain additional data elements over time, both routinely and as part of the state's evaluation efforts. It was felt that the provision of such information would improve state decision making but especially when determining whether and to what extent individuals would be eligible for long term services and supports. Particularly

important for stakeholders was having the ability to follow pertinent data elements both across departments and over time to better assess whether the waiver was, in fact, successful, and whether the state was investing enough resources to achieve its goals. Several felt that while the state may have been tracking the necessary data internally, it had yet to be shared with other interested parties. There was also concern about the state's proposed evaluation plan, which was submitted to the Federal government July 2009. Here, it was felt that state's emphasis on documenting general trends in spending and utilization only told part of the story. What was missing was data on beneficiaries' experiences, both in terms of service scope and quality. Most interviewees also wished the state would release more detailed data at more frequent intervals. Quarterly progress reports to CMS and to the RI General Assembly have subsequently provided some of the additional data requested.

### **Lessons for State Health Reform**

Rhode Island's experience with the Global Waiver provides a number of useful lessons regarding potential barriers and facilitators to designing and administering health care reform at the state-level. Specific lessons include: ensuring sufficient levels of stakeholder input and transparency throughout the program design, approval, and implementation process; devoting adequate administrative and informational resources to program administration; and carefully considering the breadth and timing of the reform strategy put into place; factors that promote adoption, for example, may, in turn, impede implementation.

#### **Ensure Stakeholder Input and Transparency at All Stages**

The U.S. Government Accountability Office (2002, 2007) has highlighted a lack of public input and transparency, both when states' Section 1115 waivers are developed and approval is sought from the federal government. Rhode Island's experience with the Global Waiver is certainly no exception. A common theme was the lack of opportunities for constructive input on the part of community stakeholders. This was evident both when program administrators designed the Global Waiver and when they negotiated approval from federal officials. Although some stakeholder meetings took place, the absence of specifics made it difficult for outside observers to provide feedback. Together the lack of community input and transparency intensified stakeholder concerns about the Global Waiver and its implications. Resulting distrust, in turn, has contributed to a more challenging implementation environment for program administrators than otherwise would have been the case.

High levels of stakeholder distrust contributed to passage of oversight legislation which requires that all but simple administrative changes be by the General Assembly before being submitted for federal approval. Somewhat paradoxically, the outcome has been greater state legislative involvement in Medicaid than existed before the Global Waiver went into effect. High levels of stakeholder distrust has also colored stakeholder views about program administrators' intentions as the implementation process has unfolded, a dynamic that has been exacerbated by widespread dissatisfaction with the Global Waiver Implementation Task Force. Most stakeholders do not believe that the Task Force has operated well, nor had much, if any impact on program administration. Agendas have primarily been set by the state; community leadership has mostly been absent; and work group recommendations largely ignored.

In light of ongoing concerns about the waiver development and approval process, the Affordable Care Act requires the U.S. Department of Health and Human Services to develop and issue regulations to ensure meaningful opportunities for public input (Alker 2012). CMS issued its final regulations on February 22, 2012. The rules first establish a process states must follow when developing their waiver applications. This includes a 30 day public notice and comment

period; a comprehensive description with sufficient detail to ensure meaningful input; two public hearings at which the public can learn about and comment on the application; and a final waiver application with specifics similar to the initial version that documents the public notice process undertaken and how it informed the final proposal. The rules next establish a process that the federal government must follow when considering what a state has submitted. This includes provision of a 15 day period in which federal notice of receipt of a state's waiver application must be given, notice of which launches a 30 day federal comment period; posting of pertinent materials on the CMS website; and requirement that the federal government not issue its final decision until at least 45 days after it has given notice. The final rule also addresses the post-approval period, requiring opportunities for public feedback within six months after implementation has begun and annually thereafter; regular reviews of waiver implementation and compliance; and release of a publically available evaluation plan and annual reports.

CMS' rules are certainly a step in the right direction. However, it is important to recognize that what CMS has established are minimum requirements for community involvement. It is likely that stakeholder expectations in this area will far exceed the parameters laid out by CMS. Certainly, for example, community stakeholders in RI would have been even more dissatisfied than they already were if only two public hearings were held before the Global Waiver was sent to CMS or if only one stakeholder meeting was held annually as implementation unfolded. Moreover, it is important to provide sufficient detail on proposed changes and to adopt mechanisms for public participation to not only keep community stakeholders informed and involved, but also to translate their input into program improvement, whether during the design, approval, or implementation stages of the policy process.

Rhode Island's experience suggests that pre-submission public forums can serve a useful role in informing community stakeholders about the state's intentions. However, a more productive purpose would be to acquire and incorporate public input into the state's plans. Ideally, the waiver development process should represent a collaborative approach whereby state officials integrate stakeholder feedback beginning with the initial concept paper, followed by the first draft, and then the actual waiver application itself. Such opportunities for feedback should continue into the federal approval process. Community stakeholders should not have to rely on their congressional delegation for information on the status of the state's negotiations with CMS. They should be able to count on state officials themselves.

