



COLLABORATING TO ADDRESS HCBS WORKFORCE CHALLENGES IN MLTSS PROGRAMS



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The NASUAD **MLTSS Institute** was established in 2016 in order to drive improvements in key MLTSS policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

The National Association of States United for Aging and Disabilities (NASUAD) represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities.

Sage Squirrel Consulting, LLC is a small, Indiana-based firm focusing on human service projects, often where operational challenges need to be identified and addressed. Sage Squirrel's mission is to work on projects that have a positive impact on how citizens experience or access services, or projects that positively impact the engagement and performance of the human service workforce.

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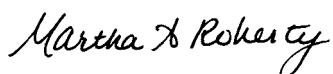
ACKNOWLEDGEMENTS

Managed long-term services and supports (MLTSS) is a growing trend across the country. States seeking to modernize and improve their long-term services and supports systems continue to turn to managed care plans to help them achieve their goals. Operating an efficient and effective MLTSS program requires thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. NASUAD is deeply engaged in providing technical expertise and assistance to our member states as they plan, design, implement, and evaluate their MLTSS programs. In recognition of states continued need for additional technical assistance, the Board of Directors created the MLTSS Institute in 2016.

Creating opportunities for thoughtful policy development, meaningful state interaction, and more effective use of limited state resources is critical to the maturation and success of MLTSS programs. I am grateful to our visionary Board of Directors, state long-term services and supports leaders, and thought leaders at national health plans who understand that well managed and high quality MLTSS programs benefit us all, and are willing to invest their time and resources to that end.

Based on feedback from our members, as well as the MLTSS Institute Advisory Council, we devoted our resources in 2018 to the issue of HCBS workforce challenges. There has been little written about the issue of HCBS workforce shortages through the lens of MLTSS programs, so we are pleased to publish this paper—the third from the MLTSS Institute—which hopefully adds to the public discourse on this most critical issue. We are deeply appreciative of the time and attention our members, and health plan leaders, gave to completing the surveys which form the basis of this report.

Sincerely,



Martha A. Roherty
Executive Director, NASUAD

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EXECUTIVE SUMMARY

The growing use of home and community based services—in lieu of institutional services—has increased demand for direct care workers. Many states have identified direct care workforce challenges as a major issue today; demographic changes on the horizon are poised to exacerbate this problem. Developing an adequate workforce is difficult for all states, but states with managed long term services and supports programs have an additional tool with which to address this challenge.

This report examines the pressures on the direct care workforce and how states and their managed care plans are developing and/or implementing workforce development strategies. While states retain ultimate responsibility for workforce policy, they can use their managed care contracts to establish expectations, or in some cases, requirements for their managed care plans' role in this effort. This report reviews challenges and promising practices in three domains:

- Network adequacy
- Rates and Reimbursement
- Quality

Key to addressing workforce issues in each of these domains is data. States, health plans, and providers all need access to accurate workforce data, and the ability to use that data effectively to project direct care workforce need, assess the quality of that workforce, and develop reimbursement strategies that support workforce adequacy without significantly increasing state Medicaid budgets.

INTRODUCTION

NASUAD established the Managed Long Term Services and Supports Institute in 2016 to drive collaborative program and policy improvement, facilitate sharing and learning among states, and to provide technical assistance to states and managed care health plans as the prevalence of managed long-term services and supports (MLTSS) increases. The first two years of the MLTSS Institute’s work—directed in part by the Advisory Council—focused on the value of MLTSS to states as well as considerations for implementing MLTSS for people with intellectual/developmental disabilities. The Institute turned to the issue of the HCBS workforce, with much discussion centering on the nature and extent of workforce-related challenges and the roles and responsibilities of states and their health plans to identify and address these challenges. This issue brief attempts to understand workforce issues in home and community-based services (HCBS) through the lens of managed care and explore if and how states and managed care health plans are working together (and with other key partners) to address HCBS workforce issues.

The growth of home and community-based services—spurred in part by rebalancing and program expansions—has highlighted the growing demand for direct care workers. Available literature on healthcare workforce challenges indicates the shortage is worsening, even approaching a

crisis. Normal economic pressures that would drive supply in response to increased demand may not apply, in large part because of the dominant role of Medicaid in funding HCBS, as well as the imperative to better control Medicaid spending.

Data regarding direct care workforce turnover rates and costs, retention, and length of employment, if collected at all, is not widely validated or shared. Absent good data and metrics, it is difficult to assess the extent of any current shortage, predict any anticipated shortages for the future, or determine what other issues may be impacting the staffing challenges in the HCBS workforce.

States have shifted how they provide long-term services and supports (LTSS) as they face growing Medicaid budgets and seek to manage that growth. One clear trend has been the move to managed care for the provision of LTSS, including HCBS. MLTSS is not a solution to HCBS workforce challenges but there is opportunity for this service-delivery system to play a partnership role with states in addressing the issue.

In the course of preparing this issue brief, NASUAD conducted a survey of states and managed care organizations (referred throughout the paper as health plans). States and health plans were asked questions about their perception of a workforce shortage, if and how they are measuring that shortage, and what practices they are establishing in order to mitigate or overcome a direct care workforce shortage. Representatives of several states and health plans were interviewed further in an attempt to elicit more context and specific promising practices. Existing literature on HCBS workforce shortages was also reviewed and are cited here if used.

“There is no issue more challenging in LTSS programs right now.”

State Medicaid staff

BACKGROUND

The HCBS Workforce

In most of the literature and labor statistics on the LTSS workforce, the term “direct care worker” is utilized to refer to workers who may otherwise be known as home care workers, direct service professionals, personal care assistants, in-home/attendant care providers, home health aide, or certified nurse assistant. Direct care workers provide the majority of day-to-day support with activities of daily living to persons in their personal homes, in adult foster homes, or in residential settings such as assisted living, group homes, or nursing facilities and other institutional settings. Activities of daily living (ADLs) include such things as bathing, eating and toileting. Direct care workers provide support to all populations—older adults, adults of all ages with physical disabilities, individuals with intellectual/developmental disabilities, and children with disabilities. In states that allow delegation of nursing practices, direct care workers may also perform some tasks that are more clinical in nature. Just as the line between nursing and direct care may fluctuate state to state, the line between CNA, home health aide, and personal care aide may also shift state to state based on state scope of practice regulations.

HCBS Workforce



- Largely female—nearly 9 out of 10
 - Median age is 47
 - 6 out of 10 identify as part of a minority group
 - Over 25% born outside of the United States
- Includes personal care aides, home health aides, and nursing assistants
 - Nearly stagnant wages
 - Median hourly wage of \$11.03
 - 2 out of every 5 workers work part-time
- Predominantly government funded (Medicaid)
 - Nearly 7 out of 10 work for a for-profit company
 - More than half receive some form of public assistance themselves
 - Of the nearly 4.3 million direct support workers, nearly half now work in home care

U.S. Home Care Workers: Key Facts (2018). Stephen Campbell. Paraprofessional Healthcare Institute.

