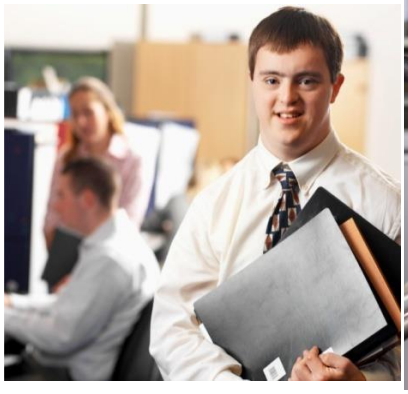


Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting:

A Toolkit for State Medicaid Agencies

Submitted by: National Direct Service Workforce Resource Center

August 2013

Table of Contents

Table of Exhibits

Tables

Preparation of this document was funded by the Centers for Medicaid and Medicare Services, Contract # HHSM-500-2011-00001I to The Lewin Group.

Authors are Erika Robbins and Betsy Dilla, The Lewin Group; Lori Sedlezky and Annie Johnson Sirek, University of Minnesota Research and Training Center on Community Living.

The draft of this paper was reviewed by the Centers for Medicare and Medicaid Services and members of the DSW Resource Center team. We would like to thank the following participants for their insightful comments: Kathryn King, Sharon Brown, Janet Freeze, Wendy Hill Petras, Michael Smith, Centers for Medicare and Medicaid Services; Yvonne Powell, The Lewin Group;

NOTE TO READER: If you have extensive direct service workforce knowledge, go to Section IV directly. Sections I, II, and III are included within the Toolkit to address the potential need for background information on direct service workforce challenges and solutions.

Introduction

A number of demographic and social trends suggest that the United States will experience a dramatic increase in the number of people needing long-term services and supports over the next 30 years. This need is projected to outpace the number of workers available to provide these services resulting in a severe shortage of direct service workers.

Driven by the "Baby Boom" generation, forecasts suggest that the number of individuals age 65 and older will increase to 72 million in 2030 and will represent 20 percent of the US population (US Census Bureau, 2010). Aging populations, particularly the population age 85 and older, may tend to have a higher likelihood of chronic conditions, functional limitations, and disability, further increasing the demand for long-term support service and direct service workers (Spillman & Lubitz, 2002).

Historically, a significant amount of long-term services and supports have been provided informally by families, and adult daughters often assume a primary role for their parents' care. It has been suggested that the availability of family caregivers may fall over time because of rising divorce rates, increasing childlessness and declining family sizes. Also, the rising labor force participation of women may reduce their ability to provide informal care (Johnson, et al, 2007). In addition, as the population of the US ages and state budgets are expected to stretch further, there is an increasing expectation that families will be the primary caregiver of their adult family member with an intellectual disability. This responsibility will increasingly fall upon siblings as parents' age and are no longer able to care for their adult son or daughter with a disability.

CMS provides Critical Guidance

"The cost of continuing education and training related to remaining a qualified direct service worker is an appropriate consideration as an allowable cost within Medicaid rate setting."

(July 13, 2011 CMS Bulletin)

In general, frail elders and individuals with disabilities prefer to live and receive their services and supports in their home (Keenan, 2010). Studies have shown that living at home and receiving home and community-based services (HCBS) can delay institutionalization, and improve quality of life for frail elders and individuals with disabilities; while being cost effective for federal and state governments.

In Olmstead v. L.C., the Supreme Court ruled that Title II of the Americans with Disabilities Act prohibits the unnecessary institutionalization of persons with disabilities and mandated that services to persons with disabilities must be provided "in the most integrated setting possible." In order to meet the integration mandate in Olmstead, federal, state and local governments have had to increase the availability of HCBS, increasing the demand for direct service workers to deliver these needed services. Access to adequate HCBS depends on the availability of a well-trained workforce of sufficient size.

The Bureau of Labor Statistics projects demand for health care support to grow 33.3 percent between 2004 and 2014, faster than any other sector of labor force demand. To meet this demand, the direct service industry will be competing for available workers with other industries that offer better wages, better benefits and better working conditions. Moreover, as stated earlier, the overall labor supply is projected to grow much more slowly than the demand for long-term services and supports. To address this imbalance between the demand for long-term services and supports and the available supply of direct service workers, it will require the commitment of federal and state government agencies and private employers to develop and implement initiatives to improve the recruitment and retention of direct service workers now and in the future.

States continue to identify and offer home and community-based service options. These services have the potential to increase the quality of life for Medicaid recipients and save Medicaid dollars. But success in implementing these options depends upon having a sufficient the labor supply. Appropriate and timely provision of home and community-based services can delay or prevent institutionalization, improve quality of life and keep long-term care costs lower. However, inadequate or unsuitable home and community-based services, or a lack of access to these services, can lead to unnecessary institutionalization, more visits to the emergency room, and an increased need for more expensive acute care.

In the July 13, 2011 Bulletin, *Coverage of Training within Medicaid Rate Setting* (refer to Appendix A), the Center for Medicare and Medicaid Services (CMS) provided guidance on Medicaid reimbursement policy for qualified provider (i.e., direct service worker) training costs. The Bulletin states that Medicaid will not reimburse training costs for an individual or entity to become a qualified provider. The Bulletin also points out that costs associated with continuing education and training for Medicaid providers are allowable service expenses under Medicaid.

