

State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages

Medicaid is the nation's primary payer for home- and community-based services (HCBS). Roughly 2.4 million workers provide services to Medicaid beneficiaries in their homes and other community settings (PHI 2021). Workforce shortages, however, limit the ability of Medicaid programs to serve more people in the community, an effort that is in keeping with the mandate of the Americans with Disabilities Act of 1990 (P.L. 101-336, as amended) and the *Olmstead v. L.C.* decision that states must facilitate community integration for beneficiaries with disabilities (MACPAC 2019).¹

The COVID-19 pandemic has exacerbated the workforce shortage and highlighted its drivers, including low wages, limited opportunities for career advancement, and high turnover. During the pandemic, HCBS workers across the country reported increased mental and physical demands in their jobs (Musumeci et al. 2021). Other HCBS workforce concerns include equity issues (e.g. wage disparities) for workers, who are largely women, and also often people of color or immigrants (PHI 2021).

This issue brief describes current issues facing the HCBS workforce and the Medicaid levers available to address them. It begins by summarizing the role of the HCBS workforce in Medicaid. Then, it describes the shortage and contributing factors. It ends by discussing current state efforts to expand the HCBS workforce including those focused on wages and benefits, training, recruitment and retention, and paying family caregivers. Many of these efforts are supported by funds made available under the American Rescue Plan Act (ARPA, P.L. 117-2).

Through interviews with state Medicaid officials, advocates representing workers and beneficiaries, and a provider association, we gained insight into the issues facing HCBS workers, how these issues affect beneficiaries, and state strategies to address them.² We also heard directly from states and an organization representing HCBS workers at the Commission's October 2021 public meeting (MACPAC 2021).

Overview of the HCBS Workforce

The HCBS workforce is made up of several types of workers who assist beneficiaries with activities of daily living (ADLs) such as mobility, personal hygiene, and eating. In addition to these essential basic functions, HCBS workers also assist beneficiaries in community integration by providing support with instrumental activities of daily living (IADLs) such as grocery shopping and managing finances. The tasks they perform may be specialized, depending on the needs of the population (e.g., children, people with intellectual or developmental disabilities (ID/DD), adults with physical disabilities, and people with dementia).



We use the term HCBS workers broadly to include direct care workers, direct support professionals (DSPs), and independent providers.

- Direct care workers include personal care aides (PCAs), home health aides (HHAs), and certified nursing assistants (CNAs). PCAs, who assist individuals with ADLs, are the most common type of direct care worker (BLS 2020). For the purpose of Medicaid payment, HHAs and CNAs are subject to federal training standards and require certification, while training requirements for PCAs vary by state.
- Direct support professionals assist individuals with ID/DD, providing a broader range of services than PCAs, such as employment support (PHI 2021). There are no federal training standards for direct support professionals.
- Independent providers are those who are employed directly by beneficiaries through consumer direction.

HCBS workers are employed either by an agency that serves as a provider enrolled with the state Medicaid agency or as an independent provider (as noted above).³

Training

Training for HCBS workers is provided in multiple ways. Many training programs take place once a person is hired, so that they can work while completing their training. Training commonly occurs through a combination of online modules, live classroom instruction from registered nurses or other professionals, and in-person training. Such programs often have a competency-based test or evaluation that workers must pass.

States determine training requirements for most of the HCBS workforce, and these can vary by state (Bryant et al. 2021). Required hours for training for HCBS workers paid through state Medicaid agencies range from 40 in New York and Virginia to 75 in Washington. For workers who are training while working, states can set a timeframe for when they must complete the training and pass the test, such as within six months of hire in Maine. Some states have required core competencies for the HCBS workforce while others delegate this task to managed care plans or workforce agencies. Relevant topics include legal and ethical issues, medical skills such as administering medications, communication, cultural competency, safety and injury prevention, and skills for working with specific populations, such as older adults or people with disabilities (Bryant et al. 2021). Many workers are also interested in further training that they may not currently receive, such as specialized care for specific conditions, first aid, and nutrition and meal preparation (Christman and Connolly 2017).

