Value Purchasing for Home and Community Based Services

Report to the Rhode Island Executive Office of Health and Human Services

Prepared under Sub-Contract to the New England States Consortium Systems Organization (NESCSO)

Final Draft
November 23, 2009

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November 23, 2009

Mr. Gerald Clay, Executive Director
New England States Consortium Systems Organization
Hoagland-Pincus Center
222 Maple Avenue
Shrewsbury, MA 01545

Re: Value Purchasing for Home and Community Based Services

Dear Jerry:

I am pleased to submit this report for transmission to the Executive Office of Health and Human Services. This report addresses one of the challenges in the Global Consumer Choice Compact Waiver, namely how to apply a value purchasing approach to purchasing home and community based services. The report frames the issues, summarizes existing data and thinking on this topic, and describes possible next steps. Our focus is on services for the elderly and people with physical disabilities, not (in this report) people with developmental and intellectual disabilities.

We appreciate the advice we have received from Tom Conlon, Lynda Giarrusso, Dianne Kayala, Tom Marcello, Elena Nicolella, and yourself. The report was written by Kevin Quinn with significant assistance from other ACS staff and consultants, especially John Andrews, Kacey Booth, Malcolm Ferguson and Yleana Sanchez. For further information, please contact Kevin at 406-457-9550 or kevin.quinn@acs-inc.com.

Sincerely,

Rick Jacobsen
Account Manager

1 Summary

The Rhode Island Global Consumer Choice Compact Waiver is among the most important Medicaid initiatives now under way in the United States. By rebalancing the long-term care system toward home and community based services, improving management and coordination of care, and transitioning its own role from payer of bills to purchaser and organizer of services, the Medicaid program is putting into place strategies that many other states are interested in.[1] In this report we discuss how a value purchasing approach could be used for home and community based services (HCBS). With a focus on the elderly and people with physical disabilities, our assignment was to frame the issues, summarize existing data and thinking, and describe possible next steps.

We follow the Global Waiver in defining two goals for home and community based services, namely rebalancing the long-term care system toward HCBS and encouraging high levels of quality and service provision. Our key findings are as follows.

- **Goal: rebalancing long-term care for the elderly and people with physical disabilities**

  1. ***Nursing facility care tends to be "pre-organized" while home care "requires organization."*** Actions to rebalance the long-term care system need to take into account this essential difference between the nursing facility setting and home-based care.

  2. ***Current HCBS services are clearly cost-effective.*** By analyzing $37 million for which we had detailed spending information, we calculated that average annual spending per HCBS client was $8,277, much less than the approximate cost of a year of nursing facility care ($67,000). Although the $8,277 average reflects some clients who received services for less than a full year, the data finding is strong enough to confirm that enabling people to live at home makes financial sense for Medicaid.

  3. ***Providing assistance with the activities of daily living is far the most common service in long-term care.*** In FY 2008, 83% of HCBS spending went to personal care providers, who assist clients with bathing, dressing, eating and other activities of daily living (ADL). In nursing facilities, most of the care similarly comprises assistance with ADLs.

  4. ***An explicit value purchasing framework would help Medicaid achieve the goals set by the 2009 legislature.*** Our proposed approach is to define goals, assemble evidence, make findings about whether the goals are being met, and then take a "return on investment" approach to identifying next steps toward the goals.

  5. ***Rhode Island currently ranks No. 46 among states in HCBS balance, implying considerable room for growth.*** Using definitions essentially identical to our own, a national study found that just 13% of Medicaid long-term care spending for the elderly and people with physical disabilities is devoted to HCBS.

  6. ***Acuity-based rates for nursing facilities will be a major improvement in the long-term care system.*** The planned introduction of acuity-adjusted payment rates to nursing facilities will even out profit margins for heavier-care and lighter-care clients, which should increase access for high-acuity clients and help avoid nursing facility placement of low-acuity clients.

7. ***To increase access to assisted living facilities, Medicaid should consider acuity-based rates.*** Currently, Rhode Island is one of 17 states that pays assisted living facilities a flat rate regardless of client, therefore creating the same incentives as in the (current) nursing facility setting to accept low-acuity clients and avoid high-acuity clients.

8. ***Payments to assisted living facilities appear relatively low. It may be necessary to increase rates to increase access.*** Medicaid's current rate is only 33% of reported private-pay rates, while Medicaid's nursing facility payment is 82% of reported private-pay rates.

9. ***Medicaid appears to be a good payer for personal care, so rates are unlikely to be an important obstacle to increased HCBS use.*** A recent state-to-state comparison shows that Rhode Island ranks high in its payment rates for personal care. This comparison, in combination with the current weak economy, suggests that payment levels are not an important obstacle to increased HCBS use. It may be more productive to improve the flow of information to individuals choosing a long-term care and to improve coordination of HCBS.

- **Goal: Providing quality home and community based services**

10. ***Department of Health report cards that address the specific needs of Medicaid clients are useful and should be continued.*** The Department of Health currently reports clinical quality and client satisfaction scores by home health agency, including the personal care agencies that are important by Medicaid clients. This initiative, unusual among states in its focus on Medicaid, should be continued.

11. ***Rhode Island is among the leading states in paying for performance in HCBS, although room for improvement remains.*** Rhode Island's quality-related incentives to home care payment rates were singled out by an AARP study as an example to other states. In addition, public reporting of quality data by the Department of Health creates indirect but important incentives to improve the quality of care. It may be useful to assess the impact to date of the rate enhancements and decide if further adjustments would be useful in encouraging quality care.

2 HCBS in the Continuum of Care

Except for informal efforts organized by friends and family, long-term care for the elderly and people with disabilities traditionally has been heavily oriented to care in institutions, specifically nursing facilities. Twenty years ago, if Medicaid was going to pay someone's long-term care costs, almost certainly the client would be sent to live in a nursing facility to live out his or her days. It was the obvious choice: the facility already existed, the door was (usually) open, and staff and services were in place.

The movement—not too strong a word—for HCBS arose from the sense among client advocates and Medicaid policy-makers that institutional placement was often unnecessary. Although some people can't be cared for anywhere else, there are many other people who can continue to live at home if only they receive specific types of assistance. Some people only need a personal emergency response system, others may need help with bathing or shopping. Since most people would prefer to live at home, such assistance is an obvious benefit to them. Moreover, in many cases HCBS costs less than institutional care. When someone is placed in a nursing facility when they could have remained at home, the outcome is a tragedy, both personally for the client and financially for the payer.

How much help a client needs varies widely, and not just by age or clinical diagnosis. Comorbidities, the patient's own functional ability, and their home and family situations all have major effects on the care needed. Table 2.1 shows our definition of acuity in the long-term care setting. Level 1 needs include simple companionship and human contact. Needs then range through basic safety (making sure the stove is off), through assistance with keeping house and taking medications, to help with bathing and dressing, to more highly skilled nursing care and therapy. Family and friends typically can handle Level 1, Level 2 and some Level 3 needs on their own, personal care aides address Level 3 and especially Level 4 needs, and RNs, LPNs, physical and other therapists address Level 5 needs. Although clients commonly need more than one level of assistance, the bulk of Medicaid long-term care spending in all settings addresses Level 4 needs, that is, assistance with the activities of daily living.

Table 2.1
What Is Acuity in the Long-Term Care Client?

Level 1: Companionship and human contact	→ Increasing need for medically trained assistance →
Level 2: Safety and security • Protection against fire risks, crime, wandering, self-harm	
Level 3: Instrumental activities of daily living (IADLs) • Medication management, housekeeping, meal preparation, transportation, money management, laundry, shopping, telephone use	
Level 4: Activities of daily living (ADLs) • Eating, toileting, bathing, dressing, transferring	
Level 5: Medical care • Regular observation and assessment by medically trained staff • PT, OT, SLP, IV medications, wound care, respiratory care	

For purposes of this paper, we differentiate long-term care settings by where the client usually sleeps at night. Home care and assisted living are both considered home and community based services, while a nursing facility is considered institutional care. Policymakers at the federal and state levels, including Rhode Island, have worked to emphasize HCBS as an alternative to institutional care. Since 1995, HCBS spending—referring to both the aged/disabled and the intellectually disabled populations—has grown at more than twice the rate of Medicaid spending overall. (The percentages are 13.2% a year vs. 6.2% a year.[2]) Spending on nursing facilities and intermediate care facilities for people with intellectual disabilities, by contrast, has grown by just 3.3% a year. Nationwide, HCBS represented 19% of Medicaid long-term care spending in 1995 but 41% in 2007.

The growth of HCBS has been impressive, but the nature of the services probably helps explain why HCBS has not grown even faster relative to institutional care. We exaggerate to make a point in saying that nursing facility care tends to be "one size fits all" while HCBS is "everyone is unique." That difference has both pluses and minuses. It is relatively simple to put more clients in a nursing facility: if the facility is already built, it can then be filled with people who receive the same set of services from the same staff in the same place. To put more people in HCBS programs, however, you need to assemble a network of disparate providers, assess which patients need which types of care, and then coordinate delivery of care in different places at different times. In contrast to a nursing facility, individual HCBS providers often do not share the same management and ownership. The differences between nursing facility care and home care are summarized in Table 2.2 (with assisted living positioned somewhere between them).

Finding No. 1: Nursing facility care tends to be "pre-organized" while home care "requires organization."

