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Abstract

Federal approval of Rhode Island's Global Consumer Choice Compact Global Waiver in 2009 provided Rhode Island with greater flexibility to modify its Medicaid program. Because 96% of long-term care expenditures in Rhode Island were directed toward institutional settings, a primary goal was to facilitate the state's efforts to shift the locus of long-term care to non-institutional settings. This study draws lessons from Rhode Island's experience with the Global Waiver for the long-term care rebalancing provisions of the Patient Protection and Affordable Care Act of 2010. Data derive from 325 archival sources and 26 semi-structured interviews. Results suggest that prospectively documenting home- and community-based services (HCBS) capacity is necessary to ensure that sufficient resources are available to meet the complex care needs of an increasingly larger service clientele. Results also suggest that increased reimbursement is especially important for attracting participating providers; so too is maintaining sufficient numbers of state regulators for purposes of monitoring quality. Barring the adoption of even more substantial changes in federal policy than included in the Affordable Care Act the distribution of long-term care spending is likely to remain stagnant in laggard states such as Rhode Island given just how difficult it is to make more than marginal progress despite the provision of additional options and incentives that otherwise should promote rebalancing. Nursing home care continues to be a mandatory benefit while most HCBS remains optional. This leaves investments in HCBS especially vulnerable to the vagaries of state budget and political processes, which when combined with the absence of minimum standards and requirements to cover all geographic areas and target populations, suggest persistent unmet need, both within and across states.

Introduction

Overall, there has been considerable growth in Medicaid home- and community-based services (HCBS) participants and expenditures which have increased from 1.9 to 3.3 million and $17 to $50 billion, respectively, between 1999 and 2009 (Ng, et al. 2012; Howard, Ng and Harrington 2011). Yet despite such progress, there is still a long way to go, with just 36% of Medicaid long-term care spending for older adults and people with physical disabilities being spent on non-institutional care (up from 17% in 1995) as compared to 66% for people with developmental disabilities (up from 30% in 1995) (Eiken, et al. 2011). Rhode Island (RI) has fared especially poorly in this regard. Despite several ongoing initiatives to improve the distribution in spending, just 4.4% of Medicaid long-term care expenditures for the elderly and physically disabled were directed toward HCBS as compared to 95.6% toward nursing homes, far below national totals. Due to a lack of investment in the HCBS sector in states such as RI, a large proportion of prevailing need goes unmet (Komisar, Feder, and Kasper 2005). Moreover, up to 19.0% of long-stay nursing home residents and 24.9% of new admissions in RI can be categorized as low care, as compared to 11.8% and 13.5% nationally, suggesting that a particularly large proportion could be transferred back to the community, or prevented from going in to a nursing home in the first place (Mor, et al. 2007).

Nationally, government officials hope to save money by meeting people's needs in the least costly settings possible. They recognize the desirability of aligning Medicaid long-term care with consumer preferences for non-institutional options to nursing home placement, with, for example, 84% of people 50 or older desiring to "age in place" and 87% of disabled individuals preferring to live at home (Gibson 2003; Kochera, Straight and Guterbock 2005). They also recognize that on a per unit basis HCBS is significantly less expensive to provide than institutional care; $44,000 per year, on average, according to one recent study (Kitchener, et al. 2006). Shifting the locus of service provision to favor HCBS thus represents a potential source of savings for the federal and state governments, as well as taxpayers. This is particularly important in light of population aging. It is estimated that by 2025 there will be 224,507 Rhode Islanders aged 65 years or older, up from 150,891 in 2005 (Proximity 2012). Growth in the number of elders will increase the demand for high quality, cost effective services, particularly since the aged and disabled, though only 24% of beneficiaries, account for 66% of program expenditures, with spending on providers that deliver long-term care constituting nearly 55% of program spending (Executive Office of Health and Human Services [EOHHS] October 2007).

Federal contributions to state Medicaid depend on the Federal Medical Assistance Percentage or FMAP, which ranges from 50% to 75% depending on per capita income. Nursing home care is a mandatory service that all states must provide under Medicaid in exchange for the federal match. States also have three major HCBS benefits that they can provide (Eiken, et al. 2011**;** Ng, et al. 2012). The program's home health care benefit encompasses nursing and home health aide services and medical supplies, equipment, and appliances. If a state chooses it may cover physical and occupational therapy, speech pathology, and audiology services as well. Home health is a mandatory benefit that must be offered to all clinically eligible Medicaid recipients on a statewide basis. Personal care services, by contrast, is an optional service offered by 34 states. It provides assistance with both basic activities of daily living (e.g., bathing, dressing, toileting) and instrumental activities of daily (e.g., meal preparation, medication administration). Like home health, states choosing to offer this service must do so statewide to all clinically eligible Medicaid recipients.

The program's 1915(c) HCBS waiver benefit may also pay for home health and personal care, in addition to case management, homemaker, adult day care, habilitation, respite care, and other options. It occasionally pays for services provided in assisted living facilities as well, though not room and board. Unlike home health and personal care, states may restrict participation in its 1915(c) waiver programs to selected populations of Medicaid recipients and particular localities and regions. They may also limit the number of participants served and choose to offer services not typically covered by the Medicaid program. In order to participate prospective waiver participants must be deemed nursing facility eligible. The total costs of each waiver program must not be more than what the federal government would have otherwise paid for institutional care. In 2009, approximately two-thirds (62.9%) of Medicaid HCBS spending derived from 1915(c) waiver services; about a quarter (24.6%) from the personal care option; only 8.7% from the mandatory home health care benefit (Eiken, et al. 2011).

Driven, in part, by the disproportionately high level of spending on nursing homes and the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.*, which reaffirmed the legal right of individuals with disabilities to choose to receive care in community-based settings as opposed to institutions, RI has long sought to rebalance long-term care spending from institutional to non-institutional settings, primarily through 1915(c) waiver services. In 2002, a joint resolution from the RI House and Senate called for a "multi-year approach to regulatory and financial reform" in long-term care. A subsequent 2005 resolution called for a study to examine the need and financing options for a variety of community-based long-term care services. Together these resolutions led to the passage of the Perry-Sullivan Long-Term Care Service and Finance Reform Act of 2006 which established a mandate to rebalance Medicaid long-term care, prevent inappropriate institutionalization, and reinvest savings from reduced nursing home use into HCBS. It also directed the state to pursue any necessary waivers or state plan amendments needed to achieve a 50-50 spending split between Medicaid institutional and HCBS, and to establish a single budget for long-term care whereby savings resulting from reduced institutional service use would be reinvested in HCBS. In addition, RI applied for and received a Federal Real Choices System Change Grant in 2002 to help rebalance long-term care. This was followed by receipt of five-year Real Choices System Change Transformation Grant in 2006.

On January 16, 2009 the federal Centers for Medicare and Medicaid Services (CMS) approved RI's Global Consumer Choice Compact Medicaid Waiver. As a consequence, RI became the first state granted permission from the federal government to operate virtually all of its Medicaid program under the state plan and a single 1115 "research and demonstration" waiver; prior to the Global Waiver, Rhode Island's Medicaid program operated under the state plan and multiple waiver authorities, including 9 separate 1915(c) HCBS waivers (i.e., Mentally Retarded-Developmental Disability, Aging and Disabled, Elderly, Personal Choice, Habilitation, Assisted Living, and three Respite care waivers). The Global Waiver 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 a five year demonstration period in exchange for the ability to make certain program changes. Rhode Island began implementing the Global Waiver on July 1, 2009. It is set to expire December 31, 2013 unless it is renewed for another five years. This study draws lessons from the long-term care provisions of RI"s Global Waiver's for rebalancing long-term care, generally, and for incentives and options for doing so under incentives and options included within the Patient Protection and Affordable Care Act of 2010, specifically. Before describing our methods and results, we identify the major rebalancing initiatives contained within the Global Waiver.

The Global Waiver & Long-Term Care Rebalancing

The most prominent Global 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 HCBS. Those deemed "high" are eligible for HCBS only and those deemed "preventive" to a restricted package of home care benefits—limited certified nurse aide (CNA)/homemaker services and minor home modifications, given available funding. Rhode Island's criterion for the "high" needs cohort is the same as what was formerly used to determine eligibility for long-term care prior to the Global Waiver. This means that a group that was previously defined as needing an institutional level of care and guaranteed access to nursing home services now does not have that option, even if funding is available. Because the new level of care provisions do not apply to the developmental disabled population or to those receiving behavioral health services, it does not impact residential care placement in either area.

