Community-Based Long-Term Care Services in Rhode Island
A Report Issued Pursuant to Joint Resolution 05-R 384 (2005)

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DEVELOPMENT AND MANAGEMENT

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Executive Summary

The Rhode Island Department of Human Services contracted with the Center for Health Program Development and Management (the Center) at the University of Maryland, Baltimore County, to conduct a study of community-based long-term care services in Rhode Island. This study was required by Joint Resolution 05-R 384 of the Rhode Island General Assembly (2005).

The study included several dimensions: a review of service rates and the rate methodologies for four specific community-based services; an assessment of workforce capacity needed to provide services in the future; and observations and recommendations regarding the potential to restructure the State's funding, across different programs, to support assisted living, home care, respite care, and adult day care.

After conducting extensive research, including data analysis, literature reviews, and numerous key stakeholder and informant interviews, the Center reached four major findings:

1. **Rate methodologies are biased in favor of institutional care, which may hinder the capacity of Rhode Island to deliver community-based care.** Rhode Island's rate setting methodologies tilt in favor of institutional care, making it difficult for community-based providers to compete with nursing facilities for workers. This creates structural issues in delivering community-based care: Rhode Island's rates for community-based services generally are below other New England states; the community-based rates are not correlated in any respect to the cost to deliver community-based services (based on prevailing wage scales and other factors); and many vacancies at community-based providers are difficult to fill within the parameters of what the providers can afford to pay.

2. **Addressing this bias by raising community-based rates may not increase access to community-based services**. Rhode Island faces challenges beyond provider rates in increasing access to community-based services. One major challenge is the absence of a systematic approach to informing consumers about the options that are available to them, at the time and in the location when they need this information. Another major challenge is the absence of planning across funding streams and programs (including Medicare) in delivering a coordinated service array to consumers. A third challenge is the cumbersome process involved in applying for community-based services.

3. **The demand for all long-term care services, including community-based services, will grow.** Not surprisingly, Rhode Island is facing a demographic wave that will increase the demand for long-term care services. The fastest growing demographic group in the state will be the old (60+), especially the oldest old. By 2010, using current eligibility rules, about 31,000 Rhode Islanders are likely to qualify for publicly-funded long-term care services.

4. **Rhode Island's approach to state budgeting could be improved, in a way that would grow access to community-based services in a budget neutral manner.** By appropriating funds to Medicaid nursing facility services in a separate budget line than the appropriation for Medicaid home- and community-based services, Rhode Island does not enable Medicaid to utilize nursing facility savings to expand access to community-based services; instead, those savings revert to the general fund. This could be altered in a budget neutral manner that would create an incentive for systems change in Rhode Island.

Based on these findings, the Center recommends:

- **Rhode Island should pursue an approach to community-based rate setting that removes the methodological biases in favor of institutional care.** Rhode Island should normalize the recruitment and wage incentives across institutional and community-based settings of care.

- **Rhode Island must improve consumers' access to information about their community-based service options by focusing on *information dissemination as a systems-level issue*.** Rhode Island will not turn the corner on improving access to community-based services by addressing this as a rate-setting issue alone. True systems-level reform will require delivering to consumers the information and options they need, when and where consumers need this information. One part of this strategy must include delivering information to consumers and providers at the time of discharge from a hospital.

- **Rhode Island must devote attention to *service delivery coordination as a systems-level issue***. The state should develop more systematic approaches to coordinate services across programs and payers. One promising option Rhode Island could consider is a capitated managed long-term care system, incorporating both Medicare Advantage Special Needs Programs and Medicaid-funded long-term care supports and services.

- **Rhode Island's legislature should adopt a global budgeting approach to Medicaid long-term care**. By appropriating funding for nursing facility services and community-based services in the same budget line, Rhode Island could better align its policy goals with its budgeting process. This would be budget neutral. This approach, known as global budgeting, has been implemented in Oregon and Washington and has succeeded in moving a greater proportion of funding toward community-based care. This would enable savings achieved by Rhode Island when it reduces nursing facility utilization (against the baseline, established during the caseload estimating conference) to be re-invested in expanded community-based services.

Purpose

The Rhode Island Department of Human Services contracted with the Center for Health Program Development and Management (the Center) at the University of Maryland, Baltimore County, to conduct a study of community-based long-term care services in Rhode Island. The study was to focus on service rates, workforce capacity, service needs, and the potential for restructuring funding for public programs providing assisted living, home care, respite care, and adult day care. This study is pursuant to Joint Resolution 05-R 384 of the 2005 Session of the Rhode Island General Assembly. Specifically, the resolution stated that the "study shall be undertaken to determine the full scope of need for long-term care services to include, but not be limited to, home care, adult day enters, accessory family dwelling units, respite services, assisted living residences and nursing facilities … [and the] study shall also include a review and recommendations of appropriate financing structures that will ensure access to services for those in need of community-based long-term care …."

Background

As early as 1997, the state of Rhode Island was discussing the issues surrounding the growing senior population of the state, including provider rate reform, quality of care, availability and utility of a seamless health information infrastructure, as well as other service delivery and care issues. In Fiscal Year 2003, the General Assembly focused on long-term care (LTC) reform with a multi-year approach to nursing home care and provider payment, culminating in a new rate-setting methodology for nursing homes that is now in place.

While the demand for nursing home care is declining in Rhode Island, as evidenced by a one-percent-per-year reduction in the number of Medicaid nursing home days, there is growing concern that the demand for community-based services for older adults and persons with disabilities will soon outstrip the state's ability to meet them. In terms of the percentage of overall long-term care expenditures devoted to home- and community-based services, Rhode Island ranks last in New England and well below the national average. Rhode Island currently spends about 10 percent of its Medicaid LTC expenditures on community-based supports and services, and 90 percent on nursing home care, excluding expenditures for persons with developmental disabilities. The national average for Medicaid home- and community-based waiver expenditures in 2002 was 20 percent.[1] Like other states, Rhode Island's continued growth in Medicaid expenditures is thought to be unsustainable. In addition, as a small state bordered by larger neighbors, there is concern about the ability of Rhode Island providers to compete for workers. Both supply and retention of direct care workers are reportedly growing problems within the provider community.

While this study will focus on community-based services to older adults, the transitioning of persons with disabilities "aging into" services for older adults presents additional challenges to the system. Persons with severe and persistent mental illness and individuals with developmental disabilities are guaranteed access to state-only funded programs, whether or not they are eligible for Medicaid. This puts additional pressure on the financial resources of the state at a time when increasing the federal Medicaid match is necessary to help accommodate the expected increased services demands from a growing population of older adults. The state reports that the acuity level of persons with disabilities aging into senior services is increasing as well.

As the demographics of an aging population continue to shift, workforce variables stress the system, the service delivery system continues to evolve to a greater emphasis on community-based supports and services instead of institutional services, and public health care costs continue to escalate, the General Assembly decided, in 2005, that it was necessary to study these growing pressure points on an already stressed service delivery and financial system.

[1] Centers for Medicare and Medicaid Services.

Methodology

The study questions the Center sought to answer are:

1. Do the current financial structures underlying publicly-funded long-term care services in Rhode Island ensure access to home care, adult day centers, respite services, and assisted living residences?

2. Can the current delivery system and financing structures be enhanced to reprogram existing funding and utilize Medicaid waivers in the most effective manner?

3. Can the Center recommend a direction for the development of a future long-term care system that better balances institutional and community-based services to meet the needs of the Rhode Island population?

The Center divided the study into six categories of exploration:

1. **Analysis of Provider Rate Structures:** The Center examined current provider rates and historic rates over the prior five years, as well as the underlying rate-setting methodologies employed. The Center then compared Rhode Island's rates and methodologies with those of the other five New England states. Finally, rate structures in the context of future capacity needed by Medicaid and other public programs were considered.

2. **Resource Mapping:** The Center initiated a review of sources of state-only funding, the impact that shifting these funds from state-only programs to Medicaid would have on people currently covered by these programs, and the regulatory and political feasibility of reorganizing identified funding and programs.

3. **Workforce Supply Analysis:** The Center gathered Bureau of Labor Statistics and other data to identify employment and vacancy patterns in the health care industry in Rhode Island and the other New England states.

4. **How People Enter the Service Delivery System:** Numerous individuals interviewed by the Center in the preparation of this report expressed views about the process individuals must go through to gain entry into home- and community-based services in Rhode Island. This section details those views and discusses possible improvements that might be considered.

5. **Analysis of Future Service Needs:** Employing Claritas data (from 2000 census data) for Rhode Island, the Center developed tables identifying estimated need for services between 2005 and 2010 by income/eligibility categories for the services which are the focus of this study.

6. **Strategies for Redistributing State Funds:** The Center explored opportunities for redistributing state-only program and/or nursing facility funds to focus more resources on community-based supports and services (e.g., by directing funds into Medicaid match-able programs). The Center's analysis identified funding streams that might be considered for redistribution, provided examples of how redistribution might be organized, and described the possible impact of redistribution on current service access, utilization, and coordination.

The Center analyzed state-provided data, state policies and regulations, national data from the Bureau of Labor Statistics and the Census Bureau, data and information from other states, and data and information provided by study informants. The Center interviewed state agency representatives, the ombudsperson, executive branch personnel and elected officials, legislative staff, Rhode Island providers, and agency staff from other states.

Analysis of Provider Rate Structures

This analysis focused primarily on Medicaid and state funds used to reimburse providers of assisted living, respite, adult day care, and home care services. Information on nursing homes, state institutions, and hospital service staff salaries and benefits was reviewed in order to draw comparisons of the effect of the Medicaid rate reimbursement system on different provider types and the state's ability to compete for competent and adequate staff. The analysis examined:

- Current payment rates for each service and how rates are established and funded
- Changes in the payment rates over the last five fiscal years
- How Rhode Island's payment rates and rate-setting methodologies compare to the other New England states
- How Rhode Island's payment rates impact the availability of providers of LTC services, especially the differential impact between institutional providers and community-based providers.

Description of Current Rate Payments and Methodologies

Similar services exist among different Medicaid-funded programs in Rhode Island, and the Medicaid rates paid for similar services are consistent across programs, including the Medicaid State Plan and Waiver programs. In addition, state-only funded programs pay the same rates as Medicaid for personal attendant care, home health personal care and homemaker services, and case management.

Adult Day Care: In FY 2004, there were 18 adult day care centers in Rhode Island, including one Program of All Inclusive Care for the Elderly (PACE) program, which is not funded in the same way as the other centers.[2] The adult day care centers served approximately 765 clients[3]. The Medicaid rate paid for adult day care in 2005 was $37.11 per day regardless of the length of the day of service. Service providers stated that the rate is related to a six-hour day, but that actual stays are closer to nine hours. There is no systematic methodology used to set the rate. Both the rate and any increases are set by the legislature. Without exception, all providers and agency representatives interviewed stated that the adult day care rate is not adequate to cover the cost of care. The Rhode Island legislature has made annual state fund grants of $50,000 each to adult day care providers to help supplement operating costs that are not covered by the Medicaid reimbursement rate.

Assisted Living: In FY 2004, there were 71 assisted living facilities in Rhode Island with 3,637 beds.[4] The current Medicaid daily rate paid for eligible assisted living residents is $35.54. There is no systematic method for setting assisted living Medicaid rates. Both the rate and any increases are essentially set by the legislature in the budgetary process. However, state funds are used to supplement residents in assisted living programs through three programs:

[2] Rhode Island Long Term Care Spending, FY 2004, A Report of the Long Term Care Coordinating Council, Lieutenant Governor Charles J. Fogarty, Chairman, June 2005, Table 7, pg. 9.
[3] Ibid.
[4] Ibid.

- **Enhanced Supplemental Security Income (SSI):** This state-funded program administered by the Department of Human Services (DHS) provides supplemental payments to individuals who reside in an assisted living center and whose total monthly income is less than $1,178. The state pays up to $575 per month to make up the difference between an individual's income and/or federal SSI payment and $1,178. Individuals living in an assisted living center who do not participate in a Medicaid waiver retain a $55 personal needs allowance and pay the remaining $1,123 as their monthly assisted living fee.

- **Medicaid Department of Elderly Affairs (DEA) Waiver:** This Medicaid-funded waiver program administered by DEA includes assisted living and pays up to $35.54 per day for assisted living services, but requires that the resident contribute any income above the maintenance needs allowance (100% of poverty, or approximately $800 per month) toward the $35.54 per diem. Residents must also pay a room and board fee of approximately $700 per month from his/her maintenance needs allowance. The provider therefore receives reimbursement of approximately $1,766 per month.

- **Medicaid Assisted Living Waiver:** This waiver, administered by DEA and funded by DHS with support from RIHMFC, [5] pays $35.54 per day from Medicaid.[6] This program allows a maintenance needs allowance of $1,178, of which $1,078 must be used for the cost of room and board. The provider receives up to $2,144 per month.

Respite Care: Respite care is offered only through DEA and is funded through different sources, none of which are Medicaid. The Subsidized Respite Care Program provides relief to primary care givers who care for persons age 55 or older. Care relief can be in the home, in adult day care, or overnight in assisted living. The program utilizes cost sharing and is administered through the DEA in conjunction with the Diocese of Rhode Island. DEA also administers a Homemaking Assistance program for people age 55 or older, or for persons with disabilities. This program provides homemaker services at a reduced rate for income-eligible people.

Home Care: In FY 2004, there were 50 home nursing care providers and 11 home care providers.[7] Some home nursing care providers do not accept Medicaid clients. The following table shows the average Medicaid rates paid for home care services as reported by DHS. The average rate includes those rates paid to agencies that participate in the Enhanced Home Health Agency Reimbursement Program. DHS provided these as average rates; interviews with and written communications from home care providers suggest that some providers are receiving lower reimbursement than others.[8]

[5] Rhode Island Housing Mortgage and Finance Company. This agency guarantees financing for certain assisted living facilities at individual rates.
[6] Within this assisted living waiver, a sub-program exists due to the fact that specific assisted living facilities were developed using Rhode Island Housing Mortgage and Finance Company financing and this waiver is required to fill those facilities' beds before sending enrollees to other assisted living providers.
[7] Rhode Island Long Term Care Spending, FY 2004, A Report of the Long Term Care Coordinating Council, Lieutenant Governor Charles J. Fogarty, Chairman, June 2005, Table 7, pg. 9.
[8] R.I. Partnership for Home Care, Inc. January 3, 2004 letter to John Young, Associate Director, Health Care Quality, Financing and Purchasing.