Overall, nursing facility care can be said to be "pre-organized" while home care "needs organization." The difference is especially apparent when there is a "shock" to the status quo, such as the client's spouse being hospitalized or a caregiver not showing up for work. A nursing facility may not even notice, but the situation at home may suddenly become a crisis.

Given the State's goal of rebalancing spending from nursing facility care to home and community based services, the differences between the settings are important in setting the path forward. In the next section, we examine spending for home and community services as it is currently.

Table 2.2
An Exaggerated View of Differences

Nursing Facility Care	Home Care
Obvious way in	Way in may not be obvious
Usually available immediately	Usually a waiting list
Feels like an institution	Feels like home
One size fits all	Everyone is unique
Need one service, get them all	Need one service, get one service
Staff and services already in place	Staff and services need to be assembled
Handles "shocks" well	"Shocks" can cause sudden instability
Economies in staffing	Diseconomies of 1-to-1 staffing, travel
More oversight of care	Less oversight of care
Care pre-organized	*Care needs to be organized*

3 HCBS Utilization in RI Medicaid

The usual definition of home and community based services comprises services paid for under HCBS waivers plus home health care and personal care offered as "state plan" (not waiver) benefits.[3] For this analysis, we analyzed MMIS claims payment for HCBS in SFY 2008 (July 2007-June 2008) using a similar definition that comprises federal Section 1915c waivers and certain other services, as follows.

- ***Aged and Disabled Waiver (01).*** $25.0 million
- ***Elderly Waiver (02)*** $6.1 million
- ***Personal Choice and Habilitation Waivers (04)*** $0.4 million
- ***Assisted Living Waiver (07).*** $2.3 million
- ***Other long-term care services provided to clients with an aid group of ABD (aged, blind, disabled).*** $3.1 million

Payments summed to $37.0 million. This figure, however, excludes approximately $6.5 million in "offline" payments made outside the MMIS under the personal choice and habilitation waivers. (As of November 2009, these payments are now being made through the MMIS.) Total HCBS spending in SFY 2008 was therefore about $44 million, compared with nursing facility spending of $307 million.[4]

Analyzing historical HCBS utilization under the four separate waivers helps us understand what HCBS utilization is likely to be under the global waiver. The lack of detail on the $6.5 million is unfortunate, but a few comments can be made based on an analysis by Dianne Kayala.[5] Personal care is the single most important provider type under the personal choice and habilitation waivers, so the comments below about personal care would also apply to the personal choice and habilitation waivers. The most notable difference is that the personal choice and habilitation waivers also included about $1.8 million in payments for habilitation (i.e., training in activities of daily living) provided in residential and adult day care settings.

With regard to the $37.0 million for which we have detailed claims data, these services were provided to 4,467 unique clients during the fiscal year. Chart 3.1 shows that 55% of these clients were age 65 and over, with another 30% in the 50-64 age group. The distribution of spending largely tracked the distribution of clients. Spending averaged $8,277 per year, with the average being higher in the older age groups (Chart 3.2). Please note that spending per client per year depends on two factors: the intensity of service received and the length of time a client receives service. In Charts 3.1 and 3.2, a unique client could be a person who received just one HCBS service during 2009 or a person who received many services throughout the year. Nevertheless,

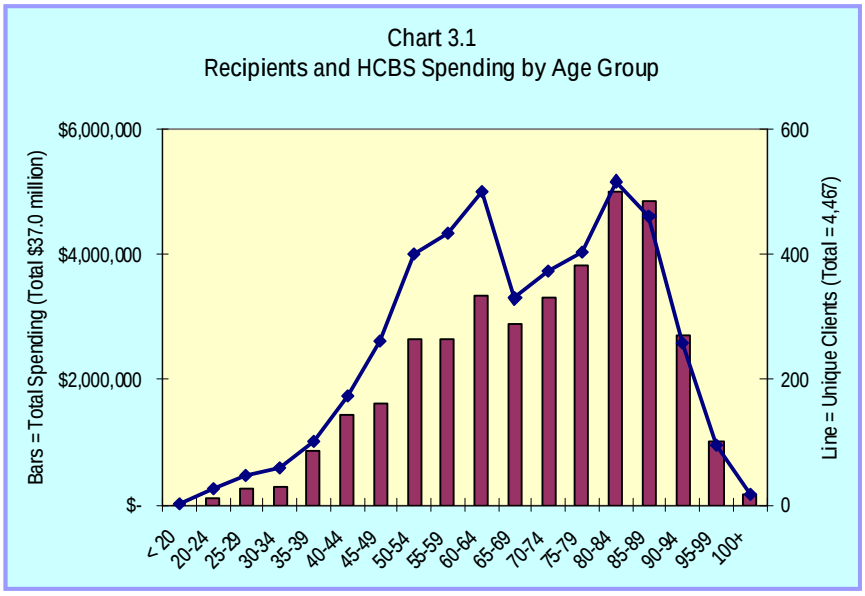
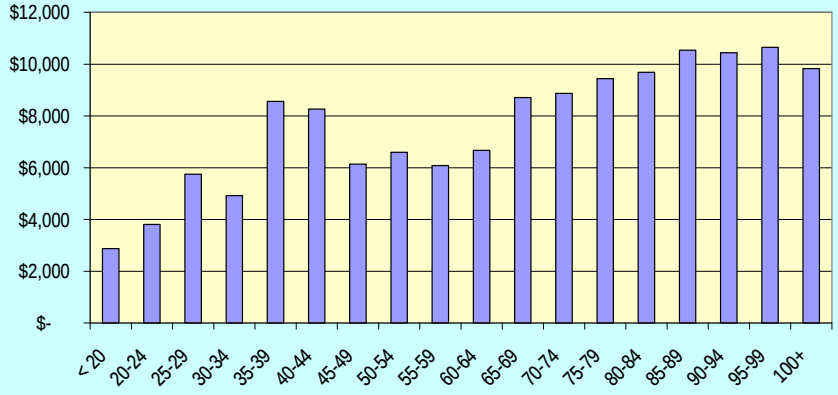


Chart 3.2 makes a very important point: that home and community based services appear to be achieving the goal of cost-effectively keeping people out of nursing facilities in Rhode Island. Chart 3.2 shows that average HCBS spending per client, at $8,277, was one-eighth of the cost of a full year of nursing facility care, approximately $67,000. The point is buttressed by Chart 3.3, which shows that HCBS spending was more than $67,000 for only 16 of the 4,467 clients.

Finding No. 2: Current HCBS services are clearly cost-effective

We say "appear to be" achieving the goal because there are two caveats. The first has to do with the fact that spending per unique client may not reflect a full year of services. The second reflects the reality that hardly anyone wants to live in a nursing facility, while almost everyone would like extra help at home. This is the famous "woodwork" effect in long-term care: that many more people "come out of the woodwork" to apply for HCBS than would agree to live in a nursing facility. All clients served through the 1915c waiver programs have been assessed as otherwise needing nursing facility care, however. As well, the data in Charts 3.2 and 3.3 are sufficiently strong that it seems very unlikely the finding of cost-effectiveness is a statistical artifact. This finding reinforces an earlier finding from a study done by the Department of Elderly Affairs (DEA). That study, which used a different methodology on a population that overlaps with the Medicaid population, found that HCBS services delayed admission to a nursing facility.[6]

Chart 3.2
HCBS Spending per Client by Age Group, 2008



Note: Spending per person per year reflects both intensity of service received and number of months in which services are received

Chart 3.3
Histogram of HCBS Spending by Client

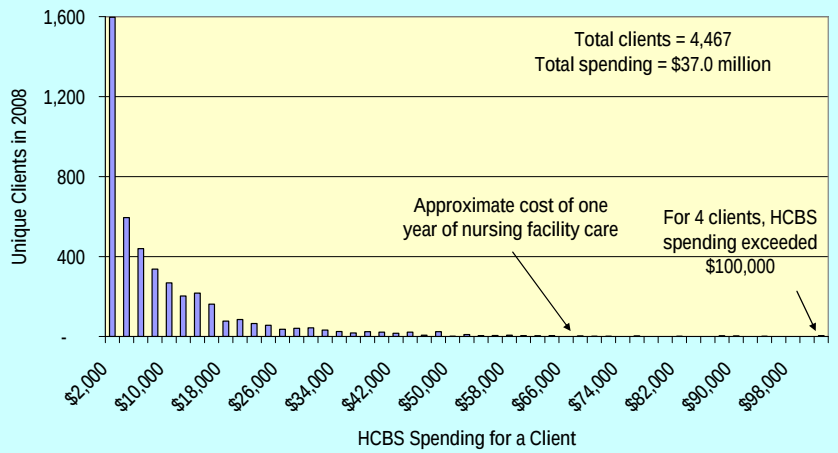


Chart 3.4 shows the split of spending by provider type. As is also true in the nursing facility setting,[7] assistance with the activities of daily living is by far the single most common service in home and community based services.

