National Oversight of Sub-National Policy Making in Long-Term Care: Rhode Island's Global Medicaid Waiver

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University of Massachusetts Boston

International Conference on Evidence-Based Policy in LTC, September 5-8, 2012

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Funding

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Investigative Team

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About Medicaid

- **Medicaid Program**
  - Jointly funded by the federal and state governments
    - Federal Government: 50 to 83% of Program Spending
  - State administration within broad federal parameters

- **Medicaid Long-Term Care**
  - ~1/3 of Medicaid program spending
  - ~70% directed toward institutional care for aged/disabled

About Rhode Island Medicaid

- **Constitutes ~25% of State Budget (SFY '06)**
  - $800 million in general revenue
  - Projected structural deficit >$350 million over 5 years
  - Medicaid Growth >>>> General Revenue Growth

- **Medicaid Long-Term Care Spending (SFY '06)**
  - 11% toward home- and community-based services
  - 89% toward nursing homes

Medicaid Waivers

- **Traditional Authority: The State Plan**
  - Permits receipt of federal funds
  - Requires state to adhere to certain requirements
- **Waivers**
  - 1915(b) (Managed Care), 1915(c) (HCBS)
  - 1115 ("Research and Demonstration")
- **Rhode Island Prior to the Global Waiver**
  - State Plan
  - 1 1115 (RIte Care)
  - 9 1915(c) (e.g., Aged & Disabled, Assisted Living)
  - 1 1915(b) (RIte Smiles)

Major Goals

- **Rebalance the Publicly-Funded LTC System to Increase Access to Home- and Community-Based Services and Supports and to Decrease Reliance on Institutional Stays**
- **Ensure all Medicaid Beneficiaries Have Access to a Medical Home Whereby Primary and Acute Care is Managed and Coordinated with Other Services and Supports**
- **Procure Medicaid-Funded Services Through Cost-Effective Payment and Purchasing Strategies That Align with Programmatic Goals**

Other Stipulations

- **Determine If the Use of Federal Medicaid Matching Funds for Otherwise Non-Eligible Populations and Services is Cost Effective**
  - Costs Not Otherwise Matchable (CNOM)
- **Make the Level of Federal Oversight and Scrutiny Commensurate with the Scope of Future Program Changes**

Federal Fiscal Certainty

- **$12.075 Billion Total Spending Cap Over 5 Years**
  - Based on historical caseload and utilization trends
  - Accounts for 7.813% rate of program growth
  - Keeps traditional matching structure intact
- **Keeps Traditional Matching Structure Intact**
  - State is at risk for spending about the cap

Rhode Island Waiver Timeline

- **Application Submittal: August 8, 2008**
- **Initial Federal Approval: December 19, 2008**
- **Final Federal Approval: January 16, 2009**
- **State Implementation: July 1, 2009**
- **Expiration: December 31, 2013**

Objective

- **To Conduct a Formative Evaluation that Identifies Factors Facilitating/Impeding the Design and Implementation of Rhode Island's Global Consumer Choice Compact Medicaid Waiver**

- **The Lewin Group's Summative Evaluation:** http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf

Methods

- **Semi-Structured Interviews**
  - 26 interviews (with 30 individuals); 3/1/10 to 5/20/10
  - State administrators, legislative staff, consumer advocates, providers representative
  - Represented various patient populations, providers types, agencies
  - Averaged approximately 1 hour each (45 minutes to 2 hours)
  - Interview transcripts coded to identify recurring themes
- **Archival Sources**
  - >325 documents reviewed
  - State administrative codes, statutes, hearings, press releases, letters, reports, newspaper articles and other documents
  - Used to cross-validate informant responses and to provide historical background

Development & Approval

State Motivation

- **Waiver Politically Motivated**
  - Spurred on by ideologically compatible federal and state administrations focused on restraining spending and delegating further responsibilities to the states

- **Waiver Driven by Budgetary Pressures**
  - Response to ongoing fiscal and programmatic pressures to reduce Medicaid expenditures during a worsening economy and increasingly adverse state budgetary conditions

Stakeholder Input

- **Developed by a Few High-Level State Officials**
  - Formulation dominated by a handful of state officials working over a short period of time characterized by growing fiscal and political uncertainty

- **Developed with Little to No Community Input**
  - There were few, if any opportunities for providers, advocates, and the general public to comment on and influence the design of the Global Waiver

Lack of Transparency

- **Limited Details During Waiver Development**
  - For a long time the waiver consisted of uncontroversial generalities. Even the final proposal lacked specifics—it proposed giving the state the power to make changes but offered few details beyond that

- **Limited Details During Federal Approval Process**
  - The Federal approval process was highly secretive

Legislative Approval

- **Legislature Approval Passively Given**
  - The State Legislature did not formally approve the waiver but passively provided its consent by not formally rejecting it within 30 days

- **A Tight Frame Colored by Promised Savings**
  - The State Legislature had limited time to act given the timing of federal approval (December 19th). It had also built in $67 million in promised first year savings into the budget; if it did not approve the waiver, it would need to find those savings elsewhere