CMS is clearly concerned about the adequate recruitment and retention of quality Medicaid providers, and in particular qualified direct service workers. Building and promoting an adequate, well-qualified, and competent direct service workforce has proven to be a particularly challenging task. Providing recognition for continuing education and training as an allowable Medicaid service expense supports states' efforts to develop direct service worker qualifications and continuing education and training requirements. This is an important step in developing a quality direct service workforce (DSW) that is prepared to meet the growing demand.

CMS wants to provide options to states under Medicaid that encourage and reward investment in the direct service workforce. In 2006, CMS created the National Direct Service Workforce Resource Center to assist states in planning to grow a qualified and competent direct service workforce. This Toolkit, presented by the National Direct Service Workforce Resource Center, focuses on Medicaid reimbursement policy for continuing education and training for qualified Medicaid providers and represents a targeted strategy to address and resolve systemic challenges of the Direct Service Workforce (DSW).

The purpose of the Toolkit is to ***present strategies and methods for covering the cost of continuing education and training for the DSW.*** These strategies are outlined fully in ***Section V.*** Additional sections are contained in this Toolkit to provide a foundation to Section V. These additional sections provide a description of the direct service workforce, key strategies to address workforce challenges, the role of core competencies and credentialing in supporting a high quality and cost effective DSW infrastructure and an overview of Medicaid reimbursement.

The Toolkit is divided into six sections. In addition, five appendices that contain additional information and resources are attached.

Section I. Understanding the Direct Service Workforce

This Section provides a description of the current Direct Service Workforce (DSW) and the important work they do. Also, it highlights the need for continued development of the DSW while discussing many of the ongoing challenges in achieving this goal.

Section II. Key Strategies to Address Workforce Challenges and Improve Service Outcomes

This Section presents specific strategies to address the challenges introduced in Section I. In addition, this Section focuses on Competency-Based Training, Wage Increases, and Apprenticeship, Credentialing and Certification Systems.

Section III. Effect of Participant Direction on Direct Service Workforce Training

The majority of Medicaid beneficiaries enrolled in participant-directed service programs choose to hire friends, family members and other individuals who they know to provide their HCBS. Section III discusses the participant-directed service delivery model and the role and training needs of direct service workforce employed by Medicaid beneficiaries enrolled in participant-directed service programs. This Section also discusses the effect of worker training related to participant direction on existing direct service workforce training programs.

Section IV. Medicaid Payment Basics

Section IV provides an overview of how Medicaid rates of payment are established with a focus on strategies for including continuing education and training cost within rate setting methodologies. Medicaid programs and their rate setting methodologies vary by state, so this section provides a general overview.

Section V. Fee for Service Rate-Setting Models: Building Training into Medicaid Rate-Setting

This Section provides an introduction and proposes a possible foundation for including training costs within a basic Medicaid rate-setting model. Section V also highlights four potential models for state deliberation.

Acuity-based Rate-Setting Model

This sub-section describes a rate setting model that offers enhanced provider reimbursement that varies based on the acuity level of beneficiaries and the complexity of their service needs.

Under this Medicaid rate-setting model, the provider receives incentive payments and is encouraged to pass through a portion of the incentive payment to the worker.

Mentorship Rate-Setting Model

This sub-section builds upon a base service description. Under this model, the worker enters the system with minimal training and has a "lattice" of educational opportunities to access in order to move across the direct service workforce.

State Training and Career Pathway Rate-Setting Model

This sub-section describes a rate-setting model that aligns with a state or national level credentialing or certification model for the direct service worker occupation. The model entails a competency-based training and education program to be delivered through state community colleges in collaboration and partnership with employers of direct service workers. Community colleges and other academic institutions provide excellent resources that may support the implementation of certification and credentialing systems for the direct service workforce. However, this model also may be applied within other contexts, such as training organizations or agencies in the public workforce system (such as *Department of Labor apprenticeship programs and Work Investment Act programs*) or programs offered through trade unions.

Developing an Incentive-Based Rate-Setting Model

This sub-section provides basic information on a 'pay for performance' rate setting method. This rate setting method encourages the addition of incentive based payments within Medicaid rate setting to establish a quality direct service workforce with goals to improve the health of the population, enhance the individuals' experience of care, and reduce the cost of care—the Institute for Healthcare Improvement's "Triple Aim".

Section VI. Conclusion

In summary, this Toolkit provides state Medicaid administrators with specific tools, strategies and key research in the field of Medicaid rate setting related to the continuing education and training. The goal of the Toolkit is to provide guidance to state Medicaid agencies on how to cover the cost of continuing education and training, increase the competence of direct service workers, improve recruitment and retention, and encourage high quality direct service access to Medicaid eligible service recipients.

Toolkit Terminology

Please note that throughout this Toolkit, the term "direct service" is used. There is not a single unified occupational title for the work provided. Included within this overarching title are workers that might go by the term "direct support worker", "nurse aide," "home health aide," "personal care assistant", "personal assistants," "personal care attendants," "home-care aides," and "home attendants." For the purpose of this Toolkit, the term "worker" is used to represent all occupational titles and "DSW" is used to represent the workforce.