Agency/Staff Reimbursement	Hourly Medicaid Reimbursement Rate
Visiting Nursing Agency Registered Nurse, Physical Therapy, Occupational Therapy	$65.73/encounter
Visiting Nursing Agency Home Health Agency	$18.98/hr
Case Management	$60/hr
Home Health Homemaker	$18/hr
Home Health Personal Care	$18.98/hr
Personal Care Attendant	$8.58/hr

The skilled nursing and therapy home care rates are set by the legislature. These rates are not determined using any systematic methodology or cost-basis.[9]

Five-Year Medicaid Rate and Methodology History

The following table shows a five-year history of Medicaid rates for specific services, all of which are based on the Medicaid payment rate. The chart does not show differences that result either directly or indirectly from state fund supplements. Increases have been limited in size and frequency.

Provider Type	FY01	FY02	FY03	FY04	FY05	Rate Setting Methodology
Assisted Living		$35.30/ day	$35.54/ day	$35.54/ day	$35.54/ day	SSI 1998 cost analysis and SSI Supplement
Adult Day Care	$35.00/day	$36.04/day	$37.11/ day	$37.11/ day	$37.11/ day	1996 Cost Analysis and occasional COLA legislation
Respite Care	Not yet collected					

[9] It is worth noting that base rates vary depending on accreditation and certifications among staff. In addition to the base rates, hourly staff usually receive add-on payments for weekend and holiday shifts, late evening and night shifts, and for special client services. Any rate increases to the base rate until 2005 only applied to the base rate. The 2005 increase included enhanced payments as well as the base rate.

Provider Type	FY01	FY02	FY03	FY04	FY05	Rate Setting Methodology
Visiting Nurse Agency Registered Nurse	$62.00/ encounter	$63.84/ encounter	$65.73/ encounter	$65.73/ encounter	$65.73/ encounter	Legislative set in 1999 with COLAs
Visiting Nurse Agency Home Health Agency	$17.34/hr	$17.87/hr	$18.42/hr	$18.42/hr	$18.98/hr	Average agency based rates 1996 Cost analysis and occasional COLA legislation
Visiting Nurse Agency Physical Therapy	$62.00/ encounter	$63.84/ encounter	$65.73/ encounter	$65.73/ encounter	$65.73/ encounter	Legislative set in 1999 with COLA
Visiting Nurse Agency Occupational Therapy	$62.00/ encounter	$63.84/ encounter	$65.73 encounter	$65.73/ encounter	$65.73/ encounter	Legislative set in 1999 with COLA
Home Health Homemaker	$15.96/hr	$16.45/hr	$17.47/hr	$17.47/hr	$18.00/hr	Average Agency based rates 1996 Cost analysis and occasional COLA legislation
Home Health Personal Care	$17.34/hr	$17.87/hr	$18.42/hr	$18.42/hr	$18.98/hr	Average Agency based rates 1996 Cost analysis and occasional COLA legislation
Personal Care Attendant	$7.84/hr	$8.08/hr	$8.33/hr	$8.33/hr	$8.58/hr	Average Agency based rates 1996 Cost analysis occasional COLA legislation
Case Management	$60/hr	$60/hr	$60/hr	$60/hr	$60/hr	Based on DEA cost evaluation

Interstate Rate and Rate-Setting Methodology Comparison

Rate Comparison across States: The following table shows a comparison of 2004 private pay rates and Medicaid reimbursement rates for specific services in Rhode Island and other New England states. Data sources include the Rhode Island Department of Human Services, interviews with Rhode Island providers, and other states' Medicaid information web-sites, administrative staff, and the recent survey conducted by the New England States Consortium Systems Organization (NESCO).[10] There are some discrepancies among the different sources. The following table reflects the Center's efforts to reconcile differences and provide a reasonably reliable comparison of Medicaid rates paid for community-based services. In addition, the table includes the range of rates paid by consumers for daily nursing home charges and hourly charges for home health aides. The nursing home consumer pay rates include average rates for semi-private rooms and average rates for private rooms.

	RI	MA	CT	VT	NH	ME
Nursing Home Per Diem Private Pay Charges[11]	$186-206/day	$260-284 /day	$210-331 /day	$210-219/day	$208-220/day	$205-228 /day
Home Health Aide Average Private Pay Charge[12]	$21/hr	$22.50/hr	$25.50/hr	$21/hr	$23/hr	$18/hr
Assisted Living[13]	SSI nonenhanced $35.23 + SSI Enhanced all eligible$35.54/day		$21.21-$73.19 $37.39 $53.67/day*	$52/day	$37.81/day	$36.79/day

[10] State sources are provided below.
Vermont: *Choices for Care Vermont Long-Term Care Medicaid Program Manual* at *http://www.dad.state.vt.us/1115waiver/H&HNeedsManual.pdf*
Maine: *MaineCare Benefits Manual*, Chapter 3 of each services section. The website is http://www.maine.gov/sos/cec/rules/10/ch101.htm. "Maine's Long-Term Care Services" information provided by the Office of Elder Services, Department of Health and Human Services.
Massachusetts: Medicaid regulations at:
http://www.mass.gov/?pageID=eohhs2modulechunk&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_regs_related_pubs&csid=Eeohhs2#114_3_43
Additional rate information provided by the Division of Health Care Financing and Policy, Massachusetts Department of Health and Human services.
Connecticut: Cost of Long-Term Care in Connecticut, Connecticut partnership at http://www.opm.state.ct.us/pdpd4/ltc/Consumer/nhrate.htm. Connecticut's assisted living rates provided by the Department of Social Services, State of Connecticut. Home Care Service Fee Schedule Update, State of Connecticut, Department of Social Services.
New Hampshire: Rates and regulation information downloaded from
http://www.nhmedicaid.com/Downloads/manuals.html
[11] MetLife, Ibid.
[12] Ibid.
[13] Assisted Living rates are based on a range of rates related to the level of acuity of the resident, e.g. incontinence, medication administration, depression, assistance for transportation, modified cognitive skills.

	RI	MA	CT	VT	NH	ME
Adult Day Care	$37.11/day	$26.71 $45.87 $57.38/day	$66/day	$11/hr	$47.07/day	$9.36/hr
Case Management	$60/hr	$47.76/mo		$65/day	$35/hr	$126.25/mo
Respite Care		$139- $160/mo* Cty. Rates	$250/mo	$11/hr	$6.00/hr	$100/mo
Personal Attendant Care	$8.58/hr	$12/hr			$16/hr	$14.98/hr
Home Health Aid	$18.98/hr	$23.96/hr	$30.00/hr	$24.16/hr	$21.96/hr	$17.20/hr
Personal Care		$12/hr				$14.98/hr
Home Health Homemaker	$18/hr	$15.24	$18-$19/hr		$16.72/hr	$14.38/hr
Skilled Nursing Home Visit	$65.73/hr	$83.17/hr	$114/visit		$75.80/hr	$117- $168/hr

*Not covered by Medicaid.

Although it is difficult to make direct comparisons among states due to different definitions and methods of accounting for Medicaid rate payments (e.g., hourly or daily rates), Rhode Island rates seem to be lower overall than rates in the other New England states. This is particularly clear for home health aides, adult day care, and skilled nursing home visits. Other states have different increments for assisted living rates, some of which are lower than the Rhode Island per diem, but all of which allow higher rates based on resident acuity and cap out at considerably higher per diem payments than the Rhode Island payment.

Comparison of Rate Methodologies

Rhode Island uses a cost basis for calculating nursing home rates. It does not use similar methodologies for calculating rates for assisted living, adult day care, home health personal care and homemaker services, personal attendant, respite care, or skilled home care.[14] Rates for community-based services were established initially by the legislature and have benefited in some years by legislatively-mandated increases. There is no history of any formal methodology used to set the rates initially or to establish rate increases. Rates are set based on annual appropriations and budget decisions by the state.

Representatives from five other states—Massachusetts, Maine, New Hampshire, Connecticut, and Vermont—were interviewed to find out how these states set rates for community-based services. Massachusetts applies the most sophisticated cost-based analysis for rates for assisted living and adult day care. Massachusetts sets rates based on provider cost and utilization reports

[14] Skilled home care includes visiting nursing home agency Registered Nurse (RN), Physical Therapy (PT), and Occupational Therapy (OT) services.

and includes some add-ons for such elements as high volume. Massachusetts has multi-tiered rates for adult day care based on client acuity. Facility-based per diem rates have variable and fixed component ceilings with annual adjustments factors that are changed from time to time.

Maine also uses a more sophisticated rate setting methodology for assisted living than does Rhode Island. Maine requires assessments of assisted living residents every 180 days in order to establish acuity level within specific categories of "resource grouping" that are reimbursed differently. In addition to the acuity component of the rate, a program allowance is added.

Investigations in New Hampshire, Connecticut, and Vermont only elicited the administrative authority for setting rates. The Center did not receive formulae or more detailed methodology information.

Other states may use more of a cost and utilization method to set rates for adult day care and assisted living services than Rhode Island. Other services seem to be set similarly based on general costs and budgetary restraints.

Comparison of Hourly Wage Rates and Benefits for Certified Nursing Aides in Institutional versus Community-Based Settings

The Center conducted interviews of representative providers from nursing homes, community home care agencies, assisted living facilities, and adult day care centers to inquire about the hourly rates paid to Registered and Licensed Practical Nurses, and Certified Nursing Aides (CNAs), and in some cases, Homemaker or Chore Workers and Med Tech personnel. Interviewees included administrators from five nursing homes, two home care agencies, two adult day care agencies, and one assisted living agency. Additional anecdotal information was obtained on pay rates for CNAs employed in state institutions.

After interviewing a number of provider representatives, it became clear that one of the obstacles to rebalancing services from nursing home utilization toward community-based services is the difficulty that community-based providers have in competing for and keeping qualified personal assistance services staff. Information from provider interviews suggests a hierarchy of competitive salaries and benefits among different provider types that are biased toward institutional service settings. CNAs working for state hospitals receive the most competitive salaries and benefits.[15] Next in the hierarchy are nursing homes, followed by semi-institutional settings like assisted living facilities and adult day care centers. Lowest in the hierarchy are home care providers. The Medicaid payment system for each of these service providers is different and the differences seem to affect the provider's ability to pay competitive wages and provide competitive benefits.

The nursing home Medicaid rate reimbursement system uses a cost basis that includes a component for direct services. State hospital budgets are established independently from

[15]Hourly wages, benefit structures, and competition issues for personal assistance staff were described by administrators of the nursing homes and community-based services. State executive staff confirmed the more competitive pay and benefit structures in state hospitals.

Medicaid reimbursements. Assisted living and adult day care are reimbursed on a Medicaid per diem basis. Home care is reimbursed on an hourly basis for specific types of services.

Overall, hourly wages and employee benefits decline on the provider continuum as it moves from institutional care toward community care and home care. Although most providers contribute some amount to employee health insurance, the amount paid by community-based providers is less. Similarly, paid vacation and sick leave decrease along the continuum.

A number of the providers interviewed believe that Medicaid rates would be more equitable through the application of an acuity factor. Adult day care providers stated that most of their clients are nursing home-eligible in terms of function and care requirements. In addition, adult day care providers are not reimbursed for "no shows" even though they are staffed to cover the number of clients that are registered to attend each day.

Home care staff must travel to their clients and in some cases are not reimbursed for either travel time or mileage. Another competitive disadvantage among home care providers is the unpredictability of hours and income. One nursing home administrator described a recent successful recruitment effort that involved hiring CNAs that had previously worked for home care agencies. The reasons people gave for wanting to leave the home care agencies and come to work at a nursing home included: not wanting to work alone, needing reliable hours, better pay rates, better benefits, and predictability of work time and hours.

The following table briefly summarizes different hourly wages and benefit structures described in interviews.

	State Hospital	Nursing Homes	Assisted Living	Adult Day Care	Non-VNA Home Care
CNA hourly rates	$16/hr	$8.75 - $13/hr [16]	$11-$13/hr	$8.50-$10/hr	$7.75-$9.75/hr
Benefits	State benefits	Sick leave, vacation, health care premium 88%-90% employer paid for individual	Sick leave, vacation, health care insurance, no pension	Sick leave, vacation, personal day leave, health care insurance premium paid by employer depending on length of time employed	Sick leave, vacation, health insurance employer pays 50% of premium and up; some employers pay travel time and mileage and others do not

[16] One nursing home administrator interviewee works in a facility where the employees are "unionized." CNA wages there range from $11.65-$14.16/hr. The interviewee also stated that some of the nursing homes that are "unionized" have closed.

Comparison of Wages for Health Care Support Workers in Rhode Island and Nearby States

The wages for health care support workers vary depending on the state and the position.[17] Appendix A describes Census reported data for fourteen health care support positions in Rhode Island, Massachusetts, Maine, New Hampshire, Vermont, and Connecticut. The following table is a comparison of the Census reported mean annual wage paid for specific health care support positions.

Position	RI	CT	MA	ME	NH	VT
Healthcare Support Occupations	$25,940	$28,075	$27,670	$22,660	$26,080	$22,780
Home Health Aides	$24,390	$25,188	$23,090	$19,640	$20,710	Not available
Nursing Aides, Orderlies, and Attendants	$25,070	$27,032	$26,110	$21,040	$24,430	$21,550

The Budget Process

The Center's analysis of the budget process for both institutional services (particularly Medicaid nursing facilities (NF)) and home- and community-based waiver services suggests that the bias toward institutional services, and therefore expenditures and disparities in provider rates, is traceable, in part, to how the budgets are constructed. The Center noted that Medicaid NFs have their own line item in the budget (http://www.rilin.state.ri.us/BillText/BillText06/H7120.pdf), whereas home- and community-based waiver costs are lumped together with other Medicaid medical expenditures. Unless one delves deep into the supporting documentation, the waiver costs are not apparent.

