

## **Collaborating to Address HCBS Workforce Challenges in MLTSS Programs**

**Tuesday May 28, 2019**

[ Please stand by for real-time captions. ]

>> Good afternoon and thank you for joining today's webinar: Collaborating on HCBS Workforce Challenges in MLTSS Programs. I am Erica Lindquist, Senior Director of the National Association of States United for Aging and Disability (NASUAD). This webinar is presented through Business Acumen Center, a part of the Business Acumen for Disability Organizations grant managed by NASUAD and made possible by the Administration on Community Living. shortly after today's session you will find appropriate recording of this webinar, along with archives of all Disability networks and Business Acumen webinars. Times for questions and answers at the end of the presentation and please answer questions in the lower right-hand corner of the screen throughout the session. Next slide please. >> Today's presenters include Camille Dobson, Deputy Executive Director with NASUAD, as well as Yonda Snyder and Debbie Pierson, both partners for Sage Squirrel Consulting LLC. Together they will discuss recently released report they co-authored called HCBS Workforce Challenges in MLTSS Programs. This report includes descriptions of challenges and promising practices that states and health plans experience when working to address this issue. And with that I'll directly hand it over to Camille, Yolanda and Debbie.

Thank you, Erica. Good afternoon everyone. Happy to be here today to talk about the paper of that we publish at the beginning of April on addressing HCBS workforce challenges in MLTSS programs. The genesis of the paper came from our work as a part of the MLTSS institute. It was created in 2016 and as a partnership with NASUAD to provide both technical assistance to the state as they were developing and implementing the MLTSS program and also to bring together state and health plan policy leaders to think about challenges and opportunity to improve LTSS through managed care arrangement such as network adequacy and consumer engagement and those kinds of issues. And so the Advisory Council that is a part of the Institute is staffed and has members from both leading and LTSS as well as national health plan leaders and they guide our work and determine basically time of topics that we pursue each

year. The papers that we have published so far can be found at the website at the bottom of this page (<http://www.nasuad.org/intiatives/maaged-long-term-services-and-supports/resources>) as well as the NASUAD website under MLTSS. The papers that we release to date, starting in 2017 we released in May two years ago are demonstrating the value of Medicaid LTSS programs and in response to the questions we were getting from state health plans and stakeholders around the argument or the case to be made of moving LTSS services into managed care systems. Last year we returned our attention to MLTSS programs for people with Intellectual and Developmental Disabilities (I/DD) and that is a growing area of focus for states that have older adults and people with physical disabilities currently in managed care but have carved out, both with I/DD and getting waiver services, and that is the next frontier for MLTSS programs.

This year we decided to focus on workforce challenges which is affecting all states. Both specific and health plan grapple with the quality of the existing workforce as well as actually having enough workers to serve people who are getting home and community-based services. While there is, sorry I'm hearing a lot of background noise. While there is a lot written about the nature of workforce shortages there is little written to date about the opportunity that states have to partner with health plans to address those issues in MLTSS state programs. And so, we talked about the issues we grapple with or what it is that's the state's responsibility and what health plans rollout and how they work together to address those issues; how can you contract and how does language help drive that in how much health plan innovation is really making a difference in the HCBS workforce shortage.

We want to explore those questions as well as identify problems and practices both with the state and health plan perspective that might not have otherwise seen the light of day from other publications that write about workforce outreach. >> Like we do with most of our papers we develop an outline of what we want to cover of what we thought were salient issues for this topic with the Advisory Council and found a partner to cowrite the brief with as we did for the first two papers and

our partners at Sage Squirrel Consulting are both former state aging and disability experts in Indiana who both dealt with aging issues as well as waivers, and experiences in dealing with workforce shortages in Indiana, so they were, you'll hear from Debbie and Yonda later which will be the meat of the presentation and their expertise in this area is incredibly valuable- we could not have done it without them. >> We gathered whatever is currently existing research out there in including federal work and a lot about HCBS work force shortages and the paper does pull together all that information together in one place. We also needed the perspective of both states and the health plans of what it is they are working on, what their challenges were and what they thought the goals are so we did a survey of those states and health plans, and a shout out to our members who answered the survey but also to the health plan partners from the Advisory Council members [ Inaudible ] as well as MTSS Association who distributed the survey and helped us get responses back . And the resources that were used to inform the paper included as an appendix in the paper. >> We sent the survey out with the questions in December and had it in the field for about a month and a half and analyzed the information and Debbie and Yonda later did follow up emails with key respondents both with the states and the health plans and then each of the states and health plans that were highlighted in the report had an opportunity to review summary that we provided prior to publication. So really trying to set the accuracy of the data.

