December 13, 2024

Medicaid Payment Policies to Support the Home- and Community-Based Services (HCBS) Workforce

Technical Expert Panel (TEP) Findings

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Overview

- Background
- Past work
- Policy issues identified in TEP
- Next steps

HCBS Workforce

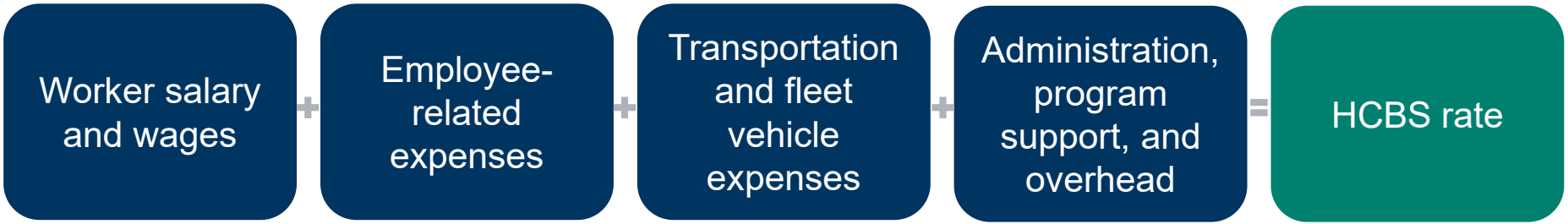
- HCBS workers include
  - Direct care workers (DCW) who assist with activities of daily living
  - Direct support professionals who assist individuals with intellectual or developmental disabilities (I/DD)
  - Independent providers employed through self-direction
- In 2023, there were approximately 3.6 million HCBS workers
  - 2.9 million home care HCBS workers (including 1.2 million employed through self-direction)
  - 0.7 million residential care aides who support individuals in group homes, assisted living, and other residential care settings
- Demand for HCBS is outpacing the growth in the HCBS workforce
  - All states report shortages in one or more HCBS settings
  - The COVID-19 pandemic has exacerbated HCBS workforce challenges

HCBS Authorities and Payment Arrangements

- HCBS is delivered under an array of Medicaid authorities, which can be combined
  - State plan authority under Section 1905(a)(24) and 1915(i), (j), and (k)
  - Section 1915(c) waivers and Section 1115 demonstration authority
- HCBS can be delivered through fee-for-service (FFS) or managed care
  - FFS: states set payment rates and pay providers directly
  - Managed care: plans can negotiate payment rates with providers unless a specific amount is required under a state directed payment
- States can also offer individuals an option to self-direct their care
  - Beneficiaries can have authority over their service budget and negotiate payment rates for self-directed services

HCBS Rate Development

- Assumptions for each rate component vary significantly based on the type of services and acuity of the population
  - HCBS providers make individual business decisions regarding how much to pay staff and what kinds of benefits and paid time off are available
  - New payment adequacy measures in the 2024 Centers for Medicare and Medicaid Services (CMS) final rule on Medicaid access establish a public reporting requirement for DCW compensation, and that 80 percent of payments for specific services cover DCW compensation



HCBS Rate Review

- HCBS rate review requirements vary by HCBS authority
  - Only HCBS programs operating through Section 1915(c) waiver authority require a specific periodicity of review (every five years)
  - CMS does not require a specific type of rate review for any HCBS authority
- **Rate studies:** comprehensive external rate evaluations that may result in changes to the underlying rate methodology
- **Indexing:** any payment rate methods that account for changes in cost over time by linking certain trend factors to payment rates
- **Rebasing:** periodic recalculation of payment rates according to new or updated data

Provider Payment Framework

Past Work on Payment Principles to Support the HCBS Workforce

Study Approach

- MACPAC contracted with Milliman to develop a compendium of Section 1915(c) waiver policies
  - The compendium was published in January 2024
- Milliman also conducted interviews with national experts and stakeholders in five states
  - The states selected use a range of authorities and delivery systems to cover HCBS and all recently conducted HCBS rate studies
  - Stakeholders included state officials, provider associations, unions, consumer representatives, and managed care plans (as applicable)

Key Findings: Compendium

- States have considerable flexibility to define HCBS services
- Rate studies are a common tool to develop and update rate assumptions, but there is variation in terms of their use and adoption
  - States vary in their frequency of rate reviews, the scope of rate studies used, and the level of public documentation provided
  - States do not always fund HCBS rates at the rates recommended by rate studies
- Many states do not regularly update HCBS payment rates
- HCBS worker wages are generally the largest component of the HCBS payment rate
  - States piece together wage assumptions through several sources including Bureau of Labor statistics (BLS) data