Training can improve job satisfaction and help workers be equipped to manage care responsibilities. In evaluations of training programs, workers who completed training reported higher intent to stay in their roles and better relationships with clients; these workers' clients experienced a reduction in emergency room visits (Stone and Bryant 2021, Luz and Hanson 2015).

Training portability, which refers to the ability of workers to use training in a variety of jobs, appears to affect the supply of workers providing services across long-term services and supports (LTSS) settings.



Many HCBS workers want opportunities for advancement through career ladders and opportunities to move between similar fields through career lattices (Bryant et al. 2021).⁴

Wages and benefits

In 2020, the median home health and personal care aide hourly wage was \$12.98. Fifteen percent of direct care workers have annual earnings below the federal poverty level (FPL), and 44 percent live in households with incomes under 200 percent FPL. About two in five (42 percent) direct care workers use public assistance programs, including 26 percent who are enrolled in Medicaid. Additionally, wage disparities exist within the workforce; women earn less than men on average, and people of color earn less than white people (Campbell et al. 2021).

The income of HCBS workers is also affected by working hours and the limited availability of overtime pay. Many (39 percent) direct care workers work fewer than 40 hours per week; many may want to work more than their current schedules (PHI 2021, Christman and Connolly 2017). Only half report receiving overtime pay when working more than 40 hours (Christman and Connolly 2017). Most report working more hours than they are paid for due to showing up early or working late (Christman and Connolly 2017).

Most HCBS workers, but particularly independent providers, lack benefits such as health insurance and retirement. Only 37 percent of HCBS workers have health insurance through their employer or a union (PHI 2021). Four out of five HCBS workers do not have retirement benefits through their employer (Christman and Connolly 2017).

Union membership for HCBS workers is associated with better pay and benefits. HCBS workers who are union members make on average \$2.00 more per hour than workers who are not unionized. Agency-employed HCBS workers are more likely to be unionized, and in states like Washington, workers in self-directed plans can unionize as well (Christman and Connolly 2017).

Agencies paid by Medicaid compete with the private home care sector for workers, which is often able to pay workers more. The private sector can provide workers with higher starting wages and hazard pay, while Medicaid providers are subject to state-determined payment rates for the provision of services only (ANCOR 2021). Such competition affects the supply of direct care workers available to serve Medicaid beneficiaries (NHFPI 2019).

The HCBS Workforce Shortage

High rates of turnover driven by low wages, lack of advancement opportunities, and worker dissatisfaction all contribute to shortages of HCBS workers. According to PHI, HCBS workers have a turnover rate of 40 to 60 percent annually (PHI 2021). This rate is higher than the overall health care and social assistance field, which had a 34 percent separation rate in 2019 (BLS 2020). Workers who reported a lack of health insurance, injuries on the job, inconsistent client assignments, and insufficient hours were more likely to report intent to leave the HCBS workforce (Stone et al. 2016).



Limited data are available to characterize workforce shortages at the national level. The U.S. Bureau of Labor Statistics collects data on home health and personal care aides, but there is no unique standardized occupational code for direct support professionals (BLS 2020). State officials and beneficiary advocates whom we interviewed shared that this lack of data is particularly challenging because, without the data, they cannot accurately estimate the size of the workforce or the average income.

Despite limited data to quantify the extent of the shortage, there is evidence that an insufficient supply of HCBS workers has led to providers being unable to take on new clients, vacancies in the workforce, and unmet beneficiary need. A 2021 survey of HCBS agencies found that 77 percent have turned away new referrals, 58 percent have discontinued certain programs or services, and 84 percent have delayed programs due to staffing shortages (ANCOR 2021). In 2018, the average vacancy rate for DSP positions was 11.9 percent for full-time roles and 18.1 percent for part-time roles (HRSI 2018). About one of every five (21 percent) beneficiaries receiving HCBS have unmet needs for assistance with daily activities, although this unmet need is likely due to both the workforce shortage and some services not being covered (Chong et al. 2021).