Moreover, the "caseload estimating conference," which is the joint effort of the legislature and the executive to collectively agree on the budget projections for Medicaid services, identifies projected costs, including NF bed days and expenditures, in November and May. If actual NF bed days and expenditures are less than projections, the "savings" are returned to the Treasury. Since home- and community-based waiver services expenditure projections are blended in an "other" category, there is no separate consideration of these expenditures relative to NF projections. Thus, there is an effective disconnect between institutional services budgeting and home- and community-based waiver budgeting, and savings that might be achieved in one budget line (e.g., NF) cannot be reinvested in another budget line (e.g., other Medicaid services, such as home- and community-based services). It should be noted that other states that have

[17] Data from the Bureau of Labor Statistics, http://www.bls.gov/oes/current/oes_nh.htm#top

successfully increased utilization of community-based supports and services and reduced dependency on NFs have the flexibility to invest savings from reduced NF utilization in expanded community-based alternatives. Global budgeting of a continuum of long-term care services provides the framework for this flexibility. Oregon and Washington are two such examples.

To further complicate the budgeting process, the caseload estimating conference only includes those waiver programs that DHS administers directly. Waiver programs administered by other departments, even though they are Medicaid waiver programs, are budgeted separately. Thus, waivers serving persons with developmental disabilities and older adults (e.g., Medicaid Community-Based Elderly waiver, Medicaid assisted living waiver) are administered and budgeted by the Department of Mental Health, Retardation and Hospitals and the Department of Elderly Affairs, respectively. The total long-term care budget, then, is fragmented, and it is not possible to shift funds from one budget line to another within an overall long-term care budget. The Center's analysis suggests that the budgeting process directly impacts how provider rates are set and how disparities in rates result over time and across providers.

While there was general consensus among those interviewed for this study that there is a disparity of rates, there was a dissenting view from one legislative leader who believes that the issue of rate symmetry is overstated. For example, in relationship to the provider rate issue, CNA salaries vary across NFs as well as between NFs and community-providers, and discussions about rate disparities masks the core, underlying problem, which is the disconnect between entering and moving across the long-term care spectrum of services. If people could be moved more quickly into community settings or be diverted from nursing home placement in the first place, more money would be available for community-based services. However, there was also recognition that, at present, money saved in NF costs cannot be shifted to community-based services.

Finally, some respondents, particularly legislative and agency leaders, expressed the view that higher provider rates do not necessarily predict improved services, including improved access to services. Providers could be paid more based on performance, or the state could incorporate a performance risk approach, where a provider agency would provide all the hours and services a consumer needs. In return, the provider could be paid a 20 – 25 percent increase over the usual rate structure in place now. Or, the state could establish a system of cost-based reimbursement, which the Center recognizes would be costly and would take several years to develop. However, a cost-based reimbursement system would help ensure greater equity in rates between community-based services and NF services.

Resource Mapping

Resource mapping is a method by which a "funding stream and service program" map is created to clarify funding and funding relationships among specified programs. The purpose of resource mapping in Rhode Island is to create a picture of state funds directed toward long-term care programs. In addition to providing a clear picture of funding streams, the mapping makes it possible to analyze opportunities to redistribute funding to increase community-based services, as well as to consider redistributing state funds allocated to long-term support programs to Medicaid funded programs in order to obtain Medicaid matching funds.

A Rhode Island long-term care resource map would clearly describe for all long-term care service programs:

- The source and amount of annual funding to support individual long-term care services programs
- The annual number and category of people who participate in each program (e.g., their income, asset, and functional criteria)
- Any statutory, regulatory, or administrative constraints on reorganizing or integrating funding

The creation of a *complete* resource map for long-term care in Rhode Island is beyond the scope of this study; however, interviews with executive and legislative staff suggest recognition by state officials of the importance of understanding current funding streams for long-term care services. For example, DHS is developing a grid that describes all the grant funds directed toward a specific service area and provider. The current focus is on adult day care.

Medicaid Budgeting

As noted in the rate analysis section, the current annual state budget for Medicaid-funded services does not enable policy makers and agency executives to see the total long-term care budget and to redirect savings and expenses within that "budget." The budget specifically identifies nursing home costs as a line item, but it lumps community-based services costs including those for home- and community-based service waivers into a category labeled "other." In addition, some funds for long-term care services that are distributed through different departments are not captured in these two lines at all, e.g. services for individuals with developmental disabilities. These separate budget line items suggest that there is no global long-term care budget and that it could require legislative action to restructure the budget to create one. Currently, savings in one budget line are simply absorbed into the total state budget rather than being redistributed to expand and support priority service areas like community-based services.

State-Funded Grants and Programs

The study identified a number of legislative grants and state funds that are administered through different state agencies and are directed toward long-term care services. For example:

- $50,000 annual grants to individual adult day care centers through the Department of Elderly Affairs (totaling $750,000 in FY 2006)
- $600,000 annual grant to Visiting Nurse Associations through the Department of Human Services (FY 2006)
- $616,675 state funds and grants for respite care through the Department of Elderly Affairs for respite care (FY 2004)
- $3.6 million for the Co-pay Program for home/care and homemaker and adult day care
- Additional state funds and grants exist for other long-term care services administered by different agencies and organizations[18] but further investigation is needed to understand the funding sources and the populations served.

The above list totals approximately $5 million. However, it is not a complete listing of state-funded long-term care services. A complete list is likely to yield a considerably higher dollar amount.

In conclusion, the Center found that a complete funding stream and service program map for Rhode Island LTC services does not currently exist. However, resource mapping is an essential first step to a full understanding of the sources of LTC funding available in the state, program offerings, individuals served, and the administrative entities responsible for LTC programs.

[18] *Rhode Island Long Term Care Spending FY 2004, A Report of the Long Term Care Coordinating Council*, June 2005. These grant- and state-funded programs may cover services not currently included in Medicaid waivers. They also cover services for individuals whose incomes and assets are too high to qualify for Medicaid. Identifying these program funds may or may not lead to any redistribution, but it will help clarify the total "long-term care budget."

Workforce Supply Analysis

As part of the Center's analysis of the context within which Rhode Island's community-based LTC programs operate, the Center undertook an analysis of workforce supply in the health care industry, both within Rhode Island and in other New England states. As will be noted below, what emerged in this analysis was that throughout New England, the health care industry is a major, leading component in the region's economy, and that health care vacancy rates across the region suggest both increasing demand for services and difficulty in attracting a sufficient workforce supply to keep up. When one couples this analysis with the projected need for LTC services in Rhode Island from 2005 – 2010, the stress on workforce supply comes into sharper focus.

Throughout New England, tens of thousands of health care workers provide health care and supportive assistance to older adults and persons with disabilities. These various provider types compete for workers from essentially the same workforce pool.[19] The objective of this workforce supply analysis is to examine the wage and employment environment for health care support workers in New England.

While data from the various states in New England is not entirely comparable, and certain data gaps exist, those data available to us demonstrate the enormity of the health care and "social assistance" workforce. For example, Connecticut reported that over 310,000 workers provided health care and social assistance services in 2004, while Maine reported approximately 31,200 workers in health care support, home health aides, and orderlies alone (excluding physicians and registered nurses).

Likewise, where vacancy data is available, it is also clear that at any given time, thousands of jobs in health care and social assistance are available. For example, Massachusetts reported almost 12,000 job vacancies in health care in 2004, or 16 percent of all vacancies in the state. In spring 2005, Rhode Island reported about 1,800 job vacancies in health care, and in 2004, Connecticut reported almost 7,700 vacancies. (See Appendix B for more detailed data from Rhode Island and other New England states.)

While labor markets and employment/vacancy statistics are never static, they do point to trends that can help support anecdotal information about the state of the current job market. In Rhode Island, most of the individuals the Center interviewed pointed to the difficulty community-based services providers have in attracting and retaining staff—especially CNAs. They also reported how difficult it often is to find an agency that can serve a new consumer because, as one individual noted, agencies "ration" the number of "slots" that are used for persons whose care is publicly funded. Another individual noted that it is not uncommon for a discharge planner or case manager to contact 12 to 14 different agencies before one is found that can initiate home-based services for an individual. These anecdotal stories are supported by the vacancy data noted in the table below.

[19] Note: In some states health care and "social assistance" are combined. The Center assumes that "social assistance" refers to welfare case workers, case managers, and others who provide social support services not directly defined as "health care," but competing for workers from the same labor pool.

Data Sources
The Center incorporated several data sources for this analysis. The Bureau of Labor Statistics provides information on state employment by occupation. Also, several state-based job and labor market surveys are included. The *Rhode Island Job Vacancy Survey* consists of vacancy data by occupation. The *Connecticut Job Vacancy Survey* includes data on employment, vacancy, and job vacancy rates. The *Massachusetts Job Vacancy Survey* incorporates information on employment, vacancy, and job vacancy rates. The *Vermont Labor Market Survey* contains information on employment by job sector, but not vacancy data. The Center could not obtain job vacancy data for New Hampshire or Maine.

The following table summarizes the employment and vacancy data that the Center was able to gather within the time and resource constraints of the study.

State	Year	Health Care Employment	Health Care Vacancies	Percent Vacancies
Rhode Island	2005	27,830 (excludes M.D.s/R.Ns)	1,815	6.5%
Connecticut	2004	310,384 (includes "social assistance")	7,697	2.5%
Maine	2004	31,220	Not available	
Massachusetts	2004	95,600 (of which, 47,400 are nursing/ home care aides)	11,927	12%
New Hampshire	2004	22,550 (excludes M.D.s/RNs)	Not available	
Vermont	2006	75,750	Not available	

Analysis of Future Service Needs

The Center was also tasked to complete a needs assessment to determine future LTC service needs in Rhode Island. Using secondary data, estimates of future service needs for home- and community-based services and nursing home care were generated for Rhode Island residents 18 years of age and older. The 2000 Census data and the Claritas Senior Life Report for the state of Rhode Island were used to estimate the number of residents who may require home- and community-based services. The numbers of active nursing home residents in Rhode Island were obtained from the Medicaid Statistical Information System (MSIS) at http://www.cms.hhs.gov to estimate future nursing home need. The upper-income level used to estimate future need is based on eligibility for home- and community-based waiver services, which is $20,844. The analysis was limited to those residents with income levels at or below $24,999 (the data source's nearest income category). Estimates of need were projected forward from 2005 to 2010 using various assumptions (see the full report in Appendix C for the detailed methodology and assumptions applied).

While the analysis did not account for factors other than disabilities and income that may influence the number of program-eligible Rhode Island residents, the data show that the need for LTC services will likely overpower existing capacity before the year 2010. The increase in demand is driven primarily by two forces: a projected increase in the number of persons in the targeted age and income group, and an increase in the number of people who report disabilities.

Based on 2000 Census data, there were 800,497 residents 18 years of age or older in Rhode Island. By the year 2010, this number is projected to increase by 8 percent to 867,379. In 2000, 62 percent of the population was 18 to 64 years of age while nearly 15 percent was 65 years of age or older. While the percentage of the total population will be similar in 2010 for these two age groups, older residents who typically require more long-term support services will experience the largest percentage of growth. From 2005 to 2010, the 60-64 age group (4.8 percent) will experience the largest growth, followed by the 85 and older age group (3.4 percent), and the 65-69 age group (3.3 percent).

Over 19 percent of Rhode Island's civilian non-institutionalized population ages 16 to 64 who meet the income requirements for this analysis reported having a disability. This number increased to 40 percent for persons 65 years of age or older. By the year 2010, an estimated 15,000 residents age 18 to 64 are projected to have either a sensory, physical, or mental disability. Well over 16,000 residents who are 65 years of age or older are projected to have either a sensory, physical or mental disability. Based on current income levels, these projected 31,000 residents are likely to be eligible for publicly-supported LTC supports and services.

Using actual nursing home admission data from December 2002 to September 2005, a regression analysis and curve estimation was generated to project future nursing home admissions through 2010. The number of nursing home residents has declined from 8,638 residents in nursing homes in December 2002 to 8,200 in September 2005. The average annual change in the number of nursing home residents is expected to decrease by 2 percent each year, with fewer than 7,500 residents predicted to be in nursing homes at the end of 2010.

In FY 2004, Rhode Island's authorized capacity in home- and community-based waiver programs was 6,275 slots (which includes developmental disabilities waiver slots), with 5,023 (80 percent) of those slots already filled. Based on the analysis, the number of residents who meet income criteria and self-reported disabilities, and therefore may qualify for home- and community-based services, will likely continue to increase. In the absence of information that may represent additional opportunities for service, and given the projected increase in service demand and existing capacity, the state will likely find that the demand for LTC services will continue to outstrip supply.

While nursing home admissions are expected to decline in the state of Rhode Island over the next few years, this decrease in not assured. Current nursing home trends may be reversed if Rhode Island citizens dependent on publicly-supported LTC services are unable to secure the supports and services necessary for remaining in the community. In addition, it is possible that the sheer numbers of individuals with higher acuity levels may contribute to a renewed upward pressure for "heavy care" nursing home services.

How People Enter the Service Delivery System

Throughout the interview process, perceived or real barriers to access to community-based supports and services emerged as a central issue.

Nationally, community-based services advocates, discharge planners, and policy makers have argued that the Medicare and Medicaid programs are structured to be biased toward institutional care, following what is commonly referred to as a "medical model." Advocates generally argue that it should be as "easy" to gain access to community-based supports and services as it is to gain access to a Medicare skilled nursing facility or a Medicaid nursing facility. Likewise, it should be as difficult to gain admission to a nursing home as it is now to gain admission to a home- and community-based services program. The reasons why this apparent bias exists are well understood in the health care community and will not be detailed here. Rather, this systemic structural bias is the departure point for this section.

Most interview respondents described an application-to-service-delivery process they viewed as frustrating and cumbersome. The typical route to services begins with a hospital stay following a serious, often catastrophic health event. For those with Medicare coverage, the "Diagnostic Related Groups (DRG) clock" begins ticking upon admission (e.g., Medicare pays a fixed price for a hospital stay under a specific diagnostic group, so there is strong pressure for a quick discharge), and the discharge planner scambles to identify post-hospital care. Often, the first post-hospital service needed is short-term rehabilitation in either a hospital rehabilitation unit or a Medicare skilled nursing facility (SNF).

For many, the short-term SNF stay results in a return to home with perhaps follow-up Medicare home health and other Medicare-covered services (e.g., durable medical equipment). However, for many others, the health event that resulted in the hospitalization can trigger a downward spiral of circumstances that make it very difficult to return home unless there is quick, decisive, and aggressive intervention to make returning home possible. This is especially true for individuals eligible for both Medicare and Medicaid ("dual eligibles"), who tend to be sicker and older with more fragile (or absent) spousal or other informal supports. Thus, a Medicare SNF stay (100 days per spell of illness) can evolve into an extended Medicaid nursing facility (NF) stay. Analyses the Center has conducted on Medicaid Minimum Data Set (MDS) data for Maryland, which is collected on all nursing home residents regardless of source-of-pay, has shown a significant drop-off in the probability that a Medicaid NF resident will return to the community if his or her NF stay extends beyond 90 days.