Of the $37.0 million, 83% went to personal care providers. More detailed information, shown in Table 3.1, shows that almost all personal care was billed using the single procedure code for 15 minutes of attendant care services (S5125). Personal care aides typically help clients with activities of daily living such as dressing, bathing and eating. They often also perform light

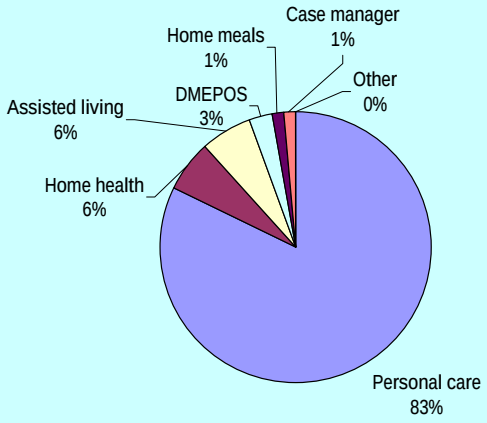
housekeeping and cooking and prompt clients to take their medications. After completing a training program of up to 120 hours, they receive an average wage of $12.26 in Rhode Island.[8] (This average covers all clients in all settings, not just Medicaid home-based care.) In 2008, Rhode Island Medicaid paid an average of $19.44 an hour ($4.86 per 15 minutes) for the personal care services covered by S5125. This fee covers the aide's wage plus other provider costs such as benefits, travel time, insurance and overhead. It also reflects rate enhancements for quality and service, as will be discussed in Section 5.2.3.

Finding No. 3: Providing assistance with the activities of daily living is far the most common service in long-term care

Among provider types, the distant No. 2 was home health services, almost all of which were billed using local procedure code X0043. This care is provided by more highly trained personnel such as registered nurses and physical therapists. Average hourly wages in Rhode Island are $32.60 for an RN and $39.41 for a physical therapist.[9] Typical services would include organizing medications, patient assessment, wound care, physical therapy, and respiratory therapy. The average claim line included 3.1 home health visits, with payment averaging $206 per line and $66 per service. (A claim line may reflect more than one date of service.)

Assisted living facilities are the No. 3 HCBS provider type by total payments. These facilities represent the middle ground between home care and nursing facilities. Typically, meals are provided and personal care aides are on staff to provide services and generally look out for the health and safety of clients. Clients usually have more privacy and more personal space than in a nursing facility. A common model is that the facility offers three or four levels of care, at different prices, based on the amount of assistance a client needs.[10] Services such as help with bathing may also be offered on an "à la carte" basis. Services are typically billed to Medicaid per month. Medicaid payment is the same regardless of the level of care. It averages $36.31 per day or $1,089 per 30-day month. (This figure is the allowed amount, including a modest contribution from the client.) For Medicaid, $36.31 compares favorably with average Medicaid payment to nursing facilities of $184 per day in 2008.[11]

Chart 3.4
HCBS Payments by Provider Type



Total payments = $37.0 million

Of the remaining services listed in Table 3.1, homemaker services (S5130) and home health aide services (G0156) are similar to the personal care and home health services described above, and are billed per 15-minute unit. Delivered meals represent 1% of HCBS spending and are paid at an average of $4.50 per meal. An emergency response system costs Medicaid $34.79 per month on average; these systems allow clients to push a button on their wrist or hanging from their neck in order to summon a neighbor or emergency responders. They are especially important when the client is home alone. Home modifications, at an average cost of $1,575, in some ways exemplify the philosophy of Medicaid home and community based services. Previously, Medicaid programs had no authority under federal law to pay a carpenter to install a wheelchair ramp, or grab bars in a bathroom, or other aids that enable a client to remain at home. Under the HCBS waivers now prevalent across the country, Medicaid programs can pay for modifications that are obviously cost-effective.

Home-based services are often provided by different organizations, such as a home care agency for personal care, possibly a second agency for nursing and therapy care, Meals on Wheels, oxygen and durable medical equipment suppliers, and Lifeline or another firm offering personal emergency response systems. If there are three or four providers, then there are three or four streams of payment generating three or four sets of financial incentives. All of this activity is typically coordinated by case managers billing codes T1016 or T1017, which are paid at $60 per hour. Case managers are often staff members of private organizations but in some states they may be state employees. Case managers represent 1% of HCBS spending but in practice their work is crucial in making the entire HCBS system function.

Table 3.1
HCBS Services by Procedure Code, 2008

Proc	Procedure Description	Unit	Lines	Units	Charges	Allowed	% of Payment	Units / Line	Pay / Line	Pay / Unit
S5125	ATTENDANT CARE SERVICES	15 minutes	147,762	6,040,338	$ 36,420,171	$ 29,339,436	79%	40.9	$ 199	$ 4.86
X0043	HOME NURSING & THERAPY VISITS	Per visit	11,049	34,693	$ 3,456,139	$ 2,279,629	6%	3.1	$ 206	$ 65.71
T2031	ASSISTED LIVING	Per diem	2,100	60,353	$ 2,191,226	$ 2,191,226	6%	28.7	$ 1,043	$ 36.31
S5130	HOMEMAKER SERVICE, NOS	15 minutes	12,606	272,015	$ 1,148,401	$ 1,100,195	3%	21.6	$ 87	$ 4.04
S5170	HOME DELIVERED MEALS	Per meal	6,402	122,379	$ 550,706	$ 550,706	1%	19.1	$ 86	$ 4.50
S5161	EMERGENCY RESPONSE SYSTEM	Per month	14,786	14,843	$ 516,816	$ 516,330	1%	1.0	$ 35	$ 34.79
T1017	TARGETED CASE MANAGEMENT	15 minutes	4,322	22,297	$ 334,422	$ 334,400	1%	5.2	$ 77	$ 15.00
S5165	HOME MODIFICATIONS	Per service	130	130	$ 207,673	$ 204,758	1%	1.0	$ 1,575	$ 1,575.06
T1016	CASE MANAGEMENT	15 minutes	1,807	8,121	$ 121,815	$ 121,815	0%	4.5	$ 67	$ 15.00
G0156	SERVICES OF HOME HEALTH AIDE	15 minutes	440	6,232	$ 80,586	$ 29,756	0%	14.2	$ 68	$ 4.77
All others			2,645	43,007	$ 480,875	$ 311,920	1%	16.3	$ 118	$ 7.25
Total			204,049	6,624,408	$ 45,508,830	$ 36,980,171	100%	32.5	$ 181	$ 5.58

Note: A claim line may represent services provided on more than one date

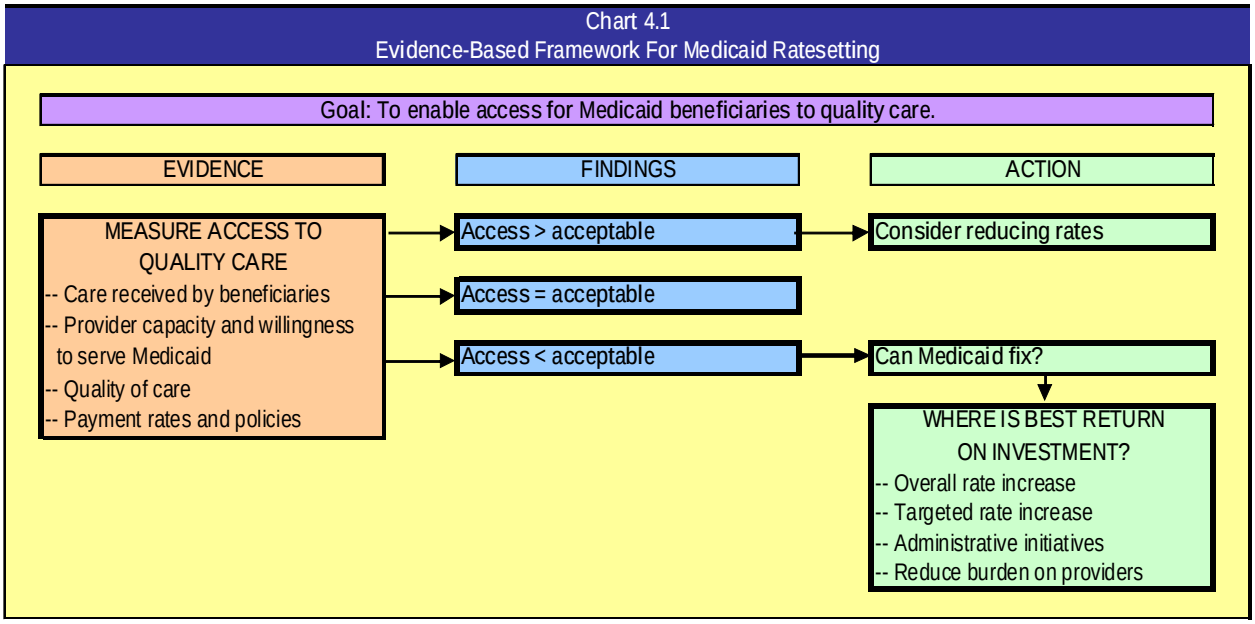
4 Value Purchasing in HCBS

In serving Medicaid clients, by far the largest lever that Medicaid agencies have is their ability to pay providers. Even in long-term care, Medicaid programs provide few services themselves, and they have little regulatory authority over how health care services are delivered. Instead, they wield their influence by deciding what services to pay for, how to pay, and how much to pay. Home and community based services, in fact, are probably the leading example of how Medicaid payment policy can change the health care system.

Over the past 40 years, the role of Medicaid (and Medicare) as a purchaser has evolved from reimburser to payer to purchaser. In the beginning, Medicaid tended to be a passive reimburser of provider costs or charges. Nationwide, Medicaid staff members had limited expertise in health care and, frankly, were so glad to have providers that they didn't ask too many questions about what was being provided. Controls tightened over time, with states moving to paying claims based on fee schedules or bundled methods such as Diagnosis Related Groups for hospital care. For Medicaid staff, the focus turned to ensuring that billed services had been provided and were being billed correctly. Now, we are seeing growing interest in a "purchasing" approach, where Medicaid programs want to know not only what is being provided, but also at what quality and what good it is doing.

