From the Frontlines to the Bottom Line

Proposals to Achieve Medicaid Savings, Improve Quality Outcomes, and Lift Caregivers Out of Poverty

May 2015 Policy Brief by SEIU District 1199 New England

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Executive Summary of SEIU 1199NE Policy Brief | May 2015

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SEIU 1199 New England members help deliver services to Medicaid enrollees and other patients in nursing homes, hospitals, and community health centers in Rhode Island, and in some cases they are also beneficiaries of the program. We are part of the Service Employees International Union (SEIU), which represents over one million health care workers nationwide.

We believe that front-line workers must be partners in any meaningful transformation of the health care system, including the Medicaid program, and that they should earn a living wage. We also believe that short-term solutions should not balance the budget via across-the-board cuts that affect services and caregivers.

The enclosed policy brief reviews the current context of discussions regarding Medicaid reform in Rhode Island, offers short-term proposals to address the budget deficit responsibly, and provides some initial thoughts on longer-term reforms. Our short-term actionable proposals outlined in the following pages are to:

1. Create a **value based-purchasing program** to improve care quality and staffing in nursing homes and reduce re-hospitalization.
2. **Increase transparency of “related party” finances** and reporting, in effort to reduce waste, fraud, and abuse.
3. Target any nursing home rate reductions toward costs **unrelated to the provision of direct care**, such as Fair Rental Value and “home office” charges.
4. Focus increased revenue and rate restoration initiatives on **direct resident care** and **workforce stability**.
5. **Claw Back: Recoup Medicaid reimbursements** that are not used for their intended purpose, especially in regards to direct labor.
6. Cap Medicaid reimbursement for **executive compensation** based on facility size.
7. Realize Medicaid savings though more **energy efficiency initiatives**.
8. **Expand Rhode Island’s Paid Family Leave Program** from 4 to 6 Weeks.

Long-term planning also must recognize the important role that frontline workers will play in system reform, and the importance of adequate compensation and training to maintaining a stable workforce that contributes to the quality of care in Rhode Island. SEIU 1199 NE is ready to work with state decision-makers and other partners to undertake this transformation.
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**Introduction**
Rhode Island is currently in the midst of reexamining its Medicaid program. Potential long and short-term reforms are under discussion by a “Working Group to Reinvent Medicaid,” which was created by Governor Gina Raimondo through Executive Order, and directed to conduct a “comprehensive review of the Medicaid program.” The General Assembly has also been highly engaged in reviewing and studying potential savings and improvements to the Medicaid program.

SEIU 1199 NE has an important role to play in this process, as both a member of the Working Group and beyond. Our members deliver services to Medicaid enrollees and other patients in nursing homes, hospitals, and community health centers in Rhode Island; in some cases they are also beneficiaries of the program. Our local union is part of the Service Employees International Union (SEIU), which represents more than one million health care workers and has played a key role in the movement to ensure that health care workers are paid a living wage.

A core principle that guides our participation in the Working Group is the belief that front-line workers have a crucial role to play in any meaningful transformation of the health care system, including the Medicaid program, and that they should earn living wages for the work they do. We also believe that short-term solutions should not balance the budget via cuts that affect services and the workers who provide those services. Longer term reforms must focus on paying for quality and health outcomes, and further developing a well-trained and adequately compensated healthcare workforce, not just on savings to the budget bottom line.

This paper 1) reviews the current context for discussions concerning reform of the Medicaid program; 2) offers short-term proposals to address budget deficit issues in a responsible manner, including but also going beyond options presented in the initial report of the Working Group; and 3) provides our initial thoughts on longer-term reforms that Rhode Island should consider.

**The Rhode Island Medicaid Context**
Thinking about how to design a path for Rhode Island’s Medicaid program in future years, it is useful to first consider the recent past and current context of spending and program design. Understanding current costs and spending trends, as well as program initiatives already underway will help in assessing potential solutions.

**Spending**
As has been widely discussed, data from 2011 suggests that Rhode Island has the second highest cost per Medicaid enrollee in the U.S.,¹ and that the state share of Medicaid spending is higher than in nearby states. However, it is worth noting that the per-enrollee spending statistic comes before the state implemented initiatives to control costs and before the ACA Medicaid expansion. Also worth noting are demographic differences (i.e., Rhode Island has a higher share of elderly and disabled people in its Medicaid program) that may explain some of the higher costs.

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Comparing Medicaid spending as a percentage of a state budget is also problematic, as differences in state budget structures and the breakdown of state and local spending make an apples-to-apples comparison difficult. A more appropriate way to compare across states is to look at total Medicaid spending as a share of state personal income. This provides a better measure of a state’s ability to invest in a given program or set of services. When measured this way, Rhode Island is still high—8th of 50 states and the District of Columbia—but in line with most nearby states (see Chart 1).

Moreover, there is evidence that Medicaid spending growth in Rhode Island has been restrained in recent years. While overall state and federal spending on Medicaid programs continues to rise, state data show that in the period from 2009 to 2013 the per-enrollee cost has actually declined. In other words, to the extent that spending on Medicaid services is rising, that growth is almost entirely due to external forces, particularly the expansion of Medicaid coverage to adults at or near the federal poverty level, which is paid for entirely with federal dollars in the near term.

Demographics

Another factor in our Medicaid spending is our aging population: Rhode Island has the highest percentage of the population that is aged 85 years and older in the entire nation, the age range that typically requires the most amount of Medicaid Long-Term Services and Supports. Looking at the U.S. Census Bureau American Community Survey Data from 2013, as well as the 3 year (2011-2013), and 5 year (2009-2013) averages, Rhode Island holds the number one ranking for the highest percentage of the population over 85 years old. In 2013, the neighboring states of Connecticut and Massachusetts ranked 2nd and 8th, respectively.

2 EOHHS response to Working Group Members regarding Medicaid trend data
http://static1.squarespace.com/static/54e689e7e4b0d1bc2505f118/t/55003cf1e4b0d42b6a3d4e28/1426078961790/WG1Q3.+Trend+Data.pdf
Rhode Island ranks 10th in the nation in terms of the percent of the total population 65 and older. While Rhode Island is on par with the nation for the percent of people 65 years and older below the poverty level, it has a larger share of elders living in poverty compared to most neighbors.