Services funded by Rhode Island's Medicaid are overseen by the five departments that constitute the state's Executive Office of Health and Human Services (EOHHS). To better promote uniformity in the administration of Medicaid-funded long-term care services, including with respect to information and referral, eligibility and referral, and care planning and care management, the state developed and implemented what it refers to as an Assessment and Coordination Organization. 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 and other functions across the state's health and human services agencies. Under this system all long-term care referrals are directed to the Department of Human Services (DHS) Office of Medical Review at which level of care determinations are made centrally by six Office of Medical Review nurses. Referrals for long-term care derive from the state's long-term care field offices, hospital discharge planners, and nursing homes, which communicate the information necessary for Office of Medical Review nurses who determine eligibility based on the use of a common assessment protocol. Determinations are subsequently communicated back to the referral source. Complex, high costs cases are also referred to a new Office of Community Programs in which four registered nurses and two social workers are charged with undertaking case management and oversight. The Office of Community Programs also supports community-based placements more generally, including managing services received by "preventive" level of care recipients along with DHS' long-term care field offices. Those who are not medically complex may also receive case management from the Department of Elderly Affairs (DEA) through six case management agencies located throughout the state.

Concomitant with this centralization, the state removed delegated authority from discharge planners to make level of care determinations, though a role for discharge planners in making discharges on weekends and holidays was retained when state staff is unavailable. Several efforts have been made to better educate discharge planners and other referral sources about the services and housing options available. This includes an April 28, 2011 discharge planning conference attended by about 200 individuals. It also includes development and implementation of Community Options Training for hospital and nursing home discharge planners in the way of webcasts and printed materials. The state has further sought to update its

Rite Resources Web-Site, an electronic database whereby discharge planners, patients and their families are provided up-to-date information on the availability of long-term care services contingent on client demographic, clinical, and service need characteristics (EOHHS 2011). The state has also established a long-term care Options Counseling Program within the state's Aging Disability Resource Center, The Point, to better provide individuals and their families with the information necessary to make more appropriate care and placement decisions.

Major waiver-related rebalancing tasks have also included designing and implementing nursing home diversion and transition projects. The diversion project includes several elements, which, in addition to better educating discharge planners and others about available options within the community, involves tasking an on-site registered nurse (RN) at Rhode Island Hospital, in collaboration with hospital social workers, to identify Medicaid beneficiaries who might be discharge safely back into the community. This RN was subsequently reassigned to the state's primary care case management program, Connect Care Choice. The state's nursing home transition program was initially operated by an outside vendor, the Alliance for Better Long-Term Care, which also runs the state's long-term care ombudsmen program. The Alliance would go into nursing homes and work with the facility, DHS/DEA staff, residents, and their families to identify persons who were both willing and able to be move safely back into the community. Individuals and families also self-referred to the program based on brochures, posters and other marketing materials that had been distributed in nursing homes throughout the state. Once the decision to transfer had been made the Alliance would work with DHS/DEA before, during, and after the transition to ensure the provision of the necessary community support. Subsequently, the state made the decision not to renew the Alliance's 18-month contract. As such, beginning July 1, 2010, DHS' Office of Community Programs has been charged with the transition program in collaboration with DHS' Office of Medical Review and DEA's Office of Community Programs, which also has experience transitioning. Beginning the last quarter of 2011 the transition program has been aided by receipt of a federal Money Follows the Person Demonstration Grant, which is set to expire March 31, 2016.

Efforts have also been made to expand access to and the availability of certain HCBS, including 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. Previously, shared living was only available to people with developmental disabilities. The Global Waiver extends these services to elderly and adult disabled Medicaid eligibles who cannot live independently and meet the state's "highest" and "high" level of care designations. Shared living permits financially and clinically eligible individuals to receive care in a host home that is supervised by a shared living agency (DHS 2010). The host caregiver can be a friend, relative, neighbor, acquaintance, or someone else; he or she cannot be a spouse or legal guardian. Host caregivers are responsible for being on call 24/7, providing socialization, a homelike environment, personal care, homemaker and chore, meals, and transportation. Through competitive contracting two agencies—The Homestead Group and Caregiver Homes—were awarded contracts to manage the shared living program, including recruiting, training, and monitoring host homes and caregivers (who receive stipends ranging from $13,000-

$18,000/year), providing RN services and caregiver respite, and implementing shared living service and safety plans. Medicaid pays the caregiver stipend only which, depending on income, might include a cost share from the care recipient; it does not pay for room and board.

Finally, CMS granted RI the authority to obtain federal matching funds for populations and services previously covered only by the state. The purpose in granting the state this authority was 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. The state's Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has been 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, RIand 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).

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 further sought to understand factors facilitating and/or impeding implementation of the Global

Waiver by EOHSS and its constituent agencies. This 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 subsequently 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 through 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 theme identified across five major dimensions—waiver design issues, fiscal and budgetary considerations, administrative issues, data and information issues, and provider considerations—were excerpted (See Table)

[Table 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

Dimension 1. Waiver Design Issues

The Global Waiver was motivated, in part, by a desire to save money by rebalancing the state's long-term care system. There was mixed feelings, however, about the potential impact of the Global Waiver on increasing state investment in HCBS. Community stakeholders were also concerned about the uncertain implications of the waiver for certain populations, including the developmentally disabled, mentally ill, and children and families.

1.a. Long-Term Care Rebalancing through Global Waiver Viewed as a Way to Save Costs

Foremost among the Global Waiver's goals was a genuine desire to bolster state efforts to rebalance long-term care. Thus, argued then DHS director Gary Alexander "rebalancing will give beneficiaries the care they prefer while saving the tax payers millions" (Office of the Governor 2008). State officials hoped to achieve both cost savings and a more consumer-responsive long-term care system by keeping care recipients out of nursing homes and other institutions, particularly in in light of the prevailing lack of progress made toward rebalancing despite Perry-Sullivan and other ongoing initiatives in this area, including the state's Real Choices grants. Thus, in announcing the intent to pursue the Global Waiver in his January 2008 annual State of the State address, Governor Donald Carcieri argued that older people should have a choice of where to receive long-term care services and that they should not have to go into a nursing home if they did not want to. State officials also felt that having the authority to provide a limited package of services to otherwise non-Medicaid eligible individuals early on in the trajectory of their disability through the waiver's CNOM programs would contribute to better care management within the community, thereby reducing the eventual likelihood of full Medicaid eligibility and long-term institutional placement. If successful, this, of course, would have the added benefit of saving money, certainly for the state but possibly the federal

government as well. Each time someone is kept at or moved down to a lower level of care, average per member per month costs declines.

1.b. Mixed Feelings about the Need of a Global Waiver to Rebalance Long-Term Care System

A number of provider representatives and consumer advocates felt that the state could have accomplished its rebalancing goals either through existing processes and initiatives such as Perry-Sullivan, Real Choices, the states Aging Disability Resource Center, and/or through more limited changes to the Medicaid program framework (Bryant 2008; The Poverty Institute 2008; Coffey 2009; Solomon 2009; Reed, et al. 2009; Freyer 2011). Indeed, it was estimated that the state could have obtained $22 million in savings from rebalancing long-term care under its existing waiver authorities simply by implementing activities that it planned to undertake already (The Poverty Institute 2008). Alternative strategies suggested ranged from relying on or modifying the state's existing 1915(c) waivers, or adopting a separate 1115 waiver targeted specifically at long-term care rather than the entire Medicaid program.

A number of respondents felt that the Global Waiver was necessary to promote further progress rebalancing in view of numerous activities that have been undertaken in this area after years of stagnation, including the adoption of the new level of care criteria for long-term care, creation of the Assessment and Coordination Organization, and operation of the nursing home transition and diversion programs. It was also felt that the Global Waiver was necessary to push the conversation forward by providing both a framework and incentives to make the requisite changes happen. Said Steven Costantino, current EOHHS Secretary and former Chairmen of the House Finance Committee, the Global Waiver "changed the mindset….creating a strong impetus to move forward toward rebalancing the long-term care system" (Freyer 2011).

1.c. Uncertain Implications of the Global Waiver for Certain Populations

The added value of rebalancing long-term care for certain populations under the Global Waiver was difficult for some respondents to discern. It was widely acknowledged, for example, that the system for caring for developmentally disabled people was working well, with most of that population already being served in the community under the state's ICF-MR waiver. Similar points were made with respect to the state's systems for caring for the mentally ill and physically disabled. By contrast, some interviewees felt that prior discussions around the state's Perry-Sullivan Legislation and Real Choices Grants helped generate consensus about the need for rebalancing, at least with respect to the state's elderly population. However, some concern remained about the state's intentions in this area, despite high levels of agreement that change needed to take place (Peoples May 23, 2008, July 21, 2008; The Poverty Institute 2008; Beckwith 2008; Katz 2008; Davis 2008). Take the state's long-term care diversion strategy, for example. Previously, anyone deemed eligible for institutional placement was eligible for nursing home care or 1915(c) HCBS waiver services. Under the new leveling system only those deemed "highest" would be entitled to coverage; those deemed "high" and "preventive" would only be eligible for HCBS, funding permitting. What criteria would be used to allocate individuals across the three groups? How many of those who would have been deemed eligible for nursing home care under the old standards would no longer be so? How extensive would the waitlists be for those given a "high" or "preventive" designation? To the chagrin of providers and advocates answers to questions such as these were not forthcoming.