The interview respondents argued that the current system for getting a home- and community-based service program in place can take from six to eight weeks, while placement in a nursing home can take place within 24 hours in most cases. One respondent reported, though, that people with serious and persistent mental illness and/or substance abuse problems enter into an aggressive multi-disciplinary case management system within 24 hours of presenting and are able to be processed through to service delivery rapidly. In addition, discharge planning begins on day one for persons admitted to psychiatric hospitals or substance abuse treatment centers, so community alternatives are in place prior to discharge. This respondent indicated that no

comparable case management system exists for older adults and persons with disabilities entering the LTC supports and services setting. Some respondents noted that it is not uncommon for a discharge planner or case manager to have to query as many as 12 to 14 different home care agencies before one is found that is willing to take on a publicly-supported consumer. Another respondent flatly stated that these agencies "ration" the number of publicly-supported consumers they are willing to take. The principal reasons given are lack of available staff and low payment rates from the state.

Several respondents, including legislative and agency leadership, pointed to problems people have accessing information about available programs, their choices and options, and how to go about actually initiating services. In addition, respondents pointed to the absence of a continuum of services, from low-intensity community-based supports to high-intensity institutional services, which, if present, would enable consumers to move seamlessly across the continuum as needs change.

While other respondents provided variations on this theme, they all told the same basic story—that in Rhode Island it is time consuming, frustrating, and, for some, ultimately futile to try to find an agency willing and able to serve publicly-supported consumers needing home- and community-based services to either forestall nursing home placement or to make a return to community-dwelling status possible. The respondents generally concluded that access problems contribute to the continued dependency on nursing home utilization.

Four suggestions were provided on how to address these common complaints about the current process for gaining access to community-based supports and services:

1. **Provide a multi-disciplinary, rapid response case management system for community-based supports and services for older adults and persons with disabilities**. The State could pattern the case management process for older adults and persons with disabilities after the apparently successful case management system already in place for persons with severe and persistent mental illness and/or substance abuse problems.

2. **Streamline application, eligibility, and other bureaucratic processes to speed approval.** Several people interviewed mentioned Rhode Island's Aging and Disability Resource Center (ADRC) grant, awarded in 2003. The desired outcome from this grant is a "single point of entry," or "no wrong door," streamlined system for identifying and gaining access to LTC services for all citizens and their caregivers. The ADRC grant provides a tangible opportunity to make systems improvements that can speed the access process.

   Related to this "streamlining" discussion is the importance of the state's ability to intervene in or participate with the hospital discharge planning process for Medicaid recipients who are at risk for institutionalization following a hospital stay. This is just as critical for dual-eligibles in a Medicare hospitalization with a likely Medicare SNF stay following discharge, because the person is likely at risk for an extended Medicaid NF

stay. Likewise, upon admission to a SNF or NF stay, the state could begin an aggressive effort to plan for discharge to community-based alternatives. In both cases, an aggressive, coordinated, electronic-based, assessment-driven case management process would be needed to influence the outcome of a hospital stay for Medicaid recipients at risk for nursing home care.

3. **Consider presumptive eligibility for Medicaid home- and community-based waiver services**. Some states have adopted a presumptive eligibility policy for individuals at imminent risk for institutionalization. "Presumptive eligibility" means that Medicaid begins paying for services immediately, while the person's application for Medicaid is going through review. The federal government is willing to provide matching funds for up to 60 days during a presumptive eligibility period.

   The objective of presumptive eligibility is to be able to act quickly to put in place such accommodations as environmental modifications, personal care attendants, adult day care, and other waiver services that, if present at the point of need, forestalls nursing home placement. It is important to note that the state assumes a financial risk with this policy. Ultimately, presumptive eligibility can save money if managed in a way that in fact reduces nursing home utilization and does not simply increase the number of persons using community-based supports and services. Some states have tried presumptive eligibility and discontinued the practice, but most states which have used it found it serves the intended purpose—diversion from nursing home placement by assuring providers and consumers that Medicaid funds are immediately available.

4. **Consider the expanded use of the full personal care options in the Medicaid state plan.** Many states have successfully utilized optional state plan personal care services to provide in-home care for persons who are at risk, or likely to be at risk, for nursing home care. As an optional state plan service, it is possible to place limits on the coverage, and eligibility criteria could help delimit its utilization. However it is done, personal care services can be an effective "gap filler" to augment the tools the state can use to help people stay out of nursing homes or to return to the community from a nursing home.

Strategies for Redistributing State Funds

The operating premise for the Center's analysis is that there is no "new money" available in the state budget to bolster the provider rates for community-based supports and services for older adults. In fact, the Governor has proposed to rescind the recent 2.2 percent increase provided through a legislative initiative, which took effect on January 1, 2006. In addition, several people interviewed stated that they understood that an across-the-board cut of 25 percent in grant funding is being considered by the Governor. Thus, the Center was tasked with exploring possible ways of redistributing existing funds to provide revenue sufficient to improve provider rates for assisted living, adult day care, respite care, and home care services for older adults in Rhode Island.

Seven approaches are discussed below that the State might consider, singly or in combination, to direct more revenue to community-based supports and services for older adults.

1. **Adopt a global budgeting approach to Medicaid.** This strategy would require legislative approval. Funding for nursing facility services and community-based services would be appropriated to the same budget line, enabling the State to better align its policy goals with its budgeting process. This approach is budget neutral. Savings achieved from reduced nursing facility utilization could be reinvested in community-based services.

2. **Coordinate services across programs and payers.** Numerous individuals whom the Center interviewed for this report urged that the State assemble all individual LTC programs in the state and all the resources associated with them and develop an over-arching system of LTC services along a continuum from self-directed care to institutional care. This would replace the current system, which is comprised of stove-piped, fragmented services abounding in inconsistencies, inequities, and systemic barriers, all of which reinforce the bias toward institutionalization. The State might consider the following two approaches:

    - **A capitated managed LTC program**. By shifting the risk and the management of the LTC system to competitive managed LTC program organizations, which would be required to meet both Medicare and Medicaid managed care requirements, the state could direct the transformation of its LTC system through contractual performance expectations, all within a budget that would not exceed (except for an agreed to "normal" growth rate) historical costs. Seven states have already implemented capitated managed LTC programs (Minnesota, Texas, Wisconsin, Massachusetts, New York, Arizona, and Washington), and Maryland and New Mexico are proposing waivers for new programs. With the passage of the Medicare Modernization Act (MMA) of 2003, which authorizes Medicare Advantage Special Needs Programs (MA/SNPs), states have an additional incentive to develop capitated managed LTC programs that include dual eligibles.

    - **Integrate existing LTC services within one organization**. Some states have successfully undertaken initiatives to integrate LTC programs under one government

unit and to consolidate budgets.[20] These integrated units of government have helped to consolidate budgets for all nursing home and community-based services; reduce or eliminate duplication and redundancy; eliminate inconsistencies and inequities in payment rates, eligibility criteria, and service limitations; maximize the federal Medicaid match; and shift spending away from institutions toward community-based services.

3. **Convert "state-only" dollars to Medicaid match-able dollars**. The state provides supplemental payments with state-only money to assisted living facilities for individuals who meet certain income and asset requirements. Some portion of those individuals are Medicaid beneficiaries. The state also provides administrative grants of $50,000 annually to some adult day care centers which provide services to persons who are also Medicaid-eligible. One proposal put forward suggested that if the state took the percentage of state-only dollars that represents the percentage occurrence of Medicaid-eligible participants in that program and directed those dollars through expense sheets as Medicaid costs, eligible for Medicaid match, the state could double the revenue (Rhode Island's FMAP rate for 2006 is 54.45 percent). One way this could be done would be for the state to raise provider rates to the actuarial equivalent of the expected increased revenue generated from the federal match, with the caveat that the great majority of it would pass through to increased caregiver rates (especially CNAs). Then, as providers reflected that increased cost for Medicaid services, the federal share would increase.

   There are five caveats to this approach, however:

   - First, it is understood that the "co-pay" programs serve people who for the most part would otherwise not be eligible for Medicaid, so state-only dollars in those programs should not be part of this proposal.

   - Second, state-only dollars do not significantly supplement home care providers; only assisted living and adult day care providers would benefit significantly, unless dollars are integrated across programs. It would not be feasible to raise the salaries of CNAs in assisted living and adult day care settings only, for example, and not raise salaries at the same time in home care, arguably the largest of the community-based programs. Thus, the state would be on the hook to provide parity across the community-based spectrum, with "new" funds mostly covering only those in assisted living and adult day care.

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[20] HCBS Promising Practices Reports, http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp#TopOfPage

Long-Term Systems Change for Aged and Americans With Disabilities: State Profiles (DHHS, June 2005). http://www.aoa.gov/press/fact/pdf/ib_ltc.pdf (3/24/06)

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (US GAO, August 1994); http://archive.gao.gov/t2pbat2/152298.pdf (3/24/06).

- Third, the flow of these state-only dollars through Medicaid must be demonstrably for Medicaid-covered services for Medicaid-eligible beneficiaries.

- Fourth, there would theoretically be "winners" and "losers" under this proposal even within assisted living and adult day care. For example, if only 40 of 100 participants in one program are Medicaid-eligible, and 70 out of 100 participants in another program are Medicaid-eligible, it is obvious that the latter program will generate greater Medicaid reimbursable costs than the former.

- Finally, state-only grants can be awarded selectively to different providers, but in Medicaid, all willing providers must be allowed to participate and beneficiaries can choose their providers. Whether this poses a problem for Rhode Island should the State seek to increase federal match for state-only dollars is a question to consider.

The principal question is whether converting state-only dollars to federal Medicaid match-able dollars will generate enough revenue to materially affect provider rates. While a detailed actuarial analysis of this proposal is beyond the scope of this study, the Center's informal analysis suggests that if fully implemented, it would not produce additional revenue sufficient to improve provider rates, and therefore, salaries and benefits for caregivers. Examining possible approaches for rendering state-only dollars as federal Medicaid match-able dollars wherever possible is prudent. However, it is important to note that those state-only dollars that might be candidates for Medicaid match are already being utilized to provide services to people and those services would need to continue to be covered should the state-only funds be funneled to other Medicaid match-able uses.

4. **Increase the availability of "self-directed" supports and services**. Rhode Island recently won approval to implement a Cash & Counseling waiver that will provide up to 450 older adults and persons with disabilities with individual budgets that will enable them to purchase their needed supports and services themselves. The state is targeting the individual budgets at 85 percent of average Home Health Agency reimbursement, assuming savings from individuals negotiating directly for supports and services. Rhode Island's approach is consistent with other states (Arkansas and Florida, for example). Savings over historic waiver costs can be plowed back into more waiver slots or invested in reserve funds for extraordinary expenses (e.g., a costly home modification), or, in Rhode Island's case, could be used to enhance funds available for improving provider rates in agency provided programs.

   As the state gains experience with the implementation of the Cash & Counseling program, the state could consider an expansion of the program to more individuals who express a desire to control their own supports and services. An expansion could result in greater savings and, at the same time, reduce pressure on agencies which currently are unable to meet demand. Other states report that individuals who participate in Cash & Counseling or self-directed programs often use more informal paid supports, employing

persons who are not currently in the workforce pool for community-based care-giving, thus indirectly increasing the workforce.

A move to greater use of self-directed programs might contribute to both an easing of the critical workforce issue and an increase in the options for community-based care that could help decrease the dependency on nursing home care as the default setting for individuals who could otherwise remain community-dwelling.

5. **Develop and implement some form of "money follows the person" from nursing facility services to community-based supports and services for older adults**. The Center's analysis suggests that in order for the state to substantially redirect existing program funds to community-based care, the source of those funds would likely come from nursing home expenditures. The Center recognizes that the state recently implemented a new rate setting methodology for nursing facility services, and the Center is not proposing to rescind or modify it. Rather, the Center suggests that the state consider permanently reducing, in a stepwise fashion, the number of state-licensed/Medicaid-certified nursing facility beds in the state over time.

   As noted in the section of this report entitled "Analysis of Future Service Needs," the number of nursing home residents has declined from 8,638 residents in December 2002 to 8,200 in September 2005, though currently the state has 8,868 licensed and participating nursing home beds. Since January 2000, there has been a 1,052-bed reduction in nursing home beds, due mostly to the closure of nursing homes. In addition, though, there are 390 "beds out of service." These are beds that can be brought back into use for Medicaid NF admissions at the facilities' discretion (after they have been out of service for at least six months) with the approval of the Department of Health. Thus, this "cushion" provides for expansion without violating the current moratorium on "new" Medicaid-certified beds.

   The average annual change in the number of nursing home residents is expected to decrease by 2 percent each year, with fewer than 7,500 residents predicted to be in nursing homes at the end of 2010. The state could consider gradually withdrawing beds from licensure/certification along this trajectory over this time period, or choose a more (or less) aggressive path to permanent reductions in Medicaid nursing home beds. The state could continue to budget the same amount that would have been budgeted without the enforced reduction in certified Medicaid beds, but allocate those funds to community-based services instead.

   Other states have sought to reduce the number of Medicaid nursing home beds using a variety of methods. For example, Nebraska implemented a nursing home conversion initiative that provided state funds to nursing homes to help them convert their facilities (or portions thereof) to assisted living units or other uses. Arizona made reductions in nursing home utilization a contractual element of their managed care programs, and reduced utilization dramatically over 10 years. In the recently enacted Federal Deficit Reduction Act (DRA) of 2005, the Congress created yet another grant program designed

to help states "rebalance" the utilization of nursing homes (and other Medicaid-financed institutions, such as intermediate care facilities for the mentally retarded) toward community-based supports and services.