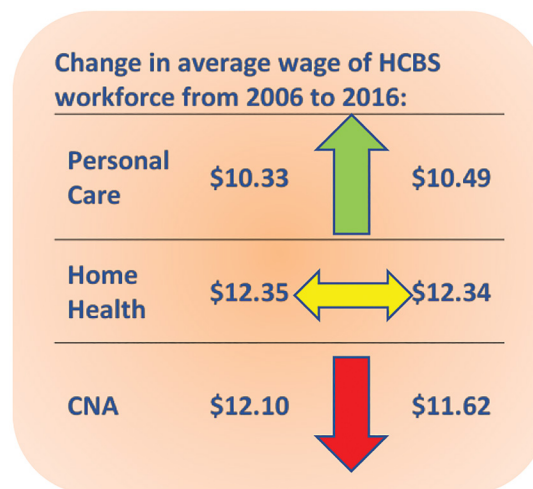
The HCBS workforce is a subset of these direct service workers providing non-medical assistance with ADLs in home and community-based settings. The largest growth in the HCBS workforce has been in personal care. According to the Census Bureau, in 2014, the direct care workforce comprised about 20% of the U.S. health workforce, approximately 3.27 million workers. Personal care aides were 46% of all direct care workers. This number represents a doubling over the previous ten years and was responsible for a 44% increase in the numbers of direct care workers in this time period.

Workforce stability is most frequently measured as employee turnover. Turnover refers to the number of people who leave employment and who are replaced by new employees. Turnover is an important workforce measure because it can signal levels of attachment by workers to their employer—high turnover generally indicates low levels of attachment. High rates of turnover are costly to employers and contribute to lower outcomes in quality of care. According to the Paraprofessional Healthcare Institute (PHI), turnover in direct care workers ranges from 45%-65%, and it costs approximately \$2200 to hire a direct care worker.¹ While some turnover is the “churn” of people moving among different LTSS employers; some of these workers leave direct care entirely and move to different types of employment. Service industries such as retail and restaurants compete for the same workforce and may be perceived as easier work for comparable wages and benefits. These trends are exacerbated when the U.S. economy is close to full employment.

Wages

Wages for direct care workers have been stagnant or declining over the past 10-plus years. While low wages are not the sole factor in the direct care workforce challenges, a wage that does not enable the worker to meet their basic needs is a barrier to recruiting more individuals into this workforce. As direct care workers tend to be in low-wage positions, state minimum wage limits can have a direct impact on median wages. According to the U.S. Department of Labor, minimum wage can vary from the federally required \$7.25 an hour (in sixteen states) to a high of \$13.25 an hour in D.C.²

In a typical market with a shortage of workers, there may be an increase in wages or other benefits to lure new workers. However, the HCBS market does not follow typical supply/demand trends. Medicaid is by far the leading formal payer for LTSS nationally, both institutional and HCBS alternatives; the largest ‘payer’ for LTSS are individuals’ out of pocket spending.³ Moreover, there are certainly pressures to balance Medicaid expenditures with other pressing state funding needs, such as education and transportation.



U.S. Home Care Workers: Key Facts (2018). Stephen Campbell. Paraprofessional Healthcare Institute.

Demographic Changes

Demographic changes impact the direct care workforce shortage from both supply and demand perspectives. The aging of the baby boomers is a key factor in growing demand for LTSS. Other factors leading to increased utilization of Medicaid-funded HCBS include improved life expectancy, changing participant expectations, and “rebalancing” policies. “By 2050, 20% of the total U.S. population will be 65 or older. This is an increase from 12% in 2000 and 8% in 1950. The number of people age 85 or older will grow the fastest over the next few decades, constituting 4% of the population by 2050, or ten times its share in 1950.”⁴ The likelihood of a person needing support with ADLs increases with age. An estimated one-third of individuals age 65 or older have some kind of functional limitation. By age 85, two-thirds will have functional limitations.⁵

On the supply side, labor projections for direct care workers vary with much of the expected growth in personal care aides. The supply of direct care workers is not expected to keep pace with projected need:

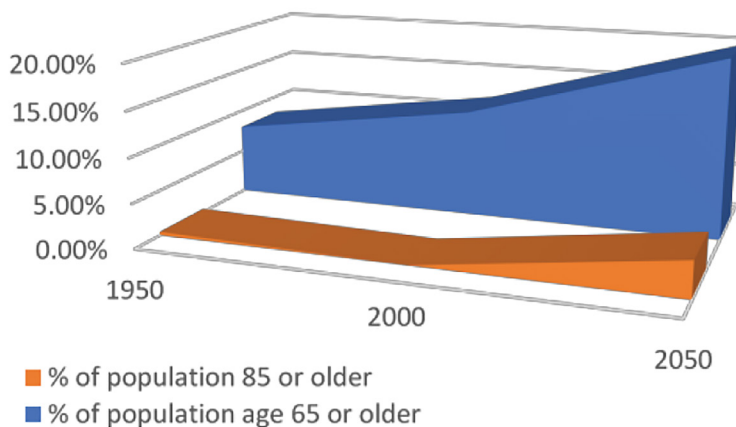
- The number of working age adults relative to older persons is becoming smaller.
- Labor force participation by women aged 20–64 is declining.
- There is political uncertainty concerning future immigration policy.⁶

Today there are 32 working age adults per person 85 years old or older. By 2050, there will only be 12.



(<https://phinational.org/policy-research/key-facts-faq/>)

Older Adult As Percentage of Total Population



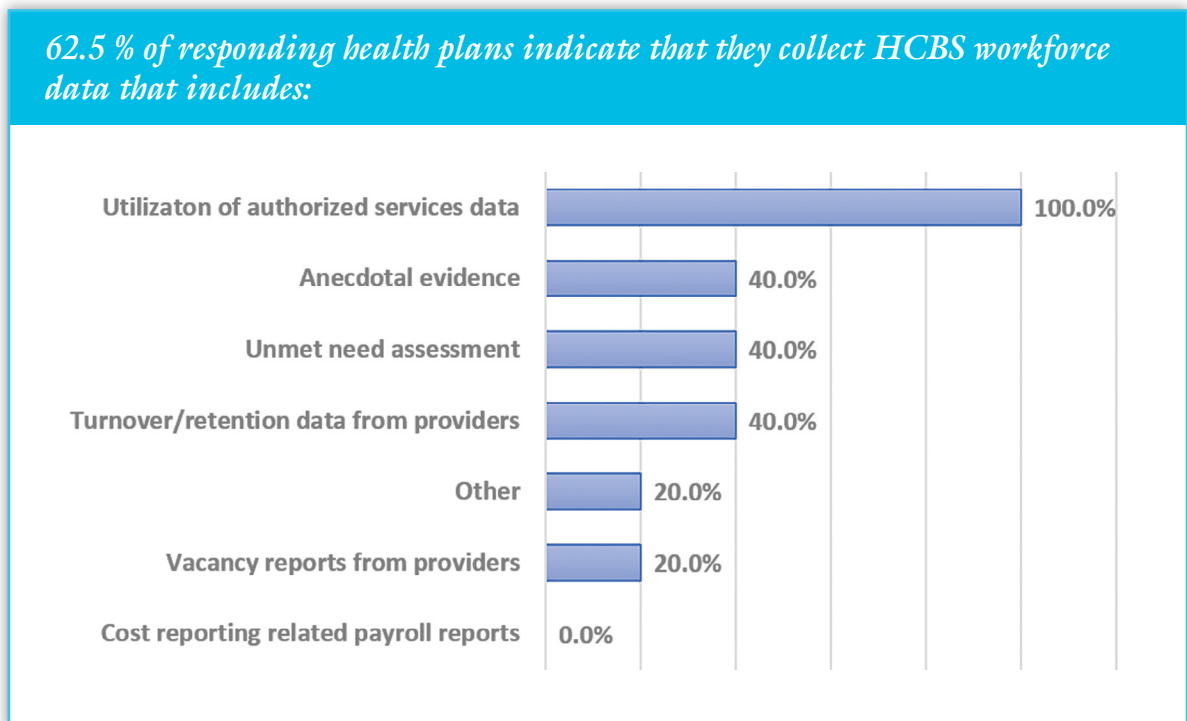
Congressional Budget Office (CBO). June 2013. Demand for Long-Term Services and Supports for Elderly People.