A major concern with the new leveling system was whether the state would 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 criteria established under the Global Waiver

(Coffey 2009; Needham 2009; Peoples May 29, 2009). In light of this concern, oversight legislation promulgated by the RI General Assembly grandfathered current nursing home residents from the new level of care provisions. First, the legislation included a provision protecting current residents who did not want to be transferred back to the community by requiring that the state's old institutional level of care criteria be applied to those living in nursing homes on or before June 30, 2009; state implementation of the Global Waiver began July 1. This provision was deemed both practical and fair since those residing in nursing home would need to re-establish themselves in the community, a daunting prospect for those who had already downsized and/or sold their home.

Second, the oversight legislation originally included a provision ensuring that someone who had voluntarily moved out of a nursing home could move back in under the old level of care criteria if they decided that they could not make it in the community. This provision, however, proved incompatible with the state's agreement with the federal government, which stated that the new level of care criteria would be applied once someone transferred out of a nursing home, so if they are classified as "high," they could not go back in even if they wanted to. Still, the General Assembly was able to include a provision within the oversight bill confirming that those scoring "highest" could be readmitted, in addition to those facing special circumstances that may adversely impact health or safety including failed placement. Although watered down, some observers nonetheless viewed this provision as important for encouraging participation in the state's nursing home transition efforts.

Dimension 2. Fiscal & Budgetary Considerations

There was general agreement that decisions made under the Global Waiver have been driven largely by the adverse fiscal and budgetary environment facing the state. As a consequence, the emphasis has largely been weighted toward controlling costs rather achieving savings and improving care through programmatic changes, including, potentially, subtle "backdoor" efforts to restrain spending. The provision of federal CNOM dollars has helped to ameliorate the impact of the recession and slow recovery on the state's rebalancing efforts.

2.a. Decisions Weighted More Toward Containing Costs than Programmatic Improvements

It was widely recognized that implementation of the Global Waiver, has been driven primarily by the state's fiscal and budgetary environment. Indeed, a dominant and recurring theme was the effect of the fiscal crisis on Medicaid, which has enhanced the focus on cost control, limited state dollars available for the program, and made it difficult to distinguish waiver-driven changes from budget-driven changes. The latter, in particular, is reflected in proposals to lower overall funding for the nursing home sector and to delay planned rate increases for HCBS providers. It also included 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. The latter, in particular, was a prime example of what many perceived to be a small short-term investment that could have considerable long-term consequences in terms of reductions in nursing home placement. Thus, most of the 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.

2.b. Indirect Impact of State Fiscal/Budgetary Crisis on Implementation

Consumer advocates highlighted what they perceived to be subtle "backdoor" efforts to restrain spending, including slower application processing speeds and reductions in the number of service hours authorized (Liberman 2010). Several reported that it was taking longer for

people with developmental disabilities to receive community services while children previously eligible for Katie Beckett services were being disqualified upon re-certification. Advocates recognized, however, that these perceptions were anecdotal and that state officials would deny that any formal changes in state policy had taken place to encourage such behavior on the part of program administrators. While state officials admit that the budget gap has taken precedence, resulting in greater stress among both consumers and providers, efforts have been made to maintain quality, eligibility, and service levels to the extent possible given the state's very challenging budgetary situation.

2.c. CNOM Dollars Helped to Ameliorate Impact of Fiscal Crisis on Rebalancing

Perhaps the most popular aspect of the Global Waiver has been the state's ability to use its CNOM authority to draw in additional federal matching funds to help finance programs previously paid for entirely out of the general treasury (Freyer 2011). This provision was particularly appreciated as the state's budget situation could have resulted in the reduction or elimination of these efforts, even with the provision of substantial federal fiscal support included in the American Recovery and Reinvestment Act of 2009. Thus, the infusion of federal CNOM dollars enabled state agencies to eliminate waitlists and to continue providing behavioral health, substance abuse, prevention, early intervention, assisted living, adult day health and other services to populations that would otherwise not have been eligible to receive Medicaid. By permitting the state to "CNOM" the DEA's Co-Pay program, for example, the Global Waiver enabled DEA to save general revenue funds and prevent cutbacks during a period of fiscal austerity. The federal government approved the use of federal dollars in this manner because it agreed that the provision of services under the Co-Pay Program was a good preventive strategy for keeping people in the community and out of nursing homes, thereby slowing the trajectory toward full Medicaid eligibility. The current absence of waitlists in RI contrasts with the situation that existed when the Co-Pay Program was entirely general revenue funded. At that time, admissions would often be frozen and waitlists established half way through the fiscal year when program administrators realized that they were going to overspend their budget. Since federal funding has been added to the mix, waitlists have been non-existent.

Dimension 3. Administrative Issues

There was widespread concern that RI did not have sufficient numbers of administrative personnel to properly implement the Global Waiver. Two areas stood out in the context of long-term care rebalancing: the state's nursing home transition and quality assurance initiatives.

3.a. General Challenges Deriving from Reductions in State Administrative Staff

Due to the loss of significant numbers of administrative personnel there was widespread concern that the state lacked the requisite staff to effectively implement the Global waiver (The Lewin Group 2008; Reed, et al. 2009; Peoples February 2, 2009, Woodcock 2010). Indeed, 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%); the Department of Children, Youth and Family Services, 63 workers (8.8%); and the Department of Health, 43 workers (10.5%) (Peoples February 2, 2009). This reduction was due to primarily to changes intended to spur retirements (Greg 2008), both due to the Governor's desire to reduce the size of the state workforce and to the exigencies of the state's budget crisis. This has, in turn, posed challenges for the state's rebalancing initiatives. Thus, at the time of the interviews neither DHS' new Office of Community Programs, which is responsible for care coordination for medically complex high costs cases, nor its new Office of Medical Review, which reviews and processes

clinical levels of eligibility, had been fully staffed up, though the state eventually completed the necessary hiring in priority areas such as these.

3.b. Challenges Administering the State's Nursing Home Transition Program

It was largely due to concerns about staff shortages and inexperience that there was controversy about whether DHS should take over the state's nursing home transition program which had been operated by the Alliance for Better Long-Term Care. While state officials admitted that the Alliance had done a fine job transitioning persons from nursing homes to the community, the decision was made beginning July 1, 2010 that DHS' Office of Community Programs would be charged with this task. Two reasons were specified for this policy change. First, DHS believed that they could administer the program at half the cost of the Alliance's $550,000 contract. Second, DHS believed that administering the program entirely within the state bureaucracy would result in a more streamlined process capable of more effective care coordination than under the current system where cases must be handed from Alliance to state control 30 days after someone had transitioned to the community.

The Alliance took issue with the state's claims, arguing its contract included the start-up fees necessary to get the program up and running and, as such, it could now run the program close to the same price that the state was claiming. It was pointed out how effectively the Alliance ran the program, with only two failed transitions to date. It was also pointed out that Alliance personnel were always available to assist transferees, conduct follow-up, and help move transferees back into the nursing home if necessary, even after the 30 day transition period expired. More broadly, there was doubt about whether the state would have the requisite resources to implement the nursing home transition program successfully. It was pointed, for example, that the Office of Community Programs was only recently established and had new personnel with other significant responsibilities on their plates.

It was further recognized that there were limits to the number of individuals that could be transferred out of nursing homes no matter who ran the program. First, you cannot transfer someone who does not want to transfer. Second, you cannot transfer people who have had one or more failed placements. Third, you cannot transfer somebody who may be at risk within the community, either because they might be provided insufficient services and supports, including unpaid family care, or have alcohol, substance abuse, or other problems that auger against successful placement. Fourth, it was inevitable that the number of potential transferees would decline over time after the "low hanging fruit" have been transitioned out. During the 18 months in which the Alliance ran the transition program (January 2009-June 2010), 133 nursing home residents were transitioned back into the community (DHS 2010-2012). In the state's first 18 months (July 2010-December 2011), 179 individuals were transitioned, approximately 30.0% of the 596 individuals initially referred to the Office of Community Programs for this purpose. Of those transferred by the state, 83.8% (150) have been transferred home with core HCBS and 12.3% (22) to assisted living.

