Direct Support Provider Retention and Recruitment Strategies for Home and Community Based Services

Medicaid Benefits and Health Programs Group
Centers for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services

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Training Objectives

- Provide an overview of workforce challenges for home and community-based services (HCBS)
- Discuss strategies that states employed to address workforce shortages during the COVID-19 Public Health Emergency (PHE) and how they can be implemented going forward to sustain recruitment and retention efforts
- Explore how approaches for assessing rate sufficiency can help ensure an adequate HCBS provider workforce
- Describe opportunities under American Rescue Plan Act of 2021 (ARP) section 9817 to address workforce shortages and strengthen the HCBS workforce

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Background

- State Medicaid agencies, provider groups, and beneficiary advocates routinely cite a shortage of direct care workers and high rates of turnover in direct care workers among the greatest challenges in ensuring access to high-quality, cost-effective HCBS for people with disabilities and older adults.
- States have also indicated that a lack of direct care workers is preventing them from transitioning individuals from institutions to home and community-based settings.
- Although workforce shortages have existed for years, they have been exacerbated by the COVID-19 pandemic, which has resulted in:
  - Higher rates of direct care worker turnover (for instance, due to higher rates of worker-reported stress)
  - The inability of some direct care workers to return to their positions prior to the pandemic (for instance, due to difficulty accessing child care, or concerns about contracting COVID-19 for people with higher risk of severe illness)
- Wage increases in types of retail and other jobs that tend to draw from the same pool of workers have also contributed to workforce shortages.

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Addressing Workforce Challenges in HCBS

- To maintain an adequate workforce during the PHE, over half of states leveraged the 1915(c) Appendix K amendment process to allow family members to serve as paid caregivers and providers of 1915(c) waiver services.
- States also used 1915(c) Appendix Ks and enhanced funding available through ARP section 9817 to implement supplemental or outcome-based payments to assist with provider recruitment and retention
- States must establish routine rate review processes to ensure HCBS provider rates are sufficient to enlist an adequate workforce

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Payment for Family Caregivers

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Paid Family Caregivers: Background

- Under Appendix K amendments, states were allowed the option to temporarily permit payment for services rendered by family caregivers or legally responsible individuals under 1915(c) waivers to ensure caregivers received financial relief for rendering services such as personal care ordinarily provided by a traditional service provider.
- States have the option to receive federal reimbursement of personal care services rendered by legally responsible individuals in 1915(c) waivers post-PHE. In order to do so states must demonstrate that the services are deemed "extraordinary care."
  - Extraordinary Care: care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

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Paid Family Caregivers for 1915(c) Personal Care (and Related Services)

- States are responsible for developing their own criteria for extraordinary care that explains how the care exceeds that of a person without a disability or chronic condition of the same age. CMS recommends that states:
  - Define ordinary care that the state considers customary for legally responsible individuals to provide to an individual who does not have a disability for all age ranges served by the waiver.
  - Develop criteria for extraordinary care that contrasts with the definition for ordinary care.
    - Specify elements of a daily routine or other activities of daily living that qualify as extraordinary care, such as specialized care required which exceeds care ordinarily provided to participants of a similar age without a disability
    - Determine requirements or specific qualifications to address participant needs, such as training or certifications, that would elevate care to extraordinary status.
  - Determine other criteria specific to a waiver population or other challenges within the state (access to a qualified provider, for example).

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Paid Family Caregivers for 1915(c) Personal Care (and Related Services)

- States must specify the following when authorizing the provision of waiver services by legally responsible individuals:
  - The types of legally responsible individuals to whom payment may be made.
  - The waiver services for which payment may be made to legally responsible individuals.
  - Limitations (if any) on the amount of services that may be furnished.
  - The procedures that are employed to ensure that payment is made only for services rendered.
  - The method of determining that services provided by legally responsible individuals is “extraordinary care”

- States must also ensure that:
  - The legally responsible individuals meets all provider qualifications.
  - Services rendered are equivalent to services supplied by other types of providers.
  - There are procedures in place to verify that services for which payment is made have been rendered in accordance with the participant’s service plan and that they meet the conditions that the state has established for the provision of such services.