Also, it is common to discuss the various "sectors" within the direct service workforce.

- **Service:** The sector that represents various disability groups such as individuals with intellectual disabilities, older adults, and individual with physical disabilities.

- **Setting:** The sector that represents the various settings in which individuals receive assistance such as homes and facilities.
- **Provider Model:** The sector that represents the various ways individuals receive services such as agency-based or participant-directed workers.

The Toolkit attempts to address all sectors within the larger direct service workforce and provide tools and resources contained in the appendices to support the strategies and methods described within. For additional resources or to learn more about the **National Direct Service Workforce Resource Center**, please visit website: www.dswresourcecenter.org. You can also email at info@dswresourcecenter.org or call 1-877-822-2647.

Purpose of Section	Section I

This section provides a description of the current Direct Service Workforce (DSW) and the important work they do. It highlights the need for continued development of the direct service worker while introducing many of the ongoing challenges to this goal.

Section I: Understanding the Direct Service Workforce

The direct service workforce represents a vital pool of workers throughout the United States that provide daily services and supports to a diverse population of individuals with a wide range of health and human service needs. There are four main service sectors that employ direct service workers. These are categorized as (1) aging, (2) behavioral health (i.e. mental health and addiction), (3) intellectual and developmental disabilities (IDD), and (4) physical disabilities services. Each service sector has historically developed its' own funding, policy, and advocacy systems which has contributed to fragmentation within the direct service workforce (DSW). The National Direct Service Workforce Resource Center (DSW RC) was created by the Centers for Medicare and Medicaid Services (CMS) with leading workforce experts across service sectors. The DSW RC implements strategies to facilitate collaboration among sector stakeholders that are instrumental to ensuring a high quality DSW (Hewitt et al., 2008).

Recent data collection has indicated that the DSW is made up of over 3.6 million workers in the United States (PHI, 2012). The workforce is comprised of both home and community-based services (HCBS) workers, such as in-home care aides and direct service workers, and facility-based workers, such as hospital and nursing facility nurse aide staff. The demand for direct service worker positions is projected to increase by 35 percent from 2008 to 2018, while overall job growth is expected to increase by only 10 percent (PHI, 2012). Home and community-based direct service workers are in highest demand within this group.

Demands on the Direct Service Workforce

The demand for direct service worker positions is projected to increase by 35 percent from 2008 to 2018, whereas overall jobs within the United States are expected to increase by only 10 percent within this timeframe.

A growing number of individuals receiving Medicaid-funded HCBS are receiving these services through a participant-directed service delivery model. For more information about the effect of participant direction on training, visit the section titled "Participant-Directed Supports and the Role and Financing of Training", which can be found in **Section III**.

Supply and demand conditions for workers represent one of several systemic challenges. These challenges are briefly outlined in Table 1 to contextualize the status of the direct service workforce within the United States. The information is based on a recent report prepared by interdisciplinary stakeholders: *A Synthesis of Direct Service Workforce Demographics and Challenges Across Intellectual/Developmental Disabilities, Aging, Physical Disabilities, and Behavioral Health* (Hewitt et al., 2008).

Table 1: Summary of Direct Service Workforce Challenges*

Issue	Description
Status and image of direct service workers	Recurrent failure to provide adequate wages, benefits, training, clear role delineation, and career pathways has reflected poorly on the public image and perception of these positions. Societal stigma associated with disabilities and aging has contributed to the stigmatization of the DSW.
Supply and demand conditions	The labor force participation of working age females, the core labor supply, will continue to level off while the baby boom generation ages and retires. As the age of workers increases, the availability of assistive technology to reduce physical demands of the job is becoming more essential.
Recruitment and vacancies	Difficulties in the recruitment of workers and filling vacant positions reflect low structural quality of these jobs and their unattractiveness compared to other jobs based on high levels of job demands, responsibilities, and stress. Worker vacancies increase stress within and across the various sectors of the workforce.
Turnover	High rates of worker turnover are a key barrier to the delivery of quality services. Consequences of the turnover of direct service workers are significant, as the estimated cost of hiring and training new workers is $4,872 per position (ANCOR, 2009) and worker vacancy rates can result in increased stress on the remaining workforce (Hewitt & Larson, 2007).Factors associated with worker turnover have been broken down into three vectors: (1) personal demographic and socioeconomic characteristics, (2) reported job characteristics, and (3) other characteristics of the facility and geographic area (Stearns & D'Arcy, 2008).
Wages and benefits	High proportions of workers (HCBS and facility-based) households earn under 200 percent of the federal poverty level and an estimated 43 percent rely on public assistance programs (PHI, 2012). Only 51 percent of workers in the US are covered by employer-sponsored health insurance, as trends of low contributions paid by employers and ineligibility based on part-time or on-call employment persist (PHI, 2012). Across occupations, workers experience the highest incidence rates of illness and work-related injuries. Workers also experience the highest rates of depression lasting two weeks or longer, but most do not have access to employer funded assistance and benefits that include mental health services.
Training and education	Workers receive far less training than other human service workers, yet workers spend more time in direct contact with individuals who receive long-term services and supports. There are few state required or employer-based pre-service training programs for the HCBS workforce. The facility-based workforce (i.e. nursing facilities, certified home health agencies and hospice) often receives formal initial and continuing training consistent with federal regulations and reimbursement coverage requirements. Most DSW training for the HCBS sector is based on varied state regulations and mandated minimum hour requirements instead of focused on competency development. There is a demand for the identification of core DSW competencies across the facility-based and HCBS sectors in order to implement high quality, competency-based training programs and policies.