In our work advising states on payment methods and payment rates, we define "value purchasing" as reducing or slowing costs while maintaining or improving access and quality of care. In other words, the goal is achieving more health for the health care dollar. To put this goal into action, we suggest the evidence-based framework summarized in Chart 4.1.[12] Simply put, the framework is to define goals, assemble evidence, make findings on whether those goals are being achieved, and then decide what are the next steps to yield the greatest "return on investment" in terms of achieving the goals.

Defining value purchasing in terms of access to quality care and applying an evidence-based framework may sound obvious, but in fact this approach differs significantly from the traditional approach taken by



many states. That traditional approach has often been reactive, without focus on goals, and centered on the interests of providers. Many states may find echoes of their own situations in the following comments.

> ''There lacks consistent standards for the determination of rates paid to providers across the Medicaid program. Presently, rates are often set on the basis of advocacy to the legislature during the budget process.''
>
> -- New Hampshire Medicaid[13]

> "For a number of reasons, Montana's Medicaid program does not have a rational system for adjusting provider reimbursement rates that can be equitably applied across all the various provider groups. As a consequence, provider rate increases have historically been implemented primarily on an individual program basis in response to specific crises or political pressure."
>
> -- Montana Medicaid[14]

To apply the framework to the present topic, we suggest the following.

- ***Defining goals.*** The 2009 Rhode Island legislature made it clear that the central goal of home and community based services is to have more of them, especially for the elderly and clients with disabilities. The legislature set a goal that 50% of long-term care spending should be for HCBS. (By one common definition, the current number is 13%—see page 12.) A related goal is to supplant the need for nursing facility care, either by diverting clients from entering nursing facilities in the first place or by transitioning nursing facility clients back into the community. That is, there should not only be more home and community based services but also fewer nursing facility services—if not in total, then certainly in relative terms. Another goal, often implicit but worth stating explicitly, is that home and community based services be delivered at appropriate levels of service and quality.

  Finding No. 4: An explicit value purchasing framework would help Medicaid achieve the goals set by the 2009 legislature.

- ***Evaluating evidence.*** Fortunately, evidence on all aspects of Medicaid performance is more available now than it has ever been. In evaluating evidence, we advocate an approach that emphasizes robustness of findings. That is, in a world of imperfect data it is better to assemble a wide variety of information and see if it all points in the same direction. If in fact, different evidence points in different directions then further analysis may be called for. We also advocate placing the greatest weight on direct evidence of access and quality. For example, if more services per client are being delivered that is probably more pertinent than a finding that provider profit margins are going down. To be sure, providers are essential partners to Medicaid in serving clients, and Medicaid programs need to stay informed about providers' financial health. But in cases of doubt, we would argue that there has been too much emphasis nationwide on provider finances and not enough emphasis on client access to quality services.

- ***Making findings.*** From the evidence, a Medicaid program can make findings about whether its goals are being reached or exceeded or whether its efforts are falling short. Contrary to common perceptions, Medicaid is not always a poor payer. If payments are unnecessarily high, then they can be reduced and the savings redeployed to other priorities.

- ***Taking action.*** If goals are not being met, then often the most obvious response is to raise payment rates. It is often also the wrong response. We suggest a "return on investment" approach. In the present case, the "return" is an increase in the volume and/or quality of HCBS services. The question is what action will generate the greatest return. Options might include an overall increase in payment rates, a targeted increase in payment rates (for example, for evening and weekend services), a change in payment methods (for example, incentives for quality), redefining the unit of payment, changes in administrative organization and processes, changes in statute and regulation (for example, regarding scope of practice), or some other change. Which action has the greatest return on investment can be a difficult question, with different answers at different times. But asking the question is essential.

5 Pursuing Value Purchasing in HCBS

In this section, we bring the previous sections together to address how the value purchasing framework could guide decisions about increasing the volume and quality of home and community based services in Rhode Island. This section should be seen as a starting place for the discussion, not as a definitive analysis. In particular, we focus on payment methods and rates, with minimal reference to other aspects of funding and delivering HCBS. This is an important caveat. For example, a previous study by the Hilltop Institute warned that access to HCBS in Rhode Island is not a ratesetting issue alone and specifically called for more attention to information dissemination, especially at the time of hospital discharge.[15] The focus of this paper, however, is limited to framing the issues, summarizing existing data and thinking, and describing possible next steps.

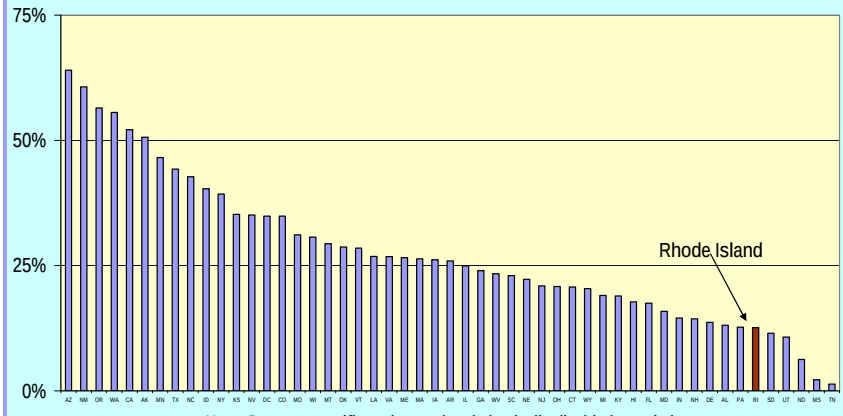
5.1 Goal: Rebalancing Long-Term Care

A centerpiece of the Global Waiver is shifting the balance between HCBS and institutional care. As Chart 5.1.1 shows, Rhode Island ranks among the lowest states in HCBS spending as a percentage of long-term care spending for the aged and disabled population.[16] This figure of 13% stands in contrast to the figure of 97% for people with developmental and intellectual disabilities, where Rhode Island ranks among the highest.

Finding No.5: Rhode Island ranks No. 46 among states in HCBS balance, implying considerable room for growth

In this sub-section, we discuss the extent to which payment methods and rates help or hinder the goal of rebalancing toward HCBS. Other considerations—statutory and regulatory authority and staffing, just to mention two—are also important but beyond the scope of this paper. Although payment methods and rates are not all that matter, they play a central role in what services are available and how they are delivered. This is especially true in long-term care, where Medicaid is the largest single funder.

Chart 5.1.1
HCBS as Percentage of Long-Term Care Spending



Note: Data are specific to the aged and physically disabled population.
Source: Burwell et al., *Medicaid Long-Term Care Expenditures in FY 2007*

5.1.1 Payment Methods—Acuity Adjustment

As discussed in Section 2, people who need long-term care range widely in acuity and therefore in the cost of care. If payment methods do not result in payment that parallels the cost of care, then providers are relatively over-paid for the lighter-care clients and relatively under-paid for the heavier-care clients. The mismatch causes well-known problems of access to care for heavier care patients. More subtly, it

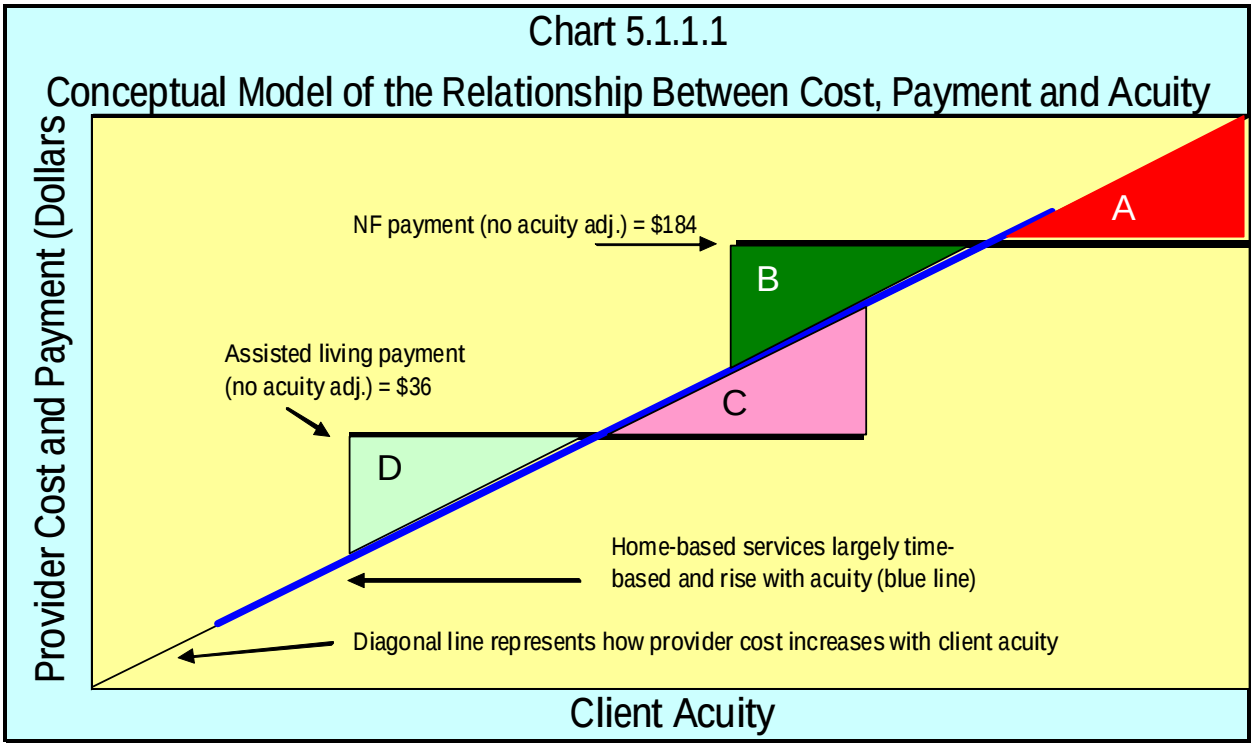
can stymie efforts to shift care to "lower" levels because current providers find that the lighter care clients are the most profitable.