Data

Primary data sources for the HCBS workforce include the Bureau of Labor Statistics (BLS) and the U.S. Census Bureau's American Community Survey (ACS). The ACS provides numbers and demographic characteristics on the direct care workforce. The BLS provides wage and benefit information. There is no federal source for workforce stability data such as retention and turnover rates. Some potential gaps have been identified in these data sources:

- BLS is based on the National Compensation Survey which has a small sample size that does not allow for separating out industry data among the direct care workforce; so HCBS data cannot be isolated;
- BLS data may not adequately capture those direct care workers who work independently and not as part of an agency;
- ACS is based on self-reporting;
- ACS separates out personal care aides but combines home health aides, CNAs, and psychiatric aides under a single group;
- ACS does not capture the proportion of independent workers; and
- ACS only captures primary employment and therefore may miss individuals working second jobs in direct care.⁷

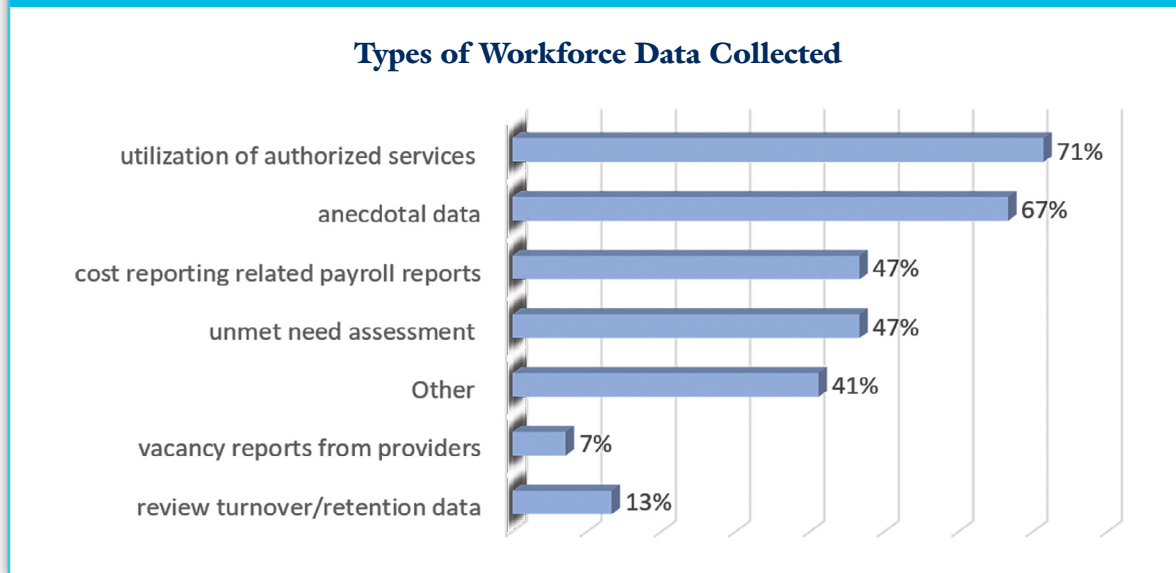
PHI provides a number of data summaries from these sources on both a national and state level.⁸ There is not a standard data source for measuring adequacy of the HCBS workforce on a given geographic level. PHI has made their national projections of future workforce needs based on historical trends. In January 2019, PHI published new workforce projections using new BLS data on occupational separations which measures the number of people who leave the workforce entirely or who leave direct care for other industries. By adding occupational separation data to growth projections, PHI calculates that there will be 7.8 million direct care workforce positions that need to be filled 2016 through 2026.



Note that there are currently about 4.4 million direct care workers. These numbers reflect the entire direct care workforce not just the HCBS workforce. PHI notes that the BLS projections indicate that “the total direct care workforce will be larger than any single occupation in 2026.”⁹

In the surveys conducted for this report, NASUAD asked states and health plans about the types of data they collect or track related to the HCBS workforce.

In NASUAD’s survey, 88% of states responding reported tracking data on the HCBS workforce...



Trends in LTSS

Shifts in Medicaid policy and programs have a major impact on the direct care workforce, directly or indirectly. Some of these shifts include the move to use more HCBS than institutional services, person centered/directed care leading to users directing their own use of personal care (called variably “self-directed”/“participant-directed”/“consumer-directed” programs), and the use of a managed care delivery system for LTSS.

“In recent years there have been efforts to shift the balance of LTSS away from institutions through the expanded use of HCBS. National spending for HCBS has increased and now exceeds that for services in an institution.”¹⁰ There are a number of factors that contribute to this “rebalancing” of LTSS spending towards HCBS: potential savings from less expensive HCBS alternatives; participant preference; and legal and regulatory requirements to provide services in settings that are more inclusive and integrated into their larger communities.

According to the Congressional Budget Office (CBO), about 80% of older persons receiving LTSS did so in the community (including residential communities that cater to older adults), while about 20% reside in institutions.¹¹ “Among all personal and home care aides, those working in homes grew from 43% to 51% of the total between 2005 and 2015, and among all nursing, psychiatric, and home health aides, the share working in homes grew from 20 to 30% of the total across the same 10 years.”¹² This aligns with the shift towards HCBS.

WORKFORCE CHALLENGES AND MLTSS

HCBS workforce issues are a factor in all states, whether or not they operate a MLTSS program. States are turning to MLTSS to increase their ability to achieve large scale goals such as “rebalancing”, budget predictability, improved care coordination, and improving outcomes for participants, according to the 2016 MLTSS Institute paper on the value of MLTSS.¹⁴ The health plan takes on these responsibilities in exchange for a capitated rate; however, the state remains responsible for oversight as well as policies and practices related to workforce development. These efforts may be linked to economic development efforts and associated with the growing recognition of the impact of the healthcare workforce on economic viability. Providers are responsible to address HCBS workforce issues through competent management of recruitment and retention practices. Health plans can serve as an additional tool to supplement state policies and procedures and drive provider performance through network management processes and payment.

While health plans can be strong partners to both states and providers as they engage in improving workforce adequacy, interviews with state and health plan staff confirmed that there is also potential for confusion or blame when expectations are not clear for all parties involved. It is imperative that roles and responsibilities for the various parties who are ensuring that the HCBS workforce is sufficient in quantity and quality be very clear. Only that clarity will enable the state to achieve its desired objectives through MLTSS.