These age and poverty demographics are of great concern since many older Rhode Islanders will need LTSS services, including expensive nursing facility services, at some point in their lives. These demographics illustrate the importance of improving the LTSS delivery system and rebalancing so more LTSS services are delivered in lower-cost HCBS settings and can prolong our elders living in the community rather than in an institutional setting. However, we also recognize that there will always be a need to provide 24-hour skilled nursing care for residents with high needs.
acuity needs both for short-term rehabilitation and longer term needs. As the resident acuity levels increase and more residents have dementia, there is a need to address how to improve staff retention and to further train and develop the workforce.

**LTSS Workforce**

Despite the spending comparison above, the wages for many frontline health care jobs are significantly lower in Rhode Island than in neighboring states, as seen below in the comparison of average wages. The **median wage** for nursing assistance in Rhode Island’s nursing facilities is **$13.14 per hour**, meaning that half of all nursing assistants are earning less than this amount.

![Average Caregiver Wages in RI, MA & CT (per BLS, May 2014)](image)

The low wages for LTSS workers results in many caregivers struggling to make ends meet, and some qualifying for public assistance to support their families. As workers struggle, it leads to higher turnover in the LTSS industry as some workers seek better wages, benefits and working conditions in other industries. Higher turnover negatively affects LTSS beneficiaries who need continuity of care so they can develop good relationships with their caregivers. Also, there is a cost associated with recruitment and retraining for vacant positions.

Nursing facility care is mostly publicly funded, through Medicaid and Medicare, and public officials and their constituents have the right to demand that their tax dollars are used to support high-quality and living-wage jobs in the LTSS sector, not poverty jobs that impede efforts to improve quality of care for seniors and persons with disabilities. As Rhode Island endeavors to improve the Medicaid program it is vital that frontline caregivers earn a living wage that enables them to support their families and to further contribute to the local economy, helping to rebuild it from the bottom up.
Global 1115 Waiver & Managed Care

The Rhode Island Medicaid Reform Act of 2008 directed the state to apply for a global waiver to establish a “sustainable cost-effective person-centered and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options.”3 This 1115 Medicaid waiver was approved in 2009, and later renewed for the 2013-2018 period. Rhode Island operates its entire Medicaid program under this waiver, with greater flexibility to design services than would be the case in the absence of a waiver. A key goal of the waiver was to rebalance long-term services and supports (see below for more discussion).

Rhode Island began to implement managed care for its Medicaid program more than 20 years ago. Over two-thirds of Medicaid beneficiaries were enrolled in managed care in 2011, including older adults and people with disabilities. Starting in 2013, the state began to integrate long-term services and supports (LTSS) into the Rhody Health Partners managed care program.4 Despite managed care penetration the percent of spending still in fee-for-service (FFS) is relatively high.5 In theory, the combination of the greater flexibility offered by the global 1115 waiver and the high managed care penetration should allow the adoption of more innovative payment and delivery model.

Long-Term Care: Institutional vs. Home and Community-Based Services (HCBS)

Generally states must cover nursing home care for seniors and people with disabilities who are eligible for Medicaid and need long-term services and supports (LTSS). They may choose to cover home and community-based services (HCBS), such as home and personal care services that enable these groups to remain at home or in other community settings. Recent decades have seen a shift from the provision of LTSS in institutional settings to a greater use of home and community-based services, sometimes referred to as “rebalancing.”

Aside from allowing seniors and people with disabilities to remain in their homes, as many prefer, HCBS services tend to be less costly, on average, than institutional care. Data compiled by the Kaiser Foundation suggest that on average 41.3 percent of long-term care in the U.S. is provided in nursing facilities, while 45.9 percent is provided via home health and personal care services (the balance of 12.8 percent is provided in facilities for the developmentally disabled and people with mental illness).6 However, in states that have moved more aggressively to rebalance services, HCBS accounts for a much greater share (e.g., 78 percent in Oregon). Not coincidentally, these states have moved simultaneously to improve compensation for the home care workforce.

Rhode Island has made several attempts at rebalancing LTSS, spurred by various legislative resolutions and passage of the Perry-Sullivan Long-Term Care Service and Finance Reform Act of

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3 Chapter 42-12.4, The Rhode Island Medicaid Reform Act of 2008, Section 4-2
5 Initial Report of the Working Group to Reinvent Medicaid, p. 3.
6 Distribution of Medicaid Spending on Long-Term Care, Kaiser State Health Facts, available at http://kff.org/medicaid/state-indicator/spending-on-long-term-care/ Home health services are typically time-limited post-acute care services that comprise a very small portion of this category; personal care services overlap or are synonymous with home care services, and include assistance with activities of daily living, such as dressing, toileting and helping with instrumental activities such as meal preparation.
A main component of the 2009 global 1115 Medicaid waiver was a proposal to rebalance services—indeed, the state’s initial application for an 1115 waiver detailed previous attempts at, and barriers to, rebalancing and stated that “[o]n the long-term care side, the State’s Medicaid reform proposal seeks to rebalance the system away from high cost institutional venues and toward home and community based settings.” The approved waiver subsumed 1915(c) waiver programs under which HCBS services had previously been offered, providing the state—at least in theory—greater flexibility to design eligibility and other program elements.

The global waiver structure has also resulted in changes in the way the state reports data on LTSS to CMS, making it difficult to ascertain how successful the waiver has been thus far in actually achieving the goal of rebalancing long-term care. Recent state data suggest that some rebalancing is taking place. For instance, a 2014 EOHHS report shows the average daily census for HCBS is growing at an average annual rate of 8.5 percent for the elder population from FY2009 to 2013, while nursing facility admissions fell by 2.5 percent on average each year during this period.

However, according to an AARP report, Rhode Island ranked last in the U.S. in 2014 when measuring the percentage of LTSS spending directed to HCBS. It is possible that this measure is affected by the reporting challenges noted above, but it seems clear that Rhode Island lags other states in rebalancing LTSS. In fact, state data also show that spending remains concentrated on the institutional side-in FY2013, about $329 million of a total $741 million in LTSS expenditures went to nursing homes, with only $80 million spent on personal care and other HCBS.