3.c. Limited Ability to Monitor the Quality of Community Service Providers

Concern was expressed regarding the ability of the state's Department of Health to monitor the quality of care provided by an influx of new HCBS providers, particularly given recent staff reductions. Supported by advocates, the leading home care association in the state lobbied the General Assembly to adopt a two-year moratorium on new licensed home care agencies (Peoples 2010). This proposal was likely motivated, in part, by the economic self-interest of existing agencies who wished to prevent entry of additional competition into the RI market, thereby maintaining their own censuses and revenue streams. However, it was also

motivated, in part, by a genuine concern, both for the quality of care provided by new entrants into the market and the ability of the state's Department of Health to monitor it.

Dimension 4. Data & Information Issues

Despite recent initiatives, there is continued need for improvements in the information used to inform RI's efforts to rebalance the long-term care system, including level of care determination. Moreover, several additional data elements were identified which should be collected and reported, both routinely and as part of the state's monitoring and evaluation efforts.

4.a. Need to Improve the Information Used to Implement State's Rebalancing Efforts

It was felt that the provision of certain additional 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. In particular, both provider representatives and consumer advocates expressed concern about the data used to inform decisions under the state's new system for leveling long-term care applicants. As noted, DHS' Office of Medical Review was granted sole responsibility for reviewing and processing clinical levels of eligibility using the new level of care instrument developed by the state. One provider representative, for example, felt that the new instrument did not adequately account for the needs of individuals with Alzheimer's disease and other dementias. The result, it was feared, was potential limitation or denial of services to those who otherwise should get them.

A more general criticism pertained to DHS making leveling decisions via desk review of information collected and delivered to them by providers. Prior to the Global Waiver, DHS nurses determined whether or not someone met nursing home level criteria based on information providers submitted directly to the state on a commonly used form. Under the new system, providers perform an assessment, sends that information to the Office of Medical Review which, in turn, transfers the results onto a second form on the basis of which a level of care determination—"highest," "high," or "preventive"—is made. That the state now requires providers to submit information on a separate form than that used by the Office of Medical Review does not make sense to some observers. That the Office of Medical Review makes their determinations, typically without seeing the applicants, or taking into account applicants' preferences, did not make sense to others.

4.b. A Need to Improve Information Used to Evaluate State's Rebalancing Efforts

A recurring theme was the need to collect and report certain additional data elements over time for purposes of evaluating the state's rebalancing efforts. It was recognized, for example, that DHS/EOHHS had indeed released some basic data, including general trends in spending and utilization across nursing homes and HCBS settings. Thus, it was reported that the relative distribution of Medicaid expenditures between community-based and institutional services has remained steady during the waiver's first three years, both for elders (~15% community, ~85% institutional) and persons with disabilities (~41% community, ~57% institutional, 2% Tavares Pediatric Center) (excluding the developmentally disabled) (DHS 2010-2012; EOHHS 2011-2012). Most interviewees, however, wished the state would release more detailed data at more frequent intervals. This included data whereby cost savings attributable to rebalancing could be readily tracked and identified, as a provision in the state's Perry-Sullivan statute requires that a portion of any savings resulting from reduced use of Medicaid nursing home care be invested in HCBS. This also included weekly or monthly data on long-term care applicants and referrals and types and amount of services received across each of the major population groups served (e.g., the elderly, developmentally disabled).

Interviewees also expressed concern with some of the assumptions underlying the data that had been released. It was reported, for example, that of 16,665 level of care determinations that have been made between July 1, 2009 and December 31, 2011, 68.8% were assigned a "highest" designation, 25.1% a "high" designation, and 5.9% a "preventive" designation (DHS 2010-2012; EOHHS 2011-2012). It was also estimated that the state diverted 546 persons from nursing home placement between July 2010 and May 2011, including 84 persons identified through Connect Care Choice, the state's primary care case management program, and 480 assigned a "high" level of care, i.e., those believed to be eligible for nursing home care under the old leveling system but not under the new three tier process adopted (The Lewin Group 2011). The latter figure, however, is based on the assumption that 30% of those assigned a "high" level of care would have chosen a nursing home rather than a community-based placement if the option had been made available to them. A number of interviewees took issue with the seeming randomness of the criteria chosen for determining the number of diversions, suggesting that more objective criteria needed be employed when making such assessments.

More generally, interviews felt that state's emphasis on documenting general trends in spending and utilization, though useful, only told part of the story. What was missing was data on beneficiaries' experiences, both in terms of service scope and satisfaction and quality. Thus, in addition to the number of applicants, interviewees wished to see data on the number of nursing home referrals and number and types of HCBS referrals, including hours served. They also wished to see data on application processing times; that is, the number of days it took from when an application was submitted to when it was approved and services provided. The number of appeals and their outcomes and presence and size of program waitlists were identified as well; so too was the need for quality measures so that the consumer experience in long-term care settings could be documented and assessed, including with respect to quality of care and quality of life and satisfaction with the services rendered. Quarterly progress reports to CMS and the RI General Assembly have subsequently provided some, though by not all, of the additional data requested (DHS 2010-2012; EOHHS 2011-2012).

Dimensions 5. Provider Considerations

Lack of planning to ensure the availability of appropriate levels of community-based resources was highlighted. Whereas some pointed to signs that the HCBS and assisted living sectors had begun to take advantage of opportunities deriving from the Global Waiver, most were less optimistic. Nursing home providers generally recognized the need to increase use of HCBS options within the state, though reimbursement remained a significant concern.

5.a. Uncertainty about the Availability of Necessary Community-Based Resources

There was widespread doubt about the capacity of the provider community to serve greater numbers of clients under the Global Waiver (Needham and Gregg 2008; Goodnough 2009; McKay and Nyberg 2009). Interviewees expressed concern that there would be too few providers to meet the increased demand for services resulting from nursing home diversions/transitions. The general perception was that while some progress toward rebalancing had taken place, the state had not accomplished what it had hoped largely due to level of community-based resources available. Specific areas of concern included assisted living, subsidized housing, adult day services, home health care, transportation, and the paraprofessional long-term care workforce (McKay and Nyberg 2009; Woodcock, et al. 2010; RI Association of Facilities and Services 2010; Allen, Gozalo, and Steinman 2011). It was reported that the state lacked sufficient assisted living and other housing stock and that there were limited slots (and therefore long waitlists) available for the state's housing programs. It was reported that the

transportation needs of seniors and disabled people had yet to be addressed although problems in this area had long since been acknowledged. It was reported that many home care agencies might not be able to meet the weekend, overnight, and evening needs of an increasingly frail and debilitated service clientele; and that there was a need for additional standards and coordination, particularly given the influx of new providers. It was reported that additional attention needed to be paid to workforce development, training and compensation; otherwise, there might not be enough caregivers to go around even if the number of agencies proved sufficient.

Several interviewees pointed to a lack of planning on the part DHS/EOHHS to ensure the availability of appropriate levels of community-based resources. To their credit, DHS/EOHHS had contracted with The Hilltop Institute at the University of Maryland-Baltimore County to conduct resource mapping (Woodcock, et al. 2010). Unfortunately, The Hilltop report was not delivered until February 28, 2010, nearly nine months after implementation of the Global Wavier began. As such, the state began its nursing home transition and diversion programs well before it had a clear idea of what the capacity of the community was to meet the expected increased demand for services. Moreover, the results of The Hilltop study were not particularly useful, not least of which was because just 84 of the 268 providers of long term services and supports surveyed responded for an overall response rate of just 31%.

5.b. Community Providers Have Increased Capacity under the Global Waiver

Some believed HCBS and assisted living providers would rise to meet expected demand, particularly if accompanied by increased reimbursement. Indeed, it was reported that once the Global Waiver was approved businesses who had an interest in serving these populations began to take advantage of available opportunities. This is reflected in reported growth in (1) the number of home care agencies applying for licensure; (2) the number of nursing home operators converting nursing home beds to assisted living beds; and (3) the number of assisted living facilities willing to take Medicaid beneficiaries because while the rate of Medicaid reimbursement may be lower than private pay, the additional clientele was attractive, particularly for those facilities having trouble filling private pay beds. Increased utilization of DEA's assisted living program was also reported, which state officials attributed, in part, to the nursing home transition and diversion efforts conducted under the waiver's auspices. In addition, the Global Waiver enabled the state both to expand its shared living program for the developmentally disabled and to establish shared living as an option for seniors and other disabled adults.

5.c. Community Providers Have Not Increased Capacity under the Global Waiver

Most interviewees were less sanguine about the responsiveness of the market to the Global Waiver. It was reported that most community-based providers had experienced little to no increase in their censuses since the waiver began. Thus, while some adult day care centers may have had experienced growth in the number of Medicaid recipients served, most censuses had remained flat, having not seen an increase in referrals (RI Association of Facilities and Services 2010). It was argued that if most new HCBS referrals derived from nursing home transfers and diversions, reimbursement rates would need to increase to better reflect the growing acuity and complex service needs of the population served. Thus, rather than paying adult day centers a single rate, multiple rates might be developed to better account for the varying resource needs of the clients cared for, including, for example, high rates for those requiring wound care, heavy medication management, and glucose monitoring.