Issue	Description
Federal and state training requirements	Federal training requirements exist for only those workers working in nursing facilities, certified home health care agencies, ICF-MR facilities and hospices that receive Medicare or Medicaid funding. In all other services and settings, states are left to set their own, if any, initial and continuing training requirements. DSW training requirements are varied based on entrenched service funding and regulation systems. In general, there are more DSW training requirements (many based on federal regulations) in the aging and physical disabilities sectors due to trends of institutional and restrictive service delivery. Training requirements for IDD services (other than Intermediate Care Facilities for the Mentally Retarded) are contingent on state policies, while there is an absence of uniform mandatory training requirements for workers in behavioral health services.
DSW career paths	There are few established career paths guiding personnel training and development within DSW occupations. Few systemic incentives are built into current Medicaid programs, such as rate-setting mechanisms that provide increased wages based on completion of training, demonstration of competence, and other career path requirements. Costs associated with training for the HCBS sector have fallen upon organizations and workers, which has resulted in low completion rates.
Supervision of DSWs	A lack of effective supervisor training and demonstration of supervisory competencies has perpetuated high rates of DSW turnover. Several studies have indicated that workers require greater access to reliable and effective supervision in order to feel supported and provide quality supports (Hewitt et. al, 2008). This is an increasing challenge within the context of service delivery in home and community-based settings in particular. It should be noted; under participant-directed service programs, the participant or his/her representative, as appropriate, may serve as the supervisor of workers who provide direct services to him/her (Flanagan, 2009). It is critical that at the point of enrollment and then consistently throughout participation in participant-directed services that the participant and his/her representative have access to trained technical assistance to enhance their ability to provide supervision.
Workplace culture and respect for DSWs	Common trends within workplace cultures manifest low levels of respect for workers. Conversely, job satisfaction and organizational commitment among workers are related to experiences of high morale, teamwork, participation in decision-making, and recognition of their vital role and competence. These factors influence higher retention, fewer job vacancies, and decreased turnover of workers. Several organizational processes have been cited as best practices in direct service workforce development.

*Unless otherwise specified, all information from Table 1 references the 2008 study, *A Synthesis of Direct Service Workforce Demographics and Challenges Across Intellectual/Developmental Disabilities, Aging, Physical Disabilities, and Behavioral Health* by Hewitt et al.

The challenges described in **Table 1** highlight systemic and structural barriers that have hindered development of the direct service workforce. In efforts to address and resolve such challenges, the authors of the report recommended key strategies to increase access to training, lifelong learning, and career paths for workers through coordinated approaches at the national, state and local levels. Such a foundational strategy was deemed “critical to preparing greater numbers of workers for direct service work as well as ensuring the quality of supports and services provided to consumers” (Hewitt et al., 2008, p. 30).

Historically, the federal government has invested in the training and development of direct service workers. Three federal agencies have primarily been responsible for this focus:

(1) The U.S. Department of Education through the National Institute on Disability and Rehabilitation Research (NIDRR);

(2) The Department of Health and Human Services (DHHS) funded projects through

(a) Centers for Medicare & Medicaid Services (CMS),

(b) Administration on Intellectual and Developmental Disabilities (ADD),

(c) Health Resources and Services Administration (HRSA), and

(d) Substance Abuse and Mental Health Services Administration (SAMHSA); and

(3) The U.S. Department of Labor (DOL) through the Educational and Training Administration (ETA).

Each of these federal agencies has played a significant role in the ongoing research, training and technical assistance, and formalizing practices to develop the workforce such as building competency models, set skill standards, and creating apprenticeship programs to guide DSW initiatives.

These investments represent significant efforts in building our nation's capacity to promote quality service provision through DSW. At the same time, there are longstanding barriers that hinder the capacity of provider organizations to develop and sustain long-term workforce development programs. One barrier is the costs associated with training. These costs often include paying workers while they complete training, backfilling workers to provide direct service while other workers are being trained, maintaining a training department, purchasing supplies and technology, creating and/or purchasing training materials, and travel. Training costs are problematic for provider organizations (Test, Flowers, Hewitt, & Solow, 2004; Larson, Doljanac, Nord, Salmi, Hewitt, & O'Nell, 2007). Yet such organizational investments are necessary; performance, worker retention and turnover or vacancy rates are often related to effective DSW training programs (Castle & Enberg, 2007; Braddock & Mitchell, 1992).