States and health plans identified three program areas that have an impact on workforce challenges: network adequacy, rates and reimbursement, and quality. All states have to assure network adequacy, deliver quality care and set rates to promote adequate, appropriate wages for direct care workers; however, in MLTSS programs, the health plans either take on some of those responsibilities or work collaboratively with the state to do so. It is important for states with MLTSS programs to clearly establish the roles and responsibilities of the health plan to be successful in those efforts and in order to create appropriate accountability approaches.

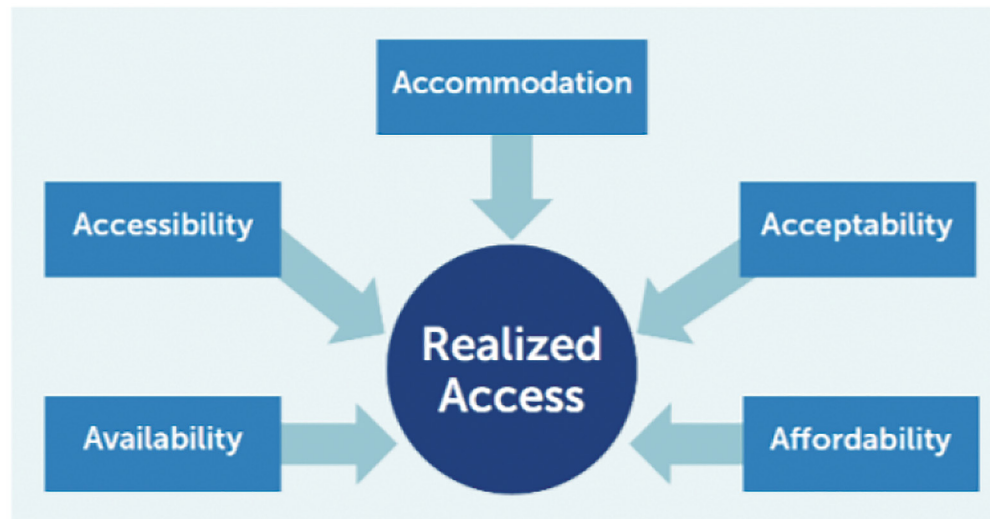
Network Adequacy

In their state plans and waiver applications, all states are required to provide assurances to CMS that they are able to develop a provider network that is adequate to serve the anticipated number of participants. States with managed care programs establish contractual network adequacy standards for the health plans which they regularly monitor. Failure to meet these requirements could result in the imposition of penalties—primarily financial—by the state on the health plan. The adequacy of the provider network is highly dependent on the adequacy of the workforce. In addition to clearly assigning responsibility for network adequacy, it is also important to have the right measures to assess network adequacy.

In their 2017 Toolkit on network adequacy, CMS notes that network adequacy, in and of itself, may not be sufficient to ensure access to care. They outline the “Five A’s of Access” which include:

1. The availability of a sufficient number of providers;
2. The accessibility of those providers based on time and distance;
3. The ability of the providers to accommodate participant’s cultural and lifestyle constraints;
4. Acceptability as expressed in comfort levels of providers and responsiveness to participants’ needs.
5. The affordability of any costs incurred by the participant (within Medicaid limitations).

Realized Access



CMS. 2017. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability

These add up to a sixth A that CMS calls “realized access”. Realized access is measured by if and how participants utilize services.¹⁵

In acute/primary care managed care programs, network adequacy has concentrated on provider access within defined geographic areas and has been heavily focused on time and distance measures, sometimes in combination with quantitative measures, such as wait times for appointments. “Stakeholder interviews indicated that some standards, such as requiring a minimum number of each provider type, were considered to be a starting point for HCBS network adequacy, particularly when states first implement MLTSS, but were not the end goal. Such standards may be relatively easy to implement and enforce but were viewed as insufficient for monitoring whether beneficiaries receive the services authorized in their care plan.”¹⁶

Information gleaned from interviews with state and health plan staff, as well as publicly available research, conclude that HCBS is different from medical care. Much of HCBS involves provider travel to the participant, rather than a participant going to a health care provider’s office. Moreover, medical care tends to be episodic in nature, unlike HCBS where services are provided more frequently, even daily, over extended periods of time. Finally, HCBS addresses many of the social determinants of health, including housing and healthy food, rather than health itself; health plans may have limited experience in delivering these kinds of services. In an interview, staff from one health plan described needing to find affordable housing and transportation for their enrollees rather than finding a residential facility placement, as an example of this difference.

These differences mean that network adequacy for HCBS needs to be measured differently than for acute/primary care; however, there are significant challenges to doing so, and it remains an evolving area of critical focus. CMS emphasizes that health plans need to be able to assess the capacity of their HCBS providers and that doing so involves examining factors that go beyond time and distance. States and health plans agree that staffing is a critical component in the health plans' and providers' ability to meet enrollee needs. Many possible capacity measures are staffing related, including staff-to-member ratios, turnover and how quickly they can hire employees to cover service needs, and their back up plans to cover unexpected employee absences. A 'gaps in care' measure shows promise for assessing realized access as well.¹⁷

Rates & Reimbursement

Whether a state has a fee-for-service (FFS) or managed care delivery system for LTSS, the pressure for meeting the workforce needs at an established rate falls heavily on providers. Because Medicaid is the dominant payer for HCBS, rates are largely outside of providers' control. Medicaid rates for HCBS services have typically not kept pace with market costs, making it more challenging for providers to recruit and retain an adequate number of workers.

States are required to pay actuarially sound capitated rates to health plans. Actuarially sound rates are required to reasonably provide for payments that cover the population and services as outlined in the managed care contract. Using that capitated rate, health plans pay providers for services rendered, most often on a fee schedule. States may outline payment minimums, such as the state FFS schedule that health plans must follow. The scope of the health plan contract (i.e. which services are carved in or carved out) can be significantly connected to how MLTSS programs achieve desired outcomes, and how capitated rates are structured. Capitation rates need to be high enough, so the health plan does not face insolvency and they are able to pay providers a rate that supports adequate access to services needed by participants.

The rate setting process at all levels is highly dependent on having good quality data and information with which to establish rates. There is a relationship between the capitated rate, the provider rate, and having an adequate number of direct care workers so that participants may access the care and services they need. Addressing reimbursement and wage issues will require states, health plans, and providers to work together within well-defined roles and responsibilities.

"The challenge is not just enough providers, but enough of the right providers."

State Medicaid staff

Quality

It is not enough to have sufficient numbers of providers—network adequacy—but also that those providers meet all required qualifications, and are trained, competent, and reliable. This can be a challenge in a sector that is dominated by low wage workers and high turnover. States with a MLTSS program have a potential partner—their contracted health plans—to address these challenges. However, interviews with states and health plans revealed that there can be confusion about who is responsible for ensuring both the number and quality of the direct care workforce. Each party can feel unsupported by the other.

Direct care workers frequently provide intimate care to vulnerable populations. Background check requirements, and other federal and state requirements for training are the traditional approaches to establishing a floor for a competent and quality workforce. Going beyond the required minimums can lead to a workforce that is more capable of participating on integrated care teams, or providing higher quality, more person-centered care that supports desired outcomes.