The general perception was that it would be difficult to bolster provider payments to those levels necessary to spur investment due to the current fiscal climate (McKay and Nyberg 2009). Planned rate increases for home care have been delayed. While adult day providers

received a funding increase under the prior Perry-Sullivan legislation, it was felt that this increase was inadequate and, as such, additional increases were required. Progress increasing access to assisted living has also been stymied by low reimbursement (McKay and Nyberg 2009; New England State Consortium Systems Organization 2009; RI Association of Facilities and Services 2010). Indeed, it was reported that only about one-third of the state's assisted living facilities accept Medicaid. Assisted living facilities receive two payments from Medicaid beneficiaries—one for board and care, which comes from the beneficiary, and the other for the services rendered, which comes from Medicaid. Combined these two payments cannot compete with what an assisted living facility can receive from a privately paying client.

5.d. Nursing Homes Did Not Actively Oppose the Global Waiver

Clearly, a major goal of the Global Waiver was to reduce the number of Medicaid long-term care recipients using nursing home care. Not surprisingly, there was some concern among nursing home operators, though most in the industry acknowledged that rebalancing was going to happen nonetheless. It was widely recognized that RI ranked near the bottom of states vis-à-vis the proportion of Medicaid spending directed toward non-institutional long-term care options despite prior initiatives aimed at making progress in this area. Some corners of the industry further recognized that there was a limit to how much the nursing home sector could be downsized given the aging of the state's population, and that the new level of care system and nursing home transition and diversion programs had not had much of an impact so far. Moreover, whatever concerns the industry had about these provisions were overshadowed by promulgation of a new acuity-based reimbursement system that concomitantly reduced overall expenditures within the sector.

Both the state and industry recognized that if comparatively lower care residents were transferred or diverted, nursing homes would be left with a frailer, sicker, higher acuity population. Thus, there was general agreement that the base nursing home payment rate should be adjusted for resident acuity to better account for the amount of resources nursing homes devoted to caring for their residents (McKay and Nyberg 2009; New England Consortium Systems Organization 2009; RI Association of Facilities and Services 2010; RI Health Care Association March 29, 2010). The nursing home industry, however, was troubled by the state's intention to pay a fixed price for the direct nursing component of their base rate, regardless of actual costs, based on the median cost in this area across all facilities during the previous year (RI Health Care Association January 5, 2010, March 29, 2010). The industry was concerned not only by the generation of winners/losers resulting from this change, i.e., those with costs below/above the median cost, but also from a simultaneous $2.6 million reduction in total state and federal nursing home funding (RI Health Care Association January 5, 2010). Still others were concerned about the potential impact of such a reduction on nursing home staffing and quality, particularly at a time when facilities were being asked to serve an increasingly fragile clientele. State officials countered that the proposed reduction was quite small given the total amount expended on nursing home care in the state.

Lessons for Long-Term Care Rebalancing

Rhode Island's experience provides lessons for states looking to make progress toward rebalancing long-term care, particular given incentives and options contained within the Affordable Care Act aimed at spurring state action in this area. Specific lessons include: (1) understanding that progress toward long-term care rebalancing will be slow in states where nursing home spending has previously predominated; (2) recognizing that there are considerable

challenges to rebalancing long-term care during adverse fiscal circumstances; and (3) learning that documenting and promoting sufficient provider capacity is critical to program success.

Rebalancing Occurs Slowly in State's Where Nursing Home Care Currently Predominates

Rhode Island would seem to be an ideal state with which to make progress on rebalancing given so little use has traditionally been made of services provided in the home- and community-based sector. While many felt that the Global Waiver was unnecessary—that the state's existing 1915(c) waivers were enough—consolidation under a single authority did serve a useful role in placing the issue more firmly on the state's policy agenda. Thus, on the plus side, the waiver has provided a framework which has served to organize discussions, consolidate initiatives, and spur progress on state efforts to rebalance the long-term care system, an area many felt the state had finally made tangible advancements on after years of limited gains.

Indeed, there is evidence to suggest that RI's rebalancing efforts have had some impact, though these trends largely began before the Global Waiver was implemented. The Lewin Group (2011) identified a 3.0% reduction in the average number of monthly nursing home users between state FY's 2008 and 2010 (from 5,565 to 5,398). Although annual nursing home expenditures generally remained steady, increasing by only 0.8% (from $296 to $299 million), total nursing home days declined as the cost per resident per day increased by 4.4% (from $148.03 to $156.80), suggesting growing acuity among the population served. By contrast, the average monthly number of HCBS users grew by 9.5% (from 3,082 to 3,375) concomitant with a 45.1% increase in annual expenditures (from $42.8 to $54.0 million).

These findings are reinforced by a Brown University study which found a 10% reduction in the proportion of new nursing home admissions that remain institutionalized for more than 90 days, from 63% to 53%, between 2008 and 2010 (Allen, Gozalo, and Steinman 2011). There was also evidence of increased activity of daily living (ADL) impairment both among new nursing home entrants and those staying institutionalized for longer than 90 days, particularly among those admitted directly from the community. Furthermore, the proportion of admissions from home defined as "low care"—that is, with no late loss ADLs—declined from 5.2% to 2.5% and 10.9% to 6.1%, respectively, among short and long stay residents. Together these results suggest a modest impact of RI's rebalancing initiatives, especially with respect to increased acuity among the state's nursing home population and reduction in the proportion staying long term, though one-quarter of long stay residents continued to be characterized as "low care."

Although there seems to have been some forward movement in expanding the use of HCBS since implementation of the Global Waiver began, the distribution of long-term care spending in RI continues to be weighted heavily towards nursing home care. That overall spending has remained largely stagnant suggests just how difficult it can be for laggard states that have historically spent substantially more on nursing home care to make more than marginal progress even with the provision of additional options and incentives that otherwise should promote rebalancing. This does not bode well for the success of the Affordable Care Act's rebalancing provisions, even among states, like Rhode Island, that seem highly motivated, either for cost or programmatic reasons, to shift spending from nursing homes to home- and community-based settings.

The Affordable Care Act seeks to address Medicaid's continuing institutional bias and to reduce prevailing interstate variation in this area by incentivizing and extending a number of Medicaid HCBS based options. Most importantly, it provides additional financial incentives and options for states to expand HCBS under Medicaid, including the State Balancing Incentive Payments program, which provides for enhanced federal matching payments from 2011 to 2015

for states increasing the proportion of spending in this area; a new Medicaid state plan option for attendant services and supports known as the Community First Choice Option; and modifications to the little used 1915(i) state plan option first promulgated under the Deficit Reduction Act of 2005. The Affordable Care Act also extends mandatory spousal impoverishment protections to community-based spouses of people receiving HCBS, provides additional funding for Aging Disability Resource Centers, and extends Money Follows the Person while shortening the length of nursing home residency required for participants to qualify for the program.

Our findings are consistent with Harrington, et al.'s (2012) argument that although providing important options and incentives for states to expand HCBS under Medicaid, the impact of the Affordable Care Act will be limited. Most importantly, unlike nursing home care, HCBS remains an optional benefit that states may offer to a restricted number of participants, according to geographic location, target group, and/or the specific types of services required. Moreover, the income level at which individuals can qualify for HCBS benefits continues to remain lower than the levels established for nursing homes (up to 300% of the Supplemental Security Income benefit in most states) (Ng, et al. 2012). Furthermore, Medicaid may not pay for room and board for those receiving HCBS, nor can room and board be counted for purposes of spending down to Medicaid eligibility as a result of the incurrence of large medical expenses under state medically needy programs (Watts and Young 2012; Woodcock, et al. 2011).

Besides leaving investments in HCBS especially vulnerable to the vagaries of state budget and political processes (Harrington, et al. 2012; Woodcock, et al. 2011), the optional nature of these programs and the continuing absence of minimum standards and requirements to cover all geographic areas and target populations suggests persistent unmet need, both within and across states. This combined with varying dispositions for making necessary structural and administrative changes to expand HCBS and to qualify for additional federal matching support provided under the Affordable Care Act suggests continuation of substantial cross-state variation in the amount of progress states make toward long-term care rebalancing.