The first effort to stimulate growth in community-based supports and services in the Medicaid program, of course, was the 1981 addition of home- and community-based waivers under Section 1915(c) of the Social Security Act. In its original form, the law included what was called a "cold bed" provision, meaning that each home- and community-based waiver "slot" had to be matched to a "bed" in an institution that would no longer be used to claim federal match. This provision was abandoned in the late 1980s, enabling states to greatly accelerate growth in community-based services. However, ending the "cold bed" provision effectively took the pressure off the impetus to reduce nursing home utilization.[21] The more recent New Freedom Initiative included a variety of efforts to continue the move toward more community-based alternatives to institutionalization, including nursing home transition grants (which Rhode Island received), and real choices systems transformation grants. The latest Congressional grant effort includes new incentives to make it more financially attractive to states to transition people who have been in nursing homes less than two years to community-based programs.

Section 6071 of the DRA—the "Money Follows the Person Rebalancing Demonstration"—provides competitive grants to states designed to increase the use of home- and community-based services instead of institutional services, to eliminate barriers (e.g., in-state law, state Medicaid plan, state budget) that currently restrict flexibility in the use of Medicaid funds for community-based supports and services, to ensure the continued provision of home- and community-based services so these services will be available when persons choose to transition from institutional to community-based services, and finally, to ensure that community-based supports and services meet quality standards and engage in continuous quality improvement.

Basically, the grants would serve individuals residing in nursing homes less than two years, and would provide the state with an enhanced match for the services they receive in the community for up to one year. Most significantly, perhaps, the state would need to demonstrate that the enhanced match will not result in a reduction in state effort relative to fiscal year 2005 or any succeeding fiscal year before the first year of the grant project. Conceptually, then, the enhanced match could provide additional federal funds for community-based supports and services for the same investment of state funds.

While the rebalancing grant program does not require a reduction in Medicaid-certified institutional beds, a state could pair the rebalancing process with a mandatory reduction in Medicaid-certified beds as suggested above, adding to the likely permanent reduction in dependency on Medicaid nursing facilities and a permanent increase in the availability and sustainability of community-based supports and services.

[21] It should be noted, though, that the downward trend in the use of public institutions for persons with mental retardation was unaffected by ending the "cold bed" provision. Other forces drove that movement.

While there was general support for the concept of "money follows the person," some legislative and agency leadership respondents raised concerns about a "woodwork" effect. The straightforward argument is that nursing home beds will be filled regardless, so growing the number of people served in the community is simply adding costs and utilization. One of the drivers of a concern about the woodwork effect in the community is that the people who go to nursing homes need nursing home care. One of the fundamental shifts that other states have made is in that very presumption—other states that have reduced dependency on nursing home utilization invest in the comprehensive, flexible supports and services needed to keep people out or to help people get out of nursing homes.

While the availability of the CMS competitive grants will not be announced any time soon, the brief discussion of them above illustrates the continued emphasis on finding effective ways to continue to increase the use of sustainable community-based supports and services.

Nursing homes faced with reductions in the number of beds the state is willing to include in their Medicaid nursing facility program could plan to increase their private pay patients, their Medicare business, convert facilities or portions of facilities to assisted living centers, and/or expand their business into home care and other supports and services programs, among other business possibilities.

6. **Consider drawing consumers, providers, advocates, and others in a broad consensus-building process to design a comprehensive long-term care system for Rhode Island.** In order to be truly comprehensive, the process would include all the disparate populations served through long-term care programs, including older adults, adults with physical disabilities, persons with mental retardation and other developmental disabilities, persons with severe and persistent mental illness, among others. As one respondent mentioned, most programs are "silo-ed" or "stove-piped," with their own constituencies, and all competing for the others' resources. The view was expressed that the state cannot reform only one segment of the continuum, e.g., community-based supports and services for older adults, without the participation of the total continuum. One respondent suggested that provider lobbies are a greater barrier to real systems reform, rather than consumer advocacy groups seeking to preserve, promote, and expand their own particular "silo."

7. **Additional waiver services.** Rhode Island could offer additional services in its current home- and community-based services waiver programs, such as adult foster care, medication management, and respite services. While these services might help Medicaid recipients avoid the need for institutional services, it was beyond the scope of this study to develop precise estimates of possible effects.

Summary of Findings

The Center's multi-dimensional study of community-based long-term care services in Rhode Island included a review of service rates and the rate methodologies for four specific community-based services; an assessment of workforce capacity needed to provide services in the future; and observations and recommendations regarding the potential to restructure the State's funding, across different programs, to support assisted living, home care, respite care, and adult day care. Four major findings resulted from this comprehensive review. Each is discussed below.

1. **Rate methodologies are biased in favor of institutional care, which may hinder the capacity of Rhode Island to deliver community-based care.**

Rhode Island's wage and benefit structures are biased toward institutional services, thus limiting the community-based provider's ability to recruit and retain qualified personal assistance workers. Rhode Island's Medicaid rate structure does not mitigate this bias. Labor market data confirm high vacancy rates in the job categories from which community-based services in Rhode Island draw their employees. Contributing to the State's difficulty in attracting and retaining labor are the generally higher Medicaid rates paid by neighboring states for similar services. However, Rhode Island's rates for in-home aides, nursing aides, attendants, and orderlies are often comparable to or higher than those in neighboring states.

Nursing home reimbursement in Rhode Island is cost-based, whereas the State reimburses community-based services providers on a per diem or hourly basis. Actual cost differentials are not taken into account when setting payment rates for community-based services, although case-by-case adjustments based on acuity levels are possible. Some community-based providers receive supplemental payments through various state funding sources, but there is no systematic method for determining the distribution of supplemental payments nor their impact on the expansion of community-based services. Over the past five years, rate increases for community-based services, which are set by the legislature, have been infrequent and limited. Increments for cost-based nursing home rates have exceeded increments for community-based services.

Rhode Island's reimbursement rates for assisted living, adult day care, in-home personal care, in-home homemaker care, in-home skilled nursing visits, and personal attendant care are consistent across programs, for both Medicaid and non-Medicaid state-funded programs. However, providers perceive a discrepancy in rates for three programs that support assisted living because the rate methodologies differ.

2. **Addressing this institutional bias by raising community-based rates may not increase access to community-based services**.

Rhode Island faces challenges beyond provider rates in increasing access to community-based services. Interviewees consistently reported the lack of a systematic approach to informing consumers about the options available to them and a frustrating and cumbersome process for applying for services. Agencies effectively "ration" publicly-funded slots for community-based services because the shortage of workers limits the number of slots available. It is far easier for

patients discharged from the hospital to be admitted to a nursing facility than to be approved for community-based services immediately upon hospital discharge.

Under the current fragmented delivery system, community-based services are disconnected from nursing facility services. The absence of planning across funding streams and programs (including Medicare) means there is currently no way to use cost savings from decreased nursing home utilization to support a coordinated array of community-based services.

To better coordinate long-term care services, the State might consider a capitated managed long-term care program, incorporating both Medicare Advantage Special Needs Programs and Medicaid long-term supports and services. The State could also consider integrating existing long-term care services within one organization, providing the framework for a coordinated array of long-term care services offered by the State.

3. The demand for all long-term care services, including community-based services, will grow.

Not surprisingly, Rhode Island is facing a demographic wave that will increase the demand for long-term care services. The fastest growing demographic group in the state will be the old (60+), especially the oldest old. Dually-eligible individuals who are older and sicker and have fewer informal supports will be more likely to transition from Medicare to Medicaid and to remain longer in a Medicaid nursing home stay. By 2010, using current eligibility rules, about 31,000 Rhode Islanders are likely to qualify for publicly-funded long-term care services. Nursing home utilization is projected to decline, but this downward trend is dependent on the growth of community-based alternatives to institutionalization.

4. Rhode Island's approach to state budgeting could be improved, in a way that would grow access to community-based services in a budget neutral manner.

By appropriating funds to Medicaid nursing facility services in a separate budget line than the appropriation for Medicaid home- and community-based services, Rhode Island does not enable Medicaid to utilize nursing facility savings to expand access to community-based services. Instead, those savings revert to the general fund. This could be altered in a budget neutral manner using a global budgeting approach, thereby creating an incentive for systems change.

To a lesser extent, other strategies might be employed to redirect and help maximize funding for community-based services. For example, it might be possible to redirect state-only funds used to finance assisted living supplements and adult day care centers so that the funds would be eligible for the federal Medicaid match. The State could increase the availability of consumer-directed care (e.g., Cash & Counseling), generating some savings and indirectly increasing the workforce through employment of beneficiaries' informal caregivers. The State might also consider applying for a "Money Follows the Person Rebalancing Demonstration Grant" from CMS when applications are solicited.

The Center's preliminary review identified over $5 million in state funds spent annually on non-Medicaid long-term care programs. However, it is likely that the State has additional resources targeted for long-term care. Presently Rhode Island has no integrated resource map that inventories and tracks current funding streams for the various long-term care programs operated by the State and the people receiving services under those programs. A comprehensive resource map will be crucial to establishing a global budgeting approach and maximizing its effectiveness.

Recommendations

Based on the findings of the Center's extensive research, data analysis, literature reviews, and key stakeholder and informant interviews, the Center recommends the following for Rhode Island:

- **Rhode Island should pursue an approach to community-based rate setting that removes the methodological biases in favor of institutional care.** Rhode Island should normalize the recruitment and wage incentives across institutional and community-based settings of care.

- **Rhode Island must improve consumers' access to information about their community-based service options by focusing on *information dissemination as a systems-level issue*.** Rhode Island will not turn the corner on improving access to community-based services by addressing this as a rate-setting issue alone. True systems-level reform will require delivering to consumers the information and options they need, when and where consumers need this information. One part of this strategy must include delivering information to consumers and providers at the time of discharge from a hospital.

- **Rhode Island must devote attention to *service delivery coordination as a systems-level issue***. The state should develop more systematic approaches to coordinate services across programs and payers. One promising option Rhode Island could consider is a capitated managed long-term care system, incorporating both Medicare Advantage Special Needs Programs and Medicaid-funded long-term care supports and services.

- **Rhode Island's legislature should adopt a global budgeting approach to Medicaid long-term care**. By appropriating funding for nursing facility services and community-based services in the same budget line, Rhode Island could better align its policy goals with its budgeting process. This would be budget neutral. This approach, known as global budgeting, has been implemented in Oregon and Washington and has succeeded in moving a greater proportion of funding toward community-based care. This would enable savings achieved by Rhode Island when it reduces nursing facility utilization (against the baseline, established during the caseload estimating conference) to be re-invested in expanded community-based services.

Appendix A

Wages for Health Care Support Workers

The wages for health care support workers varies depending on the state and the position. For instance, home health aides in Rhode Island earn on average wage of $11.73 an hour, or $24,390 annually.[1] In Massachusetts, home health aides make on average $11.10 an hour, or $23,090 annually[2]. Nursing aides in Maine make $10.12 an hour, or $21,040 annually[3]. In New Hampshire, nursing aides make $11.74 an hour, or $24,430 dollars annually.[4]

Rhode Island: Health Care Support Wages, 2004			
Occupation	Median Hourly Wage	Mean Hourly Wage	Mean Annual Wage
Health Support Occupations	$11.94	$12.47	$25,940
Home Health Aides	$10.90	$11.73	$24,390
Nursing Aides, Orderlies and Attendants	$11.72	$12.05	$25,070
Occupational Therapist Assistants	$19.51	$19.24	$40,010
Physical Therapist Assistants	$19.05	$18.76	$39,030
Physical Therapist Aides	$10.38	$10.30	$21,430
Message Therapists	$15.96	$17.46	$36,320
Dental Assistants	$14.69	$14.19	$29,510
Medical Assistants	$11.89	$12.81	$26,650
Medical Equipment Preparers	$12.78	$13.14	$27,340
Medical Transcriptionists	$15.06	$14.98	$31,160
Pharmacy Aides	$8.67	$9.70	$20,180
Veterinary Assistants and Laboratory Animal Caretakers	$8.28	$11.23	$23,370
Healthcare Support Workers, All Other	$14.07	$14.03	$29,180

[1] Rhode Island data complied from Bureau of Labor Statistics data at http://www.bls.gov/oes/current/oes_ri.htm#b31-0000

[2] Bureau of Labor Statistics, November 2004 State Occupational Employment and Wage Estimates, at http://www.bls.gov/oes/current/oes_ma.htm

[3] Data from Bureau of Labor Statistics, http://www.bls.gov/oes/current/oes_me.htm

[4] Data from the Bureau of Labor Statistics, http://www.bls.gov/oes/current/oes_nh.htm#top

Connecticut: Health Care Support Wages, 2004					
Occupation	Mid-Wage	Average Wage	Entry-Level Wage	Wage	Range
Health Care Support Occupations	$27,001	$28,075	$22,087	$20,233	$36,627
Dental Assistants	$35,867	$35,958	$28,318	$25,977	$46,150
Healthcare Support Workers, All Other	$30,000	$30,497	$21,490	$19,534	$42,442
Home Health Aides	$24,529	$25,188	$20,416	$19,453	$30,081
Massage Therapists	$39,696	$48,359	$22,371	$19,473	$92,716
Medical Assistants	$30,375	$30,618	$24,359	$23,354	$38,835
Medical Equipment Preparers	$27,457	$28,177	$22,908	$21,064	$36,059
Medical Transcriptionists	$34,737	$35,920	$28,116	$26,279	$47,683
Nursing Aides, Orderlies and Attendants	$26,768	$27,032	$22,959	$21,013	$34,347
Occupational Therapist Assistants	$42,209	$41,470	$30,983	$27,478	$54,884
Pharmacy Aides	$20,557	$21,905	$16,920	$15,937	$30,892
Physical Therapist Aides	$25,583	$25,765	$20,618	$19,413	$33,648
Physical Therapist Assistants	$38,248	$37,599	$26,444	$23,030	$52,625
Psychiatric Aides	$27,528	$27,680	$22,179	$20,233	$35,107
Veterinary Assistants and Laboratory Animal Caretakers	$21,338	$23,121	$16,778	$15,785	$34,094

Massachusetts: Health Care Support Wages, 2004			
Occupation	Median Hourly Wage	Mean Hourly Wage	Mean Annual Wage
Healthcare Support Occupations	$12.81	$13.30	$27,670
Home Health Aides	$10.93	$11.10	$23,090
Nursing Aides, Orderlies, and Attendants	$12.41	$12.55	$26,110
Psychiatric Aides	$13.31	$13.44	$27,960
Occupational Therapist Assistants	$18.43	$18.30	$38,070
Physical Therapist Assistants	$19.40	$19.47	$40,490
Physical Therapist Aides	$11.66	$12.50	$26,000
Massage Therapists	$17.26	$19.26	$40,070
Dental Assistants	$16.24	$16.48	$34,290
Medical Assistants	$14.63	$14.75	$30,690
Medical Equipment Preparers	$13.87	$14.17	$29,470
Medical Transcriptionists	$17.58	$17.72	$36,850
Pharmacy Aides	$9.10	$9.70	$20,180
Veterinary Assistants and Laboratory Animal Caretakers	$12.67	$13.40	$27,880
Healthcare Support Works, All Other	$14.23	$14.76	$30,690