Just for context and I call this the growth is and MLTSS map that shows the coverage of MLTSS programs across the country. You can see that scattered along South and Southwest and the Great Plains and off the East Coast. A number of states interested in MLTSS that have not moved forward on it are Arkansas, who just recently moved to a capitated arrangement, so they are now considered a "Blue" as a current MLTSS programs which brings us to a total of 24 states. Just about half the states have some or all of the waived program and in managed care delivery system with health plans responsible for delivering the services. >> I will turn it over to Debbie and Yonda to walk through the bulk of the report findings and they will talk to you about our best practices that we identified.

Thank you, Camille. This is Yonda Snyder. One thing we want to note from the outset is the workforce challenges we will describe are actually present in all states but for the purposes of the report and today's presentation, we are highlighting and focusing on the role of MLTSS and the relationship between state and healthcare plans in addressing those challenges. So, it's not a true comprehensive review of the nature of the workforce challenges. We do want to set the stage by noting first there are extraordinary pressures right now on the direct care workforce that are creating both current and future workforce challenges. There is real growth in home and community-based services and some of that is driven by the growth in the aging population including the fact that Baby Boomers are becoming the exploding demographic and the prevalence of the need for LTSS as people age and also the fact that there has been a policy shift in recent years as states look to rebalance away from institutional care toward more utilization of home and community-based services. The aging pressures apply to the workforce itself that is aging and shrinking as that occurs. There are more job force options for workers, particularly in the booming economy. A lot of competition for the direct care workforce from employers such as retail, entry-level manufacturing, and this is a workforce that really faces some perception challenges about the value of the work and workforce as well with stagnant wages. >> We are using the term direct care worker as a shorthand because terminology is not always shared or consistent, but when we use the term "direct care worker" we're talking about the groups that encompass home health aides, CNA's, attendance personal care attendants and direct service providers for persons with intellectual and developmental disability (I/DD). In general, this is a workforce that is largely female, with a median age of 47, as we indicated and that's actually going to be increasing. Notably, there is a high prevalence of people who do this work that identify as minority and with a significant number that our persons who are immigrants to the United States. Like you said this is a stagnant wage workforce, and we will talk more about that. This is a workforce that is highly likely to receive some form of public assistance themselves. And because of the growth with home and community-based services, there are about 4.3 million direct service support workers and that includes persons who provide support in institutional

settings like nursing facilities, hospitals, and assisted living but nearly half of them are now working in home care settings. >> Because of the changing demographics, one of the most alarming numbers associated with this workforce challenge is the shrinking availability of available workers. Today there are 32 working-age adults per person who's aged 85 and over; by 2050 there will only be 12. And this is due to the fact that the number of persons aged 85 and older proportionate of the population is going to be growing rapidly between now and then, but it is also associated with an actual decrease in the number of working age adults. This has implications for both paid and unpaid caregiving and it's also going to impact the availability of caregivers for all populations. And while we focus on the number of working age adults for 85 years or older, we will see the applicability of the shortage across all populations. Next slide and now over to Debbie.

>> Good afternoon everyone. A little bit more about wages as Yonda noted, they have been stagnant in the direct care workforce for some time. This is data from PHI and we laid it out across the map, and you can access these slides later if you need to see the data closer, but this gives you the average wages for personal care attendants and we picked that category, and they do separate analyses for home health aides and CAN's as well. This was the median level and showed where states are following as of 2017 with their average wages. Naturally this is connected and considered entry-level jobs and this very connected to minimum wage and so we also took a look at minimum wage and if you go to the next slide we did this map to reflect the state in a gray color with no wage are states that are aligned to the federal minimum wage which is \$7.25 an hour and states in blue have minimum wage that are higher than the federal minimum wage. We took a look at how or what correlation there was between states with high animal wages and whether it automatically translated into higher wages for the PCA category from that last map and as you expect there was some correlation, but it was not as strong as you might think. It aligned but not perfectly. Even states with very high minimum wages, weren't necessarily seeing extreme increases with personal care aides or other direct care workers. One thing to note with minimum wages is that there are a lot of states in the last year or two, or even