Rhode Island suggests that forums such as the Global Waiver Implementation Task Force can serve as a useful conduit for informing community stakeholders about post-approval progress. Forums such as this, however, would be much more effective if community and state participants came to some agreement on the forum's mission; that is, whether it simply advisory or an active participant in the implementation process itself. Forums such as this would also be more effective if community leadership was established early on. Achieving a balance between representation of all pertinent interests and the need to limit size in order to make discussion and deliberation more manageable is important as well. So too is the provision of sufficient state administrative support.

In an open, democratic society providing opportunities for community input is a desirable objective in-and-of-itself. As a practical matter, however, it provides opportunities for program administrators to draw upon additional knowledge and expertise from individuals representing those most intimately affected by the decisions being made. It also provides opportunities for program administrators to obtain assistance with key implementation tasks, an important consideration among increasingly shorthanded state bureaucracies. Ultimately, the familiarity

and trust that consultation and collaboration promotes should contribute to the creation of a less challenging environment both politically when new programs or initiatives are being designed and administratively when they are being implemented.

### **Devote Sufficient Administrative and Informational Support to the Tasks at Hand**

A state's capacity to undertake major endeavors is reflected in the concept of governing capacity or "ability to formulate coherent, creative, plausible policy and carry it out efficiently, effectively, and accountably" (Thompson 1998). The capacity of states to govern has increased considerably over the last forty years—state legislatures have become more professional and state administrative agencies have become better resourced and staffed. This general growth in capacity has increased confidence in the ability of states to tackle some the nation's most pressing problems. Health care is no exception. Particularly salient for programs such as Medicaid is a state's administrative capacity, or the level of resources accessible to state bureaucracies with which to influence policy, including the financial, intellectual, and personnel resources available to state agencies (Barrilleaux and Miller 1988; Derthick 1979; Schneider and Jacoby 1996; Miller 2004, 2005, 2006b; Miller and Wang 2009; Miller, et al. 2012; Walshe and Harrington, 2001). While governors and state legislators mostly concern themselves with Medicaid program spending relative to other priorities, program administrators focus on developing and implementing the particular policies that put proposed budget projections and spending objectives into effect (Miller 2006a; Schneider, Jacoby and Cogburn 1997).

Despite the importance of state capacity, "administrative expenses typically represent a small portion of the total costs of a program, and they often get shortchanged in the budgetary process" (National Academy of Public Administration 2009). Moreover, state and local governments have eliminated nearly 600,000 jobs since August 2008 while reducing investments in health, education, and other social welfare programs, largely as a result of the economic downturn (Williams, Leachman, and Johnson July 28, 2011). This has further limited states' ability to effectively implement major program changes. Rhode Island is emblematic. EOHHS and its constituent departments lost hundreds of employees. The result was high levels of stress among program administrators, not only when performing day-to-day functions but also when administering the Global Waiver, including consulting with and incorporating input from community partners. The dearth of experienced leadership with a history of working collaboratively with outside stakeholders only alienated potential allies in the provider and consumer communities even more. Program administrators were further hampered by deficiencies with the state's data and informational architecture.

Prevailing challenges in RI highlight the importance of ensuring the presence of sufficient numbers of experienced administrative personnel. This includes not undertaking significant endeavors at the same time as other policy changes are being putting into place to markedly reduce the size of the state's workforce. It also includes not undertaking significant endeavors such as the Global Waiver when the ability to fill key positions is in doubt, as occurs during major fiscal crises even with the provision of substantial federal fiscal support. Ideally, assessment should be made regarding: (1) the ability of state agencies to take on added functions and responsibilities without harming the administration of existing programs; (2) what types, if any additional personnel may be needed to effectuate the changes desired; and (3) whether or not the requisite resources are available to fill in whatever gaps may exist.

Especially important is a state's ability to retain or seek out agency leaders with both the management and communications skills necessary to oversee comprehensive reform and to work productively with community stakeholders. Appointing trusted and experienced leadership who

fit their roles well is a necessary precondition for success, not only because administration is likely to go more smoothly but also because doing so is more likely to result in buy-in both on the part of internal agency personnel and on the part external stakeholders, including state legislators, provider representatives, program beneficiaries and their advocates. Also crucial is putting the requisite technology systems in place to undertake all major programmatic tasks and to meet most reasonable data requests, including timely access to the key data elements necessary to track and evaluate progress. Here, it is important to look beyond a general accounting of program activities and tasks and spending and utilization trends to indicators of service scope and quality.

Ultimately, the goal should be to keep track of and release that information necessary to assess impact, to ensure the investment of sufficient resources to achieve program goals and to determine if and when modifications should be made. This objective would more readily be met if the federal government emphasized the “research and demonstration” component of Section 1115 waivers to make sure that states incorporated and executed detailed evaluation plans based on the most suitable social science techniques. Although rigorous independent evaluations have certainly taken place, systematic assessment of waiver performance has not been the norm for nearly two decades (Thompson and Burke 2007; Thompson 2012). State evaluations of varying quality became the norm during the Clinton administration due to the imposition of smaller research budgets and rising workloads resulting from the growing numbers of waiver applications being processed. This continued under the Bush administration where even less emphasis was placed on the inclusion or execution of state evaluation plans and political appointees demonstrated reluctance to share whatever independent evaluation results were reported. For policy learning to take place it critical that the Federal government partner with the states to “assure rigorous evaluation of the 1115 demonstrations, the synthesis of major findings, and the vigorous dissemination of these results to other states and the broader policy community” (Thompson and Burke 2007).