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Supplemental and Outcome-Based Payments

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Outcome-Based Payments During the COVID-19 PHE

- States used Appendix K and the additional Federal Medical Assistance Percentage (FMAP) through Section 9817 of the American Rescue Plan Act (ARP) to develop outcome-based payments to maintain and strengthen the HCBS workforce, including:
  - Sign-on bonuses for new hires
  - Retention bonuses for current providers
  - Supplemental payments to providers to aid with the costs of recruitment efforts
  - Enhanced payments for DSWs based on the number of hours worked to help improve retention and respond to DSW burn out
- The COVID-19 PHE prompted states to quickly respond to new health risks to protect program participants:
  - Several states provided one-time payments to providers who completed the COVID-19 vaccination regimen.
  - Most states provided payments to providers for completing trainings specific to Infection Control, FIT Testing of N-95 masks, and proper use of personal protective equipment (PPE).

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Outcome-Based Payments and Rate Setting in 1915(c) Waivers

- States can include outcome-based reimbursement for waiver services as a component of the waiver service rate setting methodology.
- Similar to other rate setting components that factor into the final payment rate, the state must be able to describe how the payment amounts are determined for milestones or outcomes.
- States offer outcome-based payments for waiver services to incentivize or reward desired participant outcomes or for services with clear and measurable milestones.
- The following two slides depict different types of non-PHE-related outcome-based payments states have historically used, that can be leveraged for workforce retention purposes.

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Examples of Outcome-Based Payments in Rate Setting Methodologies

Supported Employment	
Service Description	*Outcome-Based Payment Methodology*

• Services for individuals who need on-going support to obtain and maintain a job in an integrated, competitive setting.
• This service is designed to support successful employment outcomes consistent with the individual's personal and career goals.
	• Providers are incentivized to fade supports over time by decreasing the number of direct support hours on the job-site once the participant secures long-term employment
	• Payments are based on the expected outcome of the service component, the expected timeframe to complete the service, and the:
	  • participant's level of need or acuity
	  • level of fading achieved
	  • length of time the job has been held

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Examples of Outcome-Based Payments in Rate Setting Methodologies (cont.)

Supported Living in an ID/DD Waiver Program:	
Service Description	*Outcome-Based Payment Methodology*

• Participants acquire, maintain, and improve skills necessary to live in their own private home or a host family's home in a less intensive setting.
• Host families assist, support, and guide participants to grow the skills necessary to participate in community life and to live more independently.
	• Payments are made to providers who support a successful participant transition from a licensed Residential Habilitation service into Supported Living services.
	  • *Payment 1* is made after the new Supported Living service is rendered to the participant
	  • *Payment 2* is made after the participant has received six consecutive months of the Supported Living service

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Supplemental Payments in 1915(c) Waivers

- States have the option to make supplemental or enhanced payments for 1915(c) waiver services in addition to the base payment or the amount billed by the provider.
- States have the flexibility to design supplemental payment programs to achieve overarching waiver program goals and offer payments outside of the delivery of a waiver service.
  - States may reward providers for achieving certain quality related milestones or some measure of participant satisfaction.
  - States may also use supplemental payments to achieve state policy or program initiatives outside of the delivery of waiver services, such as aiding in providing retention efforts, promoting training and continuing education, and expanding access to care.
- States often use supplemental payments to make outcome-based payments when the milestone or incentive is not a direct cost component of rendering an individual waiver service.

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Example of Outcome-Based Payments as a Supplemental Payment

HCBS Program for Elders	
Supplemental Payment Description	*Outcome-Based Payment Methodology*

• Reward providers for delivering quality care as measured by the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, average plan costs, and length of waiver stay.
• Performance incentives reward quality outcomes and aim to improve the experience of waiver participants, outcomes, access to care, participant choice, and health and welfare.
	• Quality data for the performance standards is provided by the HCBS CAHPS
	• The waiver program rewards quality outcomes for waiver participants based on the following performance standards:
	  • Consumer satisfaction with services
	  • Consumer feedback on quality of services

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Example of Outcome-Based Payments as a Supplemental Payment (cont.)