18 months, that had pretty dramatic legislation pass to increase the minimum wage. This data is old enough even at 2017 data, that you have not seen the impact of some of the minimum wage increases that are happening in states and for some of them they were quite large. Arizona and Missouri also had an increase and in Arizona in particular it's not just a one-time increase but a planned alignment with the cost-of-living increase, trying to get to a particular level and I want to say it was \$16 or \$17 an hour within a 10 year period so they have some pretty dramatic steps up in minimum wage coming and not a lot of conversation that we can find yet that is happening in a lot of these states with what does it mean for Medicaid and that is the thing that distinguishes this, if you go to the next slide you can see where these wages are falling. Here you can see a little bit of an increase in the ten-year period from 2000 to 2016 in personal care, but this is very small and virtually is the same. Home health has been stagnant and you even see some decline in CNA in average wages during the 10 years and again this is pre- (before) a lot of these changes to minimum wage so you expect to see some increases from that but normal economic law, supply and demand law, it will tell you as the demand for the workers increase and as the supply of these workers decreases you ought to see more substantial increases in the wages they are paid. In this situation because of the predominant role of Medicaid and paying for these kinds of home and community-based services, laws of supply and demand simply don't apply. There really is a need to address Medicaid's role in this. >> And back to the Honda. Back to Yonda.

One of the pieces of information that we looked at closely was employee turnover. And what we present here is data from a workforce survey that is conducted through NCI that is focused on the direct service provider workforce for persons with I/DD. That data suggests an overall turnover rate of about 45% for workers in this category. Unfortunately, there is no good aggregate data about turnover for direct care workers outside of I/DD but the anecdotal information suggests similar high turnover rate, possibly even higher. Turnover is actually very expensive. In the initial research, we had data from PHI that noted that on average it cost about \$2200 to recruit and hire a new worker. That data does not count the

actually less quantifiable cost associated with high rates of turnover. There is a 2016 study by NCORE that states that vacancies can cost agencies between \$4200 and \$5200 in a combination of direct cost and indirect cost. The direct cost includes things like training every new employee, time and expenditures associated with recruiting. Indirect costs include things like reduced productivity and loss of client revenue. And when you add those numbers up over high rates of turnover, it does get quite costly and turnover is frequent. 56% from the same study, we learned that 56% of direct service providers leave their employment within one year and roughly 35% do so within 6 months. The turnover measure is generally regarded as a measure of workforce stability and so it does reflect the perception and validates the perception that this is a less stable workforce facing high levels of competition with other lower wage occupations including retail and restaurants in which the work may be perceived as easier. >> What is notable here is that this is a field showing very high job growth due in large part to the growth of home and community-based services. Between now and 2024, direct care is the fastest-growing segment in workforce. The Bureau of Labor Statistics data suggest that direct care workforce will be larger than any other single occupation by the year 2026 although the data is not limited just to home and community-based settings. There's recent data from PHI that really provided startling numbers and new methodology in the Bureau of Labor Statistics at which they can project actual separation data better than they can projecting not just people who are leaving the workforce entirely people who are leaving one industry and moving to another. And when they factor that data in to the direct care workforce, what they identified was that between 2016 and 2026, there will actually be 7.8 million positions that need to be filled. This includes the creation 1.4 million new positions because of the increase in demand but also its 6.4 million positions that are opening up because of turnover and not quite half of that turnover are people who are going to continue to work but leaving the industry for other types of work. Those numbers do support the fact that there is a workforce shortage and it will be approaching crisis situations. >> So now I will hand it back to Debbie to talk a little more about what this means in LTSS. >> In the paper we focused on workforce issues in MLTSS

through four different lenses and I will go back to what Yonda said that these workforce issues are not unique to MLTSS systems and they really, the issues are all the same whether in fee-for-service or MLTSS, there's just different available partnerships of how you may be able to address them. These are issues that even if you are not in MLTSS state, they have relevance for you and in the three areas we focused on were: Network Adequacy, Rates and Reimbursement, and Quality. >>

Network adequacy is an insurance that states make to CMS that there is an adequate supply of providers for the services they offer and that is an assurance that is made again whether its MLTSS system or regular 1915 (c) waiver. You make these same assurances and there's a variety of different measures that states use. A lot of them really come from the primary care side of MLTSS systems that there be a certain choice of providers that participants are not relegated to one particular position or to another provider and so they look at things like travel- distance traveled, time measures, enough positions or specialist within a certain area that people can get to as well as service initiation time.