Federal/Legislative Oversight

- **An Increased Legislative Role**
  - Subsequent legislation required all but simple changes be approved by the State Legislature before the state could seek Federal approval. Also established a Global Waiver Implementation Taskforce

- **Joint Federal-Legislative Oversight Intensive**
  - Legislature became involved in decisions it previously was not involved in. Overall oversight process more extensive than originally envisioned and, in some ways, greater than if the Global Waiver had not been pursued

Implementation

Community Taskforce

- **Heavily State Directed**
  - General dissatisfaction with the way the Global Waiver Implementation Taskforce has operated, including the absence of community leadership and a lack of productive dialogue—communication has tended to be one way with the agenda/meetings being led by the state

- **Lack of Responsiveness to Recommendations**
  - Frustration with the lack of responsiveness to recommendations developed by the Taskforce's seven work groups and absence of collaboration between the Taskforce and the state's own internal work groups

Fiscal/Budgetary Constraints

- **Driven by Fiscal and Budgetary Environment**
  - The fiscal crisis enhanced the focus on cost control, limited the amount of state dollars available for Medicaid, and made it difficult to distinguish waiver-from budget-driven changes

- **Federal Cap Has Been a Non-Issue**
  - Despite initial fears that the state might exceed the federal cap, the limiting factor has been the level of state appropriations and spending. The state cannot spend enough of its own dollars to exceed the cap agreed upon with the federal government

Administrative Capacity

- **Inadequate Numbers of State Personnel**
  - Shortage in personnel has increased stress among remaining staff, hampering day-to-day functions, let alone the added burdens associated with the Global Waiver; Dynamic exacerbated by state fiscal situation

- **Insufficiently Experienced Leadership**
  - Prior state agency leaderships had significant experience with Medicaid, and a long history of working with community partners. This is absent among key members of the state's new leadership team

Data/Information Systems

- **Lacks Requisite Data and Information Systems**
  - State continues to rely on antiquated information technology which requires substantial time, energy, and money to maintain, and precludes timely access to key data points necessary to track and evaluate progress

- **Needs to Capture Additional Data Elements**
  - To acquire a true indication of the waiver's impact, the state must collect more and better information with which to measure program access, service use, financing, cost savings, and outcomes

Inter-Agency Coordination

- **Divided Responsibility Poses Challenges**
  - Responsibility for administering Medicaid funded services are distributed across five health and human services departments, each with its own director, priorities, constituencies, policies, and staff. This inhibits the promulgation of a uniform, coherent policy

- **Waiver Promotes Collaboration/Understanding**
  - Waiver provides personnel from various departments with opportunities to get to know one another and their respective missions. Placing all money in one pool under a single waiver has helped to break down silo mentality

Inter-Sector Cooperation

- **Traditional Relations Across Sectors**
  - Siloes among advocates representing different groups requiring long term services and supports, including children, the elderly, physically disabled, developmentally disabled, and mentally ill

- **Waiver Promotes a Broader Perspective**
  - Perceived need to unite provider and advocacy interests in light of the program-wide scope of the Global Waiver has increased cooperation and understanding across individuals representing different populations

Provider Capacity

- **Uncertainty about Community-Based Resources**
  - Widespread concern that there is insufficient provider capacity to meet increased service demands under the waiver, particularly given a lack of planning to ensure the availability of sufficient community-based options for nursing home diversions and transferees

- **Would Capacity Increase? Mixed Expectations**
  - Some felt providers would rise to meet the demand, particularly if reimbursement increased; others felt the state was unlikely to bolster payments and that there had been little, if any increase in most providers' censuses

CNOM Authority

- **Brought in Additional Federal Dollars**
  - Saved the state money, supported expansions, and helped prevent service reductions. Each health and human services department has benefited (e.g., Department of Elderly Affairs' Co-Pay Program)

- **Increased Administrative Burdens**
  - State agencies had to promulgate new rules and additional monitoring for services. Providers had to work out new billing and documentation procedures while developing processes with which to determine which clients could be reimbursed for in this manner

Conclusion

Challenges

- **Dissatisfaction/Distrust Generated by the Lack of Transparency and Outside Input and Emphasis on Cost Control and Savings**
- **Imposition of Additional Legislative Oversight**
- **State Administrative Barriers**
  - Insufficient Personnel
  - Inexperienced Leadership
  - Organizational Impediments
  - Antiquated Data and Information Systems
- **Potential Gaps in Provider Infrastructure**

On the Plus Side

- **Provides a Framework Serving to Organize Discussions, Consolidate Initiatives, and Spur Progress on Long-Term Care Rebalancing**
- **Promotes Cooperation among State Agencies, Providers, and Advocates Representing Disparate Populations Affected by Medicaid**
- **Supported Rebalancing and Prevented Service Reductions through Additional Federal Dollars Obtained under Waiver's CNOM Authority**