HCBS Program for ID/DD:	
Supplemental Payment Description	*Outcome-Based Payment Methodology*
• Reward providers who employ new direct support professionals (DSP) who participate in a Certified DSP Registered Apprenticeship program. • Performance incentives aim to stabilize and structure the DSP workforce and improve the experience and outcomes of waiver participants.	• Providers receive a payment for participating in the Certified DSP Registered Apprenticeship Program. • Providers receive payments when apprentice(s) reach partial and full completion of the registered apprenticeship program. • Apprentice(s) registration and progression must be recorded in a designated database to receive payment. **Payment is not available for trainings or certifications needed to meet provider qualification requirements*

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Recap of Outcome-Based Rate Setting Methodologies vs Supplemental Payments

Outcome-Based Payment Method	Must be linked to an individual waiver service? (Y/N)	1915(c) Waiver Application Appendix	Example
Include outcome-based payment as a component of the waiver service and part of the rate setting methodology.	Y (Must be included as part of the rate setting methodology)	Appendix I-2-a	The state offers an outcome-based payment when the waiver participant obtains employment resulting from job exploration services.
Supplemental Payment	N (May be linked to an individual waiver service delivery but not required)	Appendix I-3-c	State offers an outcome-based payment to all waiver providers who successfully complete an Alzheimer's care training.

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Ensuring Rate Sufficiency

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Rate Sufficiency Requirement at §1902(a)(30)(A) of the Social Security Act

- States must assure that payments for HCBS are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area…"
- Setting sufficient HCBS rates is key to ensuring individuals receive quality care and have access to an adequate pool of providers.
- CMS depends on information provided in HCBS waiver applications to help determine the sufficiency of rates and compliance with Social Security Act 1902(a)(30)(A), which includes evaluating whether rates are meeting efficiency and economy standards (e.g., examining whether rates are too high or too low).
- Revisions, when warranted by the results of a state's rate review, can help address elements of rate setting that were not considered when rates were first set and can allow for adjustments based on current data and experience.

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Rate Sufficiency Approaches - Overview

- To ensure compliance with §1902(a)(30)(A), CMS recommends that states conduct rate reviews for HCBS at least once every five years.
- Five main rate sufficiency review approaches include:
  1. Analyze and incorporate feedback from stakeholders
  2. Benchmark waiver rates to rates for comparable services
  3. Collect evidence from quality monitoring and service utilization data
  4. Measure changes in provider capacity
  5. Benchmark rate assumptions to available data

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Analyze and Incorporate Feedback from Stakeholders

- Evaluate feedback from individuals, families, independent case managers, advocacy groups, and providers about the adequacy of direct service providers.
  - Collect data on Fair Hearings, grievances or complaints to determine whether participants experienced challenges with accessing services, locating providers, and/or receiving services in accordance with the type, scope, amount, duration and frequency specified in the person-centered service plan (PCSP).
  - Complement Fair Hearing and grievance/complaint information with data from individual and provider surveys.
- Individuals, families, independent case managers, advocacy groups, and providers give states a frontline perspective on the sufficiency of rates.
  - Individuals know whether they have access to enough qualified providers to receive the services required by their PCSP.
  - Independent case managers have a broad overview of the services available in the area and should be able to assess whether there is a sufficient number of providers to ensure access to services.

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Benchmark Waiver Rates to Rates for Comparable Services

- When submitting new or renewal waiver applications, compare HCBS waiver rates with:
  - Rates for similar services within your programs (e.g., other HCBS waivers, Medicaid State Plan services, or other similar state programs).
  - Rates for similar services paid by public or private payers.
  - Rates for similar HCBS waiver services from bordering states and/or states with demographically similar programs.
- Comparing waiver rates to the broader provider market helps promote equity and prevent unbalancing (e.g., by ensuring one target population is not incentivized over another)

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Collect Evidence from Quality Monitoring and Service Utilization Data

- Assess changes in historic service-level utilization, including the number of participants utilizing an individual waiver service and service expenditure data in the CMS 372(s) reports, to identify trends that may impact service access and provider costs.
- Review evidence related to performance measures that assess whether services are delivered in accordance with the PCSP, including the type, scope, amount, duration, and frequency specified in the plan.
  - If individuals are not receiving services in accordance with the PCSP, it could indicate that there are insufficient providers to meet individuals' needs.
  - At the same time, if individuals are receiving services in accordance with the PCSP, it may be that the service plan was developed with an understanding of what services were available, possibly masking provider adequacy issues. This highlights the need to take multiple approaches for evaluating rate sufficiency.