One thing we found in speaking with states and health plans are universal agreements that these measures just don't work that well for home and community-based services. They're not great measures of real network adequacy and access to services. Pretty universally most stakeholders prefer what's called a "gap in service" measure that require tracking and reporting instances where authorized services are not provided on particular dates or not at all and how frequently that happens and that's really the best measure so in other words looking at what a person is authorized to get versus with they actually get in terms of their home and community-based services it is the best measure of "do you have an adequate network to provide these services." That is a difficult thing to measure for a lot of states and most states indicated they were starting to track that and measure it, but they were not using it as a network adequacy measure yet. So good find in the sense to measure and track and not a great find that it's not considered a good enough measure yet and they don't have confidence and how it's being measured to make it one of the network adequacy requirements.

When states or health plans said they had network adequacy measures around gaps in service, usually it was centered on service initiation time so how long did it take a provider to get someone out to a home to start with? It is a good measure and you want to start services timely but there was no measurement to pick up what happens after that. You can get focused on 'yes we can get things started quickly and get out and initiate services and get care plans all in place' but then the really important thing is what happens after that. >> This is a diagram that was part of a CMS toolkit a couple years ago. It really goes further than just the term network adequacy to say CMS is concerned that people have access to services and so that is bigger than just the number of providers in a particular area but are they really available and accessible and can they accommodate different population types and needs and are they acceptable and affordable to people? This is just a diagram that does a good job of showing that CMS is concerned here that people truly have realized access to services. >> The second area we looked at was rates and reimbursement. This again is an area so driven by Medicaid and most home and community-based services are reimbursed through Medicaid rather than private pay or other insurance even in managed long-term care which is still Medicaid money and often even in the MLTSS system still working under fee-for-service schedule that came from Medicaid pre- MLTSS. Anyway, this is a tough area when we look at partnerships and how everyone works together on this, a lot of this really does fall to the state to have policies around rates in reimbursement. We talked earlier about the number of states that are taking one of these macro level steps of raising minimum wage or even indexing those minimum wages to inflation and others in a few states that have living wage laws that really tie back to how they set minimum wage, they are great but if you don't couple that with reimbursement strategies and ways to align Medicaid rates to that, it really pushes things downhill and puts extraordinary pressure on providers that now have minimum wage requirements that they have to meet but the rate they are being paid for service may not change at all. That was something we heard states talking about and we mentioned Arizona earlier and they are a state that was looking in depth at that and had consultants coming in to prepare a report for them on what the real impact was. We were at a

conference a couple months ago where Texas was talking about this and how even a fairly modest minimum wage increase could have a tremendous impact on the Medicaid budget. This really is a struggle to how you align these things. CMS is outlining strategies for states to use when they look at reimbursement, because the other issue is you can increase your Medicaid rates and it doesn't necessarily mean it translates into wage increase for the direct service workers. Where states are trying to do rate increases to either align with minimum wage or make these jobs more attractive for a limited pool of workers, they want to know whatever the increase they put into the rate that it gets through to the direct service workers and there's a few strategies listed here. Wage pass-throughs are one way to do that where they say here is money and I think we talked about Wisconsin in the report and their heavy investment of dollars and I think it was \$30 million a year for a two-year period that they were giving to direct service providers and asking them to pass through to the direct care workers. The caution with those is when it is not a real long-term strategy with guaranteed increases to rates, providers are reluctant to use that money to increase wages. They will tend to do one-time bonuses or other kinds of training opportunities because if they increase the wages and legislatures then decide "Well I'm not giving you that money anymore" then they are in a difficult position.

So, wage factors can be really effective but there is that caution with that. States can also set wage floors. When they increase rates for home and community-based service that use direct service workers, that there is a minimum floor the providers have to meet for wages. And similar to that they can have a minimum percentage of service rates that are directed to direct labor cost. And then we touched just very briefly on value-based purchasing and that trend paying for outcomes. We have seen a lot of that in employment services in particular. And there is a potential to use that as a way to reward direct service workers more directly. That is one option for looking at rate and reimbursement alignment. Go ahead to the next slide. >> This is the third lens that we looked at these issues through looking at quality. Investing in the quality of the direct service workforce can lead to two particular outcomes and one of those is improving the recruitment and retention