“Managed care’s emphasis on outcomes and accountability is creating a gravitational pull. This pull is moving DSPs [direct service professionals] from paraprofessional to professional status. With that comes a new aim for MCOs and providers: to develop and adopt policies to recruit, retain, and reward this important workforce.”¹⁸ The emphasis on outcomes creates a great opportunity for MLTSS states to effectively address HCBS workforce issues. One way that states and plans believe MLTSS can improve outcomes is through more coordinated and better integrated care. The direct care worker plays a critical role in an integrated multidisciplinary team. Developing this role and developing workers’ skills and capacity to perform the enhanced role may require additional training and education. The investment required to do so may pay off through improved client outcomes but may also increase worker engagement in their work. “Heightened attention on this sector, paired with a health framework that elevates the role of the worker in care delivery, can improve both the quality of jobs for workers and the quality of care for families nationwide.”¹⁹

PROMISING PRACTICES

Across the nation, actions are being taken to address HCBS workforce issues, “largely by increasing wages and benefits, promoting better training and advanced roles, collecting reliable data on the workforce, expanding access to long-term services and supports, and supporting the relationship between paid and unpaid caregivers.”²⁰ In MLTSS states, each potential tool to address the workforce issue will require states, health plans, and providers to work in concert with one another to achieve their collective goal. States were asked in the NASUAD survey to identify steps they are taking to increase or enhance their HCBS workforce capacity.

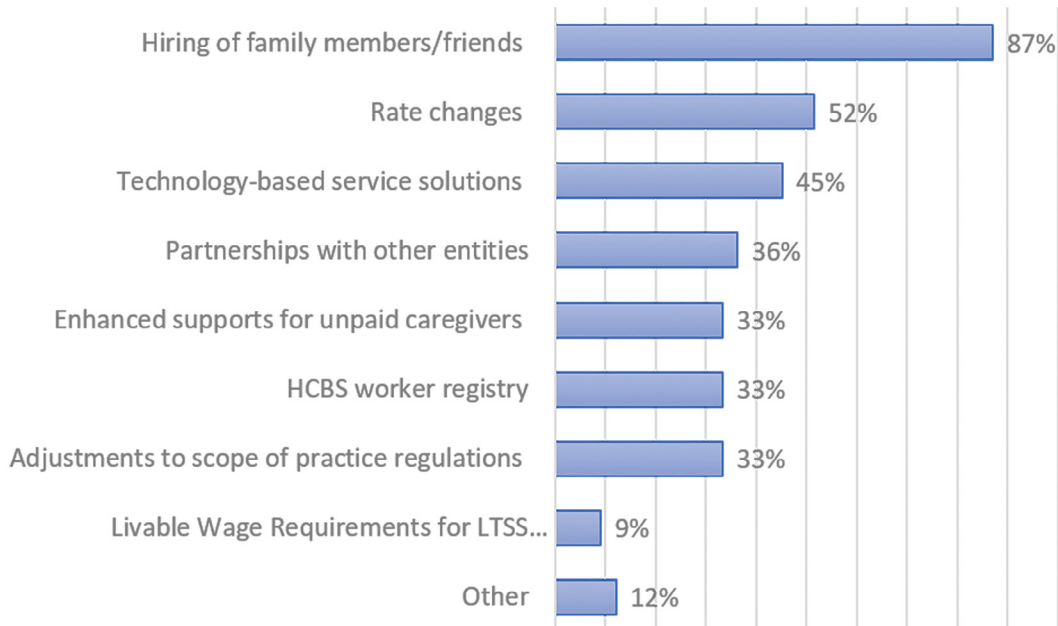
The health plans are also taking actions to address HCBS workforce challenges. One health plan administrator identified three primary issues: wages and benefits; skills building and mentoring; and recognition and inclusion as a part of the care delivery system.

Network Adequacy

In the recent NASUAD survey, MLTSS states were asked specifically about HCBS workforce related requirements in their health plan contracts. Of those that responded (10 out of 24 MLTSS states):

- 30% report having specific contract requirements with their health plans related to workforce development activities;
- 10% report having value-based payments or other incentive payments in their health plan contracts based on workforce related outcomes; and
- 50% report no workforce related requirements in their health plan contracts beyond the health plan’s responsibility to maintain an adequate network.

Steps states are taking to increase/enhance workforce capability



So, half of the MLTSS states that responded to the survey rely solely on their network adequacy requirements to establish the role of health plans in terms of addressing HCBS workforce issues.

In CMS' 2017 review of MLTSS programs, it was found that most states did have network adequacy standards specific to LTSS. These standards included choice of providers; travel distance; travel time; and service initiation time.²¹ These standards align more with primary health care adequacy standards. For LTSS, stakeholders have indicated a preference for a “gap-in-service standard, found in 14 contracts, which requires tracking—and often reporting—instances when a participant was authorized to receive a service, but the service was not provided, either on one or more dates, on time, or at all.”²² Additionally, three states also require health plans to submit annual network adequacy reports “detailing the composition of their network”. Health plans may also be required to demonstrate their processes for monitoring the timeliness of care provided to beneficiaries and for addressing deficiencies.”²³ Anecdotal information suggests that these gaps in service are frequently the result of workers not being available to provide services—a direct result of workforce issues. States and health plans must have confidence in the validity of authorized services if network adequacy is to be measured this way.

In the NASUAD survey, 87% of health plans that responded to the survey reported they regularly review HCBS utilization data to determine whether or not participants are receiving all hours of service that have been authorized on their behalf. 71% of states responding to the survey also reported track utilization of authorized HCBS units as well. A recent review of MLTSS contracts suggests that these measures have not yet been included, although it could be a valuable indicator of unmet needs that may be related to staffing challenges.²⁴

ARIZONA

“Co-Orchestrating a Response to the Workforce Challenge”

Arizona has a mature MLTSS program; their Medicaid program started as managed care in 1989 phased in under the State’s 1115 waiver. Arizona has experienced increased challenges to maintaining a stable LTSS workforce. An example of one such challenge is the increase in the state minimum wage of \$8.05 to \$10.00 in 2017 and the scheduled increase to a total of \$12.00 in 2020, with annual adjustments based on changes in the federal consumer price index after 2020. This wage increase will impact labor costs for the LTSS provider community and may negatively impact the recruitment and retention of direct care workers because the provider industry is competing with other industries for the same workforce.

As a result of workforce related concerns and their potential impact on member outcomes, the state incorporated specific workforce planning requirements into the health plan contracts beginning October 2017. The goal of these provisions was to engage the plans in proactive workforce development planning as well as establish infrastructure for workforce policy management within the plans including the provision of technical assistance to providers.

The state identified three workforce development capabilities for the health plans:

- Designating a Workforce Development Administrator
- Collecting and analyzing workforce data, then using the data to produce an annual plan that informs workforce development interventions and includes a mid-year progress report.
- Providing technical assistance and monitoring providers to develop, implement, and improve workforce recruitment, selection, evaluation, education and training and retention programs

The health plans engage regularly with the state and the provider industry to work collaboratively on workforce development. One such example is the development of standardized retention metrics for utilization by all providers and health plans.

To date, the state is pleased with the level of partnership and collaboration they are experiencing and observing among the health plans. They drew the analogy of “co-orchestration” and described it as “all the players are on the same sheet of music and playing in highly developed concert with each other.”

