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## ***CMCS Informational Bulletin***

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**SUBJECT: Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce**

### **Introduction**

This informational bulletin highlights steps available to states, providers, and others to strengthen the home care workforce, the term used in this document to encompass individuals furnishing HCBS, consistent with advancing goals of beneficiary autonomy and self-direction of needed services.

CMS and states are taking important steps to support increased access to high-quality home and community based care. These steps are helping to remedy a longstanding imbalance between institutional and home and community-based care: data for fiscal year 2014 showed that 53 percent of total Medicaid long-term services and supports (LTSS) expenditures were spent on home and community-based services (HCBS), a marked change from 2009 when only 45 percent of LTSS expenditures were on HCBS<sup>1</sup>. To continue this progress, CMS and states have moved forward with implementing recent regulations requiring greater community integration, adopting key improvements to managed LTSS, and soliciting public comment on how best to measure access to HCBS. A stable workforce, engaged in the delivery of services and supports that address the needs and preferences of beneficiaries, is a critical element to achieving continued progress.

### **Workforce Identity**

Home care workers may be employed by an agency, such as a home health agency or personal care agency, or may be employed directly by a beneficiary under self-directed service models. Because home care workers often deliver care on site in the homes of beneficiaries receiving services, and travel from home to home independently, home care workers may interact with their professional peers infrequently, which can promote isolation and disengagement, and make professional development challenging.

Establishing an open registry of workers for public use can help strengthen the identity of the workforce and improve beneficiary awareness of available, qualified home care workers. To be most effective, the registry should include individuals who have attained any required educational or training standards (discussed more below), but states can use registries in different

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<sup>1</sup> Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014. April 15, 2016.  
<https://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html>

ways, including offering it as an option but not requiring beneficiaries to select home care workers from it. Medicaid beneficiaries should be able to access these registries not only to identify workers but to also add workers, including those who are available for service provision under self-directed service models. Self-direction is an important component of the provision of HCBS, and actions taken to promote workforce stability should also support the ability of beneficiaries to exercise autonomy in determining how service provision can best meet their needs. Registry exclusions should align with state law and policy with respect to criminal history. They should also balance safety concerns with respect for the beneficiaries' right to choose a trusted family member or friend. This is particularly relevant in evaluating what training will address the individual needs of the beneficiary, and whether existing state laws regarding previous criminal history may prevent a beneficiary from choosing a trusted family member or friend. Medicaid administrative match is available to states to help fund the development and maintenance of the registry. Guidance on administrative claiming for these functions can be found at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/qa-training-registry-costs-071015.pdf>

Professional associations or unions can also help support home care worker training and development. For example, they can offer orientation programs for new home care workers on state requirements regarding qualifications, documentation, and billing; training in new requirements or best practices for the current workforce; professional support and career ladder opportunities; peer support; and an organized way to engage in design of the state's home care system. State Medicaid Agencies may, with the consent of the individual practitioner, make a payment on behalf of the practitioner to a third party that provides benefits to the workforce such as health insurance, skills training, and other benefits customary for employees (42 CFR 447.10(g)(4)).

### *Provider Qualifications and Basic Training*

HCBS differs from medical-focused services, a fact that has long been recognized by CMS, states, and other stakeholders. Recognizing the importance of balancing program integrity and self-direction, states frequently establish broad provider qualifications for HCBS provision, although the qualifications can vary depending on the specific service being provided. For services provided primarily in the home, such as personal care services, qualifications can include possession of a valid driver's license, a minimum age threshold, and the receipt of any training required by the state. Some states require basic competency-based training content such as first aid and CPR certification, etc. But such minimum qualification requirements should not restrict the ability of beneficiaries to require individualized training on the specific ways to provide care based on their own needs and preferences. Training can be provided by professional home care associations, training organizations, public Workforce Investment Act programs, or trade unions. In many consumer directed personal care programs, much of the training can also be provided directly by the beneficiary.

### *Wage Analyses*

Access to services is critical to ensuring that individuals get the care they need to live in the community, and wage thresholds help to attract dedicated and engaged workers. CMS has issued several guidance documents articulating how access is to be monitored in both fee for service (in the November 2, 2015 final regulation entitled "Methods for Assuring Access to Covered

Medicaid Services”) and in managed care (in the May 6, 2016 final regulation entitled “Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability”). In response to a Request for Information issued on November 2, 2015, CMS is considering how to develop measures to monitor access to services, including home care, on an ongoing basis. 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. Analyses of how the home care industry relates to the larger marketplace within a state are encouraged when states establish rate-setting methodologies to providers, and when providers determine the wage structure for their employees. This includes taking into account geographic differences in wages within a state. CMS notes that joint-employer relationships addressed in the Department of Labor’s final rule, Application of the Fair Labor Standards Act to Domestic Service, 78 Fed.Reg. 60453 (Oct. 1, 2013), should be kept in mind as states determine what actions to take in the context of wage adequacy.

When developing payment rates for home care services, states should also consider business costs incurred by a provider – whether a home care agency or an individually employed worker – associated with the recruitment, skills training, and retention of qualified workers. Aside from setting appropriate rates generally for this provider group, states have the option to develop tiered rate structures that provide enhanced reimbursement for services rendered by workers who are able to serve beneficiaries with more complex needs or have other advanced skills. For example, the state of Washington used tiered reimbursement rates for personal attendant services authorized under Community First Choice based on the acuity level of the beneficiary receiving services. Similarly, a state may build into its payment rates the provider’s cost of maintaining status as a qualified Medicaid provider, attending Medicaid-specific pre-service orientations or trainings, and post-enrollment training. A provider’s costs for other benefits offered to workers, such as tuition assistance, performance-based bonus payments or higher wages for shiftwork, can also be built into the rate the state pays the provider for the service rendered. For additional information on which costs may be included in developing service rates, states may refer to 45 CFR Part 75 “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.”

#### *Related Prior Guidance*

Previous guidance on programs for home care workers has been issued as part of efforts of the National Direct Service Workforce Resource Center, created by CMS in 2006. Additional information on this topic, and others such as core competencies, can be found at the following website: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/workforce-initiative.html>. In August 2013, CMS issued a Toolkit for State Medicaid Agencies titled “Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting”. Aside from providing information on training options, the Toolkit also includes a discussion of how special features of self-directed delivery systems should be taken into account. A goal of the toolkit is to provide a foundation for recognizing and addressing the sometimes disparate needs of beneficiaries, home care workers, provider agencies, professional associations, and others. Training curricula that is developed in partnership with beneficiaries directing their own services instills an understanding of the basic values and skills needed to support these individuals.

As states increasingly turn to managed care to deliver Medicaid-funded HCBS, CMS strengthened approaches to managed long-term services and supports (MLTSS) programs and resulting beneficiary protections in the Medicaid managed care final rule. For example, specific provisions require stakeholder engagement in the design, implementation and oversight of MLTSS programs. The regulation also sets standards to evaluate the adequacy of the network for MLTSS programs and the accessibility of providers to meet the needs of MLTSS enrollees. In addition, states are reminded of their obligations under *Olmstead v. L.C.*, 527 U.S. 581 (1999) and the Americans with Disabilities Act.

States interested in learning more on these topics and to request technical assistance may contact Melissa Harris, Senior Policy Advisor in the Disabled and Elderly Health Programs Group, at [melissa.harris@cms.hhs.gov](mailto:melissa.harris@cms.hhs.gov).