rate. And that happens as you dispel the perception that these are dead-end low value jobs and as you start to create career-ladders and other opportunities to be used for direct service workers - you enhance the value proposition with the service. The other outcome is improving outcomes and quality for the person served by improving the skills of the workforce that is providing services to them and it is a couple of win-win's for everyone to focus on these quality areas. As we look at these best practices between health plans and states, these quality areas are the ones where we saw the most partnerships and innovation happening. That is the big plus for MLTSS is that you can start to bring the health plan in as a partner, the state can partner with them, and with their education systems, to create different kinds of educational opportunities and skill development and career-ladders for individuals entering the direct care workforce to help them move through that. Mentoring and worker engagement were also areas that a number of plans were focusing on. It just seemed like these were great areas where you had partnerships that could have partnerships that could develop between providers, education, health plans, and states with everyone getting into the game to help develop quality. That was an easier area for partnerships to develop than to say rates in reimbursement. >> Next slide. In the report we highlighted some specific states and their promising practices but some general things that states and health plans are starting to experiment with, one is more support for unpaid caregivers to bring them into the picture and that goes with the fourth bullet point there with increased use of family and friends as paid caregivers often through a consumer directed care program. No one saw that as a solution to workforce issues but it certainly helps to pull some people in to the workforce who might not otherwise be there if they didn't have a loved one they were caring for ; they weren't someone who was going to go seek out work as a direct care worker but because they had a family member they were caring for, they could be pulled into that workforce to help cover a gap there and maybe find that they work. Some states have programs where they then try to recruit people in to making that more of a full-time career in caring for other people than just caring for their family members. Even just supporting unpaid caregivers, they have been the heroes of home and committee-based

services as well that's why HCBS is less expensive and so you keep those family and community supports in place while the person remains in the community and there is a lot of added value from that. Finding ways to support those caregivers is important. The use of technology can be significant. Whether it is assistive devices that help make people more self-reliant in getting around and their mobility, I think it is a PHI article that said you won't have robots or technology that will be able to bathe and dress someone, there's limits to what technology can do but there are lots of good uses is that can help make the job easier whether it's communication tools to help workers stay engaged when they are working remotely and out of your office. Or EBV systems which are now becoming a requirement for providers to use and there's lots of potential there to use technology in a powerful way to help track those gaps in service kinds of measures and again to improve communication, so everyone is working in a coordinated fashion to provide care. And other states and health plans and education and provider associations that are working to expand the workforce with nontraditional workers. Nontraditional workers, earlier we mentioned this is a workforce that is heavily female. So, it's 'How do we attract more men into this profession and veterans? Older workers?' And there's been a lot of look at background checks and how flexible states and health plans can or should be with allowing people with criminal history to participate in the workforce. It's a tough area because it is a really vulnerable population that is being cared for. But, that is part of the innovation of trying to figure out where we get these workers from. >> Next slide, I'll hand it back to Yonda. One of the things that we thought is that working from good data is a challenge for all players in the system whether it is the states and health plans and providers. And identifying and using data effectively is a significant challenge. We thought it was noteworthy that the results from the state survey, we found 67% rely on anecdotal information as one of their primary data sources. And we would note as well, that many provider agencies often don't have a good handle on their own data. Tennessee was focusing on this with the creation of a learning collaborative where they were partnering with an initial set of providers to assist with TA and workforce metrics and then identifying business practices that can help improve those metrics and relying on that

provider network to then disseminate those practices which was really promising. Some of this lack of knowledge may be related to a reduced business acumen but some is built into culture and a lack of overall knowledge and awareness of what can and should be measured and why those measures matter. It has been very difficult to aggregate data across health plans or across the state. And this can lead to parties talking past each other a bit. In fact it was very hard to quantify the shortage itself and one thing we saw clearly is, that the people who felt the shortage the most acutely were the providers who were looking to the health plans and states for support and in many cases the states and health plans did not necessarily see the data and information that led them to believe that there was a problem. >> You can see that this not a new problem. There have been warnings of workforce challenges for at least 15 years now by federal agencies that are all involved in funding these programs.