Rates and Reimbursement

Wage and benefit increases are perhaps the most obvious step to draw more workers into the HCBS workforce, and states are responding. CMS has noted macro-level strategies that impact the workforce at large, such as raising minimum wage requirements, linking wages to inflation, or implementing living wage laws. “CMS encourages states and providers to be mindful of the relationship between wage sufficiency, workforce health, and access to care. Wages paid to individual workers are often slow to be adjusted in response to inflation and economic growth and can lag behind wage increases in other health and service sectors.”²⁵

NASUAD survey data indicated 9% of responding states had living wage requirements for the HCBS workforce. New York is an example of a state that has living wage requirements. New York also “set wage and benefit minimums for certain segments of the home care workforce, passed the nation’s first “Domestic Worker’s Bill of Rights,” and implemented paid family medical leave.”²⁶ In a number of states, unions are instrumental in promoting wage increases and career paths for direct care workers.

Service rate increases may not always translate into wage increases for direct care staff, but states can either require increases to be passed to workers or implement incentives for health plans to do so. The 2016 Medicaid managed care rule provided explicit authority for states to direct health plans to make specified payments to providers if it is advancing a specific state quality goal.²⁷ This authority can be used by a state to mandate that their health plans establish a minimum percentage of service rates to be paid for direct labor costs.

In the most recent Medicaid Budget Survey for State Fiscal Years 2018 and 2019, states identified “gaps in community-based provider capacity (especially in rural areas) and/or direct care workforce shortages, reimbursement challenges (e.g., rising and/or more favorable rates paid to nursing facilities compared to HCBS providers) and the need to risk-adjust rates as patterns of utilization change” as challenges they face.²⁸ In the same survey, 15 states reported implementing wage increases for Medicaid-reimbursed direct care workers, while 24 states report implementing wage increases in FY 2019 (14 states in both years).²⁹

52% of responding states in NASUAD’s recent survey indicated they made rate changes to enhance capacity in their HCBS workforce. Of those states:

- 63% made a rate methodology change;
- 50% created a directed pass through for wages;
- 6% added a value-based payment related to staffing.

Rate methodology changes that incorporate indexed cost of living increases or other regular reviews increase the likelihood that wages can remain competitive with other industries. One surveyed state noted that they offer a differential rate to providers who are willing to travel into more rural parts of the state. Pass through payments require providers to spend additional rate dollars on direct care workers and can be one-time arrangements or a long-term approach. If the additional dollars are not part of a permanent arrangement, providers may find it challenging to commit them to wage increases that they will not be able to sustain when the extra dollars go away. Providers may choose instead to meet the requirement to pass on these dollars to direct care workers through bonuses or other one-time payments.

Health plans cite a limited ability to impact wages depending on how rates are determined in the state. One health plan executive noted there is no additional money to pay workers; however, she noted that health plans “have to get creative to achieve some cost savings to then be passed on to providers and require them to go to enhance wages.” Centene’s Texas affiliate, Superior Health Plan, offers an incentive program for agency providers allowing them to earn bonuses and requires that they pass on 90% of those bonus dollars to their direct care workers. In 2011, a study conducted by Kaiser Family Foundation indicated “... the reality of the capitated rates and the pressure to cut costs may preclude the development of training programs and competitive compensation for workers.”³⁰

At the provider level, agencies may be offering retention bonuses and paid training, in addition to hourly wages that are as competitive as the rate structure allows.

Value based purchasing (VBP) provides a potential tool to address rates/wages and quality at the same time. “Including measures of staffing and steps to improve the stability and qualifications of the HCBS workforce” in VBP structures can help “in establishing the infrastructure needed to deliver high quality HCBS.”³¹ States can take different approaches to VBP arrangements in MLTSS programs: specify the structure/approach through contract language or encourage VBP initiatives more generally. The choice that a state makes between direction and flexibility in VBP arrangements typically reflects its approach to oversight and management.

WISCONSIN

Making a Big State Investment in the Direct Care Workforce

MLTSS in Wisconsin evolved from a county-based Medicaid system where county organizations were administering LTSS; these banded into consortiums, and eventually those quasi-public entities became not-for-profit managed care entities doing MLTSS throughout the state. The Wisconsin MLTSS program is known as Family Care.

Wisconsin providers have been advocating since 2016 that there is a shortage of direct care workers and that the shortage was due to inadequate Medicaid reimbursement and low wages. The Wisconsin legislature in 2017 appropriated just over \$60 million dollars to be spent over the 2018-2019 biennium on directed payments to Family Care provider employees who meet the state’s definition of direct care worker.

Funds are distributed on a quarterly basis through the MCOs. Providers are free to use the funds as they deem appropriate, as long as they are used for: wage increases, retention/longevity bonuses, performance bonuses, increased paid time off, referral or sign-on bonuses, and for the payment of employer payroll taxes that result from increased payments to workers. Providers are required to sign an attestation of how they used the funds and to complete a survey about the effectiveness of these funds in meeting the state’s direct care workforce needs.

Providers are being asked if and how many times the additional funding helped them hire or retain workers, and to rate their overall perception of the extent to which this funding is effective in aiding in workforce development. The WI Department of Health Services will compile that survey data.

Quality

States are undertaking a number of initiatives to improve the quality of the direct care workforce. Enhanced skill development, engagement of the direct care worker in a participant's care team, educational opportunities and defined career ladders are different ways the quality of the workforce can be enriched. These efforts may also increase the perceived value of direct care jobs to future candidates and improve the recruitment and retention of this workforce.

In many states, Medicaid agencies partner or collaborate with state workforce or economic development agencies to give voice to healthcare and human service workforce needs as part of their state's overall workforce adequacy efforts. For example, directors of Indiana's state Medicaid agency, state unit on aging, and state mental health authority, all participated on a gubernatorial task force that was chartered to examine and address how state policies impacted healthcare workforce needs.

In the recent NASUAD survey, over a third of states (36%) responding indicated they are forming partnerships in their state to address workforce challenges. Among those states:

- 75% have partnerships with their provider trade associations;
- 50% have partnerships with their state's workforce development agency;
- 42% have partnerships with educational institutions;
- 42% have partnerships with a sister human services agency; and
- 25% have partnerships that include a special commission or task force.

While not specifically called out, in states with a unionized direct care workforce, labor unions can also be partners in addressing workforce challenges. These partnerships generally are addressing workforce quality development through enrichment of the value of the workforce. This can include promotion of education curriculums aimed at preparing individuals for careers in direct service. These partnerships may also support the development of career ladders and mentoring programs. The creation of "advanced roles, coaching supervision, e-learning and entry-level training, as well as recruitment and retention strategies" are all part of efforts in Minnesota and Wisconsin "to improve home care jobs across their states, particularly in rural areas."³²

Wisconsin launched WisCaregiver, a training program for new nursing assistants that also matches them with employers, and Minnesota launched Direct Support Connect, "a statewide job board that helps participants find workers and helps workers find the right employment fit."³³ One state responding to the survey shared they have a high school home care aide course that prepares students for a future in health care. The course enables students to earn high school credits and prepares them to take the Home Care Aide (HCA) certification exam. At 18 years of age, with their HCA credentials, students will be job-ready and in high demand by employers throughout the state. In the same state, participating community colleges also provide "bridge programs" to train and prepare HCAs to become certified nursing assistants, another step in the health care career ladder. Similarly, another state shared they are partnering with technical schools and other organizations to create a pipeline of direct support workers.

One state said it was engaging with immigrant and refugee social services to offer skills training in direct care. They are able to offer culturally competent training and the wraparound services to support the workforce as part of this initiative. This is a notable effort especially in states where the direct care workforce has a large percentage of immigrants.