By neglecting to implement training programs that can result in improved organizational outcomes, considerable dollars are diverted to maintaining status quo and respond in isolation to micro DSW workforce challenges. The expense related to turnover alone is significant for organizations that employ direct service workers. Seavey (2004) reports the direct cost of turnover per direct service worker to be at least $2,500, a conservative estimate that does not account for incurrence of substantial indirect costs. This quickly becomes financially unsustainable, as annual turnover rates in Home and Community Based Services (HCBS) range from 40 to 75 percent nationally, with the first three months post-hire being highest (Scala, 2008). While organizations struggle to accommodate for turnover expenses, individuals who receive services must manage the challenges of having frequent changes in workers and reestablishing relationships with the rotating workers. Recurrent turnover can cause a lack of continuity in the provision of direct services that makes it extremely difficult for individuals receiving services "to develop and sustain the trusting and familiar relationships that foster personal growth, independence, and self direction" (Hewitt & Lakin, 2001, p. 7). CMS has acknowledged the need to prepare a sustainable direct service workforce and has responded with new policies allowing states to include certain training costs in rate setting methodologies for Medicaid §1915(c) Home and Community-Based Services Waiver Programs. States also

may find additional guidance through CMS on the 1915i, 1915j, and 1915k of the Social Security Act at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

For Critical Reflection

- ❑ What is the status of your state's workforce capacity and need?
- ❑ Do you know the turnover rate of your direct service workforce?
- ❑ Are your state challenges consistent with the national trends? If not, what are the differences?
- ❑ Do you have a cross sector, statewide approach for providing initial and continuing education and training? If yes, how are these activities reimbursed?
- ❑ What tools do you provide to your network of providers (agency and individual) across disability groups to improve for the recruitment, retention and quality of the direct service workforce?
- ❑ What improvements can your State make to its overall training policy, as well as coverage of continuing education and training, within your participant-directed program(s)?

Purpose of Section	Section II

This section addresses the challenges introduced in Section I by describing a number of specific strategies. The goals of the strategies as well as practical ways to implement them are explored. Strategies discussed include Competency-Based Training, Wage Increases, and Apprenticeship, Credentialing and Certification Systems.

Section II: Relevant Strategies to Address Workforce Challenges and Improve Service Outcomes

This Toolkit responds to the need to increase access to training, lifelong learning, and career paths for direct service workers through coordinated approaches at the national, state, and local levels. It provides structured training and education strategies that states can implement in conjunction with CMS, in order to resolve direct service workforce (DSW) challenges and improve quality outcomes. Challenges include high turnover rates and vacancies, as well as recruitment challenges within a shrinking candidate pool and a lack of career paths within and across sectors. These challenges are summarized in Table 1 of the introduction section.

CMS provides reimbursement for continuing education costs associated with maintaining a direct service workforce. Specifically, the Introduction and Appendix A provides the following policy highlights:

> *Under section 1902 of the Social Security Act and 42 Code of Federal Regulations 430 and 447, covered services to an eligible beneficiary delivered by a qualified provider can be reimbursed… Medicaid will not reimburse training costs to become a qualified provider; however, the training costs associated with remaining qualified, such as Continuing Education credits, may be considered part of the provider's business expenses necessary for providing the service. (July 13, 2011 CMS Bulletin)*

This policy provides critical investment to develop and advance the DSW within states. It presents an opportunity for State Medicaid Administrators to develop strategies and implement responses to address workforce challenges within each state. While many of the strategies discussed in this section require initial training as a foundation, CMS only contributes financial support to continuing education and training for a worker to maintain his/her qualifications as a Medicaid provider. This Toolkit provides guidance on the Medicaid reimbursement of continuing education and training costs with insight into the development of a robust system that includes initial training as a foundational element.

Competency-Based Training

There is emerging evidence indicating that effective competency-based training approaches influence quality outcomes in service delivery. Several studies have reported worker retention associated with improvements in worker skills through training (Wright, 2009). While it is empirically challenging to measure the causal linkage between retention, training, and service quality, there is evidence suggesting that such direct links exist (IOM, 2008). This evidence reinforces long-standing anecdotal reports and logical assumptions that have suggested competency-based training outcomes improve the lives of people receiving long-term services and supports.

The importance of DSW competency development and demonstration is based on the fundamental premise that quality lives are dependent on quality support. There are links between worker competency, retention, and consumer satisfaction. A study of Home and Community Based Services in Minnesota showed that higher vacancy rates were associated with poorer consumer and family satisfaction (Larson, Hewitt & Lakin, 2004). Tenured workers have a depth of knowledge about service needs of individuals, resulting in better coordination with health care providers and reduced incidents and accidents. Workers demonstrate competency by providing consistent support through established, trusting relationships that contribute to higher quality of life for recipients of services. Their feelings of competence lead to greater job satisfaction; and job satisfaction is positively linked to retention (Larson, Lakin, Bruininks, 1998).

Direct service competencies are receiving increased attention and recognition as a critical component of workforce development. A recent literature review highlights widespread inadequacies of health and human service delivery due to workers' failure to demonstrate compliance with practice guidelines (Hoge, McFaul, Calcote, Tallman, et al., 2008), and there are several indicators that DSW training processes are insufficient. Nearly a third of service provider agencies view training as problematic (Larson, Hewitt, & Anderson, 1999).