### **Carefully Consider the Breadth and Timing of the Reform Effort**

Political and ideological alignment between the federal and state administrations is particularly important in areas such as Medicaid where the locus or venue for authoritative decision making has shifted over the last twenty years from Congress and the state legislatures to the executive branches of government. The upshot of this dynamic dubbed, “executive federalism,” is that major change in how state Medicaid programs are run primarily reflects the outcome of discussions between federal and state officials rather than statutory changes enacted by Congress and/or the state legislatures (Gais and Fossett 2005). Thus, adoption of the Global Waiver was clearly facilitated by alignment of the state and federal Republican administrations, both of which had sought to restrain Medicaid program spending in the past. This intergovernmental consensus combined with the adverse implications of the economic downturn for the state budget contributed to concern on the part of key stakeholder groups regarding the administration’s intentions, distrust that extended well into implementation of the waiver’s provisions, contributing to the institution of a more stringent legislative oversight regime than had existed previously. The fiscal crisis also led to significant reductions in state administrative personnel, increased emphasis on cost control over programmatic improvement, and delayed implementation of key program elements, including planned increases in provider payment and investments in key supports services. This has, in turn, slowed down progress and limited the level of financial savings achieved.

Overall, just \$22.9 million in state savings deriving from the Global Waiver provisions approved by CMS have been identified during the first three fiscal years of implementation, all of which could have been implemented under other authorities without a global federal cap and a far cry from year one savings of \$67 million claimed by the Governor when he first released the proposal (The Lewin Group 2011). Combined with \$42.8 million in additional federal matching dollars brought in under the waiver's CNOM authority, the state reduced its total spending by \$65.7 million as a result of the Global Waiver. Thus, although adoption of the Global Waiver was driven largely by the disproportionate share of the state budget consumed by Medicaid in an increasingly poor fiscal environment, moving forward with comprehensive reform during an economic downturn has compromised implementation and led to weaker than expected results.

Because few details had been released to the general public, critics had a difficult time fomenting a clear and coherent opposition, a dynamic compounded by substantial heterogeneity amongst the populations affected. Unlike more limited reform efforts, the Global Waiver encompassed the entire Medicaid program, and, as such, engaged all populations sectors served by the program. Because of differences in the ways these groups interact with the Medicaid (Kronebusch 1997), this, in turn, made it more difficult to achieve consensus, both with regard to grievance and strategy, than if a more limited, homogeneous subset of Medicaid beneficiaries and providers had been affected. While potentially advantageous for waiver proponents, the breadth of the Global Waiver made implementation far more challenging than if reform had been limited, say, to the state's system for providing long-term care for the elderly and people with physical disabilities. There were two key challenges in this regard. First, the large number and diversity of key stakeholder interests has posed challenges for a shorthanded state bureaucracy charged with incorporating feedback from numerous consumer advocates and provider representatives representing a variety of interests. Second, and more importantly, continued imposition of organizational barriers across departments within the state bureaucracy charged with serving the different population sectors impacted has hampered implementation.

To promote greater coordination among implementing agencies rules and incentives must be adopted to ensure the fidelity of each constituent unit to the goals of reform. Agency theory suggests that if a department, as an agent, does not perfectly represent the interests of central administration, it is because that department's interests do not perfectly coincide with central administration's goals (Pratt and Zekhauser, 1985). This implies more careful consideration of interagency flows of authority, closer monitoring, and aligning budgetary incentives so that constituent departments better conform to the interests of those leading reform. Transaction cost analysis highlights the costs of dealing with multiple departments, with the need to cross departmental boundaries contributing to "misunderstandings and conflicts that lead to delays, breakdowns, and other malfunctions" (Williamson, 1981). This suggests the advantage of bringing all Medicaid functions under one authority rather than distributing those functions across multiple departments whose leaders and staff may not be sympathetic to what state leaders are trying to accomplish. Thus, to the extent possible the goal should be to avoid agency problems and lower transactions costs by breaking down barriers that separate departments responsible for implementing Medicaid, including placing primary policy, budget, and management responsibilities in the hands of a single oversight agency. As long as Medicaid funded services are distributed across separate departments, each with its own priorities, constituencies, policies and staff, reform is likely to fall short of its ultimate goals.

## **Limitations**



We note several potential study limitations. First, we studied Medicaid reform in just one state. Consequently, our findings may not apply to other states which face substantially different circumstances. In general, however, we believe our findings are transferable. The general contours of other states' policy communities within which long-term care policy is developed and implemented is similar to that which exists in RI (Miller and Banaszak-Holl 2005; Miller, et al. 2012). Second, there may have been bias inherent in the particular interview subjects selected. Because there was no sampling frame, and we relied on a combination of purposive and snowball sampling, potentially knowledgeable individuals may have been excluded. While we are confident that we spoke with most, if not all of the relevant stakeholders, our impressions may have been dependent, in part, on the specific individuals interviewed. Finally, the study was designed to acquire detailed information on the particular topic addressed, the design and implementation of Medicaid reform through RI's Global Consumer Choice Compact Medicaid Waiver. Although providing a rich source of data, doing so sacrificed breadth for depth. Future research could build on the results reported by exploring state health reform in other areas.