And central to effective workforce planning, is the collection and utilization of workforce related data and CMS has been suggesting for several years that a minimum data set, be identified and developed and tracked but to date those efforts have not been made. That is one of the reasons why it's so difficult to quantify the shortage. There is very little consensus about what measures to use to project needs and determine adequacy of the available workforce and in fact when we worked on the paper we looked at a number of different sources and they all used different measures, different time frames, and different worker groups. And that exacerbated the problem. HRSA is the federal agency that is really taxed with measuring and the challenges associated with workforce and in 2016 , the GAO issued a report that really sent HRSA "Hey, you're not doing this very well" and in 2018, HRSA came out with their most recent report on the direct care workforce, and still noted that while demand can be measured, the challenges is in quantifying the supply of available workers made quantifying the nature of the shortage difficult and just simply there were too many variables for them to measure. In addition to the funding agencies, other organizations have been talking about this for many years. PHI, NCORE, Leading Age, and AARP and health plans have produced and issued papers in this area as well. And if we can go on to the next slide.>> You can see there really are overlapping

responsibilities. States, providers, and the health plans have real shared interest in measuring and addressing workforce challenges.

It's not always evident who is responsible for what and can result in confusion and sometimes the potential for conflict. And that is probably a major take away in the paper which is that in order for this collaboration to be effective, roles and responsibilities have to be clear using the different contractual and waiver document vehicles and everyone has to be using good information.

Now over to Debbie and go on to the next slide. >> We don't spend a whole lot of time in the paper looking specifically at the role of providers. But we touch on that and again they are of valuable partners to health plans and states and it will take everyone working together and doing their part. What does this mean for providers and what can you do? You can advocate strategically and focus on what you can control. And providers very often, whether it is earned or not, or seen at the state and health plan level as largely advocating for just increases in rates. Sometimes this is for very good reasons. Sometimes rates that are out of alignment and need some increases. But don't always focus on rates because rates overall are not going to solve the problem. For one, there's not an endless supply of money and in some cases though it's not even all about the money. You can reach a minimum acceptable level of salaries and still have trouble attracting people into this workforce. There are other practices and systemic changes that are of value in workforce development that you may want to advocate for and be sure you participate in. Many states formed taskforces and working groups around these issues to either raise awareness or help create new innovative approaches whether it's in a MLTSS state using a health plan as a partner as well or even just between the state and providers in a fee-for-service. But if those things are happening in your state, you should advocate for them and making sure you focus on your own internal operation is also important and being efficient and effective in how you run your business. Know your numbers. Know what the turnover rate is and what the vacancy rate is. Manage the time to hire and make sure you focus on good recruiting and retention practices within your own organization. Learn to identify and sell your value propositions. These are again jobs that have a core value perception and so all of the players have to work

together to make sure people understand how rewarding this work can be and making sure you recruit people who are drawn to that. That want to make a difference. And lastly, embracing those person-centered practices that we talk a lot about in terms of consumers and participants in the program, but using those same values for worker centered supervision and being person-centered when it comes to individual direct service workers. You can add to their engagement and that leads to better retention and better recruitment too also because people are seeing increased value in these jobs.

>> And the next slide has some resources on it for recruitment toolkit items and other competencies to help train supervisors and these are all publicly available resources. They are easy to access and many of you are a member of trade associations that some states have unions representing direct service workers and these are all great resources and partners to help address these workforce issues across the board. Those are a few resources we want to share, and I think we'll hand it back over to Erica with the next slide and see if we have any questions.

Excellent, thank you all, thank you. There are questions coming in, so you can enter them in the Q & A box on the lower right hand corner of the screen and we will start with what we have in the system already and one is "Did you compare turnover rates prior and after DLL 40 hour rule? And does companion care have an impact?"

We did not make that comparison. That would be an interesting one to look at. The NCI workforce study is fairly new and so I'm not sure that we can get data that could really reflect that but that would be an interesting thing to look at.

Another is a little bit more opinion based but "Do you think that it would be possible for Congress to look again at the Direct Support Professional Caregiver Act and fund the gap in unfunded minimum wage laws while holding the states that has passed HCBS reimbursement to direct support professional staff? >> I would love to hear what Camille would say there because I think she is closer to that level.