Several organizational and policy-related factors influence trends of low performance among the DSW (O'Nell & Hewitt, 2005). For example, service provider organizations report challenges in maintaining high job performance expectations of workers while minimizing turnover and balancing demands for needed delivery of supports (ANCOR, 2001). There are various strategies that must be incorporated on multiple levels for organizations and systems to address poor performance in the direct service environment. One of the most integral strategies involves development and implementation of high quality competency-based training programs.

Foundation of Workforce Development and Standardizing

When rigorously developed and effectively implemented, competencies serve the important function of informing workers and their supervisors About requirements of job performance.

CMS provides Critical Guidance

"The cost of continuing education and training related to remaining a qualified direct service worker is an appropriate consideration as an allowable cost within Medicaid rate setting."

(July 13, 2011 CMS Bulletin)

Competencies are considered a foundation for workforce development. When rigorously developed and effectively implemented, competencies serve the important function of informing workers and their supervisors about requirements of job performance. Competencies also provide indicators that are necessary to develop effective curriculum for worker training, orientation, and continued staff development. The utilization of competencies in the DSW reinforces shared values of direct service workers' skills and growth (Hoge et al., 2008).

Competency-based training is a systematic skill-building approach that targets learners' achievement of specific competencies. Competencies describe the essential knowledge, skills, and abilities that workers are expected to successfully develop, demonstrate, and apply to their jobs as a result of the training. Competency-based training programs are especially applicable to the DSW because they provide an individualized format for learning. In this format, workers may be trained based on competencies relevant to their diverse and ongoing training needs. However, there are several barriers to widespread delivery of effective and individualized competency-based training. Various federal and state mandated training regulations have influenced service providers to meet only minimum requirements, while it is widely recognized that further training is necessary to meet standards of person-centered support and quality service delivery.

There is a persistent need to develop training programs that *not only* meet minimum training requirements and state regulations (when available), *but also* target specific competencies that workers need to deliver quality, individualized services. The current CMS Medicaid reimbursement policy for continuing education and training provides impetus for state agencies to apply and implement competency-based workforce training and development initiatives.

Figure 1: Outcomes Associated with Competency-Based DSW Training

Credentialing and Apprenticeship Programs

US Department of Labor Registered Apprenticeship Programs are widely recognized as an approach to address industry wide training and development needs. Historically, apprenticeship programs were most common in trade industries, and had not been applied within the Long Term Services and Supports Sector until 2003 when the first registered apprenticeship programs were developed for occupational titles within long term services and supports sectors. Since that time, US Department of Labor approved Apprenticeship Programs have been developed for Certified Nursing Assistants (CNA), Direct Service Professionals/Specialists, Home Health Aides (HHA), and Health Support Specialist (HSS).

Registered apprenticeship offers a number of potential advantages for both DSW and long-term service and supports providers. Workers earn salaries while applying their newly acquired skills in the context of their real work setting, and incremental pay increases are earned as apprentices reach interim credentials that reflect increasing levels of competency. National and statewide competency-based credentialing programs are built upon this same framework, though potentially allowing states more flexibility in the implementation, skill acquisition measures, and wage increases associated with each level of the credential.

There is considerable overlap in the definitions and operations of certification, credentialing, and apprenticeship programs. Descriptions of each are:

- ***Certification programs*** are a formal recognition of specialty knowledge and skill in a profession. Certification is a prerequisite for employment in some occupations, and is governed by a national board representing the profession or industry. It certifies that an individual has received specific occupation related training needed to enter a job. The State Training and Career Pathway Model in this Toolkit is a proposed state certification model that aligns with standards of the National Alliance for Direct Support Professionals (NADSP) Credentialing Program and Dept. Of Labor Registered DSP Apprenticeship Program.
- ***Credentialing programs*** are also a formal recognition of specialty knowledge and skill in a profession. However, credentials typically represent ongoing training and competency proficiency beyond a certification that is needed to for an occupation. Credentials are often nationally portable, as those who fulfill credentialing requirements shall be recognized for their worker skills and knowledge in any state where they may choose to work. Credentials are typically associated with a greater level of specialization in an area and credentialed staff members receive higher wages.
- ***U.S. Department of Labor (DOL) registered apprenticeships*** are administered by the Employment and Training Administration (ETA) through its Office of Apprenticeship, which establishes minimum standards and regulations for these programs. A business, organization, union, or association manages the apprenticeship under federal and state program standards. A formal Apprenticeship Agreement governs the experience of each apprentice, which includes on-the-job training and related instruction requirements, and incremental wage increases at each level. Upon completion of the program, an apprentice receives national recognition of skills and knowledge achieved. The State Training and Career Pathway Model in this Toolkit (p. 58) proposes a state certification model that aligns with standards of the DOL Registered Apprenticeship Program for direct service workers.

Table 2 provides a list of competency based apprenticeship programs that are currently in place in LTSS, based on Hoge and colleagues' (2008) and the current authors' review.