### **Conclusion**

Although the Affordable Care Act markedly increases the federal role in the health sector, responsibility for implementation falls principally on the state. In almost every area state governments face critical decisions, not least of which include whether or not to participate in the Medicaid expansion and to form their own health insurance exchanges. States further face a plethora of Medicaid design issues; for example, whether to test new payment and delivery models, to respond to incentives to expand HCBS, to participate in federal initiatives aimed at better integrating care for Medicaid recipients who are also eligible for Medicare, and to devote the resource necessary to improve Medicaid outreach and enrollment and to coordinate Medicaid eligibility with the exchanges. Medicaid waivers will continue to play a significant role in permitting states to shape the direction of health care reform within the basic contours of the Affordable Care Act's provisions. Indeed, beginning January 1, 2017, states will have the option to apply for five-year waivers to go their own way within health reform; that is, to achieve the goals established by the Affordable Care Act but by other means. No matter the path taken RI's experience with the Global Waiver suggests several lessons that may increase the likelihood of success. These include ensuring sufficient levels of stakeholder input and transparency throughout the program design, approval, and implementation process. These also include devoting adequate personnel, data and information resources to program administration, not least of which to improve coordination across disparate elements of the state bureaucracy within which the Medicaid program is based. Carefully considering the breadth and timing of reform is critical as well. Overambitious reform, for example, during periods of fiscal scarcity is unlikely to be a breeding ground for success.

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**Figure 1: Timeline of Key Events in Rhode Island Global Waiver Application Process**

- **June 2006:** Perry-Sullivan Long-term Care Reform Act passes
- **October 2007:** Government study, *The Future of Medicaid*, is released
- **January 2008:** Governor announces plan to pursue the Global Waiver
- **February 2008:** Legislation authorizing pursuit of the Global Waiver introduced as part of FY 2009 budget
- **June 26, 2008:** Legislation authorizing pursuit of Global Waiver signed into law as part of FY 2009 budget
- **July 29, 2008:** Global Waiver application released to the public
- **August 8, 2008:** Global Waiver application submitted to the Centers for Medicare and Medicaid Services
- **December 19, 2008:** State receives initial federal approval of the Global Waiver; General Assembly had 30 days to review the waiver and if desired, vote to block it, but it chose not to do so
- **January 16, 2009:** Global Waiver receives official federal approval and takes effect
- **July 1, 2009:** State begins implementing Global Waiver's provisions; General Assembly establishes legislative oversight and process for community input
- **December 31, 2013:** Global Waiver is set to expire unless renewed for another five year

**Table 1: Category I, II, and III Changes, and State and Federal Oversight Requirements**

	Description	State Requirement	Federal Requirements
<b>Category I</b>	A change that is administrative in nature which the state has authority to change under the State Plan or demonstration's Special Terms and Conditions. Does NOT affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies, or cost sharing.	Changes must be presented to the permanent joint legislative committee on the Global Waiver for approval prior to implementation.	State must notify CMS of change (informal). CMS approval not required for implementation.
<b>Category II</b>	A change that could be made as a State Plan amendment or through 1915 waiver authority without a change in the waiver's Special Terms and Conditions (STC) or the section 1115 waiver and expenditures authorities. May affect benefit packages, health delivery systems, cost sharing levels, and post-eligibility contributions to cost of care. Does NOT affect beneficiary eligibility.	Changes must be approved by the General Assembly prior to implementation. DHS/EOHHS must also comply with existing public notification and hearing process prior to implementation.	State must comply with State Plan public notice process. State must notify CMS in writing prior to implementation, and must provide justification and assurances that such changes are consistent with program goals, improve program operation, would be permissible under a State Plan or section 1915 waiver, and are cost-effective. CMS approval not required before implementation, but federal matching funds will not be provided for changes that are implemented but not approved
<b>Category III</b>	A change requiring modifications to the current waiver or expenditure authorities or Special Terms and Conditions and any change not clearly defined as Category I or II*	Changes must be approved by the General Assembly prior to implementation. DHS must also comply with existing public notification and hearing process prior to implementation.	State must comply with State Plan public notice process. State must notify CMS in writing and submit a demonstration amendment. CMS approval necessary prior to implementation.

\*Examples: all eligibility changes; changes in mandatory benefits; spend-down level changes; cost-sharing in excess of 5% of family income; benefit changes not in accordance with existing federal statute; post-eligibility treatment of income; and amendments requesting change to budget neutrality cap.