We don't typically comment on legislation. In any opportunity for the federal government to send the state more money, to address workforce issues, we would be in support of. I would say that more broadly. As you know states have significant budget constraint in Medicaid in general. People like don't the fact that Medicaid takes up more and more of the state general fund budget. There's always a continued pressure that states have to address and many of which are outside of the state's control. As Yonda said, the low value perception of direct care workers and the fact that Medicaid is one of the only payers for these services and there's no affordable market. But there is a lot of competing priorities that states have to make choices and sadly, on the other thing was economic aspect to approve and recruit direct support care professionals in employment and it's not just about the money, there are other factors, but we are in favor of any opportunities for the federal government to recognize the need for professional funding for HCBS. >> We have a couple questions targeting the research that is out there and one is "Are you following research on direct care workers dissatisfaction with the assistive / transfer aides available for home health?" >> I think we need some clarification. Not sure what that means.

There is a specific site here and maybe we can move past. >> Another one is "Are you considering the recommendations coming out of the National Occupational Research Council and include homecare as an important future focus?" >> I don't think we saw that directly but it would be a good thing to- this is one we commented on before, this is sort of a silent crisis I mean when you look at the numbers they are very scary but we are not hearing national conversations about some of this yet. Anything that drew attention to that is a very good thing. >> Here's another, "Do you have any recommended best practices to include worker engagement?" >> I think the materials that the University of Minnesota, that we highlighted at the end of the presentation, those are designed specifically for the workforce that provide services to people with intellectual and developmental disabilities (I/DD). In reality a lot of those are pretty universal practices. And I would certainly direct people there. But it is about aligning your recruitment practices to find the workers who run

the best fit. And managing them and engaging them at their highest level. The development of job enrichment and job enhancement are ways to add and emphasize that valued perception of this work that retail and restaurant work may be perceived in many ways as easier. It's certainly not as life-changing as this work can be but even in life-changing work if we look at [inaudible] it does not promote your ability to impact lives. It will contribute to higher levels of turnover.

The paper focuses much on the provider level efforts around employee engagement. One of the benefits of MLTSS is to move towards better care coordination and better moving in even when we talk about social determinants of health, who better to advise the health plan on what is happening on the ground with their members than their direct service workers that are right on the front line. Starting to involve them more directly in the care team, and have their input in the process, it does a lot to engage those workers and change that value perception so there's lots of benefits to both the employee engagement and also through the outcomes of consumers as you start to engage direct service workers in that care coordination process. >> Thank you. Alright another question, "What our options for providing pay or incentives to unpaid family members to compensate for care hours and or expenses. The National Family Caregiver Support Program states that they do not currently allow primary caregivers to receive pay, only education and limited group services. Are their options?">> That varies depending on the state you are in. It has to be spelled out in the state programs. In the report, we highlight Washington state and innovative new waivers that they have put in place to support caregivers even in what I'll call "Pre-Medicaid" situations where individuals may not be yet eligible for Medicaid services but Medicaid dollars can be used help support caregivers and avoid that decline even financial decline into Medicaid eligibility or activities in daily living and their actual care condition levels decline into nursing facility level care that then make them eligible. Washington has programs that way but a number of states do consumer directed care programs or what is called structured family care. And it provides support in the form of nursing visits or nursing support through again a great use of technology is virtual support from nurses and social workers

to help family members address situations that they are dealing with as well as providing them with daily stipend to help offset some of their care. >> "Can you share specific examples where the success in setting wage floors?"

The short answer is no. We did not uncover any particular state or health plan situations where they had made significant changes to their reimbursement or the pass-through setting wage floors that had an obvious demonstratable impact to direct care wages and some of that may be because a lot of these things are new innovations in the last couple years just like the minimum wage increase and we don't yet have data that is showing what the impact might be. >> The last question, "With so many caregivers being foreign-born, are you seeing impacts on the reduction of immigration or decrease in deportation stemming from immigration policies?"

I don't think we have data that would demonstrate that real clearly. I don't think it... It should be part of the discussion.

Definitely cited as a concern. That is the issue and I don't know if it as been demonstrated yet. We will start to see it as... it's policy. >> Part of the reason is a lot of that immigrant workforce, many of them are working in the gray market that's not well captured and the data that we look at which is the paid workforce through agencies and Medicaid programs. Also there are a large proportion of people who are not native-born who are working in the group that may be covered more as unpaid caregivers because they're not reflected in the labor statistics. >> Thank you. That does put us at times so thank you again the three of you and for everyone . The webinar slides and programming will be available at [www.hcbsbusinessacumen.org](http://www.hcbsbusinessacumen.org) along with the rest of the webinar archive. Thank you so much for joining us today and look forward to talking with you again in June.

Thank you.

[ Event Concluded ] >>