Table 2: Competency-based Certification, Credentialing, and Apprenticeship Programs in LTSS

Program	Based on Competency Set	Description
Certification International Certification and Reciprocity Consortium/ Alcohol and Other Drug Abuse (IC&RC)	Addiction Counseling Competencies (TAP 21)	The IC&RC is a non-profit organization in existence since 1981 that represents 76 member agencies within 44 states, 3 U.S. military branches, 6 Native American territories, and 22 countries worldwide. The member boards have certified over 40,000 workers in the addiction field.
Certification & Credential National Association of Alcoholism and Drug Abuse Counselors (NAAADAC) Credentialing System	**Addiction Counseling Competencies (TAP 21)**	The NAAADAC is a membership organization in existence since 1972 that represents over 75,000 workers in the addiction field, with 46 state affiliates. In addition to providing advocacy, the NAAADAC has offered national certification with basic and specialized credentialing tracks since 1990. The NAAADAC Certification Commission manages the credentialing process and over 15,000 workers have been certified.
Certification U. S. Psychiatric Rehabilitation Association (USPRA) Certified Psychiatric Rehabilitation Practitioner (CPRP)	Adult Psychiatric Rehabilitation/Recovery-Oriented Mental Health Services for Adults Competencies (CPRP)	The CPRP Certification has been established since 2001 and the test based credentialing process is operated by USPRA. The certification is recognized and/or required by state Medicaid regulations in 15 states. More than 2,600 DSWs in the behavioral/mental health sector have received CPRP certification.
Apprenticeship U.S. D.O.L. Long-Term Care Registered Apprenticeship Programs; Federal Guidelines for Certified Nursing Assistant (CNA), Home Health Aide (HHA), and Health Support Specialist (HSS) Certification Programs	Competency Standards for Physical Health and Aging	The DOL ETA Office of Apprenticeship establishes minimum standards and provides technical assistance for these independently managed programs. These credentials are nationally recognized and portable. The impact and accessibility varies across states.
Certification Michigan Association for Infant Mental Health (MI-AIMH) Endorsement for Culturally Sensitive, Relationship Focused Practice Promoting Infant Mental Health	Infant Mental Health Competency Guidelines	The MI-AIMH established the “endorsement” program in 2002, which offers a multi-level process for certifying and registering workers in the infant mental health field. There are 13 state associations that are affiliated with implementing this program in the Endorsement League of States. This process has had a significant impact in the field. Michigan Medicaid policies have been rewritten to require staff endorsement and employers have deemed endorsement as a preferred qualification.

Program	Based on Competency Set	Description
Credentialing National Alliance for Direct Support Professionals (NADSP) Credentialing Program	National Alliance for Direct Support Professionals (NADSP) Competencies	The NADSP promotes educational opportunities, increased wages and benefits, and increased status and recognition of the direct service workforce. The NADSP Credentialing Program is a tiered voluntary credentialing program that is built upon the NADSP Competencies (adapted from the Community Support Skills Standards and Community Residential Core Competency sets. The Department of Labor (DOL) Registered Apprenticeship program guidelines for workers are based on the NADSP competencies and credentialing program, with active apprenticeship programs in four states. Some state service systems have demonstrated formal support of this program through requiring and/or providing incentives for NADSP Credentialed workers.
Apprenticeship U.S. D.O.L. Registered Apprenticeship Program for the occupation of Direct Support Professional (Direct Support Specialist)	National Alliance for Direct Support Professionals (NADSP) Competencies	The NADSP promotes educational opportunities, increased wages and benefits, and increased status and recognition of the direct service workforce. The NADSP Credentialing Program is a tiered voluntary credentialing program that is built upon the NADSP Competencies (adapted from the Community Support Skills Standards and Community Residential Core Competency sets. The Department of Labor (DOL) Registered Apprenticeship program guidelines for workers are based on the NADSP competencies and credentialing program, with active apprenticeship programs in four states. Some state service systems have demonstrated formal support of this program through requiring and/or providing incentives for NADSP Credentialed workers.

While there has been significant progress in creating a competent direct service workforce, as evident by the development of competency models, as well as credentialing and apprenticeship programs (such as direct support professionals, CNA, HSS, and HHA job occupations), many barriers still exist in connecting workers to the training and apprenticeship programs within long-term services and supports. Barriers that prevent workers from accessing and completing competency-based training and credentialing programs include:

1. Lack of state level collaboration and information sharing on best practices across states, and
2. Lack of funding or understanding of how to create statewide policy and structures to maximize federal Medicaid dollars to support worker training.

This Toolkit outlines a process in which states can develop their Medicaid reimbursement methods to absorb the costs of ongoing/continuing staff competency-based education and training, and provide wage increases based on provider qualifications, and share information through illustration on best practices in competency-based training and the potential for partnership between providers and provider-based training, and community college instruction.

Structured apprenticeship and/or credentialing programs built upon validated competencies provide a standardized and effective competency-based training delivery and performance evaluation system. Apprenticeship and credentialing programs can be scaled as desired by the state, and customized as needed to reflect unique support characteristics within the population served in the state. Apprenticeship and credentialing programs are also necessary to the development of career pathways for direct service workers within and across organizations, states and long term services and supports sectors.

Wage Increases

Wages are sometimes the reason that a worker may leave his or her job. While the primary purpose of the Toolkit is to present methods for covering the cost of continuing education and training for the DSW, this section provides insight into wage increase strategies, which may be implemented in part through these Medicaid payment methodologies as demonstrated in ***Section IV***.