**Table 2. Major Themes Pertaining to Four Major Topics with Illustrative Quotes**

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**Phase 1: Waiver Design & Development**

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**1.a. The Global Waiver Was Politically and Ideologically Motivated**

“One of the things we really wanted...was...to test the financial model. You pick up a newspaper in this country once a week and you find out some state is talking about [how] it can’t sustain Medicaid. We actually wanted to say, ‘Well, try us. Rhode Island is a small state; we’ve got some good budget projections. Give us a bag of money; give us the rules you want us to run by, and let us see what we can do.’” (State Official)

“This governor being the Republican that he is wanted to do something that was more along the lines of good Republican politics.” (Provider Representative)

“There were conversations with CMS in the waning days of the Bush administration...There appeared to be a fair amount of interest...both on the part of the Bush administration, as well as the local administration in attaining a waiver that had a cap on expenditures. That turned out...to be a driving force in getting that approved.” (Provider Representative)

**1.b. The Global Waiver Was Developed by a Few High Level State Officials and Consultants with a Lack of Public Input**

“[Because] the stakeholder community, in general, had felt really sort of shut out of the drafting process and not included in the original design and discussions around how this might work...we [were] not confident that our constituents’ best interests [were] being weighed in this process.” (Provider Representative)

“They were saying that [these consultants] were doing this voluntarily and then became clear...that they were, in fact, paid...It doesn’t make any sense to say that a consulting firm is working for free; that’s just not something that makes any sense; cognitive dissonance, like you’re telling me that I just need to believe you? And so I don’t believe you, but now I have to work with you, and you’ve lied to me on this, but you won’t admit that you lied. It just created a very negative atmosphere.”(Consumer Advocate)

“To my knowledge, there were no meetings where DHS or EOHHS sat with stakeholders and said, ‘What would you like to see in the waiver? What are your concerns about the waiver?’ It was all these public hearings where they presented and then people commented.” (Consumer Advocate)

“When they submitted the proposal to CMS...they listed all these community forums...[and] you’d see your name on the list and you’d think, ‘Wow, that was considered a community forum’...[because] it was a lot of reporting at you; it wasn’t necessarily opportunity for dialogue.” (Provider Representative)

“For somebody like me who had done years of work in partnership with the state, for this to kind of come out of nowhere, it was such a violation of trust...I know a lot of people share that concern. ‘Why weren’t we consulted?’...This was kind of something literally dropped out of the sky on us.” (Consumer Advocate)

### **1.c. Limited Details Were Released to the Public During Development of the Global Waiver**

“This general statement of principles on slides was great, but there was literally no information when you dove down in terms of how that would be implemented, what the details were. And it often wasn’t because they were holding back information...it simply was it was not yet designed...They were designing the airplane as they were flying it.” (Other Executive Official)

“They presented it as there would be economy and efficiency of having all of the Medicaid programs in one bucket so to speak but I don’t think they ever clearly were able to document how those efficiencies and economies would take place.” (Consumer Advocate).

“A lot of the reason why we were seeking the waiver was for new authority and flexibility but we did not have established programs in mind, per se. We had this idea that, well, let’s get authority first, develop it [later].” (State Official)

“There was lots of concerns that the state was getting some blanket waiver of federal laws without them really having to be specific about what they would do. They were given flexibility to carve out different populations and offer them different benefit packages but we didn’t know who those populations were, or what the benefit packages were, that kind of thing. ” (Consumer Advocate)

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## **Topic 2: Federal Approval & Legislative Oversight**

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### **2.a. Lack of Transparency in the Federal Approval Process Contributes to Stakeholder Distrust**

“I don’t believe the advocates felt that they had access to the federal reviewers. My recollection is that it was not a transparent process.” (Consumer Advocate)

“[She] writes to CMS, ‘We’re very frustrated with the lack of transparency in the waiver process, as your agency is considering the state’s proposal. Since the submission of the waiver, we have not been able to obtain information about the negotiations between CMS and the state. We hear that major changes to the waiver are being considered...We urge you to make public the status of the waiver, as well as major changes that are being considered. The public should be afforded the opportunity to weigh in with your agency on these changes, either through written comment or public hearing once it’s been provided with advance written information about the revised waiver submission.’” (Consumer Advocate)

## **2.b. Congressional Delegation as a Conduit for Information about Federal Approval Process**

“Clearly, there were people [in our congressional delegation] who were tracking it and getting information for us and letting us know what they were seeing, what they were hearing. That was one of the few ways that we could really get information.” (Legislative Staff)

“We would tell [the Congressional delegation] what we understood were the risks associated with the waiver...I know [that they] tried to influence CMS and tried to exert some pressure on the process. And in the end it didn’t really make a difference because they approved it.” (Provider Representative)

## **2.c. A Tight Time Framed Colored by Promised Savings Led to State Legislative Approval**

“We had to act quickly. I think we gave ourselves some date like January 11[,2009] and the legislature convenes January 5. So, we had very little time to make a decision.” (Legislative Staff)

“When you have savings of X [built into the state’s budget] document, you either have to go along with it, or you have to find a way to add money to cover the savings if you’re not going to use those savings. And I think that [was] a huge...factor...that, ‘Okay, if we don’t do this, where are we going to get the money?’” (Legislative Staff)

## **2.d. An Increased Oversight Role for the State Legislature in State Medicaid Decision Making**

### Traditional Oversight Mechanisms

“Everything budgetary obviously goes through the legislature...that’s the easiest way to give oversight is to fund it or not to fund it.” (Legislative Staff)