Chart 5.1.1.1 offers a conceptual model of acuity adjustment under current Rhode Island payment methods. The vertical axis is provider cost. The horizontal axis is patient acuity. The diagonal line shows how, in principle, provider cost increases as client acuity increase. This increase occurs because heavier care patients need more hours of staff time, more specialized staff time, special supplies and equipment, etc. Three types of providers are shown: nursing facilities, assisted living facilities, and home-based care. In practice, as we saw in Section 3, home-based care is very largely personal assistance. Also as shown in the conceptual model, the three provider types overlap. Many clients could be cared for either at home or in assisted living, in assisted living or in a nursing facility, or even at home or in a nursing facility.

In an ideal set of payment methods, the payment methods for each of these provider types would incorporate acuity adjustments so that provider margins (profitability) would be very similar for different clients despite the differences in client needs and in setting. In Rhode Island, what do we see?

- ***Nursing facilities***. Currently, nursing facilities are paid per diem rates based on cost reports. Although there may once have been a link between a nursing facility's cost and its average acuity, analysis of recent Rhode Island data shows there is almost no relationship today between a facility's average acuity and its average cost (and therefore its average payment).[17] The chart therefore shows a horizontal bar at the 2008 average rate of $184. Any clients more costly than $184 a day (Area A) will be relatively unprofitable and we can expect to see access problems. Any clients less costly than $184 (Area B) will be relatively profitable, and we can expect to see facilities quite interested in attracting and retaining them.

  Because the Medicare program has historically paid for post-acute clients that are relatively expensive, it saw all the access problems inherent in the dynamic described above. In 1998



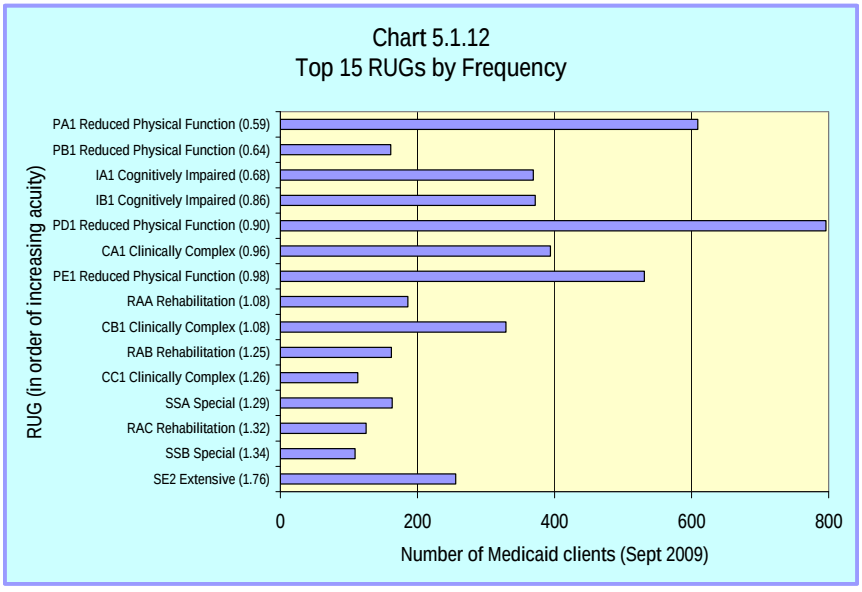
Medicare therefore introduced Resource Utilization Groups (RUGs) to adjust payment for acuity. Many states have also adopted RUGs-based payment. It not only helps them obtain access for heavier care patients but also helps them rebalance their long-term care systems toward HCBS by evening out the profitability of patients with varying levels of acuity.

Finding No. 6: Acuity-based rates for nursing facilities will be a major improvement in the long-term care system

The 2009 Rhode Island legislature enacted language to implement acuity-adjusted payment for nursing facilities in January 2010.[18] As of November 2009, the Medicaid program and ACS Government Healthcare Solutions have calculated average RUG scores for each client in each facility. As shown in Chart 5.1.1.2, among the most common 15 RUG groups there is a three-fold range in acuity, from a relative weight of 0.59 for RUG PA1 (reduced physical function, ADL 4-5) to 1.76 for RUG SE2 (extensive services 2, ADL >6). Facility-specific payment rates, which are now being calculated, will not vary to the same degree because the average acuity casemix score only affects part of the per diem rate and because a "corridor" will limit increases and decreases by facility. Nevertheless, implementation of acuity-based payment for nursing facilities is a major step toward rebalancing the long-term care system. It should both increase access to nursing facilities for heavier-care clients and facilitate access to home and community based services for lighter-care clients.

Finding No. 7: To increase access to assisted living facilities, Medicaid should consider acuity-based rates.

- ***Assisted living facilities***. Currently, Rhode Island is one of 17 states that pays assisted living facilities a flat rate regardless of patient acuity.[19] This is indicated by the horizontal line at $36 in Chart 5.1.1.1. In parallel with nursing facilities, clients whose acuity level puts them in Area C will have difficulty obtaining access while clients in Area D will be relatively attractive to the facilities. Because of this incentive, another 19 states use tiered rates, typically paying three to five rates depending on the number of ADL limitations and cognitive or behavioral impairments. Another four states achieve the same effect using casemix-based payment. (The other states use various other approaches.) If at some point the State does want to increase use of assisted living facilities, then we recommend consideration of acuity-based payment.



- ***Home-based services.*** As described in Section 2, home-based services are paid for on a fee-for-service (FFS) basis, right down to each 15 minutes for the vast bulk of services. If a specific client has unusually high needs, then providers are allowed to add the state-specific U9 modifier to the

procedure code, which results in additional payment of $1 per 15 minutes. As a general statement, many payers are wary of FFS payment because it so obviously encourages provision of services even if they may not be beneficial. But for purposes of the present analysis, FFS payment has the strength of being almost automatically geared to match patient acuity. If the client needs more hours of personal assistance or more specialized resources such as RN-level care, then providers are motivated to provide the care because every additional service draws additional payment. In Chart 5.1.1.1, the heavy blue line representing payment for home-based services therefore tracks the upward diagonal line representing the relationship between patient acuity and provider cost. Therefore, unless the State moves to a new method for paying for home-based services, we do not see a need for acuity adjustment beyond the U9 adjustment currently in place.

5.1.2 Payment Methods—The Unit of Payment

The central feature of any payment method is the unit of payment. Whatever the unit of payment, the provider's financial incentive is to increase the number of units and decrease its own cost per unit. The payer's incentive is the mirror image: to ensure that the units of service are not inappropriately high and the level of service within each unit not inappropriately low. Hospital care is the clearest example. When hospitals are paid a percentage of cost, they have incentives to increase cost. When hospitals are paid per diem, they have incentives to increase the length of stay but decrease their own cost per day. And when hospitals are paid per stay, the incentive switches to decreasing length of stay. As the unit of payment becomes broader and broader, it also becomes increasingly important to adjust for client acuity. When hospitals are paid by cost, an acuity measure is not needed. But if hospitals are paid per stay, then it becomes important to make payments reflect client acuity (e.g., by DRG) in order to prevent the kind of access problems for heavier care clients that were discussed above.

The other key feature of the unit of payment is what services are included and excluded from the unit. Before 1998 for example, Medicare made separate payments to therapists when they provided services to nursing facility clients. When Medicare changed the definition of the per-diem payment to make the nursing facility responsible for therapy and other ancillary services, average cost per day fell 21%.[20] The change also resulted in increased coordination of care between the nursing facility and the therapists, since the facility now had clinical and financial responsibility for both routine and ancillary costs. In retrospect, the increased coordination seems to make excellent sense, for both clinical and financial reasons.

As Rhode Island moves to rebalance its long-term care system, the following comments on the unit of payment may be helpful.

- ***Nursing facility.*** The unit of payment is a day of care, which is the nationwide standard. It is always a good idea, however, to check on the nature and number of services received by nursing facility clients that are paid separately, outside the per diem rate. Physician, hospital inpatient and hospital outpatient are three provider types that almost every payer pays for separately. For therapy services, supplies, equipment, routine ambulance transports and other provider types, it is often worth asking the question whether payment should be bundled into the nursing facility per diem. In any case, we do not see the nursing facility unit of payment as an obstacle to rebalancing the long-term care system.

- ***Assisted living.*** Again, the unit of payment is a day of care, which is appropriate. The definition of that day, however, is a trickier question. If the State moves to acuity-adjusted payment by

level of care, then it would be appropriate to try to minimize the number of other services that are paid for separately. Among the states, Rhode Island is in about the middle in terms of scope of services now included in the daily rate.[21] Medicaid's opportunities to bundle payment are probably constrained by prevailing patterns of how assisted living facilities are organized. (Medicaid's influence is limited because it only accounts for an estimated 10%-20% of industry revenue nationwide.[22]) Assisted living facilities would expect to be held responsible for the costs of personal care and 24-hour staffing, for example, but may not be organized or licensed to be responsible for therapy services.