One analysis of the waiver’s effect on LTSS suggested that some of the barriers to rebalancing included the waiver’s focus on cost containment and decisions to delay rate increases for HCBS providers in the early years of waiver implementation, as well as challenges administering the state’s nursing home transition program. The same analysis describes “widespread doubt about the capacity of the provider community” to serve people eligible for HCBS, and notes concerns about the ability of the state to appropriately monitor the quality of HCBS services and a lack of data that would allow assessment of whether the state was complying with the requirements to invest savings due to reduced nursing home utilization in HCBS.

The above analyses suggest that there is little room to further reduce Medicaid spending without affecting core program functions. It is certainly worth the effort of elected officials and other leaders to attempt to identify program savings, but the automatic assumption that Medicaid

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7 Miller et al., p.4.
9 EOHHS Annual Medicaid Expenditure Report, p.25.
13 Ibid., p.12-14.
spending growth is out of control is worth questioning. At the same time, the apparent slow progress in shifting to HCBS point to potential longer-term savings that could be achieved from rebalancing LTSS, in the broader context of the state’s adoption of managed LTSS. As the state develops a plan for short-term savings, decision-makers should attempt to identify savings that will not affect the provision of services. Similarly, proposals for long-term reforms should focus on systemic reforms, such as rebalancing, rather than cuts to services.

### Short-Term Savings & Investment Proposals

As stated earlier, a core principle to SEIU is the belief that front-line workers have a crucial role to play in any meaningful transformation of the health care system, including the Medicaid program. We also believe that short-term solutions should not balance the budget via cuts that affect services and the workers who provide those services, and that longer term reforms must focus on paying for quality and health outcomes, and further developing a well-trained and adequately compensated healthcare workforce, not just on bottom line budget savings.

The “Initial Report of the Working Group to Reinvent Medicaid” made several proposals to produce short-term Medicaid savings. We support the themes of payment and delivery system reforms, targeting fraud, waste, and abuse, and administrative and operational efficiencies, and the strategies contained, especially moving away from fee-for-service payment models towards value-based purchasing, continuing the ongoing work to rebalance the long-term care system towards community settings, and improving care coordination across providers and systems. Fortunately, the budget revenue projections are not as grim, with the revenue estimating committee projecting an additional $107 million in revenue this budget year and an additional $37 million for 2015-2016, so there is opportunity to take a portion of the additional revenue to invest in creating a sustainable health care system and workforce which will improve the quality of care. The following are our key proposals for short-term savings, which build upon the Working Group’s recommendations:

1. Create a value based-purchasing program to improve care quality and staffing in nursing homes and reduce avoidable re-hospitalizations

We support the recommendation to create an “incentive program to reduce long stays and improve care quality and staffing in nursing homes.” However it is essential that workforce-related quality metrics be included at the inception of the incentive program, rather than just as suggested quality metric ideas. The two main workforce related quality metrics we recommend for inclusion are the direct care staff turnover rate and the level of direct care staffing (adjusted by the average acuity levels of residents). A Kaiser Family Foundation report suggests that improving staff-to-resident ratios and reducing turnover is one strategy to assist in lowering avoidable re-hospitalizations. This proposal is also in line with legislation proposed this year at the General

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15 Kaiser Family Foundation “To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care Facility Residents” October 2010 [http://www.kff.org/medicare/upload/8110.pdf](http://www.kff.org/medicare/upload/8110.pdf)
Assembly (S-322 Senator Gayle Goldin and H-5282 Representative Patricia Serpa) that encourages managed care organizations in consultation with EOHHS to develop incentives for nursing facilities that demonstrate lower direct care staff turnover.16 There is academic consensus that lower staff turnover and higher staffing levels result in better quality outcomes, and these are two important measures that impact all residents and are easy for residents and their families to understand. A 2013 analysis using survey data from a nationally representative sample of 1174 nursing homes demonstrated that nursing homes with high CNA turnover had more than triple the odds of resident pain, and approximately double the odds of both pressure ulcers, and urinary tract infections.17

There are other states that use staff turnover rates, staff retention or direct care staffing levels as quality metrics in their Medicaid value-based purchasing programs, such as Georgia, Illinois, Iowa, Kansas, Ohio, and Minnesota, providing models for implementation of such a program. Moreover, in the CMS Medicare Skilled Nursing Facility Value Based Purchasing demonstration, both staffing levels and nursing staff turnover were used as quality metrics.

The Working Group proposes two separate incentive programs, one focused on discharges to the community and re-hospitalizations and another focused on other quality metrics (which might include staffing and retention levels, etc.), but it is unclear how much of the pooled funding will be dedicated to each program. We suggest that more funding be dedicated to the other quality metrics at first, since as indicated in the report there is work to be done to further develop additional capacity for home and community based services, so it may take a while for community discharge rates to increase significantly. We also note that the Centers for Medicaid and Medicare will be introducing a value based purchasing program for skilled nursing facilities by October 2018 that will be based on performance on an all-cause hospital readmission measure, so the Medicaid dollars should be focused on other quality metrics, such as reducing staff turnover, staffing levels, and other key metrics for nursing home residents.

2. Increase transparency of “related party” finances and reporting, in an effort to reduce waste, fraud, and abuse.

One of the principles mentioned in the Working Group’s May 1 initial recommendations is to build “transparency into a complex system and into its guiding policies and regulations.”18 There are many specific ways that this could be accomplished, particularly in the long-term care industry, where many nursing facilities have adopted complex ownership structures where various related parties own different aspects of the business.

In this model, one related party owns the real estate, another related party owns the operating company, another related party owns the management company, and another related party owns

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16 [http://webserver.rilin.state.ri.us/BillText/BillText15/HouseText15/H5282.pdf](http://webserver.rilin.state.ri.us/BillText/BillText15/HouseText15/H5282.pdf) and [http://webserver.rilin.state.ri.us/BillText/BillText15/SenateText15/S0322.pdf](http://webserver.rilin.state.ri.us/BillText/BillText15/SenateText15/S0322.pdf)
18 [http://reinventingmedicaid.ri.gov/initial-report-recommendations-for-fy2016/](http://reinventingmedicaid.ri.gov/initial-report-recommendations-for-fy2016/)
the pharmacy or therapy company. Such a complicated structure can result in the operating company, which files the annual cost report, appearing as operating with very minimal net income or even operating at a loss. However the related party companies may be making substantial profits, but the Medicaid agency and the public are unaware since nursing facility related parties are not required to disclose their financial statements. This is important since some related party transactions could be inflating operating costs, which in turn increases the baseline costs on which Medicaid reimbursement rates are determined. By having more transparency of true profitability of the industry, it could lead to Medicaid savings in the future.