Recognizing Challenges to Rebalancing Posed by Adverse Fiscal Circumstances

At the height of the recession, states continued to expand access to HCBS but the pace of expansion slowed while additional cost and utilization controls were added to the waitlists, enrollment caps, and coverage limits already in place (Smith, et al. 2010). Nationally, state waitlists for 1915(c) waiver services grew. Just before the recession, from 2006 to 2007, the number of individuals on waitlists declined by 7% (Ng, et al. 2012; Ng, Harrington, and Howard 2011). At the start of the recession, however, from 2007 to 2008, the number on waitlists increased by 17%; a year later, from 2008 to 2009, by 19%. Currently, there are more than 511,174 waiting for 1915(c) waiver services in 39 states, with average waiting times extending more than two years (25 months). There have also been cutbacks to both Medicaid- and non-Medicaid funded HCBS services during this time period (Center on Budget and Policy Priorities 2010; Mollica, et al. March 2009; Shishkin 2008; Walls, et al. 2011).

Home- and community-based services providers are at a disadvantage in the competition for scarce resources. Thus, although general consensus exists about the desirability of rebalancing long-term care (Miller, Mor, and Clark 2010; Grabowski, et al. 2010), HCBS options are at particular risk during periods of fiscal retrenchment. Not only is nursing home care a mandatory service but the nursing home industry' is one of the most powerful lobbies in state government (Hrebenar and Thomas 1998-2007; Miller 2006a; 2006b; Miller and Wang 2009a, 2009b; Miller, et al. 2012; Nownes, Thomas, and Hrebenar 2008). Perhaps the strength of the nursing home lobby is best reflected in the Hrebenar-Thomas study in which hospital and

nursing home associations were ranked the fifth most influential interest across the fifty states in 2007 behind business, teacher, utility, and manufacturer interests (Nownes, Thomas, and Hrebenar 2008). By contrast, senior citizens/AARP, the closest proxy for HCBS providers given strong preference for rebalancing among the elder advocacy community (Miller, Mor, and Clark 2010; Grabowski, et al. 2010), were thirty-ninth most influential, next to last on the list, just ahead of pro-tobacco interests. Being heavily dependent on Medicaid for revenue, nursing homes have been especially active in trying to influence policy in this area, with such activity being associated with Medicaid policies affecting nursing home spending, eligibility, enforcement, and reimbursement (Barrilleaux and Miller 1988; Grogan 1999; Harrington, Mullan, and Carrillo 2004; Miller 2008; Miller 2006a, 2006b; Miller and Wang 2009b; Miller, et al. 2012).

Home- and community-based services providers are also at a comparative disadvantage given the way annual increases in provider reimbursement are structured. Costs from which provider reimbursement levels are derived must be inflated forward to account for changes in market conditions. This can be accomplished through legislatively determined adjustments and/or nationally or locally derived indices previously written into statute or state regulation (Miller, et al. 2009). This is an important distinction because annual legislative authorizations are quite different than building an inflation method into the law or regulation that will be applied regardless of state fiscal circumstances. The latter method, which is often indicative of state nursing home reimbursement systems, tends to propel annual payment increases that, in turn, encourage steady growth in spending (Woodcock, et al. 2011). The former, which is often indicative of state systems for reimbursing HCBS providers, tends to retard annual payment increases that, in turn, discourage consistent growth in spending on such programs.

Home- and community-based services providers are at a further disadvantage in that most states (44) have adopted nursing home provider taxes, which enables them to draw in additional federal matching funds without concomitant increases in state expenditures, thereby helping bolster nursing home provider payment levels (Kaiser Family Foundation 2013; Miller and Wang 2009b). A provider tax enables states to collect revenue from providers, which is then used to pay for services rendered to Medicaid recipients, thereby leveraging federal matching dollars without additional state expenditures. Although providers cannot be "held harmless," meaning that states cannot guarantee return of 100 percent of providers' contributions, taxes limited to 6% of providers' gross revenues can be returned in the way of increased reimbursement without violating federal prohibitions. Few, if any states have adopted provider taxes for purposes of boosting payments to HCBS providers.

There are also challenges associated with the short-term investments necessary to get state HCBS programs off the ground. Expansion has been driven, in part, by widespread belief that HCBS saves money relative to institutional services due to substantially lower per capita costs. This belief that rebalancing saves money is prevalent despite evidence suggesting that HCBS expansion can increase overall costs if services are not adequately targeted toward those who otherwise would have had entered a nursing home. Inadequate targeting combined with the presence of substantial unmet need can result in large numbers of potential beneficiaries coming out of the "woodwork," a challenge long thought to hamper the cost-effectiveness of HCBS programs (Grabowski 2006; Weissert 1993). Recent research suggests that only when nursing home admissions are avoided does investment in HCBS payoff from a cost-effectiveness perspective (Kaye, LaPlante, and Harrington 2009). It also suggests that expanding HCBS requires short-term increases in expenditures before institutional spending declines and long-term cost savings achieved (Kay, LaPlante, and Harrington 2009; Mollica, et al. March 2009).

Rhode Island has adopted a number of strategies with which to promote proper targeting. These include adoption of the new three-tier level of care eligibility determination system—"highest," "high," and "preventive, with only those deemed "highest" being entitled to nursing home care, though those deemed "high" had previously been eligible as well. These also include creation of a central inter-agency mechanism—the so called Assessment and Coordination Organization—for making level of care determinations, supporting community-based placements, implementing consistent case management practices, and conducting high cost case reviews. Tasking an on-site RN to collaborate with hospital social workers through the state's primary care case management program to identify Medicaid beneficiaries who might be discharged safely back into the community has contributed to the state's targeting efforts as well.

The need to make short-term investments in the interest of obtaining subsequent longer term savings has proven somewhat problematic, however, as RI has sought to expand use of HCBS during the economic downturn. This, perhaps, is the major reason why the state did not make more progress rebalancing long-term care than it has to date. Community stakeholders, for example, were concerned about the state's decision to forgo a $400 increase in the monthly income allowance to help defray necessary housing, transportation, and other costs. While perhaps making short-term budgetary sense, this decision hampered beneficiaries' ability to remain at home and in the community. The same is true for substantial reductions in state administrative personnel, which while serving in part to address the state's short-term budget deficit, made implementation of the Global Waiver more challenging by comprising the state's program planning, applications processing, quality monitoring, among other functions. Lack of sufficient numbers of experienced state personnel is particularly problematic for the regulatory sphere. There is the general perception that quality standards and measurement may not be as well developed in home care as in nursing homes (Miller, Mor, and Clark 2010; Mor, Miller and Clark 2010). It is also easier to monitor care provided to several hundred people being cared for in a single nursing home than the quality of care provided to the same number being cared for in their own homes by unsupervised staff.

Documenting & Promoting Sufficient Provider Capacity

There is substantial variation in long-term care policy and market characteristics, both within and across states. This variation is reflected in differences in the policies that state and local governments adopt, say, with respect to Older Americans Act programs, state-only funded initiatives, and, of course, Medicaid, whether in relation to provider regulation, payment, eligibility, benefits, and overall spending (Feinberg, et al 2004; Ng, et al. 2012; Howard, Ng and Harrington 2011; Kitchener, et al. 2007; Miller 2002; Synder, et al. 2012; Reinhard, et al. 2011; Woodcock, et al. 2011). It is also reflected in differences in the demand and need for care; for example, the number and proportion of chronically ill and frail elders, adults with physical and developmental disabilities, and children with special health care needs; as well as differences in the need for government assistance, perhaps as best indicated by the unemployment rate and proportion of individuals at or near the poverty level (Synder, et al. 2012; Reinhard, et al. 2011). It is further reflected in differences in service supply, whether family caregivers (Arno 2006), nursing homes (Harrington et al. 2008; Harrington, et al. 2011), assisted living facilities (Mollica September 2009; Stevenson and Grabowski 2010), home care agencies (Centers for Medicare and Medicaid Services 2011), adult day care centers (Rosato, Lucas, and Howell-White 2005); home health and personal care aides (Seavey and Marquand 2011); and options for transportation and housing (Farber, et al. 2011). The costs of care vary substantially as well (Metlife Mature Market Institute 2012; Reinhard, et al. 2011).

Rhode Island's experience suggests the importance of documenting and accounting for prevailing provider capacity, particularly if the goal is to markedly increase use of non-institutional alternatives to nursing home placement. The lack of capacity among community providers to serve significantly greater numbers of clients was one reason observers believed that the state had not progressed further rebalancing the long-term care sector. This is something that state officials would have been aware of and, perhaps, been able to address proactively had resource mapping been undertaken before rather than after beneficiaries started to be diverted and transitioned, and if more providers had elected to participate once resource mapping did take place. Clearly, prospectively documenting provider capacity is important because if the plan is to rely more on HCBS resources it is critical that the extent to which those resources are able to meet the complex care needs of an increasingly larger service clientele be assessed. It is also critical that every effort be made to achieve as high a response rate as possible if survey methods are used, perhaps through some sort of financial incentive or other inducement.