The demand for HCBS workers will likely continue to grow due to aging populations, beneficiary preferences for living in the community, and rebalancing initiatives. One study estimated there being 8.2 million HCBS job openings from 2018 to 2028 (PHI 2021).

Medicaid Levers for Increasing HCBS Workforce Capacity

States have taken a variety of approaches to addressing the HCBS workforce shortage, focusing on four main areas: wages and benefits, training, recruitment and retention, and support for family caregivers.

ARPA created a new funding opportunity for such efforts by temporarily increasing the federal medical assistance percentage (FMAP) specifically for HCBS by 10 percentage points. States may receive increased FMAP for approved activities from April 1, 2021 to March 31, 2022. States have until March 31, 2024 to spend these funds and were required to submit plans detailing how they will use them. Below, we highlight state ARPA plans that target the HCBS workforce, along with specific state examples.

Wages and benefits

Rates for HCBS, like all other Medicaid services, are set at the state level. Medicaid payment levers differ for agency-employed and independent providers. For agency-employed workers, Medicaid makes payments to the agencies, which in turn pay workers on an hourly basis. Independent providers are paid by the beneficiary for whom they provide care. In 38 states and the District of Columbia, beneficiaries in self-directed plans have some authority to set rates for their providers (Musumeci et al. 2020).⁵

In some states, wage pass-through laws are being used as a tool to raise wages of agency-employed HCBS workers.⁶ Under these laws, when state Medicaid agencies increase provider rates, they are required to pass on the higher payment to workers. As of 2019, 14 states had such laws in place. These laws function in two primary ways. Some states require a percentage of the rate increase to be passed on while other



states require a specific dollar amount. These laws may also be implemented in a variety of ways. For example, Washington's law is negotiated through union contracts, requiring that raises in pay to independent providers negotiated through the union also apply to agency-employed HCBS workers.⁷ New York's wage pass-through law uses a formula to calculate the dollar amount required for the wage pass-through, and the formula is based on the minimum wage, which varies by county (Yearby et al. 2020).⁸

Washington state has implemented improvements in wages and benefits for all types of HCBS workers, including workers employed through agencies and self-directed plans. By working with Service Employees International Union (SEIU), the union representing HCBS workers, the state raised wages for all types of direct care workers. The state acts as the employer for HCBS workers in self-directed plans, allowing them to pool benefits, including health care and retirement, for this population. Washington has the highest median hourly wage for HCBS workers at \$15.14 (PHI 2021). Washington's wage pass-through parity law requires that agencies pass on wage increases from the state to the worker in the same way independent providers benefit from the wage increase.⁹ The base hourly wage for Washington HCBS workers is \$15, with further opportunities for advancement based on tenure and skills.

Thirty states plan to use ARPA funds to plan for or implement changes in payment policies, such as increasing payments to workers, implementing monetary incentives, and conducting studies on new rate structures. For example, Indiana plans to extend the temporary rate increase implemented for HCBS workers during the COVID-19 pandemic and increase hourly payment for consumer-directed services by 15 percent. Maine plans to use ARPA funds to set the HCBS worker minimum wage at 125 percent of the state's minimum wage, and the state will use state-only funds to continue the increased wages once ARPA funding is expended (NASHP 2021a).

Training

Many states have developed training programs to improve job satisfaction and service quality. Twenty-six states require a minimum number of hours for training, and 34 states require a competency-based assessment for PCAs. Some states have a set curriculum for all home health aides, some tailor the content to the beneficiary type, and others have continuing education requirements (Bryant et al. 2021). Most of these training requirements apply only to agency-employed HCBS workers (PHI 2021).

Although as noted above, there are no federal training requirements for PCAs, but activities funded under the Personal and Home Care Aide (PHCA) State Training Demonstration Program initiated in 2010 by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) could serve as a model for a training program for PHCAs. The demonstration provided grants to six states that developed training programs incorporating a minimum of nine core competency areas (Morgan et al. 2018).

