Patti Killingsworth Testimony to the House Energy and Commerce Subcommittee Hearing

Supporting Access to Long-Term Services and Supports:
An Examination of the Impacts of Proposed Regulations on Workforce and Access to Care

October 25, 2023

Summary of Major Points

1. The national shortage of workers to deliver the assistance individuals need is the greatest challenge facing LTSS programs, those they serve, and those who administer them.
2. The direct care workforce that supports individuals receiving LTSS is a common one, with home health and personal care aides working across long-term services and settings to deliver care.
3. Policy decisions relative to care in an institutional setting cannot be made without due consideration of the impact of such policies on the much larger number of people receiving (or waiting to receive) HCBS. CMS should not perpetuate and even exacerbate longstanding institutional biases in the Medicaid statute through workforce policies that drive a greater share of a limited direct care workforce as well as LTSS expenditures away from community and to the institutional setting.
4. The pass-through % for HCBS payments, while well-intentioned, has fundamental flaws and will not assure that the Medicaid payment is adequate—including the payment to the direct care worker.
5. We need a more thoughtful, data-driven approach that seeks to understand what constitutes an adequate payment for these services, how it should be appropriately allocated between the wages of direct care workers and other essential indirect employer and agency costs, and how this can be accomplished across long-term services and settings in a way that does not favor institutional care over HCBS, but assures equitable access to care for Americans in the setting of their choice.
6. Key elements of a comprehensive LTSS Direct Support Workforce strategy include:
   - Uniform federal minimum training requirements with demonstration of competency for all direct workforce categories (nursing home and HCBS);
   - Career pathways across public secondary schools (to support recruitment) and post-secondary institutions (to support retention);
   - Expanded scope of practice to encompass medication administration and performance of routine health care tasks (elevating the role with commensurate increases in pay and focusing an also limited RN workforce on the more complex skilled nursing functions);
   - A common approach (for both nursing homes and HCBS) to ensure the adequacy of Medicaid funding and payment to the direct care workforce, including:
     - Transparent, accountable reporting of Medicaid LTSS payments and costs that will enable a complete understanding of Medicaid payment adequacy for these services;
     - A data-informed approach to assuring payment adequacy based on analysis of a minimum of 2 years of actual Medicaid payments and costs;
     - A consistent policy approach across Medicaid Nursing Facility and all HCBS programs, providers, and populations (which share a common workforce and workforce challenges); and
     - Enhanced FFP for state investments in increased payments to direct care workers delivering services in more cost-effective HCBS settings (to promote continued rebalancing of Medicaid payments for HCBS relative to institutional care and to achieve a more equitable balance in the wages paid to the direct care workforce across setting types).
7. We must also look beyond workforce solutions to person-centered approaches that prioritize and support independence and optimize the use of limited workforce resources through the expanded use of assistive technology and other alternative support options.

Dear Honorable Chair of the House Energy and Commerce Committee Cathy McMorris Rodgers, Honorable Chair of the Subcommittee on Health Chair Brett Guthrie, and distinguished members of the Committee:

My name is Patti Killingsworth. I am a career public servant with more than 25 years of State Medicaid experience, the vast majority in Long-Term Services and Supports (LTSS)—most recently as the longstanding Assistant Commissioner and Chief of LTSS for TennCare, the Medicaid Agency in Tennessee. I am a former Medicaid beneficiary and lifelong family caregiver for my son (who had lifelong disabilities and special health care needs), parents, step-parent, grandparents, and parents in-law. I currently serve as the Chief Strategy Officer for CareBridge, a value-based healthcare company dedicated to supporting Medicaid and dual eligible beneficiaries receiving HCBS to maximize their health, independence, and quality of life. I am also a newly appointed Commissioner to the Medicaid and CHIP Payment and Access Commission. I respectfully submit this testimony not as a representative or on behalf of any agency or organization, but based on my personal and professional experience in Medicaid LTSS and my commitment to older adults and people with disabilities and their families, as well as the states, health plans, and providers who serve them.