“The Senate House Committee...joint with the Finance Committee...almost instantly began having hearings where [they’d] bring [the administration in] to present...‘What’s your infrastructure? Who’s there? Who’s going to be making these decisions? What’s your plan? What’s your approach? What’s coming first? What’s coming next?’ And the Senators would have input through that way or at least would make public what the plans were.” (Legislative Staff)

“Certainly through our normal budgetary processes and other informal hearings...There is communication and interaction between all the EOHHS departments and the General Assembly’s fiscal offices about the wavier programs. We definitely on an going basis do report on the programs, so I think there is oversight and interaction.” (State Official)

### Specially Enacted Oversight Mechanisms

“There’s the separate statute...that said to the Governor’s Office before you proceed with any category two or three changes from CMS, you have to have legislative approval. So, even if it’s not a statutory change that has to happen, they still have to come to the General Assembly and say, ‘This is what we’re planning to do’...so sometimes they wouldn’t need a state law change to make it, if they wanted to change benefits, but they would still have to go to the General Assembly to say, ‘Our plan is to make this benefit reduction.’” (Consumer Advocate)

“The biggest thing was that imposition that every change that was a Category II or III had to be approved by the legislature. Certainly the feds did not contemplate that. They gave us the flexibility to avoid doing that...So what we gained in the flexibility from the federal side, we completely lost on the state side. The majority of the Medicaid program is operated under the waiver authority. It really has expanded the ability of the General Assembly to get involved in decisions.” (State Official)

“I would contend [that] they ended up with more restrictions than if they had just made some of these programmatic changes [without the Global Waiver]...It seemed like the state had these hoops they had to go through at the federal level and now they have these hoops they have to go through at the state level.” (Provider Representative)

“The General Assembly sort of added a whole other layer of approval and everything that DHS was not anticipating. They were trying to make this supposedly more flexible and to change the time that it takes to make decisions, and they did...shorten the timeframe that CMS has to respond [but] now with the oversight legislation...I don’t think that there have been a whole lot of efficiencies in terms.” (Consumer Advocate)

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### **Topic 3: External Influences on Global Waiver Implementation**

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#### ***3.a. The Global Waiver Task Force Has Been Heavily State Directed***

“They’re not really asking them to give any input. They’re really just sitting them in a room and reporting off that this is what we’ve accomplished, sort of, this month. It’s just too bad, because they could use those resources.” (Consumer Advocate)

“I have really been impressed with the degree to which the officials in the state of Rhode Island go to be inclusive with the advocacy community, and providers. And I think in a sense it’s almost led to an inertia, and to make it harder to change things, because there are so many interests involved all the time, it’s very confusing.” (Consumer Advocate)

“The thing that [the government] has to have is a vision of the entire program, rather than looking at it piecemeal. Everybody [on the Task Force] has their own piece they’re looking at...That’s part of the challenge.” (State Official)

“A good portion of that frustration is directly related to the fact that there was no community chair who is involved in setting agendas, and setting the goals and vision for the Task Force.” (Provider Reimbursement)

### **3.b. There Has Been a Lack of State Responsiveness to Task Force Recommendations**

“[Although] we all know that Medicaid can be improved in different ways, very few things can happen quickly and save a lot of money and help people. So...we have ideas like over the next two, three, four years if we change the system from one way to another it would save money; people would get better care, but it’s not going to save you \$17 million...or whatever you need to save in the next two months, that’s just not the way good planning happens.” (Consumer Advocate)

“DHS actually proposed the idea of these work groups, and it was a very odd situation, because they came to a meeting and said, ‘Here’s what the work groups are going to be.’ There was no discussion of what do we think ought to be done. It was like, ‘Here’s the work groups; everybody needs to sign up for a work group.’” (Consumer Advocate)

“[It’s] all very one-way. It’s all very, ‘Give us the information, we’ll make a decision.’ There’s not that sort of reciprocal process.” (Provider Representative)

“We have no evidence, no proof that any of the work we did, any of the writing, any of the recommendations [informed implementation of the Global Waiver]. (Provider Representative)

“It’s sort of like they’ve moved on, like that was something they gave out last time. There was never any real discussion about what are we going to do and what are we not going to do. And in the meantime the Governor comes out with his budget, which contains cuts, and which everybody goes crazy about because they’re not using the recommendations that people had made.” (Consumer Advocate)

### **3.c. Greater Integration with State Efforts Is Necessary for Task Force Success**

“[Without greater integration] there’s a danger of what I’ll term ‘parallel play’ wherein...there’s tremendous actual stakeholder involvement...but [not] in the area where the actual decisions are...being made.” (Other Executive Official)

“There are some really hard things that have to happen, and tough decisions, especially in bad budget times, but when you do it together, when you do it collaboratively, you make a lot more progress. Not everybody is going to be 100 percent happy, but you can at least support each other going forward...The state has what they refer to as...the external task force, that’s us, and the internal work groups. Why aren’t we working together? I don’t get it.” (Consumer Advocate)