Rhode Island's experience also highlights the need to think broadly about the providers needed to successfully keep potential nursing home residents at home and in the community. This includes ensuring that there are sufficient numbers of high quality assisted living facilities, adult day care centers, and home care agencies, both available and willing to participate in Medicaid. It also includes ensuring the recruitment and retention of sufficient numbers of home health and personal care aides, whether they work independently or for an agency or facility, if the growing demand and need for care is going to be met. Ensuring the availability of affordable housing and transportation options is critical as well. Prior research suggests just how important overcoming transportation barriers, both in terms of service scope and assistance, and limited housing options, both in terms of affordability and accessibility, can be to ensuring the success of state's rebalancing initiatives (Farber, et al. 2011; Libson 2006; Robinson, et al. 2012; Rosenbloom 2009; Wardrip 2010). Although still small, RI's new shared living program holds promise in this regard by permitting Medicaid beneficiaries to receive personal care, homemaker, transportation, and other services provided by a host caregiver/home, which may include a friend, relative, or neighbor other than a spouse/guardian.

Thinking broadly about providers further requires efforts on the part of policymakers to ensure the necessary resources have been put into place to connect individuals and families to needed services and supports. Rebalancing long-term care increases the burden on unpaid caregivers for unlike nursing home care, very few HCBS programs pay for room and board or 24/7 care and supervision (Miller, Allen and Mor 2008). Moreover, unlike nursing home care, few HCBS programs provide all the services necessary to meet individuals' needs. Instead, care recipients must typically find and coordinate services provided by multiple sources, a considerable challenge during periods of crisis (Kaiser Family Foundation December 2007). Strategies adopted in RI to inform client decision making reflect this perspective. These include efforts to better educate hospital discharge planners and other long-term care referral sources about service and housing options in the community, including updates to the state's Rite Resources Web-Site which provides up-to-date information on the services and supports available. These also include efforts to improve the state's Aging Disability Resource Center, The Point, as a "one-stop-shop" where individuals, families, and providers might obtain the necessary to make appropriate care decisions.

Rhode Island's experience further highlights the special importance of provider reimbursement. Most observers in Rhode Island felt that the market had not responded to expected increases in demand, primarily because the level of reimbursement continued to remain

low, especially in light of heightened acuity and complexity among the population served. This suggests the importance of investing additional state dollars to build up the community network of providers, although doing so is yet another supportive measure that is difficult to undertake during challenging economic times. It also suggests the desirability of paying providers multiple rates that better account for varying resource needs and, in so doing, promote access among the more difficult cases that otherwise would have entered a nursing home. Evidence strongly suggests that it is primarily payment issues that explains why assisted living facilities choose either not to participate in Medicaid or to restrict their participation if they do (Carlson and Coffey 2010; National Senior Citizens Law February 2011).

Rhode Island's experience suggests that under certain circumstances the nursing home industry may come to accept, or at least not actively oppose, rebalancing. Although RI's nursing home operators expressed some concern about the loss of Medicaid revenue, they recognized that rebalancing was going to happen given the marked spending imbalance in favor of nursing homes in the state. They also believed that there were limits to how much the industry could be downsized both in light of population aging and because good transfer candidates would become increasingly scarce over time. Moreover, nursing homes in RI, like in other states, have increasingly relied on alternative revenue sources deriving from a growing volume of short-term post-acute and rehabilitative patients (Decker 2005). Thus, at the same time revenue deriving from Medicaid has declined with the growth of assisted living and other HCBS options, the proportion of revenue deriving from Medicare's skilled nursing benefit has risen.

Another important consideration for the nursing home sector is adjustment of reimbursement for resident acuity. Diverting or transferring relatively low care cases from nursing homes leaves a frailer, more resource intensive long stay population behind. Explicitly accounting for resident acuity in a state's reimbursement system, therefore, should help increase nursing home buy-in where rebalancing is concerned. Of course, the manner in which major reimbursement policy changes such as case-mix is instituted matters in this regard (Miller and Wang 2009a, 2009b; Miller, et al 2012). That RI's case-mix system disproportionately benefited certain industry segments and was adopted with a small reduction in overall payments made adoption more contentious than otherwise would have been the case. A certain degree of contention may be unavoidable, however. It is the rare reimbursement change that does not generate winners/losers or results in increases in overall payments in the current fiscal climate.

Limitations

We note several potential study limitations. First, we studied long-term care 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 long-term care 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 additional issue areas beyond long-term care rebalancing.

Conclusion

Federal and state officials have sought to rebalance long-term care away from institutions toward home- and community-based settings with the intention of providing services and supports in the most preferred, least costly settings possible. This desire to shift the locus of care will only grow with intensity as the prevalence of functional and cognitive impairment increases with population aging. Whereas the number of Americans 65 years or older will increase from 38.9 to 88.5 million between 2008 and 2050, the number 85 years or older will increase from 5.7 to 19.0 million during this time period (Federal Interagency Forum 2010). If the needs of this future cohort of elders are to be met it is critical that extant deficiencies with the nation's long-term care system be addressed. Most (83.8%) long-term care specialists nationally report favoring rebalancing as one strategy for improving service delivery in this sector, including nearly all consumer advocates (91.0%), government officials (89.6%), policy experts (92.8%),and non-nursing home provider representatives (84.8%); even half (47.3%) of those representing the nursing home sector report favoring rebalancing (Miller, Mor and Clark 2010).

Despite seeming consensus about the need to increase use of home- and community-based resources, some states have made substantially more progress rebalancing than others, with for example, the proportion of Medicaid long-term care expenditures directed toward non-institutional care for elderly and physically disabled Medicaid recipients ranging from 4.4% in Rhode Island and 10.2% in North Dakota to 62.1% and 78.7%, respectively, in Washington and New Mexico (Eiken, et al. October 31, 2011). Findings suggests that the rebalancing provisions of the Affordable Care Act will likely fall short in laggard states such as RI despite the provision of additional options and incentives for doing so. Because nursing home care continues to be a mandatory benefit while most HCBS remains an optional benefit that states may provide within particular geographic areas to specific target populations, investments in HCBS remains especially vulnerable to the vagaries of state budget and political processes. This suggests persistent variation in the proportion of long-term care spending on home- and community-based settings, both within and across states. For those states wishing to make progress, however, RI's experience with the Global Waiver provides several lessons. These include prospectively documenting provider capacity to ensure that sufficient resources are made available to meet the complex care needs of an increasingly larger service clientele, increasing reimbursement to attract sufficient numbers of participating providers, and maintaining sufficient numbers of state regulators for purposes of monitoring quality.

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Table: Major Themes across the Five Major Dimensions Examined with Illustrative Quotes

Dimension 1: Waiver Design Issues

1.a. Long-Term Care Rebalancing Through the Global Waiver Was Viewed as a Way to Save Costs

"[The Global Waiver was sought b]ecause of the large share of the costs…and the large share of people [in nursing homes and because] nobody was completely satisfied with that part of the delivery [system]." (Legislative Staff)

"Clearly we need to save money because…nursing home care is one of the big cost drivers in Medicaid…So there's a reality to need to do that but as a benefit of that reality we were able to look at innovative ways to use home and community care services, which is really a good thing." (State Official)

"On the long-term care side the state was really quite far behind, despite whatever efforts had been put in over the years…It was another one of those things which I term all talk and no action...A lot of work, a lot of talk, a lot of planning, but not a lot of doing." (State Official)

"While rebalancing long-term has been on the table for years and years it wasn't really moving forward and quickly…Since that was sort of the cornerstone of the waiver, it has really put the department on the hook to move that forward. So, I see that as another value of the waiver, even though it could have happened without the waiver." (Consumer Advocate)

1.b. Mixed Feelings about the Need of a Global Waiver to Rebalance Long-Term Care System

<u>The Global Waiver Was Not Necessary to Rebalance the Long-Term Care System</u>

"We…noted at the time that rebalancing long-term care could be done without this comprehensive Global Waiver that had a lot of unknowns to it; for example, it could possibly be done by a separate 1115 waiver or some changes to the 1915(c) waiver process." (Consumer Advocate)

"[State officials] could have actually done 90 percent [of what they sought to achieve through the state's] existing waivers and state plan amendment." (Consultant)

"[The government] could have rebalanced the long-term care system without the Global Waiver." (State Official)

The Global Waiver Was Necessary to Rebalance the Long-Term Care System

"The good thing about having a bigger long-term care waiver is it pushes the conversation… The people who have been having this conversation for 20 years all of a sudden have an actual way to make it work and a financial incentive to make it work, which they'd never had before." (Executive Branch Official)