Overview and Implications of National Workforce Shortage

The national shortage of workers to deliver the assistance individuals need is the greatest challenge facing LTSS programs, those they serve, and those who administer them. In a recent Kaiser Family Foundation survey of state officials administering Medicaid HCBS programs in all 50 states and DC, all respondents affirmed the shortage of direct care workers in their respective states.[1] Increased demand for LTSS—due in part to an aging population combined with greater longevity for people with

[1] Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey | KFF (https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/)

disabilities, is outpacing the workforce supply. Nearly 9.3 million total direct care jobs will need to be filled between 2021 and 2031.[2] Yet, during the same period that Americans aged 65 and over (the population most likely to need LTSS) will almost double, from 49.2 to 94.7 million, the population of adults aged 18 to 64 (the group most likely to provide direct care) will remain relatively constant. There are no longer enough people to deliver all the support and assistance older adults and people with disabilities need.[3]

Challenges recruiting and retaining a stable workforce to deliver HCBS is a longstanding problem—dating back decades. Contributing factors include low wages, few (if any) benefits, poor quality training, and lack of advancement opportunities. The COVID-19 public health emergency exacerbated workforce challenges, leading to even higher vacancy and turnover rates. This results in even more significant gaps in capacity to deliver needed HCBS to those already enrolled in HCBS programs and necessarily inhibits expansion of HCBS to the more than 650,000 individuals on HCBS waiting lists. The negative impact extends beyond those who need care and their families, affecting providers (increased overtime and turnover costs), Medicaid health plans (challenges with network adequacy and timely service delivery), and states.

For individuals living in nursing homes, where a single caregiver is responsible for assistance to multiple individuals living in the same facility, the impact of workforce shortages is multiplied. Analyses of CMS Payroll Based Journal data from nursing homes found that a single worker supports on average 12 residents, with some workers supporting significantly more.[4] Workforce shortages in nursing homes

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[2] https://www.phinational.org/policy-research/key-facts-faq/

[3] U.S. Census Bureau. 2017. 2017 National Population Projections Datasets, Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2016 to 2060. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html; analysis by PHI (July 2020), Direct Care Workers in the United States: Key Facts - PHI (phinational.org) (https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-3/)

[4] US-Nursing-Assistants-2019-PHI.pdf (phinational.org) (https://www.phinational.org/wp-content/uploads/2019/08/US-Nursing-Assistants-2019-PHI.pdf)

thus affect multiple residents, depriving them of timely access to support and assistance for basic daily needs, including nutrition, hydration, toileting, bathing and dressing, safe transfers, and mobility. The COVID-19 PHE shined a bright light on the perils of congregate living, with disproportionately high case and death rates across many of America's nursing homes.

The Need for a Comprehensive LSSS Workforce Policy Strategy

Perpetuating Institutional Biases

While quality of care is critically important for the more than one million Americans receiving nursing home care, and Congress and the Centers for Medicare and Medicaid Services (CMS) can and should take policy actions to ensure the adequacy *as well as the quality* of staff delivering care in these facilities, policy decisions relative to care in an institutional setting (including minimum staffing standards) cannot be made without due consideration of the impact of such policies on the much larger number of people receiving (or waiting to receive) HCBS.

The direct care workforce that supports individuals receiving LTSS is a common one, with home health and personal care aides working across long-term services and settings to deliver care.[5] Given that nursing homes (along with assisted living facilities) already offer the highest average hourly wage for direct care workers,[6] minimum staffing standards for nursing homes will likely draw additional workers from an already severely strained community-based system. At the same time, the proposed rule is expected to drive increases costs of Nursing Facility care for Medicaid-covered residents by $26.9 billion over 10 years, undermining states' efforts to rebalance the relative share of expenditures for HCBS versus institutional care in their LTSS systems.

There are longstanding biases in the Medicaid statute that favor institutional over community-based care that Congress should address. Medicaid Nursing Facility services are a mandatory benefit while

[5] Home Health and Personal Care Aides (bls.gov) (https://www.bls.gov/oes/current/oes311120.htm#ind)
[6] See footnote 5 above.

HCBS are optional. Freedom of choice of LTSS settings defaults to the more expensive institutional benefit. And Federal Financial Participation covers room and board in a nursing home, but is strictly prohibited for such purposes when an individual, even living far below federal poverty level, resides in the community. CMS should be careful to not perpetuate and even exacerbate these institutional biases through workforce policies that drive a greater share of a limited direct care workforce and Medicaid LTSS expenditures away from community and to the institutional setting.

Shortcomings in the 80 Percent Pass-through Requirement

As a separate strategy, CMS proposes to require that at least 80% of all Medicaid payments for homemaker, home health aide, and personal care services go to compensation for direct care workers (DCWs) (pass-through requirement). CMS further proposes a complicated structure by which States must annually report on the percentage of payments that are spent on compensation for direct care workers. It is a policy that is well-intentioned, but has fundamental flaws as well as unintended consequences.