In their responses to NASUAD’s survey and interviews conducted for this report, health plans reported a number of initiatives to improve the quality and quantity of the HCBS workforce:

- One health plan noted the importance of mentoring programs for direct care workers.
- Another health plan indicated they are working on a collaboration with local trade schools or universities to create standardized core training and career ladder opportunities in some areas.
- One health plan talked about being responsive to requests from direct service workers. For example, a worker might need to know how to prepare a meal that a person with diabetes can eat. Providing them with an online video training on healthy meal preparation could be a useful tool.
- Another health plan offers a CNA scholarship program as well as a direct worker education program.
- Several health plans indicate they were working on new initiatives or partnerships to address HCBS workforce training but did not yet have details to share.

Provider organizations have long been engaged in efforts to address HCBS workforce challenges by focusing on the supply side, primarily recruitment and retention strategies. Providers are competing for a limited pool of quality workers. LeadingAge noted that instability of the direct care workforce has led to increased provider costs, concerns about access and quality, and poor working conditions.³⁴ Provision of more technical assistance in these areas by states or plans is another promising practice. Tennessee established a provider learning collaborative with one focus area on improving recruitment strategies and management practices to retain workers.

The PHI has been clear that “to ensure enough direct care workers in the years ahead, this sector must attract a more diverse labor pool.”³⁵ This could mean targeting younger workers, older workers, and men. Some of the provider practices health plans and states noted as part of the NASUAD surveys include:

- Revising job titles, job postings and interviewing styles depending on the position; for example, as opposed to posting ‘seeking DSP’ the agency may change the position name to ‘Independence Coach’ to make the position more appealing;
- Provider collaboration to develop career fairs or partner with local colleges; and
- Providers investing in recruitment tactics that include more comprehensive job previews and ride-along/s prior to employment.

TENNESSEE

Building the Value of the DSP Workforce

In 2016, Tennessee implemented Employment and Community First CHOICES, expanding MLTSS to serve persons with intellectual and developmental disabilities. The state implemented this program with network adequacy requirements based on timely initiation and service provision and established higher rates for many services than had been paid in legacy 1915(c) waiver programs. They also developed preferred contracting guidelines to support MCOs in building networks of providers with the right expertise to serve this population; two MCO's even collaborated to jointly credential an implementation network of providers based on those guidelines.

These efforts were insufficient to mitigate the impact of workforce shortages at program launch. Although the state had language in their managed care contracts since 2010 requiring MCOs to have a workforce development strategy, little progress had been made. When the impact became acute at the new program's launch, there was some perception among MCOs that this was a problem beyond their purview to solve.

The state had been grappling with workforce issues for this population prior to the implementation of the new program and had done multiple rate increases over recent years, but the workforce problem appeared to be getting worse. They began to ask, "If reimbursement wasn't the only problem, what else did they need to do?"

The state ultimately engaged with national subject matter experts in competency-based education and in workforce challenges to develop a comprehensive approach to workforce development for direct care workers. Through this initiative, they are partnering with community and technical colleges to provide a consistent, competency-based training program, rooted in person-centered practices, that supports the development of career ladders for direct care workers, including the opportunity for college credits. Their objective is twofold: improve the quality of care by improving the quality of the workforce; and to change the perception of direct care work as a dead-end job.

Through its work with the University of Minnesota's Institute on Community Integration, the state is establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time. Over a period of years, about 45 providers will be engaged in a statewide learning collaborative and will receive training and technical assistance on using workforce data to drive improvements through the adoption of practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served, including organizational and business model changes. They hope to use the learning collaborative group to mentor other providers to increase data and workforce capability.

Value-based payment strategies will be implemented to incentivize provider adoption of practices that will lead to desired outcomes. Incentives will also be aligned at the worker level by implementing pass-through incentive payments to ensure wages are increased as workers increase their level of competency and complete the training program. VBP approaches will transition to financial incentives for specific workforce and quality of life outcomes once practices expected to result in the outcomes have been effectively adopted. The strategy will initially be implemented in Employment and Community First CHOICES, but many providers participate across programs, thus spreading the impact of this work to other populations.

Other Promising Practices

Support for Unpaid Caregivers

Many individuals in need of long-term services and supports receive this support from unpaid caregivers—family, friends, neighbors, churches. Increasing this support could be an alternative to the paid direct care workforce. However, this is a shrinking pool as well. Demographic changes such as individuals having fewer children, higher divorce rates, and more economic mobility (adult children living farther away from parents) have reduced the availability of unpaid caregivers. Still, unpaid caregivers provide a great deal of support to individuals in need of LTSS. AARP estimated the value of this support in 2013 at \$470 billion, surpassing Medicaid spending in that year.³⁶ It is critically important to support these caregivers in this contribution. All states have family caregiver support programs under the Older Americans Act. Many expand those programs with state funding as well. The state of Washington implemented an 1115 waiver that provides targeted Medicaid supports to caregivers in order to delay or reduce future LTSS needs. These programs can impact the HCBS workforce capacity by helping to support the continued involvement of unpaid caregivers. This reduces the need for paid caregivers to supplement the care provided. One health plan administrator referenced the use of caregiver stress assessments and interventions they offered to stressed caregivers, both paid and unpaid.

WASHINGTON

Targeted supports to unpaid caregivers

One state that is supporting unpaid caregivers is Washington. Tailored Supports to Older Adults (TSOA) is an 1115 waiver, funded under the Medicaid Transformation Project Demonstration that provides services to unpaid caregivers. While eligibility for the program is determined by the person who is receiving supports, the services themselves are targeted to the person who is providing the supports. To be eligible, the person must be age 55 or older and “at risk” of needing long term services. The program is targeted toward people who aren’t currently financially eligible for full Medicaid benefits.

The services are designed to assist the unpaid caregiver get the supports that they need to sustain their own health and well-being while continuing to provide high quality assistance as an unpaid caregiver. Services include caregiving related training or education, health maintenance or therapeutic supports for the caregiver, specialized equipment or supplies, and may include limited personal assistance. The needs and preferences of the caregivers and their care recipients are assessed and then services are approved at one of three levels depending on the results of that assessment. There is no health care benefit associated with TSOA.

Technology Solutions

In the NASUAD survey nearly half the responding states (45%) indicated they were implementing technology-based service solutions, like telemedicine and other remote monitoring systems. These alternatives can help to reduce demand on the HCBS workforce as well as provide support for unpaid caregivers. However, much of the work of the HCBS workforce is providing hands-on assistance with activities of daily living such as bathing, dressing, ambulation, etc. and cannot be delivered remotely.