States are also using career ladders and lattices to further professionalize the HCBS workforce and make these jobs more appealing, given that these typically offer little opportunity for advancement. For example, in Alaska, the HCBS worker training program can be applied toward a CNA or HHA certificate (Bryant et al. 2021). Interviewees suggested that another opportunity for career ladders could be to create opportunities for HCBS workers to advance to management roles in DSP agencies or move into other fields such as social work and case management.



Career lattices allow for training portability so that workers can move between similar fields. States can enhance career lattices with uniform training that applies to multiple jobs, such as working in nursing homes and assisted living facilities. In Maine, the certificate received after completing the training can be used in multiple long-term care settings (Bryant et al. 2021).

It is important to note that not all HCBS workers want to pursue the career long term. In our interviews, state officials shared concerns that training may serve as a barrier for those entering the career for short periods. States address this concern by making some training required and other programs, like career ladders and lattices, optional.

Additionally, in our interviews, beneficiary advocates expressed concern about the medicalization of HCBS, meaning a focus on medical tasks rather than on the expressed personal needs of the beneficiary. Training that does not emphasize person-centeredness could reinforce medicalization.

Some state officials have expressed concern that new training programs could decrease the supply of workers who can complete the required training and tests. For example, in Washington state, approximately 85 percent of HCBS workers passed the test after the state's required 75 hours of training. At issue is what happens to the other 15 percent of workers who did not pass and thus may leave the workforce. Because the state identified language proficiency as a barrier to passing the test, it now offers training and testing in more than 10 languages (MACPAC 2021).

Tennessee developed a comprehensive training program for its HCBS workforce that included a career ladder and wage increases. HCBS workers are employed through agencies that contract with managed care plans, and the state requires managed care plans to support the development and adequacy of the workforce. Through a state innovation model test grant, Tennessee developed Quality Improvement in Long-Term Services and Supports (QuILTSS), a competency-based training program that is tied to wage increases for workers. The QuILTSS Institute is run through a partnership between the state Medicaid agency, the Tennessee Department of Labor, and Medicaid managed care plans. Training is based on an apprenticeship model, where new DSPs are supervised by trained DSPs, receiving training while working. As the workers gain skills, their hourly wages increase. In addition to the required training for all HCBS workers, those who stay in the career long-term have opportunities for additional learning and advancement (Tyler et al. 2017).

Thirty-three states plan to undertake training initiatives using ARPA funds, such as creating training curricula on specific topics, tying training to wage increases, and providing opportunities for workers to ascend career ladders. For example, North Dakota plans to create a new training platform for all HCBS workers that focuses on cultural competency and person-centeredness (NASHP 2021a).

Recruitment and retention

States are also working to recruit new workers through pipeline programs and publicity campaigns and to retain the existing workforce by addressing sources of worker dissatisfaction.



Interviewees discussed building a workforce culture that involves stronger supervision and peers to support workers and offer mentorship as one approach to retention. These interventions target specific causes of worker dissatisfaction associated with workers leaving the field (Stone et al. 2016). Interviewees described peer-matching programs as a solution to combat the isolation of the job and help workers address on-the-job problems. Additionally, states like Washington are working on supportive supervision programs so that workers feel supported at work and know how to report issues or ask for assistance (MACPAC 2021).

Worker retention can also be enhanced when there is a good match between workers and their clients. Factors such as desired hours, language, and location affect the worker's experience and the beneficiary's care. Ten states use matching registries for this purpose, of which three are state-run (PHI 2021). For example, Minnesota created Direct Support Connect, a statewide job board where workers and beneficiaries can create detailed profiles and search for potential matches (Bradford 2017).

To recruit more workers, some states are developing pipelines for high school and college students that permit students to train for jobs while completing credit toward their degree. For example, Washington's Medicaid agency collaborated with the Office of Superintendent of Public Instruction to develop a 90-hour training program that high school students can take for both school credit and count toward the required HCBS worker training (Maki 2021). In Tennessee, some community colleges offer the classroom portion of the mandatory training and award 18 hours of credit for completing it (Ward et al 2021). Arizona recruits workers through a training program at 27 career and technical high schools, where high school students can earn credit while completing the state's required PCA training program (MACPAC 2021).