Rhode Island should adopt legislation such as the law in Connecticut (Public Act No. 14-55)\textsuperscript{19}, which requires nursing homes to submit cost reports annually including an accounting of any related-party transactions that occur during the reporting period. The act requires for-profit chronic and convalescent nursing homes to include with their cost reports the most recent finalized annual profit and loss statement from any related party that receives $50,000 or more per year from the home for providing it with goods, fees, and services.

Under the act, “related party” includes any company related to the nursing home through a family association, common ownership, control, or business association with any of the home’s owners, operators, or officials. “Family association” means relationship by birth, marriage, or domestic partnership.

In addition, legislation introduced this year at the General Assembly (S-301 Senator Satchell and H-5110 Representative Serpa\textsuperscript{20}) requiring certain social services entities to disclose the compensation for the top 10 administrator and executives and the sources of funding will provide greater transparency to the public and better equip Rhode Island’s leadership to protect public tax investment.

3. **Target any nursing home rate reductions toward costs unrelated to the provision of direct care, such as Fair Rental Value and “home office” charges.**

Rather than an across-the-board reduction in rates for nursing facilities, we recommend that reductions be made to components of the fee-for-service rates that do not impact direct resident care. For example, the rate reduction could be in the form of changing the Fair Rental Value System (FRV) methodology to be more in line with other states, or restricting the charges a multistate chain can bill for “home office” expenses unrelated to resident care.

**Fair Rental Value**

Several states have opted to utilize a fair rental value (FRV) system as a means to provide facility specific Medicaid Fee-For-Service reimbursement for capital costs for nursing facilities. FRV helps to simplify the capital cost methodology compared to a traditional reimbursement model, which is


\textsuperscript{20} [http://webserver.rilin.state.ri.us/BillText/BillText15/HouseText15/H5110.pdf](http://webserver.rilin.state.ri.us/BillText/BillText15/HouseText15/H5110.pdf) and [http://webserver.rilin.state.ri.us/BillText/BillText15/SenateText15/S0301.pdf](http://webserver.rilin.state.ri.us/BillText/BillText15/SenateText15/S0301.pdf)
Based on the facility’s actual costs (mortgage, lease, depreciation, interest, plant & equipment). Under fair rental value, the State is essentially “renting” facility beds from nursing home operators for purposes of providing care to Medicaid recipients. The rental rate is established as a percentage of the value of the facility based on its age.

A key component of FRV is the rental factor or rate of return. It is typically based on the average 10, 20, or 30-year yield on U.S. Treasury bonds plus a risk premium of, say, two to three percentage points. Rental factors range from lows of five to six percent to highs of eight or nine percentage points in many states. Rhode Island uses a floor-to-ceiling rental factor corridor of no less than 9 but no greater than 12 percent; the rental factor is currently set at 9 percent.

Rhode Island has used an FRVS methodology since 2004, which consists of the various components such as a rental factor, value per bed, maximum age of the building, and annual depreciation. Rhode Island explored additional reimbursement methodology changes in 2012. The proposal for Fair Rental Value (FRV) is to treat it as a modified pass-through component by using five quintile rates based on the weighted average of individual rates within each grouping. The proposed quintile per diem rates are: $12.37, $14.03, $15.65, $18.00, and $20.00 according to a March 15, 2012 document on the EOHHS website. The assumption is that the underlying FRVS calculations would remain, and then facilities would be placed into their associated quintile.

Options to consider for limiting FRVS payments to nursing facilities
Rhode Island could produce some Medicaid savings that will not directly impact direct care services by making some adjustments to the FRVS calculations, such as:

a. Reduce the rental factor range from 9% floor to 12% ceiling, to a 5% floor to 10% ceiling. For the 2015-2016 fiscal year, a rental factor of 7% could be used. A higher rental factor can be used for more expensive parts of the state, such as urban areas. For example, in Maryland nursing facilities located in the city of Baltimore receive a higher rental factor compared to other areas of the state.

b. Reduce the value per bed from $66,000 (which includes a $4,000 equipment value) to $60,000. Could also include a location adjustment factor for more expensive parts of the state, such as urban areas. For example, in California a location adjustment factor is applied based on zip code.

c. Increase the annual depreciation rate from 1.5% to 2%, and the maximum age of a building from 35 to 50 years. For example, North Carolina, New Jersey, and Georgia use a 2% depreciation rate, Virginia uses a 2.86% depreciation rate.

Making such changes will reduce the per diem FRVS rates that facilities receive, as opposed to an across-the-board reduction that is not targeted to the overhead and non-direct care portions of the reimbursement rate. Rhode Island would not be the first state to reduce their FRVS costs in favor of focusing on improving quality; Virginia reduced their FRV rental factor rate from 9.0% to 8.0%

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over a four year period in order to secure an additional $10 million in funding for systemic quality improvements.\textsuperscript{22}

Rhode Island reimburses quite generously for capital costs, with a weighted average FRVS reimbursement of $15.70 per Medicaid resident day.\textsuperscript{23} For example, even under the new rate system proposal of using weighted averages for five quintiles, the range is $12.37 to $20.00 per Medicaid resident day, which is a large portion of the $218/day average Medicaid rate. These rates are significantly higher than rates in California where rents and property values are higher in many parts of the state compared to Rhode Island. In California, for the 2014-2015 rate year, the range of FRVS per diems were $6.38 to $16.05, with a median of $7.30 and average of $7.63.\textsuperscript{24}

A reduction of $5 in the FRVS per diem could produce savings of $8 million total funds, which is nearly 45% of the proposed $17.9 million in total fund reductions (3% across the board reduction and no COLA adjustment) in the Governor’s budget proposal.