- ***Home-based care.*** Here, the status quo is highly disaggregated—per 15 minutes of personal care, per 15 minutes of case management, etc. Equally significant is that providers of service to the same client are often different organizations paid separately. As discussed in Section 2, home-based services typically need to be organized, and that organization may not be available on the short notice needed to forestall someone being admitted to a nursing facility. There is also at least a theoretical issue of how well can care truly be coordinated when providers are paid separately. A key impetus in development of the Program of All Inclusive Care for the Elderly (PACE), for example, was to combine under one roof clinical and financial responsibility for almost all services received by a client. The research necessary to assess coordination of home-based care in Rhode Island is outside the scope of this study, but we recommend that the State ask the question of whether current methods of coordinating and paying for care will be appropriate as home-based services become more prevalent. We note that the Hilltop Institute, in its 2006 analysis, mentioned the potential for bundled payment care to result in improved coordination of care.[23]

5.1.3 Payment Levels

While payment *methods* affect the rebalancing initiative through the incentives and disincentives they create, payment *levels* affect the initiative through the amount of funding provided. To take an obvious example, more people will want to be personal care aides when wages are $30 an hour than when wages are $10 an hour. Determining appropriate payment levels is a challenging task that ideally should be based more on evidence of access to quality care than on provider concerns about their own cost and profitability. The following discussion cannot address this topic comprehensively but it does include evidence that may be useful in future analysis.

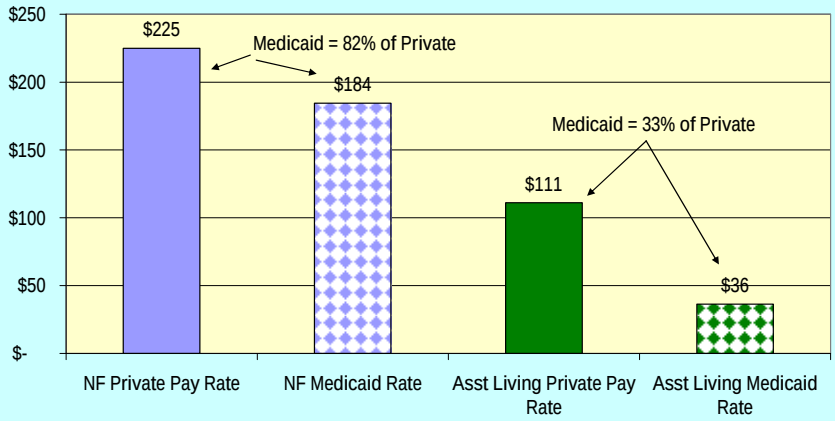
- ***Nursing facility***. Nursing facility per diem rates are not directly relevant to the availability of home and community based services, except in the (unlikely) event that they were so high as to attract constant entry into the industry. In any case, a ranking of 41 states showed that Rhode Island paid the 11th highest per-diem rate in 2006, although it was lower than Connecticut or Massachusetts.[24]

Finding No. 8: Payments to assisted living facilities appear relatively low. It may be necessary to increase rates to increase access.

- ***Assisted living facility.*** Assisted living rates are not easily comparable across Medicaid programs, because of differences in definitions, included services, and policy on room and board costs. The Hilltop study, however, did suggest that Rhode Island rates in 2004 were slightly lower (3%-6%) than rates in Connecticut, New Hampshire and Maine, and much less than in Vermont.[25] (Massachusetts was not shown). Another study, done recently for the American Health Care Association, also suggests that Rhode Island's rate is relatively low.[26]

Chart 5.1.3.1 provides additional evidence, namely a recent comparison of private-pay and Medicaid rates for nursing facilities and assisted living facilities. First, we note that assisted living at $36 a day is obviously a better financial deal for the State if the client otherwise would be in a nursing facility at $184 a day. Second, the gap between private-pay and Medicaid rates is much wider for assisted living than for nursing facility care. For nursing facility care, the Medicaid rate equals 82% of the typical private-pay rate. For assisted living, the Medicaid rate is just 33% of the private-pay rate. Even recognizing the approximate nature of the comparison, the gap is notable. This finding suggests that low rates may be a barrier to increasing the number of clients in assisted living.

Chart 5.1.3.1
Private-Pay and Medicaid Per-Diem Payment Rates in Rhode Island

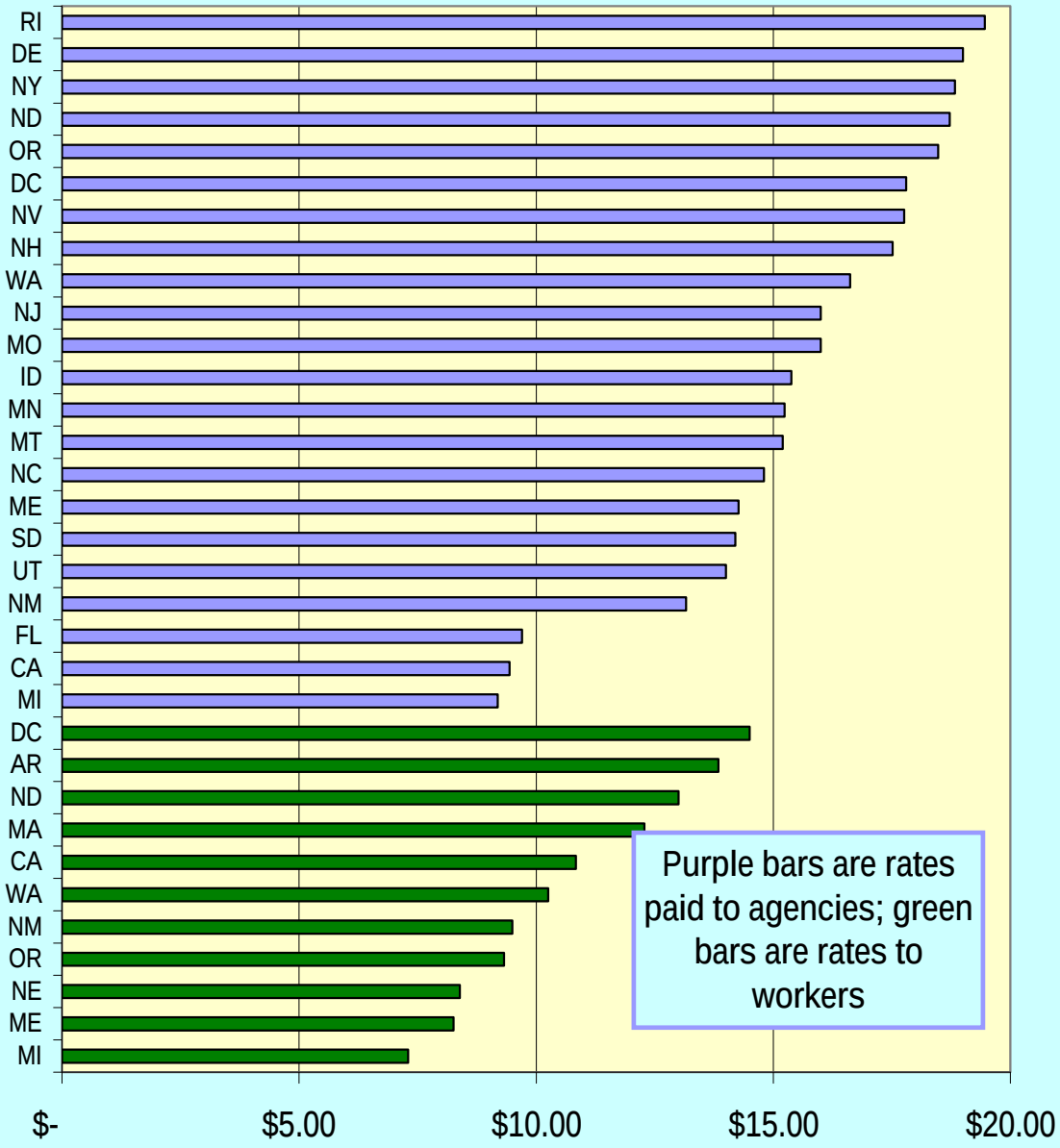


Sources: *MetLife Market Survey* , ACS analysis of Medicaid claims data

- ***Home-based care.*** Personal care is the single most important payment rate. Chart 5.1.3.2 shows the results from a recent comparison of Medicaid hourly payment rates published by the Kaiser Commission on Medicaid and the Uninsured.[27] The purple bars show the rates paid to agencies and the green bars the rates paid to individual providers. The Kaiser Commission's Rhode Island rate of $19.46 is essentially identical to the rate of $19.44 that we calculated in Section 3. The implication of Chart 5.1.3.2 is that it is not obvious that Rhode Island rates are set too low. However, we should note that the Kaiser data show only an individual provider rate for Massachusetts and do not show any rates for Connecticut. As well, the Hilltop study reached the opposite conclusion from 2004 data.[28] Further information presumably will come from the pending Hilltop survey of home and community based service providers in Rhode Island.[29] That survey asks respondents to provide detailed information on payment rates from Medicare, Medicaid, self-pay and other payment sources.

Finding No. 9: Medicaid appears to be a good payer for personal care, so rates are unlikely to be an important obstacle to increased HCBS use.