CMS reports in the NPRM that the 80% proposal is based on feedback from States that implemented wage pass-through requirements as part of targeted rate increases for certain HCBS under section 9817 of the ARPA. An important distinction is that ARPA funds were used primarily (if not exclusively) by States for targeted rate *increases* on top of an existing Medicaid reimbursement structure that was designed to account for the administrative costs incurred by agencies (beyond the cost of frontline DCWs). To my knowledge, an analysis has not been completed to determine if the same threshold could reasonably be applied across the totality of the Medicaid payment. Moreover, a pass-through approach necessitates an extraordinarily burdensome reporting structure to ensure that the specified percentage of the Medicaid payment is indeed passed through, but still fails to ensure that the intended outcome of Medicaid payment adequacy is achieved.

A pass-through percentage will not assure that the Medicaid payment is adequate—including the payment to the direct care worker. It will simply ensure that a uniform percentage of the Medicaid payment is passed through. We need a more thoughtful, data-driven approach that seeks to understand what constitutes an adequate payment for these services, how it should be appropriately allocated between the wages of direct care workers and other essential indirect employer and agency costs, and how this can be accomplished across long-term services and settings in a way that does not favor institutional care over HCBS, but assures equitable access to care for Americans in the setting of their choice.

Key Elements of a Comprehensive LTSS Direct Support Workforce Strategy

Pay is one of a set of key elements of a comprehensive LTSS Direct Support Workforce Strategy. Using evidence-informed and best practice approaches, the strategy should include:

- Uniform federal minimum training requirements with demonstration of competency for all direct workforce categories (nursing home and HCBS);
- Career pathways across public secondary schools (to support recruitment) and post-secondary institutions (to support retention);
- Expanded scope of practice to encompass medication administration and performance of routine health care tasks (elevating the role with commensurate increases in pay and focusing an also limited RN workforce on the more complex skilled nursing functions);
- A common approach (for both nursing homes and HCBS) to ensure the adequacy of Medicaid funding and payment to the direct care workforce, including:
    - Transparent, accountable reporting of Medicaid LTSS payments and costs (nursing home and HCBS) that will enable a complete understanding of Medicaid payment adequacy for these services—this would require that CMS develop and disseminate a standard cost-report

template, along with guidelines for reporting and technical assistance opportunities for the often small and relatively unsophisticated entities that are providing these services;

- A data-informed approach to assuring payment adequacy based on analysis of a minimum of 2 years of actual Medicaid payments and costs;
- A consistent policy approach across Medicaid Nursing Facility and all HCBS programs, providers, and populations (which share a common workforce and workforce challenges); and
- Enhanced FFP for state investments in increased payments to direct care workers delivering services in more cost-effective HCBS settings (to promote continued rebalancing of Medicaid payments for HCBS relative to institutional care and to achieve a more equitable balance in the wages paid to the direct care workforce across setting types).

The Critical Importance of Alternative Services and Supports

At the same time, we must recognize that given the demographics of an aging population, i.e., an ever-widening gap between the number of people who will need LTSS and the younger generations who could be employed to deliver them, this overwhelming challenge will not be solved by efforts to increase the supply of the home care workforce through adequate Medicaid reimbursement alone. While taking reasoned and data-driven and evidence-informed approaches to increase the supply and quality of the DCW, we must also look beyond workforce solutions to person-centered approaches that prioritize and support independence and optimize the use of limited workforce resources.

Assistive technology represents a critically underused resource in supporting older adults and people with disabilities living in the community. A recent study found that "unmet need for HCBS is consistently and significantly associated with poor health and community living outcomes among Medicaid users," with the highest percentage of unmet need (54%) being from a lack of assistive technology.[7] Providing

[7] Chong N, Akobirshoev I, Caldwell J, Kaye HS, Mitra M. *The relationship between unmet need for home and community-based services and health and community living outcomes. Disabil Health J.* 2022 Apr;15(2):101222. doi: 10.1016/j.dhjo.2021.101222. Epub 2021 Oct 9. PMID: 34657829.

simple, low-cost assistive devices that enable an older adult to resume independent bathing, dressing, or toileting can restore lost privacy and dignity. Remote job coaching can empower an adult with intellectual disabilities to work more independently and confidently alongside his or her peers, knowing that direction and support is available if needed.