Key Findings: State Interviews

- Medicaid rate setting is the primary strategy that states use to address HCBS workforce challenges
- When designing and updating rates, stakeholders stressed the importance of:
  - Comprehensive, data-driven, and aligned rate assumptions
  - Regularly updating rates to account for a changing HCBS policy environment using tools like rate studies
- States also discussed the potential for non-financial strategies to promote the HCBS workforce beyond traditional FFS rate setting
  - Examples include training and credentialing programs, public campaigns, family caregivers
  - Found limited data about the effectiveness of the strategies implemented to date

TEP Findings

Study Approach

- MACPAC contracted with Milliman to conduct a TEP on HCBS payment policies
- The purpose of the TEP was to understand:
  - What payment policies states should consider when setting HCBS payment rates to promote HCBS workforce adequacy
  - The role of rate development and maintenance approaches in supporting the identified payment principles
  - The potential of payment strategies beyond rate setting and rate updates to support access to adequate HCBS workforce
- Participants included state and CMS officials, plan associations, actuaries, and consumer representatives

Comprehensive Rate Assumptions

- HCBS wage assumptions may not reflect the full scope of HCBS workers' skills and responsibilities or the time spent conducting program activities beyond the direct provision of care
- HCBS rates may not reflect beneficiaries' distinct cultural, geographic, or care needs, including:
  - The cost of translation services and culturally appropriate meals
  - Travel needed to reach rural beneficiaries
  - Variations in patient acuity
- States may use productivity adjustments, local payment rate adjustments, or code modifiers to account for non-billable activities or adjust a rate for specific costs

Aligned Rate Assumptions

- Payment rates vary across HCBS delivery models, programs, and geographic regions, as well as across the LTSS system more broadly
  - Rates for the same or similar services may vary across FFS, managed care, and self-directed models, as well as across different population-based programs
  - Wage components may also differ due to geographic variations in minimum wage laws
- Rate variations can lead HCBS workers to participate in models or programs that offer the highest wage
- States can use rate alignment or variations to incentivize adequate workforce participation according to beneficiary need

Data Challenges

- States need strong and consistent service definitions to ensure that rates are comprehensive and aligned
  - HCBS service definitions and reporting vary significantly across and within state HCBS programs
  - Stakeholders and legislatures often lack an understanding of what each service entails and how services differ from one another, which can create challenges in building or funding rates
- States need timely and accurate base data to build and maintain appropriate rates, especially when it comes to wage data
  - There is no single reliable data source for HCBS worker wages across states and HCBS
  - Wage sources include state wage data, average wages from provider surveys, provider cost reports, minimum wage levels, market rates, and stakeholder feedback
- The 2024 Medicaid access rule may improve HCBS data transparency and standardization

Setting and Updating Rates

- Rate studies are an effective tool for building adequate rates, but bring challenges including:
  - Administrative burden
  - Financial barriers to implementation
  - Unintended external effects
- Stakeholders highlighted importance of determining an appropriate periodicity for rate studies, including across HCBS services
  - Some stakeholders suggested aligning rate studies, others suggested a staggered approach
- Indexing and rebasing offer a less burdensome approach to updating rates
  - Budget constraints remain a concern
  - Rate structures may be locked in rather than allowed to evolve with changing policy environments or population needs

Payment Strategies

- Some states use wage add-ons such as one-time bonuses, stipends, and enhanced rates to supplement worker payments
- States have also begun covering technology such as remote supports to facilitate remote treatment and relieve HCBS workforce constraints
- States may also incentivize the HCBS workforce through value-based payment (VBP) approaches or state directed payments
  - HCBS programs have had little success implementing VBP approaches to date due to administrative barriers and with right-sizing payments once implemented
- Many of the payment strategies states have adopted were financed by enhanced funding provided by the American Rescue Plan Act (ARPA), which must be used by March 31, 2025
- Stakeholders have mixed opinions and limited evidence regarding the success of these strategies to date

Next Steps

Next Steps

- Staff would appreciate Commissioner feedback on how TEP findings should inform MACPAC's future work in this area, including potential policy options
  1. Should more HCBS authorities (other than those operated through Section 1915(c) waiver authority) be required to conduct regular rate reviews?
  2. Where HCBS rate reviews are required, what should they consist of? How should rate studies, indexing, and rebasing fit into rate review requirements?
  3. How can CMS help ensure HCBS payment rates and wage components reflect the full extent of HCBS worker contributions?
  4. How can CMS help states mitigate or control workforce shifting associated with lack of rate alignment? Should states or CMS support more consistent service definitions to promote rate alignment?
  5. Is there a role for CMS, Congress or the states in promoting and maintaining sufficient wage data to support HCBS rate-setting?

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