Chart 5.1.3.2
Medicaid Payment Rates for Personal Care, 2007



Source: Kaiser Commission for Medicaid and the Uninsured

5.2 Goal: Quality and Service

We are not specialists in measuring the quality of home and community based services, so the following discussion should be viewed as preliminary. We hope that it will serve as the basis for further efforts to evaluate and reward the quality and service.

5.2.1 Quality and Service Goals

We place quality and service goals into six categories, as follows.

- ***Attendance.*** We list this goal separately because of its unique degree of importance in the HCBS setting. A basic goal is that HCBS staff show up at the client's home. Anecdotally, attendance is a particular problem on nights and weekends or when there is bad weather, school closures, transit disruptions, etc. As noted in Section 2, home and community based services sometimes have trouble dealing with "shocks" such as the caregiver being absent. One of the key reasons to pay agencies rather than individuals is that agencies presumably have better back-up plans for no-shows.

- ***Structural measures.*** This term refers to the "structure" within which care is provided. For example, how well trained are the staff, is the organization accredited, does the building (in the case of assisted living) meet certain standards?

- ***Process measures.*** This term refers to how care is delivered. For example, did clients eligible for flu shots receive them?

- ***Outcome measures.*** The long-term care sector focuses more on outcome measures than other areas of health care. Examples include the percentage of clients who get better at moving around and the percentage of clients who suffer less pain. Note that appropriate risk adjustment can be essential in measuring outcomes, particularly since many Medicaid long-term care clients have progressive conditions in which slowing the decline is a more realistic goal than reversing the decline.

- ***Customer satisfaction and quality of life.*** Every health care consumer has views about their providers, but perhaps especially so for recipients of personal care. It is one-to-one care, in the patient's home, usually for hours each day. Clients can be asked specifically about the care they receive. More generally, quality of care can be inferred from more general questions such as "Do you feel in control of your life? Do you feel safe and well cared for?"[30]

- ***Fraud and abuse.*** As in every aspect of life, fraud and abuse are always a concern. In the setting of home and community based services, there are risks to both the client and the payer. Potential problems affecting the client include theft, fraud, and physical and/or emotional abuse. Potential problems affecting the payer are charging for services not provided or providing services not needed. These problems can arise with or without the client's knowledge.

5.2.2 Measuring Quality

Rhode Island appears to do a better job than most states in measuring the quality of home and community based care. For example, it was the first state to require public reporting of home health client satisfaction data, specifically including "non-skilled" agencies that provide personal care.[31] Because Medicare has led public reporting efforts nationwide, to date these efforts have focused on hospitals and skilled nursing facilities. The Rhode Island survey was a rare example focusing on services provided mainly to Medicaid clients. Questions referred to topics such as ease of arranging care, care from aides, and the helpfulness of office staff.

On the same webpage (Table 5.2.2.1), the Department of Health makes available data by home health agency on clinical outcome measures such as improving mobility, admissions to hospital after home health care, and improving client ability to take medications. These data are drawn from a national Medicare dataset (OASIS) and are therefore of limited applicability to the Medicaid population. (Medicare pays for skilled home health for clients recovering from a hospitalization, while Medicaid clients tend to use what is sometimes unfortunately called "custodial care.") Nevertheless, the information may be useful to some Medicaid clients, particularly those whose needs are similar to those of the typical Medicare client.

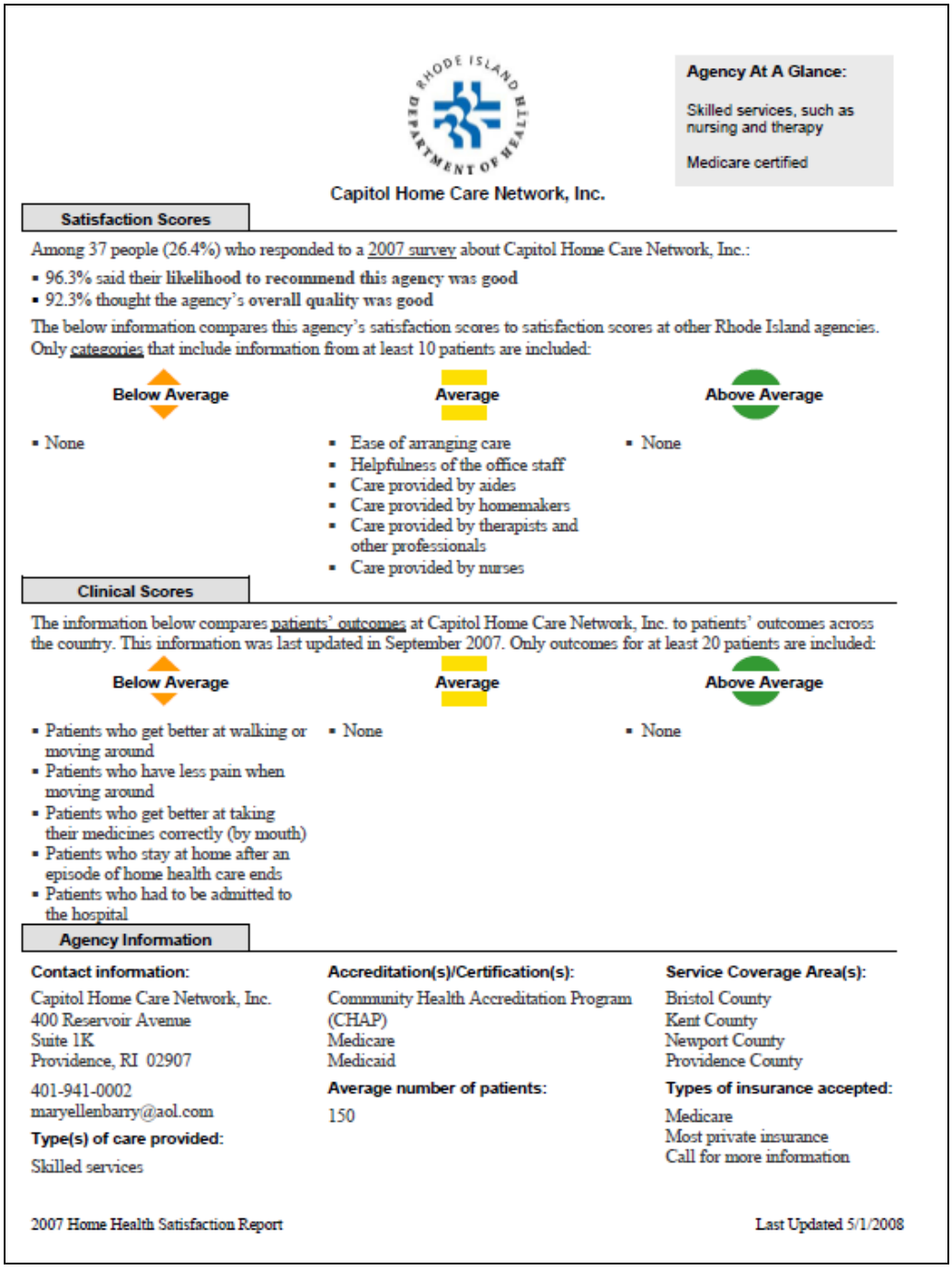
Finding No.10: Department of Health report cards that address the specific needs of Medicaid clients are useful and should be continued

The above two sources focus on providing information at the provider level, which is very useful to clients and their families who are choosing caregivers. Another perspective is to examine how well the state's long-term care system is meeting the needs of the population. In a recent report to the Department of Human Services, Susan Allen and Julie Lima summarized what is known about levels of unmet need and processes of care such as blood pressure screening and breast cancer in the elderly and disabled populations.[32] Noting that information gathering is typically funded with one-time grant money, they also made two specific recommendations about how to improve information about quality and other aspects of care provided to people receiving home and community based services. Those recommendations are to make use of computerized assessment tools at time of initial placement and every year thereafter, and to make state-specific use of instruments such as the Personal Experiences Survey.

One beneficial aspect of the Global Consumer Choice Compact being a waiver under Section 1115 of the Social Security Act is that the compact will be formally evaluated. In addition to the evaluation results themselves, the process of preparing the evaluation will result in collection and analysis of data that can inform decisions about value purchasing.

Table 5.2.2.1

Example of Home Health Agency Report Card



Capitol Home Care Network, Inc.

Agency At A Glance:

Skilled services, such as nursing and therapy

Medicare certified

Satisfaction Scores

Among 37 people (26.4%) who responded to a 2007 survey about Capitol Home Care Network, Inc.:

- 96.3% said their **likelihood to recommend this agency was good**
- 92.3% thought the agency's **overall quality was good**

The below information compares this agency's satisfaction scores to satisfaction scores at other Rhode Island agencies. Only categories that include information from at least 10 patients are included:

Below Average	Average	Above Average
▪ None	▪ Ease of arranging care ▪ Helpfulness of the office staff ▪ Care provided by aides ▪ Care provided by homemakers ▪ Care provided by therapists and other professionals ▪ Care provided by nurses	▪ None

Clinical Scores

The information below compares patients' outcomes at Capitol Home Care Network, Inc. to patients' outcomes across the country. This information was last updated in September 2007. Only outcomes for at least 20 patients are included:

Below Average	Average	Above Average
▪ Patients who get better at walking or moving around ▪ Patients who have less pain when moving around ▪ Patients who get better at taking their medicines correctly (by mouth) ▪ Patients who stay at home after an episode of home health care ends ▪ Patients who had to be admitted to the hospital	▪ None	▪ None

Agency Information

Contact information:

Capitol Home Care Network, Inc.
400 Reservoir Avenue
Suite 1K
Providence, RI 02907

401-941-0002
maryellenbarry@aol.com

Type(s) of care provided:

Skilled services

Accreditation(s)/Certification(s):

Community Health Accreditation Program (CHAP)
Medicare
Medicaid

Average number of patients:

150

Service Coverage Area(s):

Bristol County
Kent County
Newport County
Providence County

Types of insurance accepted:

Medicare
Most private insurance
Call for more information

2007 Home Health Satisfaction Report

Last Updated 5/1/2008

This page from the Rhode Island Department of Health website shows an example of an agency that provides serves both Medicare and Medicaid clients. The example was chosen because it includes both satisfaction scores and clinical scores. Agencies that do not serve many Medicare patients usually do not have clinical scores shown.