Independence First is an approach to the delivery of Medicaid LTSS that begins with a commitment to supporting people in ways that will empower them to have as much independence and autonomy in their own lives as possible. Congress should embed throughout all applicable sections of the Medicaid statute an overarching goal and default expectation that Medicaid LTSS should maximize independence in the most integrated setting appropriate. It should be our expectation for the people we serve and our expectation for ourselves in how we support them.

Independence is the goal; technology is the method—at least a big part of it in terms of helping achieve the goal. When planning and delivering services and supports, a *Technology First* approach seeks ***first*** to identify opportunities to leverage an ever-evolving continuum of technology options—from the very simple to the very complex—that can empower people to be more independent in their daily lives: at home, at work and in their communities. Examples range from durable medical equipment (e.g., a tub transfer bench or toilet safety frame) to simple assistive devices such as bathing and dressing aids that increase independence to perform daily living activities (e.g., a long-handled shower nozzle or sponge to help with showering or a sock aid to get dressed in the morning). It can also include newer technologies like electronic pillboxes and wearable medical alert devices (including fall detection devices) as well as virtual reality options to help prepare individuals for employment and tele-video support from staff in a remote location who can assist when needed on the job or at home.

An *Independence First* or *Technology First* approach does not mean that people will not need or receive in-person support any more, but it means we will look *first* for ways to empower them with alternative supports, using in-person supports to fill care gaps when needed. Having access to technology solutions

allows people more consistent access to the supports they need, improves their quality of life, helps use a limited workforce more efficiently so that more people can access needed services, and as a side-benefit, is more cost-efficient and sustainable.

As we begin to expect independence, it will impact everything we do. We must change the way we assess individuals' strengths and needs, develop service plans, and deliver services while ensuring a person-centered approach remains central. Instead of identifying deficits in activities of daily living or instrumental activities of daily living and then authorizing paid in-person supports to perform each of those activities for the person, we seek to understand a person's current level of independence in performing each of those activities, the challenges they face with independence in each area, the potential safety risks, and their own personal goals for independence. As part of person-centered planning, we then seek to help them accomplish their own personalized independence goals by identifying the best technology solutions as well as other alternative services that will empower as much independence for them as possible.

We must offer benefits that support independence. Medicaid benefits should be structured and/or health plans (in managed Medicaid programs) should have flexibility to ensure streamlined access to technology and other alternative services that increase independence and inclusion and offer a more effective and cost-efficient way of meeting individuals' needs. State and contracted health plans should simplify and expedite approval processes for personalized assistive technologies that support independence and integration, especially if they can lower costs compared to the alternative.

LTSS quality systems must focus on the outcomes that matter most to people, including employment, independence, and inclusion. Independence and other meaningful quality outcome measures should drive oversight, evaluation, and quality improvement processes across HCBS programs. Quality data should be publicly reported, available and understandable to individuals and their families to guide their selection of high value health plans and providers.

Finally, Medicaid payment for HCBS must be modernized to ensure it pays for what we say we value – independence, employment, inclusion, and community living – and not just for the delivery of more services. Under value-based payment, HCBS providers would have an incentive to deliver services that maximize independence instead of billable hours. CMS should strongly encourage states to contract with health plans and providers that are willing to accept financial responsibility for outcomes including independence, employment, and integration for people with disabilities. Program evaluations should measure the extent to which the transition to value-based payment improves independence and integrated community living.

It will take time for the HCBS system to embrace an independence first approach. But with 1 in 5 U.S. citizens reaching retirement age[8] within the next seven years and the U.S. having the highest number of individuals in its history over age 85,[9] time is running out. We must start now to rebuild a system where independence and community integration is prioritized, supported, valued, and rewarded.

Technology will never replace the high-value, in-person care that many individuals need. A comprehensive data-driven workforce solution remains critical. At the same time, however, increasing the use of assistive technology and other alternative services can lessen the strain on both human and financial resources. For many older adults and people with disabilities, it offers a significant opportunity to help ensure reliable access to assistance they need to live safe, meaningful lives in the community with increased independence and improved quality of life. And in a world where the gap between workforce demand and supply is growing, it may well be the difference between living in an institution or living with a level of independence in the community that makes life worth living.

[8] https://www.census.gov/library/stories/2018/03/graying-america.html
[9] https://www2.census.gov/library/publications/decennial/2020/census-briefs/c2020br-07.pdf