Assistive technologies, such as motorized wheelchairs, lifts, and advanced products that assist with transfers can all be helpful in reducing some demand for HCBS workers by making it possible for individuals to be more independent and need less assistance. They may also make the job of the HCBS worker easier and safer, reducing the potential for injuries and expanding the care they can provide in the home. Providers caution against using technology to reduce demand for direct care workers, noting “automation and robots cannot replace the value of personal connection and hands-on support in direct care”.³⁷ However, they still recognize the value of technology in addressing HCBS workforce challenges. Seven examples of this potential were included in PHI’s 2018 Direct Care Workforce Year in Review:

- Maximizing communication with use of handheld devices to report and manage client issues;
- Digital ads and mobile device application access to drive recruitment;
- Engaging online audiences;
- Technology that supports independence;
- Improving workhours through online job registries matching job openings and workers;
- Connecting workers directly to participants through online registries; and
- Training widespread audiences.³⁸

Scope of Practice Modifications

About one-third of states (33%) responding to the NASUAD survey indicated they have adjusted their scope of practice regulations. Scope of practice regulations define the allowed activities for a given role. Nurse delegation is a part of scope of practice, defining what activities require a nurse and what can be done by a home health aide under the supervision of a nurse. “A number of states, including Oregon, Kansas, Texas, Minnesota, New Jersey, and New York have enacted nurse delegation provisions, but the latitude and interpretation of the provisions vary tremendously. The issue is important because nurse delegation provides more autonomy for the worker and also offers an opportunity to create career specialties (for example, medication aide) that may empower workers and perhaps lead to higher wages.”³⁹ There are also regulations in each state to define limits on activities that a personal care worker can provide so there is opportunity for flexibility there as well. Naturally, there are real concerns for health and safety that must be weighed in these decisions.

Increased Use of Family and Friends to Provide Direct Care and Services

Other state actions attempt to expand the pool of potential HCBS workers. Many states support or encourage hiring of family members or friends. This can happen through the agency model where an approved provider hires the individual to provide the care, or through participant-directed care options available in many Medicaid HCBS programs. In participant-directed care, the worker is hired directly by the participant. The participant may be supported in their role as employer by a case manager and a fiscal intermediary service that provides payroll support. These family members and friends are often new to the HCBS workforce. They have not been and, in fact, may not be interested in providing care to other participants. They add to the capacity of the workforce as a whole. If well supported and trained, they may even consider remaining in the workforce and caring for others.

About one-third (33%) of states responding to the survey report using HCBS worker registries to help match individual workers to participants to help address existing supply and demand.

THE CHALLENGE OF ACCURATE DATA ON THE DIRECT CARE WORKFORCE

As far back as 2004, the Health Resources and Services Administration (HRSA) called upon states to engage in workforce planning, including documenting the anticipated extent of the workforce shortage. “Without accurate and timely counts of workers, it is impossible to understand the relative roles of different types of workers in the long-term services and supports system. It is also impossible to monitor and track changes in the direct care workforce, let alone develop reliable forecasts on which to base plans and programs.”⁴⁰ A 2009 report by CMS reiterated the need for workforce planning and noted that states should be collecting a minimum data set on workforce that included data on the numbers of workers, their compensation and benefits, and the stability of the workforce.⁴¹ Numerous reports in recent years have documented the anticipated workforce shortage associated with the aging of the baby boomer generation.

Despite these earlier alarms, in 2016, the GAO found significant gaps and inconsistencies in how state and federal agencies were collecting and using workforce related data. The GAO report described the broad availability of federal data about the LTSS workforce but noted this data was not collected in a manner that supported systemic projections or assessment of needs. The GAO noted HRSA is the federal agency chartered to monitor supply and demand of the healthcare workforce and called upon HRSA to work more aggressively to develop methods to overcome these data limitations and to develop projections for the HCBS workforce. The GAO also found some states had conducted studies of their LTSS workforce, but these were one-time studies and were inadequate to ongoing workforce planning.⁴²

A HRSA report released in 2018 made projections of national direct care workforce demand through 2030. Notably, this report did not address projections for the supply of direct care workers. HRSA cited a multitude of factors for their inability to adequately model worker supply:

“...predicting how health care delivery may change over time; ... how a greater focus on team-based care may alter staffing levels; and estimating how improvements in technology may change staff loads. ... Setting-specific workforce supplies are likely dependent on a number of factors, including wage competitiveness, employment benefits, workplace environment and workplace recognition. These factors are especially important in understanding the dynamics and fluidity in workforce occupations where little or no specialized training is required.”⁴³

There is not consensus around how to define the direct care workforce for measurement purposes. HRSA uses data from the ACS which classes nursing assistants, home health aides, personal care aides, and psychiatric attendants as the direct care workforce. The BLS classifies home health aides and personal care aides together, but measures nurse aides separately. The 2017 AARP Scorecard uses the number of Home Health and Personal Care Aides as an indicator of access to care by measuring the number of aides per 100 persons with ADL disabilities and simply ranks states on this number.⁴⁴ Efforts to actually define and benchmark the adequacy of the LTSS workforce are rare. A 2018 report by Altarum lays out a case for defining adequacy and benchmarking but uses different measures and different numbers than the LTSS Scorecard.⁴⁵

HRSA specifically identified the need for data on wages and benefits. Direct care provider agencies are the ultimate sources of this data, but many provider agencies lack the capacity or the capability to collect or use this data effectively. States and plans need accurate and consistent workforce data in order to be able to measure provider capacity, and to support the establishment of fee schedules, capitated rates, or other types of payments. States and health plans will need to support providers in the improvement of data collection and reporting.

The development and collection of a minimum data set as proposed by CMS would provide states with a tool to aid in this type of assessment and benchmarking. States and plans may benefit from technical assistance in these data-related areas. One suggestion is to gain a better understanding of the scope and nature of how states, plans, providers, and participants are experiencing workforce issues by conducting a more comprehensive, detailed and validated survey of workforce shortages or other challenges.

SUMMARY

There is no “silver bullet”, single solution to HCBS workforce issues. It will require multiple actions across state agencies, provider networks, educational institutions, economic groups, and even advocacy groups. These are large systemic issues that require actions from the macro (state) level to the micro (provider) level and the program level in between.

“We view it as a partnership with the state; no one alone will be able to solve this entire problem and we would look to the state to lead on whatever their priorities may be.”

Health plan administrator

Contracted health plans can be a significant resource to states with MLTSS programs; they can be a valuable partner in addressing HCBS workforce issues, but their existence does not relieve the states of their macro level responsibilities for workforce development. Nor are providers relieved of micro level responsibilities to have good recruitment and retention practices. Health plans at the program level can support state and provider efforts. Each actor—state, health plan, and provider—has responsibilities that must be clearly defined in program design, contracts, and rate structures.

Recent growth in MLTSS programs has significantly impacted stakeholders with little prior experience in managed medical care. This includes both state agencies (outside of Medicaid) who administer HCBS waivers and as well as providers of HCBS. Improving their knowledge and capacity for working within the managed care contractual

framework could facilitate their participation in developing well-designed contracts that incentivize desired behaviors or leading indicators, or reward outcomes achievement, at both the plan and provider levels.

Moving forward, well-defined and structured data collection and analysis will be essential. It’s possible the introduction of health plans as partners in MLTSS states will help to move the needle on workforce issues. The only way to determine if that is so will be through measurable data over time. States and plans are engaged in a number of promising practices. They will need to be able to assess whether or not those efforts are helping with HCBS workforce issues and good data is the key to that. Improved, consistent, regular data collection from the provider level on up will make it possible to assess the extent of any current HCBS workforce shortage, predict any anticipated shortages for the future, or determine what other issues may be impacting staffing challenges in the HCBS workforce.

“LTSS is not just another set of benefits to manage—social determinants of health, employment, boots on the ground. Plans have varying levels of expertise in managing these kinds of needs.”

State Medicaid Agency staff

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