“Some of the people who are currently involved in trying to operate the Task Force and do some other things, they were not involved in this process of doing the waiver, so a lot of them are suffering the disappointment, and unhappiness, and resentment of people when they had nothing to do with the original process to begin with. They’re living with this pain of the past, and the sins of the past.” (Provider Representative)

“One of the things that we’ve really struggled with is their recommendations come through, we may have put together a piece of legislation or a budget article, but we don’t have the final say...It goes to the Governor’s Office and to the Budget Office, and ultimately, we lose control, and we can’t even tell you what we were pursuing.” (State Official)

“We’re not using the Task Force as well as we could. It’s a huge drag to meet these people every month; I mean, it’s hard, because you have to stop your work...We also have to have staff supporting each one of [the work] groups in addition to doing their own jobs, and trying to carry on, on a day-to-day basis.” (State Official)

“I would say that [EOHHS] and DHS puts a lot of energy into meeting with consumer advocacy groups, hearing their concerns, working with them, getting input from them to inform the process. And I think...our programs have benefited from it, and our clients have certainly benefited from it.” (State Official)

### **3.d. Mixed Assessment of Relationships among Population Sectors/Systems**

#### Relationships among Population Sectors Remains Siloed

“Out in the community the provider network is still siloed and there’s still divisions...I don’t think we’ve broken those walls down as we’ve tried to put reform in place.” “[Different populations are] still [pitted against one another]” (Other Executive Official)

“Advocates and providers know what they know and they generally do not know what’s going on outside of the little area in which they operate. Even when they were talking to each other, they were talk past each other.” (State Official)

#### Waiver Promotes a Broader Perspective and Cooperation

“Things are sort of converging in terms of where these people fall. Some of these [BHDDH] providers, they’re almost like assisted living now, since the populations are that old...The Homestead Group, which is a big provider up in Woonsocket that does the groups homes and...care for the real developmentally disabled population, [is] opening an adult day center in their facility, initially to care for their own clients as they age but also...other populations....So I think there’s going to be more convergence.” (Provider Representative)

“For the first time, you have a very diverse, extremely large group. You have a real combination of providers as well as other advocates really at the table trying to deal with the whole waiver implementation...in the same room listening to the same language, and the same reporting mechanism. It really helps in the broader perspective of any conversation that takes place related to services for any population.” (State Official)



“It was good for the advocates and the providers [that] they created this kind of loosely assembled group that made them acknowledge that they are all a piece of this Medicaid pie. Instead of having the [developmentally disabled] people against the kids or against the old people in the nursing homes, there was some semblance of putting us all together at the same table.” (Provider Representative)

### **3.e. Waiver Implementation Driven Primarily by Fiscal and Budgetary Environment**

“I’m not sure if those [policy changes] are results of the Global Waiver or just the fiscal situation we’re in.” (Consumer Advocate)

“I’m not quite sure how we’re going to achieve the goals that are stated from the outset...The deficit we’re facing in Rhode Island definitely impacts on opportunities that we as a state might be able to recognize under the waiver, if circumstances were better.” (Provider Representative)

“It’s all about the money...What the state is doing is squeezing money out of Medicaid.” (Consumer Advocate)

“Our vision and goal from a purist perspective was we could do a lot more on an individual basis in terms of providing services to people, but we just haven’t been able to get there, because of the budget gap. And [that has] taken...precedent over everything else at this point in time.” (State Official)

### **3.f. Stakeholder Concerns Ameliorated by the Federal Stimulus, Funding Cap, and CNOM Authority**

“All I can say is thank goodness for the federal stimulus package because if we didn’t have these federal requirements, what’s called the MOE, the Maintenance of Effort requirements, I think RIte Care would be sliced and diced in a million ways to Sunday by now.” (Consumer Advocate)

“In general, the enhanced FMAP delayed or prevented the need to make some really, really tough decisions. It allowed us to go forward and do some things with implementation, because there was an influx of money coming in.” (State Official)

“The cap is really not a cap...the cap is like star wars...I mean they couldn’t spend \$12 billion if they tried in five years” (Provider Representative)

“You have to remember under the cap our Medicaid expenditures are driven by state spending and we just knew the state didn’t have the money...The way general revenue was moving, even if things had improved substantially, we knew we weren’t going to hit the cap, and we knew we had a fiscal and an administrative cushion because of the incoming CNOM.” (State Official)

“A good part of the waiver in these economic times is that those state funded programs might have been cut were it not for the ability to get the federal matching dollars...[A program] that had been proposed to be cut, for example, last year [because it was state funded], now it wasn’t on the chopping block...because...now its federal and state funded.” (Consumer Advocate)

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#### **Topic 4: Internal Influences on Global Waiver Implementation**

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##### **4.a. Inadequate Numbers of State Personnel to Administer the Global Waiver**

“Because of all the staff cuts that we’ve had in all the different agencies, I don’t know if there’s enough people that have the expertise to implement the Global Waiver the way it was meant to be” (Consumer Advocate)

“We had very serious concerns with the ability of the administration to implement any of it, they had absolutely no staff.” (Legislative Staff)