Another strategy to increase public interest in joining the HCBS workforce is undertaking publicity campaigns to promote entry into the HCBS workforce. For example, a 2018 campaign in Wisconsin included videos advertising the rewarding aspects of the work and highlighting it as a career ladder to other health care jobs. Through this campaign, the state advertised the free training and testing offered for HCBS workers and received 9,000 new applicants for the training program (Hostetter and Klein 2021).

The Arizona Medicaid agency's Office of Healthcare Workforce Development works with managed care organizations (MCOs) to identify and address barriers to worker recruitment and retention. Several Arizona MCOs worked with PHI, a national advocacy organization for direct support workers, to disseminate a survey about barriers to workforce retention. Identified barriers included inadequate supervision, need for advancement opportunities, and lack of continued training (McCall 2021). Currently, Arizona MCOs are working to address these concerns with the support of ARPA funds.

Thirty-two states plan to use ARPA funds to work on recruitment and retention through programs such as hiring bonuses, retention bonuses, and scholarships for further training. New York plans to fund bonuses across their HCBS system and further subsidize providers who improve recruitment and retention. Maine plans to use ARPA funds to run a marketing campaign, developed with the help of its workforce council, that aims to recruit more workers (NASHP 2021 a).



Paying family caregivers

States can also pay family caregivers as part of a workforce strategy. Although this option is available in all states, the specifics of who can be paid vary. State plan personal care options do not allow spouses or legal guardians to be paid for providing care, but states have the option to pay this group using Section 1915(c) waivers.

Paying family caregivers can be beneficial for the beneficiary and the state. This option allows many beneficiaries to select care that is culturally competent and in the language they speak. Paying family caregivers does not cost state Medicaid programs more, as these caregivers are providing care where a person would otherwise hire an unrelated independent provider (Teshale et al. 2021). Additionally, family caregivers can often provide more flexible hours than other providers.

Historically, federal policy has restricted Medicaid's ability to pay family caregivers due to concerns about isolation, caregiver burnout, and conflicts of interest. However, beneficiaries receiving care from paid family members have similar satisfaction with their care and similar community living outcomes to those receiving paid care from others (Edwards 2014).

Due to the workforce shortage and the COVID-19 pandemic, there has been growing interest in expanding which family members can be paid to provide care. In 2020, 17 states used Appendix K flexibilities permitted by the public health emergency to allow more payment for family caregivers in their Section 1915(c) waivers (Ujvari et al. 2020). For example, Virginia's 1915(b)/(c) program allows for self-direction including paying family caregivers. During the COVID-19 pandemic, the state expanded who can be paid as a caregiver to include spouses and parents of minors (Teshale et al. 2021). One rationale for this policy was to limit COVID-19 exposure, as family caregivers do not provide care to multiple clients (Ujvari et al. 2020).

Thirty states plan to use ARPA funds to support family caregivers, seven of which specifically plan to increase pay to family caregivers. Illinois plans to allow parents to serve as paid caregivers in one of its existing waivers, and Minnesota plans to increase the rates for family caregivers in an existing consumer-directed program (NASHP 2021b).

Endnotes

¹ *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).

² From October to November 2021, MACPAC conducted interviews with state officials from Arizona, Tennessee, and Washington; and representatives from the Service Employees International Union (SEIU) 775 and The Arc.

³ An estimated 1.2 million independent providers work via self-directed waiver services. These workers commonly already have a relationship with the person they support. They often lack training and employment protections (PHI 2021).



⁴ Career ladders refer to opportunities for advancement within the same career, such as being promoted to a management position or gaining a certification like CNA. Career lattices refer to moving into a similar field, such as moving from the HCBS workforce into another long-term care setting.

⁵ For self-directed plans, beneficiaries receive a budget that they use to pay their HCBS workers serving them.

⁶ Wage pass through laws can be implemented through statute or regulation.

⁷ WA ST § 74.39A.310 (2018).

⁸ New York Public Health § 3614-c (2019).

⁹ WA ST § 74.39A.310 (2018).

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