Maine: Health Care Support Wages, 2004			
Occupation Title	Median Hourly Wage	Mean Hourly Wage	Mean Annual Wage
Health Support Occupations	$10.39	$10.90	$22,660
Home Health Aides	$9.55	$9.44	$19,640
Nursing Aides, Orderlies and Attendants	$9.98	$10.12	$21,040
Psychiatric Aides	$13.76	$13.32	$27,710
Occupational Therapist Assistants	$17.25	$17.65	$36,710
Physical Therapist Assistants	$18.38	$17.90	$37,220
Physical Therapy Aides	$10.32	$11.05	$22,990
Message Therapists	$17.06	$16.73	$34,790
Dental Assistants	$13.08	$13.47	$28,020
Medical Assistants	$12.38	$12.71	$26,440
Medical Equipment Preparers	$11.19	$11.61	$24,160
Medical Transcriptionists	$13.21	$13.99	$29,100
Pharmacy Aides	$8.13	$8.65	$18,000
Veterinary Assistants and Laboratory Animal Caretakers	$11.21	$10.78	$22,430
Healthcare Support Workers, All Others	$12.06	$12.08	$25,120

New Hampshire: Health Care Support Wages, 2004			
Occupation	Median Hourly Wage	Mean Hourly Wage	Mean Annual Wage
Healthcare Support Occupations	$11.96	$12.54	$26,080
Home Health Aides	$9.97	$9.96	$20,710
Nursing Aides, Orderlies and Attendants	$11.62	$11.74	$24,430
Occupational Therapist Assistants	$18.39	$18.22	$37,890
Physical Therapist Assistants	$18.57	$18.71	$38,910
Physical Therapist Aides	$12.35	$12.27	$25,520
Massage Therapists	$21.51	$24.63	$51,240
Dental Assistants	$17.57	$17.09	$35,540
Medical Assistants	$12.93	$13.24	$27,530
Medical Equipment Preparers	$12.25	$12.53	$26,060
Medical Transcriptionists	$14.49	$14.51	$30,180
Pharmacy Aides	$8.35	$8.91	$18,530
Veterinary Assistants and Laboratory Animal Caretakers	$8.77	$9.18	$19,090
Healthcare Support Works, All Other	$12.60	$12.64	$26,290

Vermont: Health Care Support Wages, 2004			
Occupation	Median Hourly Wage	Mean Hourly Wage	Mean Annual Wage
Healthcare Support Occupations	$10.31	$10.95	$22,780
Nursing Aides, Orderlies, and Attendants	$10.20	$10.36	$21,550
Occupational Therapist Assistants	$15.98	$16.03	$33,340
Physical Therapist Assistants	$16.92	$16.78	$34,910
Physical Therapist Aides	$11.25	$11.39	$23,700
Massage Therapists	$18.27	$19.36	$40,020
Dental Assistants	$15.41	$15.14	$31,490
Medical Assistants	$12.34	$12.62	$26,250
Medical Transcriptionists	$13.77	$13.41	$27,890
Pharmacy Aides	$9.46	$9.50	$19,750
Veterinary Assistants and Laboratory Animal Caretakers	$8.99	$9.25	$19,230
Healthcare Support Works, All Other	$10.80	$12.03	$25,010

Appendix B

Workforce Supply Analysis
Employment and Vacancies by State

Rhode Island

As shown in the table on the following page, Rhode Island's health care support industry reported the most vacancies in the state. Registered nurses had the most openings at 962, with nursing aides and orderlies at 630 vacancies. There were 223 openings for licensed practical and licensed vocational nurses. Of the 8,116 total vacancies in Rhode Island, 20 percent were for registered nurses, nursing aides, orderlies, and attendants.[5]

[5]"Top 35 Occupations with the Most Estimated Vacancies," *Rhode Island Job Vacancy Survey 2005: An Assessment of Private Sector Employment Opportunities in the Ocean State.*

Rhode Island: Top 35 Occupations with the Greatest Number of Estimated Vacancies, June 2005	
Occupational Title	**Estimated Vacancies**
Registered Nurses	962
Nursing Aides, Orderlies & Attendants	630
Cashiers	592
Retail Salespersons	561
Personal & Home Care Aides	539
Waiters & Waitresses	374
Customer Service Representatives	340
Maids & Housekeeping Cleaners	339
Laborers & Freight, Stock & Material Movers, Hand	307
Counter Attendants, Cafeteria, Concession, & Coffee Shop	290
Restaurant Cooks	275
Food Preparation Workers	245
Licensed Practical & Licensed Vocational Nurses	223
Carpenters	214
Security Guards	180
Combined Food Preparation & Serving Workers	140
Dinning Room & Cafeteria Attendants & Bartender Helpers	129
Tellers	127
Insurance Claims & Policy Processing Clerks	126
First-Line Supervisor/Managers of Good Prep & Serving Workers	123
Teacher Assistants	119
Truck Drivers, Heavy & Tractor-Trailers	119
Bookkeeping, Accounting & Auditing Clerks	113
Preschool Teachers, Except Special Education	101
Executive Secretaries & Administrative Assistants	100
Mental Health Counselors	89
Telemarketers	89
Stock Clerks & Order Fillers	89
Data Entry Keyers	89
First-Line Supervisors/Managers of Office & Admin. Support Workers	88
School Bus Drivers	88
Bartenders	84
Dishwashers	82
Accountants & Auditors	75
Recreation Workers	75
Total	8116

Connecticut

In Connecticut, the health care support industry registered the most job vacancies in the state in 2004 with 7,697 vacancies, or a job vacancy rate of 2.5 percent.[6] Economists believe this trend in vacancies reflects the demand for health care services and treatment as a result of the aging population.[7] The "health care and social assistance" category employs the most people in Connecticut (18 percent of estimated employment) and posted the most job vacancies (14 percent of total vacancies).

Connecticut: Vacancies by Industry Group, 2004			
Industry Group	**Number of Vacancies**	**Estimated Employment**	**Job Vacancy Rate**
Health Care and Social Assistance[3]	7,697	310,384	2.5%
Accommodation and Food Services	5,998	105,669	5.7%
Retail Trade	5,885	204,790	2.9%
Manufacturing	3,401	198,574	1.7%
Wholesale Trade	3,318	109,357	3.0%
Construction	2,849	74,970	3.8%
Finance and Insurance	2,574	167,245	1.50%
Professional, Scientific and Technical Services	1,940	83,956	2.3%
Education Services	1,596	120,184	1.3%
Management of Companies and Enterprises	1,382	34,286	4.0%
Public Administration	1,250	115,097	1.1%
Other Services (except Public Administration)	1,144	42,975	2.7%
Real Estate and Rental and Leasing	698	18,693	3.7%
Transportation and Warehousing	650	32,516	2.0%
Information	372	37,319	1.0%
Total All Industry Groups	53,146	1,766,912	3.0%

[6] *Connecticut Job Vacancy Survey* Spring 2005.

[7] *Connecticut Job Vacancy Survey* Spring 2005.

Maine

Maine's Department of Labor estimated that more than 18,000 health care support workers (e.g., "direct care" workers) were employed in the state in 2001[8]. The number grew to an estimated 18,540 individuals in 2004.[9] In that same year, the total number of persons employed in health care support organizations and as home health aides and nursing aides, orderlies, and attendants was 31,220.

Maine: Occupational Employment, November 2004	
Occupation	Estimated Employment
Health Care Support Occupations	18,540
Home health aides	3,770
Nursing Aides, Orderlies, and Attendants	8,910
Psychiatric Aides	370
Occupational Therapist Assistants	80
Occupational Therapist Aides	20
Physical Therapist Assistants	300
Physical Therapist Aides	150
Massage Therapists	120
Dental Assistants	1,030
Medical Assistants	1,490
Medical Equipment Preparers	190
Medical Transcriptionists	730
Pharmacy Aides	140
Veterinary Assistants and Laboratory Animal Caretakers	520
Healthcare Support Workers, All others	720

[8] *Without Care: Maine's Direct Care Worker Shortage* by Lisa Pohlman of the Maine Center for Economic Policy, 2003 at http://www.mecep.org/publications.htm

[9] *2004 Occupational Employment & Wage Estimates for Maine.*

Massachusetts

In 2005, the number of job openings in Massachusetts' health support sector was 3,065. Overall, Massachusetts reported 11,927 vacancies in health practitioner and support categories.[10]

Massachusetts Job Vacancies by Industry, 2nd Quarter 2005		
Industry Name[1]	Number of Vacancies	Job Vacancy Rate
Total, all jobs	72,813	2.6%
Management	4,758	2.2%
Business and Financial Operations	3,371	2.4%
Computer and Mathematical	3,056	2.9%
Architecture and Engineering	2,096	2.9%
Life, Physical, and Social Services	1,647	4.1%
Community and Social Services	1,960	3.5%
Legal	298	1.2%
Education, Training and Library	3,527	1.8%
Arts, Designs, Entertainment, Sports & Media	686	1.6%
Health Practitioner and Technical	8,862	4.8%
Healthcare Support	3,065	3.3%
Protective Service	1,781	2.5%
Food Preparation and Serving Related	6,878	2.7%
Building & Grounds Cleaning & Maintenance	1,624	1.5%
Personal Care and Service	2,417	3.3%
Sales and Related	8,419	2.6%
Office and Administrative Support	8,260	1.5%
Farming, Fishing and Forestry	128	n/a
Construction and Extraction	2,353	2.0%
Installation, Maintenance and Repair	1,351	1.3%
Production	2,655	1.4%
Transportation and Material Moving	3,621	2.1%

[10] *Massachusetts Job Vacancy Survey, Hiring Trends by Industry and Occupation.*

New Hampshire

New Hampshire reported employment of 13,850 health care support workers in 2004. The total number of persons employed in health care support organizations and as home health aides and nursing aides, orderlies, and attendants was 22,550.

New Hampshire: Occupational Employment, 2004	
Occupation	Estimated Employment
Healthcare Support Occupations	13,850
Home Health Aides	1,880
Nursing Aides, Orderlies and Attendants	6,820
Occupational Therapist Assistants	100
Physical Therapist Assistants	290
Physical Therapist Aides	140
Massage Therapists	200
Dental Assistants	1,190
Medical Assistants	1,050
Medical Equipment Preparers	140
Medical Transcriptionists	450
Pharmacy Aides	130
Veterinary Assistants and Laboratory Animal Caretakers	330
Healthcare Support Workers, All Other	780

Vermont

As shown in the table on the following page, total current reported employment in Vermont's health care industry is 75,750. Health care and social assistance workers accounted for 42,350 of this total.[11]

[11] Employment statistics for health care and the social assistance sector come from *Vermont Labor Market*, February 2006.

Vermont: Non-farm Employment, January 2006 (Preliminary)	
Occupation	Number of Employees
Total Nonfarm	304,950
Total Private	251,100
Goods Producing	51,600
Manufacturing	36,250
Durable Goods	26,150
Computer & Electrical Equipment Manufacturing	9,300
Fabricated Metal Products Manufacturing	3,050
Machinery Manufacturing	3,000
Transportation Equipment Manufacturing	2,450
Furniture & Related Product Manufacturing	2,150
Non-Durable Goods	10,100
Foods Manufacturing	3,750
Construction	14,600
Natural Resource & Mining	750
Service Providing	253,350
Trade, Transportation and Utilities	59,250
Wholesale Trade	10,000
Retail Trade	40,300
Food & Beverage Stores	9,500
General Merchandise Stores	2,800
Transportation, Warehousing and Utilities	8,950
Utilities	1,700
Transportation and Warehousing	7,250
Information	6,250
Financial Activities	13,050
Financial & Insurance	9,900
Real Estate, Rental & Leasing	3,150
Professional and Business Services	21,250
Professional, Scientific and Technical	12,750
Administrative, Support and Waste	8,150
Educational and Health Services	54,500
Educational Services	12,150
College, Universities and Professional	6,600
Health Care and Social Assistance	42,350
Ambulatory Health Care Services	15,650
Hospitals	10,900
Nursing and Residential Care Facilities	6,850

Appendix C

Community-Based Services Needs Assessment
For Service Period 2005 - 2010

Background
The Center for Health Program Development and Management was tasked to complete a needs assessment to determine future home- and community-based services needs for the state of Rhode Island. This analysis provides an estimate of the need for services between 2005 and 2010 for residents who are 18 years of age and older and living in the community.

The target population was defined based on eligibility criteria for the following community-based waiver programs: Aged and Disabled, Department of Elderly Affairs (DEA), Assisted Living, Habilitation, and Severely Disabled. The upper household income eligibility criterion is $20,844 for the above-mentioned programs. Age eligibility ranges from 18 years or older for the Habilitation and Severely Disabled Waivers, and 65 years or older for the Aged and Disabled, DEA, and Assisted Living waivers.

Data Sources
Two primary data sources were used to construct the estimates: 2000 Census data and the Claritas 2005 Senior Life Report for the state of Rhode Island.

- The 2000 Census data were limited to the number of non-institutionalized people 18 years of age and older.
- The 2005 Claritas Senior Life Report is based on 2000 Census data and provides comprehensive information on persons 55 years of age and older for demographics such as income by age group, household living arrangements, and self-reported physical or self-care limitations.
- Active nursing home resident data from the Medicaid Statistical Information System (MSIS) at www.cms.hhs.gov was used to identify current nursing home trends.

Analysis Assumptions
A number of assumptions were developed and applied to identify the target population and to adjust data to estimate the actual number of people who may be at risk for needing publicly funded community-based supports and services. While some of the home- and community-based waiver programs offered have a minimum age limit of 18 years, the Aged and Disabled, DEA, and Assisted Living Waivers have a minimum age limit of 65 years. As a result, two age groupings were used in this analysis: 18 to 64, and 65 and over. Data assumptions include:

- Population estimates were developed based on the 2000 Census population projections for Rhode Island.
- A household density factor was used to estimate the number of age- and income-qualified persons in Rhode Island. The density factor was established by dividing the total number of persons in each of the two age groups by the total number of households

in each of the age groups. The household density factor is 2.07 for the 18-64 age group and 1.56 for the 65 and older age group.