“We’ve had dramatic reductions in the state employee workforce. There have been huge retirement changes that have seen people leave in droves. I think that depleted manpower has certainly affected the state’s ability to implement some provisions of the waiver.” (Provider Representative)

“The Medicaid agency is incredibly heavily reliant on consultants. Without the consultants the staff is dead in the water. Over time they’ve become infantilized with just giving stuff to the consultants.” (State Official)

“With the state of the economy being what it is and the state a little reluctant to put additional admin money out there, I think DHS, DEA, and [BHDDH] have been [unable to bring] additional staffing on [even though] maybe a dozen people in key positions at certain points...could help move the agenda” forward.” (State Official)

“People are overwhelmed. I think that anybody that’s been there for any length of time is being asked to do a wide range of activity, some of which they have no expertise in, and they’re kind of dancing as fast as they can to catch up, but that’s very hard.” (Provider Representative)

##### **4.b. Insufficiently Experienced Leadership within the State Has Hampered Implementation**

“The brain trust, the historical knowledge within Medicaid, the people who knew how Medicaid ran in Rhode Island were all gone.” (Provider Representative)

“There were big changes where [former acting Medicaid Director] had sort of started it and then he retired, because they had that whole state retirement sort of fiasco in the middle of it, where all their senior people all retired. Certainly DHS has said that they’ve had some difficulties with staffing, and...the new Medicaid Director, it’s just she’s so bright and energetic, but you just wonder how much one person can do, you know?” (Provider Representative)

“[The EOHHS Secretary] didn’t know that there was a deep history of working together with advocates in the state in these different [health and human services] areas [nor knew] how to work with the people that were doing it, and become partners with them, rather than just go ahead and do what you want and not ask until it’s all over.” (Consumer Advocate)

#### **4.c. Mixed Assessment of Global Waivers Impact on Interagency Coordination**

##### Divided Responsibility for Medicaid across Departments Still Poses Challenges

“[The waiver] certainly does provide a framework for a truly integrated coordinated system of care, but the institutional structures don’t allow for that, and unless that changes, we will not be in a position where we can ultimately [get as far as we would like to go].” (State Official)

“You have separate directors who do have their separate authority and [the state’s] ability to hold other entities accountable for how they spend those Medicaid dollars is always going to be an issue, because the money and the policy from the perspective of the Directors is in their own domain.” (State Official)

“Functionally, the Secretary has authority over all of them but in reality...the scope of the Secretary is largely a function of how much support you have in the Governor’s Office, or from the legislature, and that’s variable; it depends on the issue, almost.” (State Official)

“Quite frankly, all of these directors didn’t want to let their stuff go...Politically, this was a very difficult consolidation to do and we never really pulled it off.” (State Officials)

##### The Global Waiver Promotes Collaboration and Understanding across Departments

“Part of the reason this was a rewarding experience was it did give us an opportunity to really collaborate closely with our partners [in the other departments]...Even though this is a tiny state...people don’t know what each other does. We’re now learning what is available through other departments...That’s a good thing, because sometimes we serve similar populations, or even the same population.” (State Official)

“So, we came to an agreement that in fact because the savings come to DHS that DHS would fund the service, but [BHDDH wrote the regulations and program plan while both departments] administer and manage the benefit together. That was a very positive development, and it’s been a beneficial service that’s now available.” (State Official)\*

#### **4.d. Lack of Data and Information Resources Has Posed Challenges for Waiver Implementation**

“There’s a lack of technology…it’s been a huge problem for many years. We’re trying to tackle that.” (State Official)

“Anything we do, any change, no matter what the direction is, costs money, because we have archaic systems that need to be programmed.” (State Official)

“I’ve gone to…[the heads] of the DHS offices and everything and this antiquated system, like this computer system, just doesn’t even allow them to spit it out. I said, ‘You mean your system can’t tell me on a weekly basis this, this, this, and this?’ ‘No.’ It’s like you’re kidding.” (Provider Representative)

“There are no metrics, because they don’t have a lot of staff and they don’t have a really good data system…It’s really hard to judge or to measure what success they’ve had. Is it financial success? Is it the number of clients being serviced in home care versus nursing homes? They don’t have good data, so you could argue that this is a failure very easily…Or you could argue that it’s a total success. I wouldn’t know what was true.” (Consumer Advocate)

#### **4.e. Need to Incorporate Additional Information into States’ Monitoring/Evaluation Activities**

“Here’s my gripe about the whole process, what we don’t get is data! We don’t get it…I want to see raw numbers.” (Provider Representative)

“The other thing that we wanted was greater transparency in reporting data on what was happening, so we could keep score on rebalancing and also costs, of how this was going.” (Consumer Advocate)

“We don’t know how this is working because we need to know how many applications for Medicaid funded services are filed each month…How many are approved? How many are denied?...If people are found eligible, what’s the scope of services?” (Consumer Advocate)

“If we’re making changes, no matter how small they might seem, we should be evaluating that, and that doesn’t mean just counting numbers. The state should be looking at the impact on human beings in this state....I so far have really not seen anything concrete in terms of like how do we know that those they diverted from nursing homes are satisfied, feel supported, that kind of thing?” (Consumer Advocate)

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\*Quote derives from legislative hearing