<table>
<thead>
<tr>
<th>Example of Proposed FRVS Changes for 10 year old facility with 120 beds:</th>
<th>Current</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Value per bed</td>
<td>$66,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Facility Bed Value</td>
<td>$7,920,000</td>
<td>$7,200,000</td>
</tr>
<tr>
<td>Depreciation %</td>
<td>1.50%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Age of Building</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$(1,188,000)</td>
<td>$(1,440,000)</td>
</tr>
<tr>
<td>Net Value (Facility Bed Value – Depreciation)</td>
<td>$6,732,000</td>
<td>$5,760,000</td>
</tr>
<tr>
<td>Land Value (10% of Facility bed value)</td>
<td>$792,000</td>
<td>$720,000</td>
</tr>
<tr>
<td>Total Facility value (Net Value + Land Value)</td>
<td>$7,524,000</td>
<td>$6,480,000</td>
</tr>
<tr>
<td>Rental Factor</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Fair Rental Value Return (Rental Factor x Total Facility Value)</td>
<td>$677,160</td>
<td>$453,600</td>
</tr>
<tr>
<td>Medicaid resident days</td>
<td>41,610</td>
<td>41,610</td>
</tr>
<tr>
<td>FRVS per diem (FRV Return/ Mcaid resident days)</td>
<td>$16.27</td>
<td>$10.90</td>
</tr>
</tbody>
</table>

Annual Difference: $(223,560)  
Per Diem Difference: $(5.37)

**Home Office Costs**

Another option to explore that does not impact direct care costs is to review how Medicaid reimburses for the indirect care rate component and consider placing restrictions on home office charges for out of state offices for multistate chains. It is important for Medicaid dollars to be spent as efficiently as possible and to limit administrative overhead costs that are not related to the care

\textsuperscript{22} Virginia Department of Medical Assistance Services, 2014 http://www.dmas.virginia.gov/Content_atchs/pr/NF%20Price-Based%20FAQs%20as%20of%202015%202015.pdf

\textsuperscript{23} EOHHS “Medicaid Pricing Options for NF Services in Rhode Island” PowerPoint presentation November 3, 2011

\textsuperscript{24} CA FRVS calculation spreadsheets can be accessed at http://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTCAB1629.aspx
of the residents. This is primarily relevant to Nursing Homes chains operating in RI, but the DDO *Seven Hills* based in MA should be examined as well.

For example, in Oregon, chain organizations are regulated under Oregon Administrative Rules, which stipulate exactly what a home office is and what services it renders that Oregon may reimburse. One such restriction is on compensation from the home office: “… Where an owner receives compensation from the home office for services to the facility, the compensation is allowable only to the extent that it is related to resident care and to the extent that it is reasonable as defined under owner's compensation.”

4. **Focus increased revenue and rate restoration on direct resident care and workforce stability.**

When the discussions regarding “Reinventing Medicaid” began, the revenue picture appeared grim. However, new revenue projections as well as utilization data present state leaders with an opportunity to enact changes that redirect more resources to frontline care, improve quality outcomes, and lead to long-term stability in both the care-delivery model and in caregivers’ lives. We recommend that any additional revenue directed toward the nursing home rates should be directed toward direct care labor, such as increasing staffing levels and wages and benefits to increase staff retention and lift workers out of poverty.

The Working Group recommends increasing the nursing home provider assessment from 5.5 percent of net patient revenue to the federal maximum of 6.0 percent to help fund the incentive programs. We would support increasing the nursing home provider assessment only if any additional federal matching funds be directed to improving the direct nursing and other direct care components of the Medicaid reimbursement rates. Additionally, an accountability mechanism can be utilized to ensure that additional reimbursements are used for their intended purposes (see Recommendation #5).

As is clear from the chart on page 4, wages for Certified Nurse Assistants in Rhode Island are below neighboring states. Additional funding can help many of the CNAs who cannot currently make ends meet receive a wage increase and get closer to earning at least $15 per hour.

The table on the following page also shows that wages for CNAs in Rhode Island appear to be relatively flat. The difference from the 10th percentile to the 90th percentile of Rhode Island nursing assistant hourly wages is relatively small, and less than in neighboring states. A smaller differential indicates that workers who have made their career at a nursing facility are not seeing their wages grow significantly.

Adequate wages that keep pace with the cost of living are an important factor in reducing staff turnover, which in turn contributes to ensuring a well-trained, high-quality workforce.
### 2014 State Hourly Wage Information for Nursing Assistants employed in Nursing Facilities

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated Total Employment</th>
<th>10th percentile hourly wage</th>
<th>Median Hourly Wage</th>
<th>90th percentile Hourly wage</th>
<th>% Difference Median Hourly Wage to RI</th>
<th>Difference between 90th and 10th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>43,600</td>
<td>$10.55</td>
<td>$15.47</td>
<td>$18.61</td>
<td>17.7%</td>
<td>$8.06</td>
</tr>
<tr>
<td>Connecticut</td>
<td>13,550</td>
<td>$11.98</td>
<td>$14.57</td>
<td>$18.61</td>
<td>10.9%</td>
<td>$6.63</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>21,300</td>
<td>$10.33</td>
<td>$13.45</td>
<td>$17.65</td>
<td>2.4%</td>
<td>$7.32</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>4,700</td>
<td>$10.52</td>
<td>$13.14</td>
<td>$15.99</td>
<td>5.47%</td>
<td>$5.47</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>3,090</td>
<td>$10.04</td>
<td>$13.10</td>
<td>$17.34</td>
<td>-0.3%</td>
<td>$7.30</td>
</tr>
<tr>
<td>Vermont</td>
<td>1,590</td>
<td>$9.83</td>
<td>$12.42</td>
<td>$14.73</td>
<td>-5.5%</td>
<td>$4.90</td>
</tr>
<tr>
<td>Maine</td>
<td>4,510</td>
<td>$8.83</td>
<td>$11.20</td>
<td>$14.49</td>
<td>-14.8%</td>
<td>$5.66</td>
</tr>
</tbody>
</table>

The public overwhelmingly supports raising wages for workers that care for our most vulnerable residents. In a recent Fleming & Associates poll, **69.1% of Rhode Islanders polled** support the idea that **front line workers** who care for Rhode Islanders with developmental disabilities or elderly nursing home patients deserve to be paid a living wage of at least $15 per hour see chart.