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Measure Changes in Provider Capacity

- Routinely measure changes in provider attrition and provider capacity (e.g., staff turnover, retention, etc.), particularly following any change in waiver service rates.
  - An increase in provider capacity may be indicative that the change in rates was sufficient to attract new providers into the market.
  - A decrease in provider capacity may indicate that current rates are no longer sufficient, or if following a rate change, that the change in rates was insufficient to attract new providers.
- States may also consider continuously monitoring the providers' capacity using billing data or a provider survey. Examples of data collected include:
  - Units of service rendered per provider
  - Number of individuals served.
  - Amount of overtime used per direct service worker.
  - Staff attrition rate.

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Benchmark Rate Assumptions to Available Data

- Review rate assumptions including direct service worker wages, benefits, and administration and program support costs used in fee schedule rate setting and compare this with a market data analysis.
- Many states already use the direct service worker wage as the basis of their final rate and then apply various factors and adjustments, such as benefits, administration and program support factors.
  - Comparing the base wage to the wage paid in the market for similar services helps states understand if rates are being set to attract a quality workforce, in addition to a sufficient number of providers.
  - Comparing the percentage of the rate assumed for benefits, administration and program support to other fee-for-service rates developed within the state provides a benchmark for the efficiency and economy of the rates.
- States can compare the base wage from the rate model to wage data from state run facilities, or publicly available data from the Bureau of Labor Statistics.
- States can compare benefit, administration and program support assumptions to similar assumptions in other state program rates, such as assumptions from state employees or at state-operated facilities, costs within nursing facilities (removing room and board-related costs) or among other HCBS waivers.
- CMS strongly encourages states to continuously monitor the Medicaid direct service worker wage in the state to ensure that the providers are paying the comparable wage used for rate setting.

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Rate Revisions and Adjustments

- Results of the rate sufficiency review might lead the state to perform one or more of the following rate revision methods:
  - Rate Adjustment: The state revises the rates based on budgetary, programmatic and/or other legislative changes.
  - Rate Rebase: The state maintains both the existing waiver service definitions and methodology but adjusts the individual inputs that comprise the rate with new data.
  - Bundled Rate Recalibration: In the case of bundled service rates, the state recalculates the bundled rate when the services and/or mix of services changes.
  - Rate Methodology Redesign: The state develops an entirely new rate setting methodology for a given waiver service
- Rate revision requires a waiver amendment, which will also require public notice.

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Opportunities under ARP Section 9817 to Address Workforce Shortages and Strengthen the HCBS Workforce

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ARP Section 9817

- ARP section 9817 provides states with a temporary 10 percentage point increase to the federal medical assistance percentage for certain Medicaid HCBS
- States must supplement but not supplant state funds expended for Medicaid HCBS in effect as of April 1, 2021. To demonstrate compliance, states must:
  - Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
  - Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
  - Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.
- States are expected spend an amount equivalent to the amount of additional federal funding they receive to implement one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.
- States are expected to fully expend the funds on activities to enhance, expand, or strengthen HCBS by March 31, 2025

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State Activities to Enhance, Expand, or Strengthen HCBS under ARP Section 9817

- States can implement a broad range of activities to enhance, expand, or strengthen HCBS under ARP section 9817.
- Most commonly proposed activities include:
  - **Activities to recruit and retain the workforce**
  - Workforce training
  - Quality improvement activities
  - Reducing or eliminating HCBS waiting lists
  - Expanding use of technology

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Examples of State Activities to Recruit and Retain the Workforce under ARP Section 9817

- Offering sign-up or incentive payments
- Increasing rates or implementing acuity-based rates
- Establishing career paths for Direct Care Workers
- Creating worker registries
- Conducting rate studies
- Offering retainer payments

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Examples of Workforce Training Activities under ARP Section 9817

- Creating new standardized training programs for workers
- Expanding or updating existing training opportunities
- Developing on-line training platforms
- Offering certification programs and tuition support to providers, caregivers, and Direct Care Workers to further their careers

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Summary

- Many states reimbursed family caregivers to address workforce challenges during the COVID-19 PHE. This strategy can be leveraged beyond the PHE to address workforce shortages at-large.
- States are encouraged to develop creative outcome-based payment approaches to assist with their provider recruitment and retention efforts.
- Routine and comprehensive review of HCBS payment rates is critical for ensuring providers have sufficient financing to attract and maintain an adequate workforce.
- States implemented multiple strategies for addressing workforce shortages using ARP Section 9817 funding that can provide valuable lessons learned going forward.

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