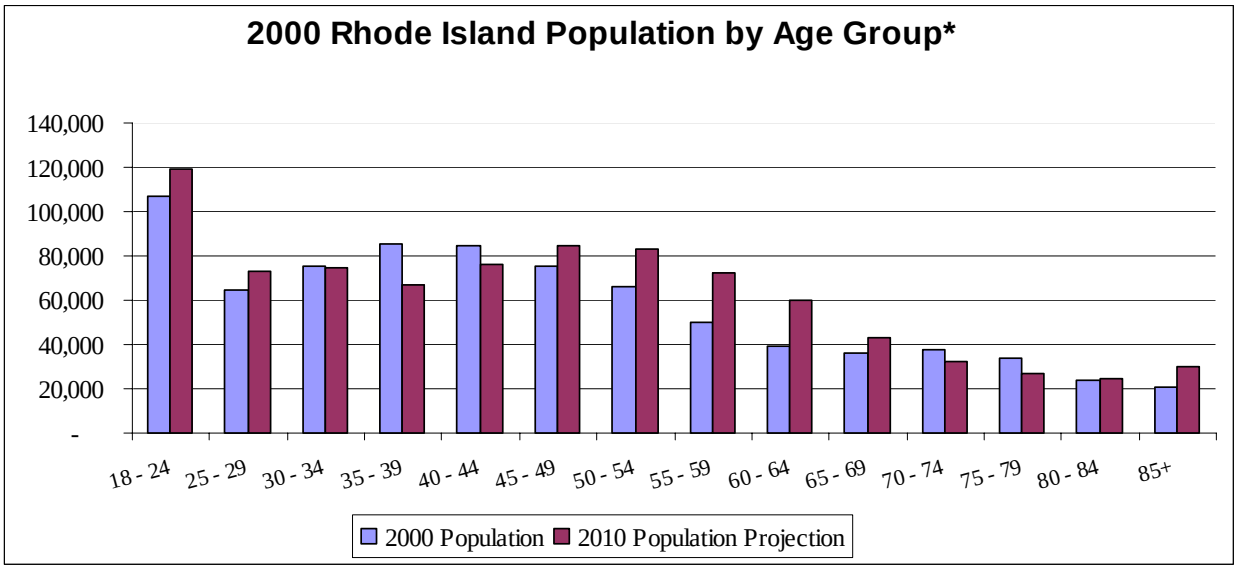
Methodology

This review is limited to persons 18 years or older and living in the community (i.e., not institutionalized). While the upper income level for program eligibility is $20,844, the closest Census data income level is $24,999, which was used for this analysis. Use of this higher income level could result in an overestimate of need. Census projections were used in conjunction with household income data to estimate a range of residents who may require services provided by the state of Rhode Island. Actual trend data for Rhode nursing home resident counts were used to project future nursing home trends.

Population Trends

Figure 1 shows the 2000 Census figures and the projected population in 2010 by age groups. Based on the 2000 Census, the population of Rhode Island residents 18 years of age or older was 800,497. By the year 2010, this number is projected to increase by 8 percent to 867,379. In 2000, 62 percent of the population was 18 to 64 years of age, while nearly15 percent of the population was 65 years of age or older. By 2010, the expected percentages in these two age groupings will remain relatively stable, though noteworthy increases are expected in the 60-64, 65-69, and 85 and older sub-age groups.

Figure 1



* Based on U.S. 2000 Census Population Projections

Table 1 provides the total eligible population of persons who are 18 years of age and older by age categories. In 2000, residents aged 18 to 24 years made up the largest segment of the population, while residents aged 85 years or older made up the smallest segment. However, by 2010, the 85 and older population will outnumber both the 75-79 and the 80-84 age groups. From 2005 to 2010, the average annual increase in the overall population is projected at 1 percent. Within the 1 percent overall increase, the three largest average annual increases by age category are in the 60–64 age group (4.8 percent), the 65-69 age group (3.3 percent), and the 85 and older age group (3.4 percent).

Table 1: Estimated Population in the Community for Persons 18 Years of Age or Older

Age	Census 2000	Projected 2005	Projected 2006	Projected 2007	Projected 2008	Projected 2009	Projected 2010	Average Annual Increase*
18 - 24	106,607	107,434	106,572	108,415	112,794	116,633	119,441	1.6%
25 - 29	64,732	72,638	77,388	79,350	78,170	75,926	73,332	1.3%
30 - 34	75,594	66,782	65,067	64,822	66,714	70,186	74,354	1.3%
35 - 39	85,364	76,220	75,043	73,724	71,729	69,601	67,169	-2.4%
40 - 44	84,946	85,067	83,516	81,397	79,476	77,337	75,854	-2.0%
45 - 49	75,429	84,767	85,551	85,869	85,361	85,087	84,401	.1%
50 - 54	66,434	74,929	77,218	79,147	81,188	82,564	83,216	2.3%
55 - 59	49,982	64,514	66,661	67,003	68,002	69,710	71,955	2.6%
60 - 64	39,007	47,186	49,255	52,873	55,124	57,565	60,299	4.8%
65 - 69	36,023	36,000	36,615	38,030	40,208	41,903	43,338	3.3%
70 - 74	37,661	31,903	31,395	31,338	31,480	31,877	32,255	-.2%
75 - 79	34,076	31,588	30,751	29,606	28,651	27,788	27,266	-2.8%
80 - 84	23,745	26,017	25,999	25,791	25,614	25,189	24,606	-.7%
85+	20,897	25,383	26,414	27,462	28,316	29,091	29,893	3.4%
Total 18 +	800,497	971,330	837,445	844,827	852,827	860,457	867,379	.9%
Total 65 +	152,402	150,891	151,174	152,227	154,269	155,848	157,358	.7%

* Average annual increase is based on the annual increase each year from 2005 to 2010.

Age- and Income-Qualified Population: Tables 2a and 2b are subsets of the population described in Table 1. These tables provide data on the number of persons in each age group who fall into discrete income categories. The number of people in each category was calculated by multiplying the number of households in each age group by the household density factor for that age group. The results for each age group within each income category were then totaled to provide the total number of persons in each income level. The data in the first column were obtained from the 2000 Census, while the estimates for years 2005 through 2010 were obtained by applying a 0.896 percent annual population increase factor to the 18 to 64 age group and a 0.714 percent population increase factor to the 65 and older age group. The population increase factor is based on the average annual increase for years 2005 through 2010 in the Rhode Island population projections for each of the age groups.

The 2000 baseline number of people who meet the age and income parameters established for this analysis is 149,303 for persons aged 18 to 64 and 66,889 for those aged 65 and older. In 2010, those meeting the parameters in the 18 to 64 age group will increase by 9 percent to 163,233. A similar increase of 9 percent, up to 73,130 in 2010, will occur in the 65 and older population. The highest percentage of residents fall into the less than $10,000 income category for both age groups.

Table 2a: Age- and Income-Qualified Population 18 to 64 by Income Level

Income	2000	2005	2006	2007	2008	2009	2010
Less than $10,000	55,333	57,857	58,375	58,898	59,426	59,958	60,496
$10,000 - $14,999	30,655	32,053	32,340	32,630	32,923	33,217	33,515
$15,000 - $19,999	29,833	31,194	31,473	31,755	32,040	32,327	32,616
$20,000 - 24,999	33,482	35,009	35,323	35,639	35,959	36,281	36,606
Total	149,303	156,113	157,511	158,923	160,347	161,783	163,233

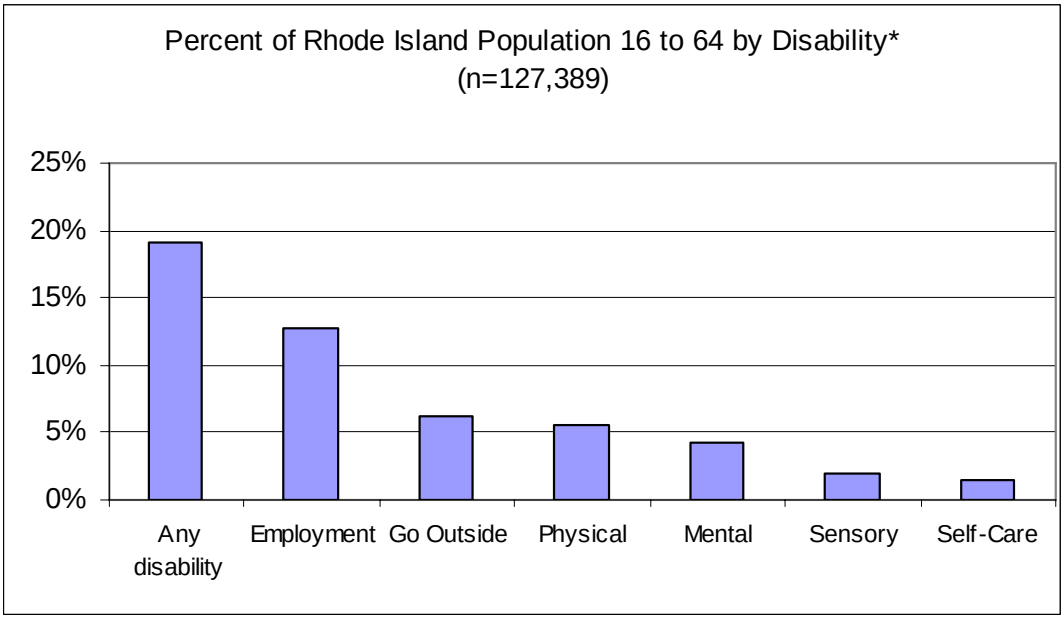
Table 2b: Age- and Income-Qualified Population 65 and Older by Income Level

Income	2000	2005	2006	2007	2008	2009	2010
Less than $10,000	21,954	22,749	22,912	23,076	23,240	23,407	23,574
$10,000 - $14,999	17,801	18,446	18,578	18,710	18,844	18,979	19,114
$15,000 - $19,999	15,003	15,547	15,658	15,770	15,882	15,996	16,110
$20,000 - 24,999	12,131	12,571	12,660	12,751	12,842	12,934	13,026
Total	66,889	69,940	70,566	71,199	71,837	72,480	73,130

Disability Trends

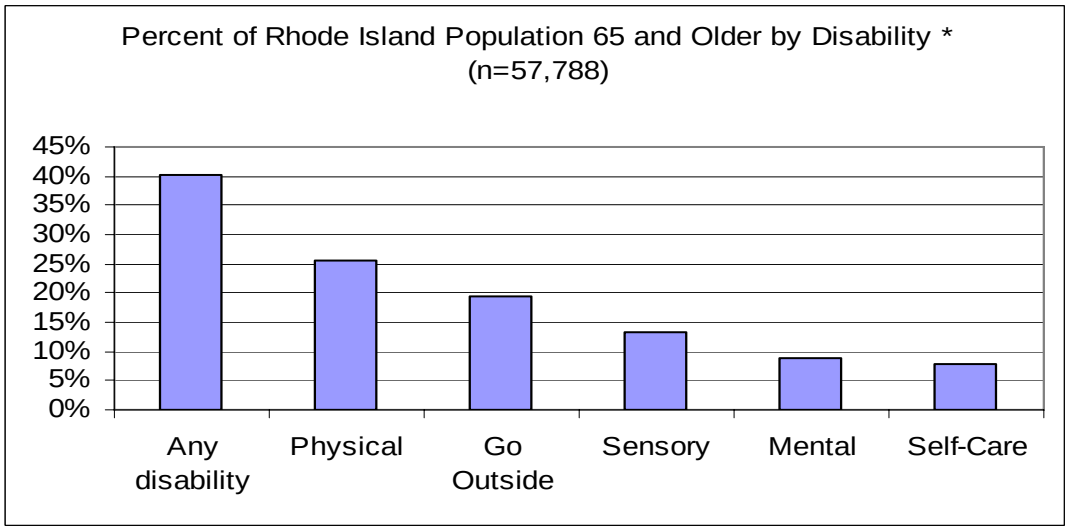
Based on the 2000 Census, 19.1 percent of Rhode Island's civilian non-institutional population aged 16 to 64 reported having a disability (either sensory, physical, mental, self-care, or going outside)(Figure 2). The largest percentage of people in this age group reported having an "employment" disability (13 percent), while the smallest percentage reported having a "self care" or "sensory" disability (2 percent each). The percentage of residents reporting a disability increased to 40.3 percent for persons 65 years of age or older (Figure 3). For this age group, the largest percentage (26 percent) reported having a "physical" disability, while the smallest percentage (8 percent) reported a "self-care" disability.

Figure 2



* Based on U.S. 2000 Census Data

Figure 3



*Based on U.S. 2000 Census Data

Self-Reported Disabilities/Limitations: The eligibility criteria for most of Rhode Island's home- and community-based waiver programs include the presence of a disability. To determine the number of persons who may require these programs, 2000 Census data were used to estimate the number of persons in the population of interest who have reported a disability.

Tables 3a and 3b provide information on the number of persons reporting physical, mental, self-care, go outside, sensory limitations, or combinations thereof. Census respondents were asked to select a disability category that best describes their limitation. The limitations are described as: physical (conditions that limit one or more basic physical activities such as walking, climbing stairs, or carrying); self-care (problems with dressing, bathing, or getting around the house); go outside (problems going outside of the home alone to shop or visit a doctor's office); sensory (blindness, deafness, or a severe vision or hearing impairment), or mental (learning, remembering, or concentrating). Some categories included multiple limitations (e.g., limitations in self-care and a physical disability, or limitations in both self-care and going outside). The following table shows selected disability categories relevant to this study as reported in the 2000 Census. Estimates for the 18 to 64 age group may be slightly overstated as 16- and 17-year-olds are included in the 2000 Census disability data.