The non-profit nursing home industry association, LeadingAge RI, recommended to the Working Group that it “ensure nursing home reimbursement allows for sufficient and stable direct care staffing, which is critical to quality care and good outcomes.” This is an area where both industry

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26 Fleming and Associates Poll conducted April 8 through 13, 2015 with 350 registered voters via telephone, Commissioned by Working Rhode Island. MOE 5.5%,
and labor agree, and dedicating additional funding toward reimbursement improvements for direct care wages and additional staffing is warranted.

5. **Claw Back: Recoup Medicaid reimbursements that are not used for their intended purpose, especially in regards to direct labor.**

Another means to producing savings and to tackle potential fraud, waste, and abuse is to authorize the state to recoup Medicaid reimbursements that were not used for their intended purpose. There is precedent for doing so, for example, Article 13 of the 2001 Rhode Island budget provided an additional per diem payment for nursing facilities to increase staffing or wages and benefits, and required retroactive repayment to the state if facilities did not expend the funds appropriately.

One area to examine is the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) reimbursements to private Developmental Disability Organizations (DDOs). As part of the rate development process, BHDDH provided a rate increase to DDOs to enable them to make upward adjustments to wages and benefits, and assumed that Direct Service Providers (DSP) are receiving wages of $11.55/hour.\(^{27}\) BHDDH should recoup a portion of reimbursement from DDOs that pay most or all of their DSP’s less than $11.55. (Note: prior to cuts in 2011 the DSP rate was $12.06/hour and BHDDH in 2011 set a “Benchmark Rate” of $13.97/hour).

There is also legislation proposing to increase the DSP benchmark rate to $13.97 with annual cost of living adjustments to encourage hiring and retention of competent, qualified, and caring individuals, making the claw back proposal all the more important (Senator DiPalma S-44 and Representative Hull H-5170).\(^{28}\) It is especially for important for this community to have as much continuity of care with their providers, and raising wages for direct care staff is an important element to increase staff retention and quality.

### 2014 State Hourly Wage Information for Personal Care Aides\(^{29}\)

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated Total Employment</th>
<th>10th percentile hourly wage</th>
<th>Median Hourly Wage</th>
<th>90th percentile hourly wage</th>
<th>% Difference Median Hourly Wage to RI</th>
<th>Difference between 90th and 10th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>23,420</td>
<td>$ 9.71</td>
<td>$ 12.35</td>
<td>$ 15.68</td>
<td>14.6%</td>
<td>$ 5.97</td>
</tr>
<tr>
<td>Connecticut</td>
<td>19,500</td>
<td>$ 9.18</td>
<td>$ 11.82</td>
<td>$ 16.26</td>
<td>9.6%</td>
<td>$ 7.08</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>4,700</td>
<td>$ 9.50</td>
<td>$ 10.90</td>
<td>$ 14.04</td>
<td>1.1%</td>
<td>$ 4.54</td>
</tr>
<tr>
<td>New York</td>
<td>123,550</td>
<td>$ 9.00</td>
<td>$ 10.82</td>
<td>$ 14.11</td>
<td>0.4%</td>
<td>$ 5.11</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>3,950</td>
<td><strong>$ 8.82</strong></td>
<td><strong>$ 10.78</strong></td>
<td><strong>$ 13.82</strong></td>
<td><strong>-4.6%</strong></td>
<td><strong>$ 5.00</strong></td>
</tr>
<tr>
<td>Maine</td>
<td>10,720</td>
<td>$ 8.16</td>
<td>$ 10.28</td>
<td>$ 13.18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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\(^{27}\) [http://www.bhddh.ri.gov/ddd/pdf/Public%20Notice%20Related%20to%20Jan%201%202014%20changes_1_1_1.pdf](http://www.bhddh.ri.gov/ddd/pdf/Public%20Notice%20Related%20to%20Jan%201%202014%20changes_1_1_1.pdf)  
6. **Cap Medicaid reimbursement for executive compensation based on facility size.**

Another means of producing savings that do not directly affect direct patient care is to place limits on Medicaid reimbursement for administrators’ and executives’ compensation.

- **Nursing Homes:** There is a precedent for capping executive compensation based on the nursing facility’s size. In 2009 through its “Principles of Reimbursement” the state created different reimbursement caps for administrators and assistant administrators based on the size (number of beds).\(^{30}\) We feel that these caps could go further than they did in 2009, and recommend examining this issue more closely.

- **DDO:** In Rhode Island there 39 DDOs, many of which have unreasonable executive compensation. For example, in 2011 Community Living of Rhode Island which serves fewer than 60 consumers received over $2.7 million from the State through BHDDH. At the time, the couple running the agency paid themselves nearly $400,000 in total compensation,\(^{31}\) while most direct care workers were paid between $8-9 per hour.

As in the long-term care industry, we suggest creating executive compensation groups based on the number of consumers being served. CEO’s and administrators at much smaller operations should not be receiving Medicaid reimbursements that exceed the compensation of CEO’s and operators at much larger and more complex agencies. Capping Medicaid reimbursement may push some unethical or inefficient players out of the system and free up more resources for direct consumer services. Both New York and New Jersey have issued executive order capping Medicaid reimbursement for DDO’s.\(^{32}\)

7. **Realize Medicaid savings though more energy efficiency initiatives**

Although the Working Group suggested that energy efficiency could be included in one of the new nursing facility quality incentive programs, we propose a broader energy efficiency initiative that leverages the purchasing power of the state to incentivize energy savings for all facility-based providers that participate in the Medicaid program, such as DDOs, Nursing Homes, Hospitals, and Health Centers. EOHHS and skilled nursing facilities should work with the Rhode Island Office of Energy Resources to develop public-private partnerships to begin developing more efficient and cost effective energy use which is paid for with Medicaid dollars. This would save Medicaid money, help the environment and create jobs.