"While rebalancing long-term care has been on the table for years and years it wasn't really moving forward and quickly…Since that was sort of the cornerstone of the waiver, it has really put the department on the hook to move that forward. So, I see that as another value of the waiver, even though it could have happened without the waiver." (Consumer Advocate)

1.c. Uncertain Implications of the Global Waiver for Certain Populations

Global Waiver Viewed Less Favorably in Relation to Non-Elderly Populations

"It's been a little bit frustrating from the DD perspective to be kind of grouped into this rebalancing initiative, when in fact, we do provide community-based services and have for years." (Provider Representative)

"'We're going to go to more community-based care…The community mental health system's been about the community-based care since the beginning and we're like, 'how are you going to get another couple million out of us doing that?" (Consumer Advocate)

"Most of [the state's] Medicaid services have been community based…We really don't have large institutions here, so in some respects Rhode Island is a little ahead of the curve….in terms of the kinds of supports it provides to people with disabilities." (Consumer Advocate)

Global Waiver Viewed More Favorably in Relation to the Elderly

"Groups concerned about long-term care for seniors may have had a different initial reaction than the children's groups and groups in mental health and developmental [disabilities] because of the fact that there had been ongoing stakeholder meetings with DHS about how to achieve rebalancing." (Consumer Advocate)

"I had confidence in that process that we used and in the people who were in that small group that we would do what we could do to—I'm going to use the word, [to] 'protect' consumers." (Consumer Advocate)

Oversight Legislation Included Protections for Current Nursing Home Residents

"If a person was in a nursing home we weren't going to be able to touch them…unless they explicitly said they wanted to move out. We'd have to use our old level of care every time we assessed them." (State Official)

"If someone's 'highest' in a nursing home…and now they level that person as 'high,' the person's out of the nursing home…Well, they've sold their home…Where are they going to go? They have to re-establish an apartment? Get pots and pans? Learn to cook again? Think about it." (Provider Representative)

"So, there is some protection but it's not the broad protection of who's in a nursing home on this date, 'I agree to go out, I'm always entitled to go back in.'" (Consumer Advocate)

Dimension 2: Fiscal & Budgetary Considerations

2.a. Policy Decisions Weighted More Toward Containing Costs Than Programmatic Improvements

"I'm not sure if those 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)

2.b. Indirect Impacts of State Fiscal/Budgetary Crisis on Global Waiver Implementation

"What's happening is that because of the state budget crisis people are slower to get services and sort of, again, the state is just trying to save money, so it's not acting on applications as quickly as previously, and we lack information about the scope of services that people are getting." (Consumer Advocate)

"I firmly believe that some of the changes that we're making will result in a better system, a more transparent system, and a better level of care for individuals. If we were doing that without attempting to achieve savings, this would be a piece of excellent work. Unfortunately, we are doing it under the umbrella of attempting also to provide a savings target that, yes, has presented a lot of stress both to the community and for our own staff, as well." (State Official)*

2.c. CNOM Dollars Have Helped to Ameliorate the Impact of the Fiscal Crisis on Long-Term Care Rebalancing under the Global Waiver

"The greatest thing that came out of it for the state was the CNOM areas where they were able to grab Medicaid dollars that they hadn't been able to get before." (Provider Representative)

"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)

"The Global Waiver allowed us…[to fund] the [co-pay] program at a slightly higher level [and accrue] savings [in] general revenue funds, because we had the federal match, so we were extremely happy that it was accepted and approved by CMS…to qualify as a CNOM." (State Official)

"Every year in the past it's been frozen…as the state sort of ran out of money as the fiscal year went on but as part of the waiver that population became eligible for a federal match…and at the end of the day, they've seen a slight budgetary increase and they haven't had problems with the waiting lists for the last two years. [That's] probably one of the main, big successes of the waiver for the home and community based providers." (Provider Representative)

Dimension 3: Administrative Issues

3.a. General Challenges Deriving from Reductions in State Administrative Staff

"They don't have a lot of resources to actually get things done, so it's tough for them." (Consultant)

"If you look at the numbers of people that were available a couple of years ago to what's available now, it's pretty frightening" (Consumer Advocate)

"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)

3.b. Challenges Administering the State's Nursing Home Transition Program

"[I'm] concerned about…not putting a lot of additional burden on staff that's already stretched out…[The state's decision] creates confusion in me because I still know people over at DHS and I know that they are high level of stress. I know that they don't have the personnel necessary to do day-to-day functioning." (State Legislator)*

3.c. Limited Ability to Monitor the Quality of Community Service Providers

"In the last 15 months [there have been] 14 new applications [from home care agencies looking to enter the state]. We could be up to 76. Give me a break! The Health Department's staff is probably down a third, the ones that are supposed to be overseeing these people." (Provider Representative)

"It's fine do all these things, but Health has one inspector doing home care and they're swamped…If you start putting all these people in home care agencies, how is anybody going to monitor it?...If you got 50,000 agencies opening up, there's no way you can keep track of them and there's no way to know what they're all doing…You want to do all this stuff and then you cut the legs out from the state agencies. I mean, you need people to be able to do these things." (Consumer Advocate)

Dimension 4: Data & Information Issues

4.a. ***Need to Improve the Information Used to Implement State's Rebalancing Efforts***

"The level of care form is unfair to those that have dementia and related diseases…It doesn't really correlate the fact that many folks with dementia actually are very capable with their [activities of daily living] and yet can't make good decisions and would wander into the streets." (Provider Representative)

"There's no allowance for client participation. This assessment is done blind, by a nurse in an office, who gathers medical information about this person. Never once is the customer or client asked what they want or what they think they need." (Provider Representative)

4.b. The Need to Improve the Information Used to Evaluate State's Rebalancing Efforts

"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?..Now, I'm not saying it's not happening; I'm just saying I haven't seen it…That's the transparency issue." (Consumer Advocate)

"It's a lot of really loose assumptions that are the basis for what they report out as their success. If they put somebody in a high category and that person's living at home, they take some percentage of that and say well that person would have gone into a nursing home if we hadn't done this. Well, who knows if they would have gone into a nursing home or not…It's never really been understood how they came up with that and how much they're actually doing." (Provider Representative)

Dimensions 5: Provider Considerations

5.a. Uncertainty about the Availability of Necessary Community-Based Resources

"You can't move people out of a high level of care into the community without a sufficient safety net to assist them and I think some of it may be that those community based resources were not all in place, or at least not to the extent that would be needed to support the influx that was anticipated." (Provider Representative)

"If I'm a car company and my designers design a car, at some point those designers have to talk to the production people, because they can't design something with materials that don't exist…And then they've got to test that design with the consumers that are going to use it. This is just business school 101. None of that went on with this. These guys just made stuff up with no regard for what the system could actually do." (State Official)

5.b. Community Providers Have Increased Capacity under the Global Waiver

"[We] believed that home care providers would put people on their payrolls and train them if there was opportunity to pay them for it and I haven't heard of too many instances that that hasn't been happening. Adult day providers were a limited source and they need some brick and mortar, but again, if we were able to find slots for those individuals and maybe give them additional funding…they would open their doors." Still others pointed to a "profusion of new home care agencies starting up, new assisted living, new adult day care." (State Official)

5.c. Community Providers Have Not Increased Capacity under the Global Waiver

"Adult day services [currently receives] one straight rate. One thing that could be done that would be helpful is to provide for an enhanced rate for those adult day programs that are serving persons with dementia…[or]…who need skilled care." (Consumer Advocate)*

"One of the ways you build capacity in the community is look at the rates that you're currently paying community providers…If you're actually trying to attract more people into that line of business then maybe…put together a series of incentives that would help them to make a decision to come into that marketplace. There's no resources for doing that." (Provider Representative)

"Adult day health in Rhode Island has had one of the lowest funding rates [in the nation]…[though] just last year [it] got a pretty significant rate increase…from about $40 a day to about $50…But it is still far below other states." (Provider Representative)

"Assisted living is like the linchpin of rebalancing "[but] it's just not available yet…Medicaid pays assisted living $1,830 a month and most assisted [living facilities] charge their private residents maybe twice that. It's not an inviting thing if you're an assisted living provider." (Provider Representative)

5.d. Nursing Homes Did Not Actively Oppose the Global Waiver

"The industry might undergo some contraction, but given the demographics of Rhode Island, for example, there's, I think, a limit to how much it can downsize, and so the concerns would be maintaining a quality viable industry, while it happens. There's no putting your head in the sand. Rebalancing was happening with or without the waiver anyway." (Provider Representative)

"In moving from a cost to price based reimbursement system, they're just sort of taking it from one and giving it to another; redistributing the same dollars in a fashion that really has very little to do with resident acuity." (Provider Representative)

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*Quote derives from legislative hearing