5.2.3 Paying for Quality

Paying for quality does not ensure quality, and many providers deliver quality service regardless of financial incentives and disincentives. Yet it seems obvious—and there is a large body of evidence from health care and elsewhere—that you tend to get what you pay for. Currently, Rhode Island providers have the following financial incentives to deliver quality care. Note that an incentive can be direct or indirect, and indirect incentives are not necessarily less powerful than direct ones.

- ***Rate enhancements.*** The basic rates for personal care and related services can be increased if agencies meet various quality-related standards, as shown in Table 5.2.3.1.

- ***Consumer choice.*** A powerful incentive to deliver quality care exists when the client has choice over which individuals provide care to them.

- ***Reputation.*** Providers have reputations with hospital discharge planners, State staff, consumer advocates and other people who may be in a position to recommend agencies and other providers to clients and their families. Web-based "report cards" such as the Rhode Island 2007 Home Health Agency Satisfaction Survey play an increasingly important role in determining reputation.

- ***Liability concerns.*** Every provider presumably bears in mind the financial implications of civil, criminal or administrative legal proceedings that may arise from poor quality care.

Table 5.2.3.1
Quality-Related Payment Differentials Incorporated in RI Personal Care Rates

Item	Description
Shift differential	For services provided on nights, weekends, and holidays.
Staff education and training	For the provision of a comprehensive in-service training program at a frequency of 20 percent above Rhode Island Department of Health licensure requirements with 100 percent staff attendance.
Accreditation	For achievement of state accreditation and/or accreditation from the Joint Commission for Accreditation of Healthcare Facilities (JCAHO)/Community Health Accreditation Program (CHAP).
Client satisfaction	For providers who maintain a log of client complaints and resolution procedures followed.
Continuity of care	When no more than two aides per client provide services to at least 85% of individuals receiving between 10-20 hours of agency home care services each week.
Worker satisfaction	For improved staff retention such that 75% of employees who work a minimum of two weeks are continuously employed for at least six months.
Client acuity	For services provided to a client assessed as being high acuity by the agency's registered nurse based on the minimum data set for home care.

Note: Client acuity is not a quality measure, but is included in order for the table to be comprehensive.

Source: Dorie Seavey and Vera Salter, *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants* (Washington, DC: AARP Public Policy Institute, 2006), p. 10.

Finding No. 11: Rhode Island is among the leading states in paying for performance in HCBS, although room for improvement remains

As in some other areas of Medicaid performance (such as RIte Care), Rhode Island has done more to link payment and quality than most other states. A report from the AARP Public Policy Institute, for example, highlighted the rate enhancements as an example for other states.[33] Nevertheless, it is very likely that opportunity exists to tighten that link. A next step would be to analyze the impact so far of the rate enhancements and decide if adjustments would make sense. These could be done in budget neutral fashion.

Notes

[1] See Gary Alexander, "Sustainable Medicaid Reform for R.I.," *Providence Journal*, August 29, 2008; State of Rhode Island and Providence Plantations, *The Rhode Island Global Consumer Choice Compact Proposed Waiver*, Submitted to the Centers for Medicare and Medicaid Services, March 26, 2008; Rhode Island Legislature, P.L. 09-068, Article 23.
[2] Brian Burwell, Kate Sredl and Steve Eiken, *Medicaid Long-Term Care Expenditures in FY 2007* (Thomson Reuters, 2008), p. 1.
[3] Burwell et al., *Medicaid Long-Term Care Expenditures*, p. 1.
[4] Kacey Booth, "Along the Continuum of Care… Rebalancing the Long Term Care System with Home and Community Based Services," Deliverable to the RI Department of Human Services, Mar. 12, 2009, p. 10.
[5] Dianne Kayala, "Home and Community-Based Service Trends," Deliverable to the RI Department of Human Services, June 19, 2009.
[6] Rhode Island Department of Elderly Affairs, *Preliminary Findings: Impact of DEA Services on the Entry of Clients to Rhode Island Nursing Homes* (Cranston, RI: DEA, Feb. 2008).
[7] In nursing facilities, 67% of direct patient care hours come from aides, 23% from licensed practical nurses, and just 10% from registered nurses. American Health Care Association, *Trends in Nursing Facility Characteristics* (Washington, DC: AHCA, June 2009), p. 4.
[8] U.S. Bureau of Labor Statistics, "May 2008 State Occupational Employment and Wage Estimates: Rhode Island," available at www.bls.gov/oes/2008/may/oes_ri.htm#b31-0000. For a personal care aide, we referred to the BLS category of home health aide.
[9] U.S. BLS, "State Occupational Employment and Wage Estimates."
[10] Robert L. Mollica, *State Medicaid Reimbursement Policies and Practices in Assisted Living* (Washington, DC: AHCA, p.p. 10-11.
[11] $184 was the average allowed amount per day of nursing facility in 2008. Actual Medicaid reimbursement per patient day was approximately $35 lower, due to patient cost-sharing. We focus on the allowed amount because it reflects the payment rate set for Medicaid for providing services to a Medicaid beneficiary.
[12] Kevin Quinn, "How Much Is Enough? An Evidence-Based Framework for Setting Medicaid Payment Rates," *Inquiry* 44 (Fall 2007), pp. 247-256.
[13] John Stephen, *New Hampshire's Granite Care: Recommendations to Modernize Medicaid* (Concord, NH: Department of Health and Human Services, 2004)
[14] Montana Department of Public Health and Human Services, *Montana Public Health Care Redesign Project*, (Helena, MT: DPHHS, 2004), p. 39.
[15] Center for Health Program Development and Management, *Community-Based Long-Term Care Services in Rhode Island*, Report Issued Pursuant to Joint Resolution 05-R 384 (Baltimore: UMBC, April 2006), p. 2.
[16] For Rhode Island, Burwell and colleagues calculated that HCBS represented 13% of long-term care spending for the aged and disabled population in 2007. The actual figures used were $43.3 million for HCBS and $299.9 million for institutional (nursing facility care). These are quite close to the data for SFY 2008 that we described in Section 3, thereby providing reassurance about the consistency of the Burwell data with our own analysis.
[17] Rhode Island Department of Human Services, *Acuity Adjusted Rates for Rhode Island Nursing Facilities: A Report to the Rhode Island State Legislature* (Cranston, RI: DHS, November 2009).
[18] P.L. 09-068, Article 23, Section 1, amending §40-8-19 of the Rhode Island General Laws.
[19] Mollica, *State Medicaid Reimbursement Policies and Practices in Assisted Living*, pp. 10-15, 139-140.
[20] Kevin Quinn, "Dividing a Trillion-Dollar Pie," *Healthcare Financial Management*, April 2004.
[21] Mollica, *State Medicaid Reimbursement Policies and Practices in Assisted Living*, pp. 149-150.
[22] Kevin Quinn, "Medicaid's Role in the Many Markets for Health Care," *Health Care Financing Review* 28:4 (Summer 2007), pp. 69-82.
[23] UMBC, *Community-Based Long-Term Care Services*, p. 2.
[24] Eljay LLC, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, Report to the American Health Care Association (October 2008), p. 5.
[25] UMBC, *Community-Based Long-Term Care Services*, p. 11.
[26] Mollica, *State Medicaid Reimbursement Policies and Practices in Assisted Living*, pp. 27-136.

[27] Terence Ng, Charlene Harrington and Molly O'Malley, *Medicaid Home and Community-Based Service Programs: Data Update*, Report 7720-02 (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2008), Table 12.
[28] UMBC, *Community-Based Long-Term Care Services*, p. 12.
[29] The Hilltop Insitute, *Survey of Providers of Long-Term Supports and Services in Rhode Island* (Baltimore: UMBC, July 17, 2009).
[30] National Commission for Quality Long-Term Care, *From Isolation to Integration: Recommendations to Improve Quality in Long-Term Care*¸ Final Report (NCQLC: Washington, DC: Dec. 2007), pp. 23-26.
[31] Rhode Island Department of Health, "Rhode Island Department of Health Releases First Annual Statewide Report on Patient Satisfaction with Home Health Care," news release. May 29, 2008. Survey results are available at www.health.ri.gov/chic/performance/homehealth/index.php.
[32] Susan M. Allen and Julie C. Lima, *The Needs and Experiences of the Adult RI Medicaid Population*, Report to the Rhode Island Department of Human Services (Providence, Brown University, April 2009).
[33] Dorie Seavey and Vera Salter, *Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants* (Washington, DC: AARP Public Policy Institute, 2006).