Table 3a
Estimate of Persons 18 to 64 Self-Reporting Disabilities in the 2000 Census by Income

Income	Physical	Self-care	Go Outside	Sensory or physical or mental	Sensory and physical and mental	With either a sensory, physical, mental, or self-care
Less than $10,000	1,992	1,107	3,320	5,091	2,213	5,146
$10,000-$14,999	1,104	613	1839	2,820	1,226	2,851
$15,000-$19,999	1,074	597	1,790	2,745	1,193	2,774
$20,000 -$24,999	1,205	670	2,009	3,080	1,339	3,114
Total	5,375	2,986	7,149	13,736	5,972	13,885

Table 3b
Estimate of Persons 65 and Older Self-Reporting Disabilities in the 2000 Census by Income

Income	Physical	Self-care	Go Outside	Sensory or physical	Sensory and physical and mental	With either a sensory, physical, mental, or self-care
Less than $10,000	3,293	1,756	4,171	7,442	593	7,530
$10,000-$14,999	2,670	1,424	3,382	6,035	481	6,106
$15,000-$19,999	2,250	1,200	2,850	5,086	405	5,146
$20,000 -$24,999	1,820	970	2,305	4,112	328	4,161
Total	10,033	5,351	12,708	22,675	1,806	22,943

Estimation of Need for Community-Based Services and Supports: Tables 4a, 4b, 4c, and 4d provide estimates of the number of persons who, because of self-reported limitations, may require community-based long-term services and supports. The information is provided by income categories and age, which may be useful in determining need based on existing program eligibility criteria. Table 4e provides a summary of the four tables, with information summarized by disability type for each year and age group. Estimates for the 18 to 64 age group may be slightly overstated as 16- and 17-year-olds are included in the 2000 Census disability counts.

The number of Rhode Island residents aged 18 to 64 with an annual income of less than $25,000 who will have either a sensory, physical, or mental disability is estimated to increase from 13,736 in 2000 to 15,018 in 2010. An increase from 15,233 in 2000 to 16,654 in 2010 is estimated for residents in the 65 and older age group with the same income level. For both age groups with incomes less than $25,000, the largest number will require assistance with activities outside of the home. Both groups are estimated to have the smallest number who will require assistance with self-care activities.

Table 4a: Total Estimates of Persons Who May Require Community-Based Services in 2005-2010 for Incomes Less Than $10,000

Year	Age Group	Self-care	Physical	Sensory or physical or mental	Sensory and physical and mental	Go outside
2000	18-64	1,107	1,992	5,091	2,213	3,320
2005		1,157	2,083	5,323	2,314	3,471
2006		1,168	2,102	5,371	2,335	3,503
2007		1,178	2,120	5,419	2,356	3,534
2008		1,189	2,139	5,468	2,377	3,566
2009		1,200	2,159	5,517	2,398	3,598
2010		1,210	2,178	5,566	2,419	3,630
2000	65+	1,756	3,293	7,442	593	4,171
2005		1,836	3,443	7,781	620	4,361
2006		1,853	3,474	7,851	626	4,400
2007		1,869	3,505	7,921	631	4,440
2008		1,886	3,537	7,992	637	4,480
2009		1,903	3,568	8,064	643	4,520
2010		1,920	3,600	8,136	648	4,560

Table 4b: Total Estimates of Persons Who May Require Community-Based Services in 2005-2010 for Incomes From $15,000 to $19,999

Year	Age Group	Self-care	Physical	Sensory or physical or mental	Sensory and physical and mental	Go outside
2000	18-64	597	1,074	2,745	1,193	1,790
2005		624	1,123	2,870	1,247	1,872
2006		630	1,133	2,896	1,259	1,888
2007		635	1,143	2,922	1,270	1,905
2008		641	1,153	2,948	1,281	1,922
2009		647	1,164	2,974	1,293	1,940
2010		653	1,174	3,001	1,304	1,957
2000	65+	1,200	2,250	5,086	405	2,850
2005		1,255	2,353	5,318	423	2,980
2006		1,266	2,374	5,366	427	3,007
2007		1,277	2,395	5,414	431	3,034
2008		1,289	2,416	5,462	435	3,061
2009		1,300	2,438	5,511	439	3,088
2010		1,312	2,460	5,561	443	3,116

Table 4c: Total Estimates of Persons Who May Require Community-Based Services in 2005-2010 for Incomes From $20,000 to $24,999

Year	Age Group	Self-care	Physical	Sensory or physical or mental	Sensory and physical and mental	Go outside
2000	18-64	670	1,205	3,080	1,339	2,009
2005		701	1,260	3,220	1,400	2,101
2006		707	1,271	3,249	1,413	2,119
2007		713	1,283	3,278	1,425	2,138
2008		720	1,294	3,308	1,438	2,158
2009		726	1,306	3,337	1,451	2,177
2010		733	1,317	3,367	1,464	2,196
2000	65+	970	1,820	4,112	328	2,305
2005		1,014	1,903	4,300	343	2,410
2006		1,023	1,920	4,338	346	2,432
2007		1,032	1,937	4,377	349	2,454
2008		1,042	1,955	4,416	352	2,475
2009		1,051	1,972	4,456	355	2,498
2010		1,061	1,990	4,496	359	2,520

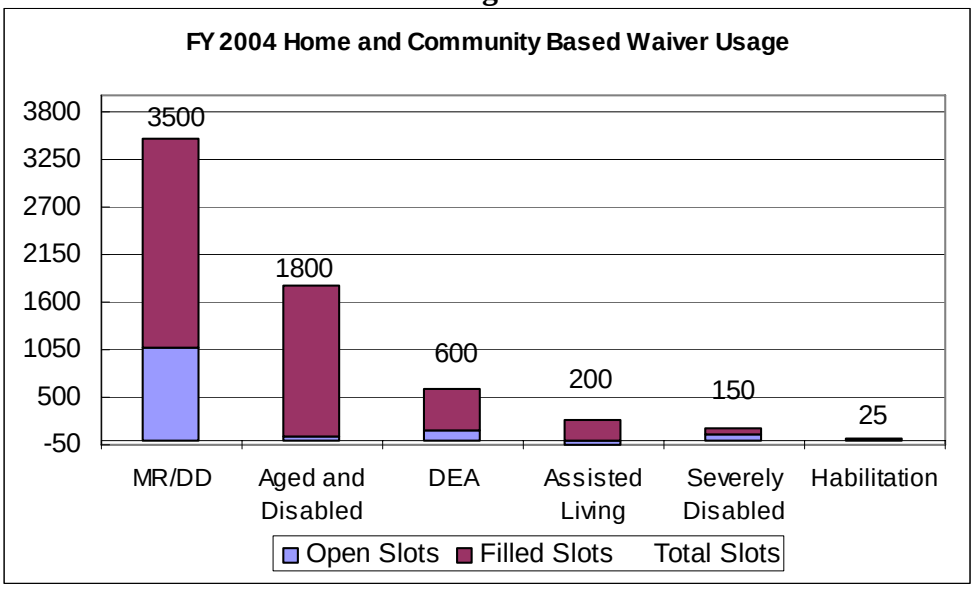
Table 4d: Total Estimates of Persons Who May Require Community-Based Services in 2005-2010 for Incomes $0 to $24,999

Year	Age Group	Self-care	Physical	Sensory or physical or mental	Sensory and physical and mental	Go outside
2000	18-64	2,987	5,375	13,736	5,971	8,958
2005		3,123	5,620	14,362	6,243	9,367
2006		3,151	5,671	14,491	6,299	9,450
2007		3,179	5,721	14,621	6,356	9,535
2008		3,208	5,773	14,752	6,413	9,621
2009		3,237	5,824	14,884	6,470	9,707
2010		3,266	5,876	15,018	6,528	9,794
2000	65+	3,594	6,740	15,233	1,214	8,537
2005		3,758	7,047	15,928	1,269	8,926
2006		3,792	7,111	16,070	1,281	9,006
2007		3,826	7,174	16,214	1,292	9,087
2008		3,860	7,239	16,360	1,304	9,168
2009		3,894	7,303	16,506	1,315	9,251
2010		3,929	7,369	16,654	1,327	9,334

Rhode Island Home- and Community-Based Waivers

Rhode Island offers six home- and community-based waiver programs to eligible residents (Figure 4). Each waiver targets a specific population such as persons who are 65 and older, persons with developmental disabilities, and persons who are severely disabled. In FY 2004, there were 6,275 waiver slots available across the six waiver programs, with 5,023 (80 percent) of those slots being utilized. The annual income eligibility for each of the waivers is $20,844, which is reflected in the $24,999 income level used in the analysis. Based on the estimates for future service needs, the current capacity level may not meet the demand for service.

Figure 4



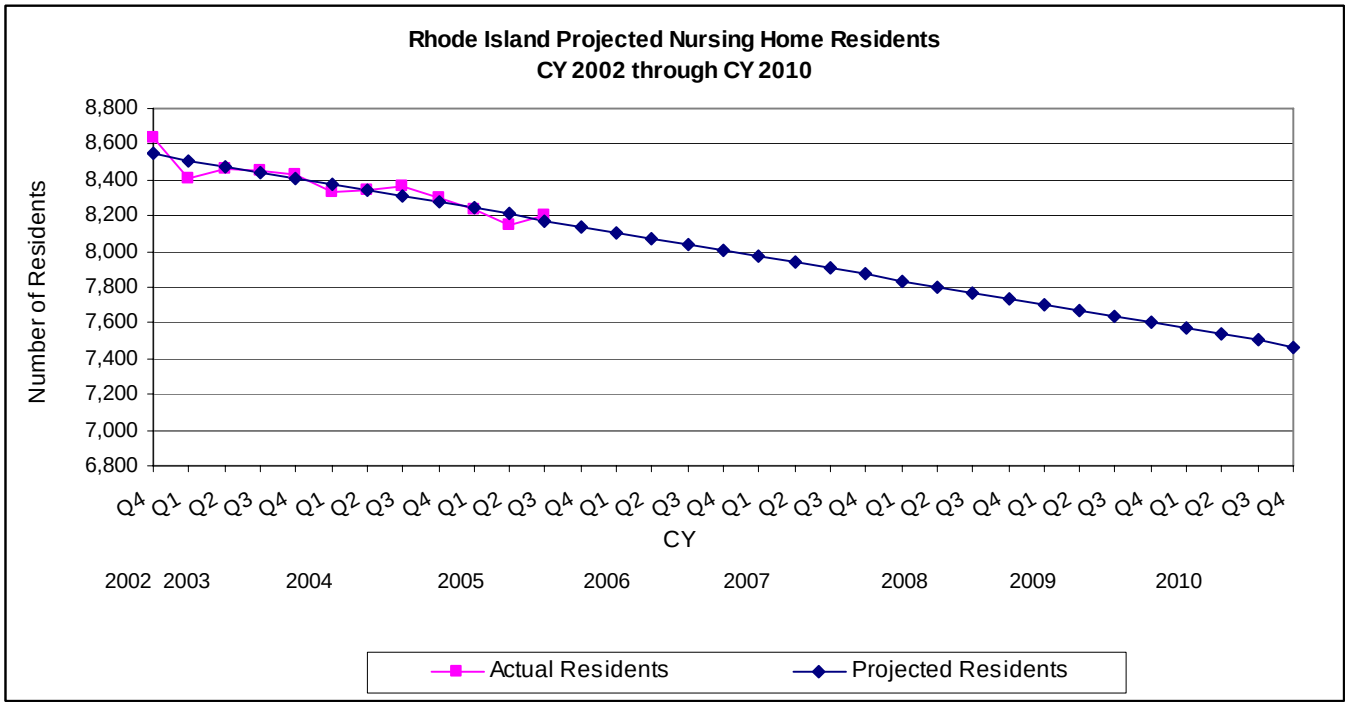
Nursing Home Trends and Projections

Data from the Medicaid Statistical Information System (MSIS) at www.cms.hhs.gov was used to identify current trends in the number of nursing home residents in Rhode Island and to predict future nursing home trends. Specifically used was the Minimum Data Set (MDS) Active Residents Information Report that summarizes nursing home resident counts by state from December 31, 2002, through September 30, 2005.

The number of nursing home residents has declined since December 2002 and this trend is expected to continue through 2010. As of December 31, 2002, there were 8,638 residents in Rhode Island nursing homes; by September 30, 2005, there were 8,200. On average, 8,360 people were in nursing homes each quarter during this period, with an average decrease of .2 percent noted each quarter.

To predict future counts of nursing home residents, a regression analysis (curve estimation) based on trend data from December 2002 through September 2005 was used. Figure 5 shows the actual number of nursing home residents and the predicted number of nursing home residents through 2010. The average annual change in the number of residents is expected to decrease by 2 percent each year, with less than 7,500 residents predicted to be in nursing homes at the end of 2010. It is important to note that this trend is predicated on the continued maintenance of the cap on new nursing home beds and on the continued and expanded use of community-based alternatives to institutional care.

Figure 5



Summary

While this analysis does not account for factors other than disabilities and income that may influence the number of program-eligible Rhode Island residents, the data does show that the need for long-term care services will likely overpower existing capacity before the year 2010. The increase in demand is driven primarily by two forces: a projected increase in the number of persons in the targeted age and income group, and an increase in the number of people with disabilities.

Older residents who typically require more long-term support services will experience the largest percentage of growth. From 2005 to 2010, the 60-64 age group will experience the largest growth, followed by the 85 and older age group, and the 65-69 age group (3.34 percent).

Over 19 percent of Rhode Island's civilian non-institutional residents aged 16 to 64 who meet the income requirement for this analysis reported having a disability. This number increased to 40 percent for persons 65 years of age or older. By the year 2010, an estimated 15,000 residents aged 18 to 64 are projected to have either a sensory, physical, or mental disability. Well over 16,000 residents who are 65 years of age or older are projected to have either a sensory, physical, or mental disability. Based on current income levels, these projected 31,000 residents may be eligible for publicly supported long-term care supports and services.

In FY 2004, Rhode Island's authorized capacity in home- and community-based waiver programs was 6,275 slots, and the vast majority of those slots were already filled. Based on this analysis, the number of residents who meet the income criteria and who self-reported disabilities, and, therefore, may qualify for home- and community-based services, will likely continue to increase. In the absence of information that may represent additional opportunities for service, and given the projected increase in service demand and existing capacity, the state will likely find that the demand for long-term care services will outstrip supply.

While nursing home admissions are expected to decline in the state of Rhode Island over the next few years, this decrease in not assured. In the absence of an expanded and re-engineered system of community-based supports and services, current nursing home trends may be reversed as Rhode Island citizens dependent on publicly supported long-term care services will have fewer options for remaining in the community.