The Rhode Island FY 2008 budget included an energy conversation retention credit for nursing facilities\(^{33}\), but unfortunately it was never implemented. The language and criteria for the program


\(^{31}\) [http://1199ne.seiu.org/page/-/Clark%202011%20page%2012%20scan.docx](http://1199ne.seiu.org/page/-/Clark%202011%20page%2012%20scan.docx)


\(^{33}\) Section 40-8-20.2 of the General Laws in Chapter 40-8 entitled “Medical Assistance”, [http://webserver.rilin.state.ri.us/PublicLaws/law07/law07073.htm](http://webserver.rilin.state.ri.us/PublicLaws/law07/law07073.htm)
could be used as starting point for developing a new and broader initiative, and the proposed Rhode Island Green Infrastructure Bank in Article 24 of the Governor’s FY2016 budget could be a vehicle to develop these ideas further. Other states have established public-private partnerships to make publicly-funded health care vendors more energy efficient, including:

- Maine developed the Maine Municipal Bond Bank to provide energy assistance and funding to universities, hospitals and nursing homes.
- Wyoming has developed the Wyoming Energy Conservation Improvement Program and used ESCO’s (Energy Service Companies)
- The Washington Department of Enterprise Services (DES) has a developed energy saving performance contracting program that partners the organization with an ESCO and DES.
- New York state is in the midst of conducting energy audits of nursing facilities in order design a public/private energy capital financing program

8. Expand Rhode Island’s Paid Family Leave Program from 4 to 6 Weeks.

In 2013 Rhode Island became the third state in the country to create a paid family leave program (Temporary Caregiver Insurance) to bond with a newborn child or take care of a seriously ill child, spouse, domestic partner, parent or grandparent, which is funded by employee payroll deductions. There is already anecdotal evidence that workers who use TCI to care for an ill or injured family member at home enable them to either delay or prevent admission into a more expensive nursing facility. We suggest examining the potential benefits and Medicaid cost savings that can be produced by expanding the number of weeks of paid leave from 4 to 6 weeks which would give families more time to explore their options (especially as we continue efforts to rebalance long-term care).

Proposals and Ideas for Long-Term Reform

The initial focus of discussions by the Working Group and the General Assembly has been on short-term changes to fill a projected FY2016 budget deficit (though projections have obviously changed). The Working Group is also charged with proposing longer-term reforms to transform the Medicaid program, and as budget activity winds down the General Assembly, it will turn to this task as well. As the discussion of rebalancing in the first part of this paper suggests, reforms driven chiefly by a desire to cut spending are unlikely to achieve real system transformation. Thus any discussion of longer-term changes to the Rhode Island Medicaid system need to focus not just on the near-term bottom line, but on systemic changes that will meet the quality of care, improve Rhode Islanders’ health, and control costs. Simultaneously, we must have an honest discussion about the role of frontline health care workers in system transformation, and the importance of living wages, workforce standards, and opportunities for training and advancement.

In the sections below, we first discuss some promising reform models that have been implemented in other states, including in states where SEIU has a strong presence and has participated in

34 http://www.leadingagency.org/linkservid/EC2CCB83-9E9B-8EB4-D282A10380EBAA7/showMeta/0/
development and implementation of delivery system reforms. We then offer some initial recommendations to promote further rebalancing of LTSS, and discuss some specific examples of workforce training and participation in integrated care and quality improvement initiatives.

**State Reform Models**

As discussed above, adoption of the Rhode Island Global Consumer Choice Compact in 2009 was touted as a new model for state waivers. The waiver was renewed in 2013 and is now known as the Rhode Island Comprehensive Demonstration. While the waiver ostensibly provides the state with greater flexibility to design its Medicaid program in creative and cost-effective ways, the very creation of a Working Group to Reimagine Medicaid reflects the limits of the current 1115 waiver when it comes to health delivery system payment and reform. In the period following implementation of the 2009 waiver, other states have moved ahead to implement much broader reforms, often in the context of an 1115 waiver. In thinking about reforms—which would likely entail changes to the current 1115 waiver when it comes up for renewal in 2018, or substantial amendments to it before that date—the Working Group should consider the following:

- **Oregon Health Plan**
  Several years ago, Oregon began a detailed planning process that led plans for transformation of the state’s health system and to the creation of the Oregon Health Authority, which includes the Medicaid and CHIP programs, as well as employee benefits. Like Rhode Island, Oregon operates its Medicaid program, known as the Oregon Health Plan, under a broad 1115 waiver, which was approved in 2012. Unlike Rhode Island, however, this waiver is structured to allow the state to implement delivery system changes that will help achieve the triple aim of better patient experiences, improved population health, and a reduction in per capita cost growth. Under the waiver Oregon is developing Coordinated Care Organizations (CCOs) – community-based, risk-bearing managed care organizations that meet certain governance standards and have community advisory councils. Medicaid beneficiaries will enroll in CCOs and the state will pay for services using global payments (comprised of a capitated rate, plus possible incentive payments). The CCO budgets will be controlled locally, and different types of providers will work together to emphasize preventive care and coordination of physical and mental health services. The Oregon waiver also requires the state to commit to bending the cost curve by achieving a two percentage point reduction in the per capita growth trend.

- **Delivery System Reform Incentive Payment (DSRIP) Programs**
  DSRIP programs have been implemented as part of a broader 1115 waiver, in California (the first such program, in 2010), Texas, Massachusetts, New Jersey, Kansas, and New York. Massachusetts’ program (known under a slightly different name, Delivery Reform System Transformation Initiatives, or DSTI) was recently renewed for three years. Under these programs states receive federal matching funds that support projects designed to help transform the state’s payment and health delivery system. Projects must be approved by the Center for Medicaid and Medicare Services (CMS) and providers must meet agreed-upon metrics in order to receive payments. Initially focused on investments in safety net hospitals, DSRIP funds are now being used to support a broader set of reforms. The most
sweeping DSRIP initiative is the one underway in New York, which includes both hospital and non-hospital (community health centers, etc.) providers. The program is structured using coordinated networks of care that are anchored by a lead hospital (“Performing Provider Systems”), which must set goal for clinical improvements in areas such as behavioral health, diabetes care, and HIV/AIDS care. Under the New York model, not only must providers meet metrics in order to receive DSRIP payments, but the state as a whole must also meet goals for reducing avoidable hospitalizations. New York must also show progress in moving toward a value-based payment system by the end of the waiver period. The state risks losing some of its DSRIP funding if it fails to meet these goals.

- **Massachusetts Chapter 224 Health Reform Law**
  Approved in 2012, Chapter 224 (“An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation”) sets goals for future growth of public and private health costs, creates new state entities to oversee health providers, and contains many provisions designed to promote changes in the delivery of health care and systems of payment for that care. In its broad, multi-payer scope, Chapter 224 is somewhat similar to the efforts that Oregon has taken in recent years, although it goes further in setting a statewide target for cost growth and creating structures designed to hold all types of providers and payers accountable for meeting spending targets. While the law contains provisions to facilitate creation of Accountable Care Organizations (ACOs) generally, it recognizes that the state has more power to create ACOs and implement delivery system reforms within the Medicaid program that it controls. Thus, it requires that MassHealth, the Massachusetts Medicaid program, adopt alternative payment methodologies for the majority of care provided to enrollees, and also provides—at least in initial years—payment incentives for providers who agree to adopt these methodologies. Development of an ACO that is anchored by a major safety net hospital and includes community health centers and other providers is currently underway.

Another key component of Chapter 224 was creation of a Health Policy Commission (HPC), a quasi-independent entity that establishes the health cost growth benchmarks and holds annual hearings to monitor cost trends. It will also certify Accountable Care Organizations and Patient Centered Medical Homes and has the power to review entities with costs that exceed growth benchmarks and require them to take corrective action. The HPC is governed by a board of 11 members with different types of health care expertise and experience. The power of the HPC to monitor the overall health care market will help control both Medicaid and commercial spending growth.

**Long-Term Care Rebalancing**

As discussed above, and as reflected in the Working Group’s initial report, LTSS beneficiaries are more likely to receive services in an institutional, rather than a community-based, setting than are beneficiaries in other states, despite past initiatives to advance rebalancing of LTSS. Clearly, more

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work is needed in this area. We generally support the recommendations discussed in Initiative 8 of the Working Group report, but would go further:

- The Working Group report notes that provider rates “may be a factor” in Rhode Island’s lower rate of HCBS utilization, but the discussion of rate adequacy focuses almost exclusively on assisted living facilities.\(^{36}\) While these facilities may be one component of a long-term care strategy, the state should not rely on them as the main vehicle for provision of LTSS. Rather, Rhode Island should seek to develop a robust network of HCBS providers, especially personal care aides, and should ensure that they receive a living wage. Recent studies show that raising wages for home care providers to $15 per hour will not only help stabilize the workforce but will also have a positive economic impact on local economies.\(^{37}\)

- Future proposals should reflect the important role of worker organizations in facilitating access to providers of home and personal care services. It is not a coincidence that some of the states with the highest percentage of HCBS services are states where SEIU represents providers who work for home care agencies and for individual consumers under consumer-directed HCBS models. Four such states — California, Oregon, Washington, and Massachusetts — are among the top eight states with the highest level of HCBS services.\(^{38}\) In Washington in particular, SEIU’s strong home care worker presence allowed the union to work with the state in rebalancing LTSS, creating training opportunities, and identifying revenue sources to support these efforts.

The Role of the Health Care Workforce in Delivery System Reform

Transformation of the Rhode Island Medicaid program — or the state’s health delivery system more broadly — cannot succeed without the active participation of a well-trained and adequately compensated workforce. Around the country, SEIU members have been actively engaged in initiatives to improve the quality of care where they work. Examples include:

- **Nursing Home Quality**
  In recent years, a small portion ($2.8 million) of revenue derived from the Massachusetts nursing home provider tax has been dedicated to a program for facilities with established cooperative labor-management efforts around quality improvement initiatives that help facilities meet the requirements of the state’s Nursing Facility Pay-for-Performance Program.\(^{39}\)

  The 2015-2016 New York enacted budget includes $46 million for a nursing facility advanced training initiative, which will provide funding to facilities that meet a direct care staff retention standard and then follow an approved training program aimed at early

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detection of patient decline to reduce avoidable hospital admissions. The training program will be developed in cooperation between nursing home providers and union representatives and approved by the state.40

- Community Health Workers
  A number of states have begun to expand the use of Community Health Workers (CHWs), in recognition of the role these workers—who are often based in community health centers—play in bridging the gap between traditional service models and community-based prevention, and in helping ensure that care is provided in a culturally competent manner. In California, the Worker Education and Resource Center (WERC), a labor-management partnership and training fund, has partnered with SEIU Local 721 and the Los Angeles County Department of Health Services (LADHS) to train CHWs who will work on medical teams serving patients with complex care issues.

- Enhanced Home Care Pilot Project
  St. John’s Well Child and Family Center, a Federally Qualified Health Center in Los Angeles, created a 12-month pilot project designed to integrate clinic and home care services to improve health outcomes for seniors and people with disabilities. Under the pilot project, home care workers received training and became part of a health care team overseeing care to people enrolled in California’s In-Home Support Services (IHSS) program. Results of the project suggest that it lowered emergency room use and helped improve the experience and quality of care for participants.

Conclusion

The health care delivery system is in a state of transformation nationally. As more people gain coverage under the Affordable Care Act, attention is turning to bending the cost curve and ensuring that all people, including those who have newly gained coverage, have access to high quality care. This concern is not confined to Medicaid programs—the federal government recently announced it intends to require most Medicare payments to be made under value-based and alternative (non-fee-for-service) payment methodologies, and commercial insurers are increasingly moving to new payment models.

The Medicaid reform process currently underway in Rhode Island was inspired in the short term by a need to address a budget deficit. Although the size of that deficit has shrunk, the longer-term project of transforming Medicaid will continue. As it does, we urge elected officials to focus on real, systemic reforms to help develop the health care delivery system that Rhode Islanders deserve. Ongoing discussions must recognize the important role that frontline workers will play in meaningful system reform, and the importance of adequate compensation and training to maintain a stable workforce and deliver high-quality of care to Rhode Islanders. SEIU 1199 NE is ready to work state decision-makers and other partners to undertake this transformation.