In the process of implementing effective payment methodologies for Medicaid LTSS, it is critical to examine the impact of wage increases on workers. Systematic improvements in workers' wages represent a key area for planning and action in devising a comprehensive resolution to DSW challenges (Hewitt et al., 2008). This sub-section describes processes and associated outcomes of wage increases applied in the DSW. Current CMS Medicaid reimbursement policy for continuing education and training provides impetus for state agencies to implement wage increase strategies linked to continuing education and competency-based training as exemplified within ***Section V***.

Why are wage increases important?

Worker wages impact the consistency, reliability, and quality of LTSS delivery. According to an extensive review provided by the Institute of Medicine (IOM, 2008), there is substantial evidence indicating that higher wages lead to lower turnover rates among all LTSS sectors. The State of Wyoming experienced a dramatic decrease in turnover rates of workers from an average of 52 to 32 percent, after state funding was allocated to increase wages (Lynch, Fortune, Mikesell, & Walling, 2005; Sherard, 2002). San Francisco County nearly doubled the wages of home care workers over a 52-month period, and within that time, annual turnover decreased from 70 to 35 percent (Howes, 2005). Significant reductions in turnover, as well as increases in job satisfaction and workers' intent to stay, have been measured as a result of higher wages implemented in DSW demonstration projects (Howes, 2006).

Not only do wages have an impact on the retention of workers, but wages also play a role in recruitment. Low wages correlate with high vacancy rates in the context of direct service positions (UMN, 2006). Several studies indicate that even modest increases in DSW compensation attract new applicants to the direct service field (Wright, 2009). Further, both wages and benefits are considered central to recruiting and retaining DSWs (Senecal, Livingston, & Reback, 2008). Access to and improvement of health insurance and other fringe benefits for workers constitutes an additional related area relevant for planning and action in devising a comprehensive resolution to DSW challenges (Hewitt et al., 2008).

Linking wage increases to workers' advancement in training programs (i.e. career pathways, apprenticeships, credentialing, or certification programs) represents an important coordinated strategy that may be implemented on the state level (Harris-Kojetin et al., 2004). *The Workforce Improvement for Nursing Assistants: Supporting, Training, Education, and Payment for Upgrading Performance (WIN A STEP UP)* program in North Carolina implemented a wage increase framework that improved staff competency through training, and this resulted in significantly lower turnover compared to a matched comparison group (Wright, 2009).

What are strategies for increasing wages?

Several strategies have been employed with the intent to increase DSW wages and benefits. Seavey and Salter (2006) studied this question and identified **seven strategies** used by states, localities, and advocates for improving wages and benefits of workers, including:

1. Wage Pass-Through Legislation,
2. Rate Enhancements Linked to Provider Performance Goals,
3. Reform of Methods For Rebasing and Updating Reimbursement Rates,
4. Litigation Against State Medicaid Agencies
5. Collective Bargaining by Direct Service Workers,
6. Living Wage Ordinances and Minimum Wage Improvements, and
7. Health Insurance Initiatives Targeting Direct Support Professionals.

It is important to note that strategies for increasing worker wages often require approval through legislative action. Wong, Kaye, and Newcomer (2007) utilized the framework of identified strategies to complete a systematic search of state legislation. They identified thirteen bills or legislative appropriations passed into law that increased wages of workers by increasing the Medicaid reimbursement rate (such as a living wage adjustment), amending current laws, or providing health insurance parity. The researchers deemed these thirteen bills or legislative appropriations as promising practices that may be used as exemplars for other states (see http://www.pascenter.org/pas_workforce/promising_practices.php).

What is a wage pass-through program?

The most prevalent mechanism for stimulating increased direct service workforce compensation in the United States is the wage pass-through (IOM, 2008). A wage pass-through program entails additional state-level allocation of Medicaid funds that are added to reimbursement rates for the specific and express purpose of increasing worker wages (IOM, 2008; PHI, 2003). Twenty-one states have implemented wage pass-through laws with expectations of addressing the shortage of workers within LTSS (PHI, 2003). Most of these programs were mandatory, and some states allowed flexibility in exactly how the funds were to be used to improve staffing. Wage pass-through programs have also been considered as an option for funding the health care benefits of workers in states such as Wisconsin (PHI, 2006).

How are wage pass-through programs structured, designed, and implemented?

There are two methods that are commonly used by states to calculate the amount to be allocated for wage pass-through programs (PHI, 2003). The first method involves identifying a set dollar amount to increase wages “per hour” or “per patient-day” within the Medicaid reimbursement rate. A 1999 survey found that 10 of 16 states implementing wage pass-through programs used this method, with pass-through amounts ranging from 50 cents to $2.14 per hour or up to $4.93 per patient-day. The second method requires that providers spend a percentage of a specific rate increase on higher compensation. A 1999 survey found that 6 of 16 states established wage pass-through programs as a percentage of the increased reimbursement rate.

For example, in Minnesota, 80 percent of the state's 40 percent rate increase was earmarked for worker wages and benefits (PHI, 2003).

In addition, researchers at PHI (2003) have studied approaches to designing and implementing wage pass-through programs. Their analysis identified **seven key issues** that states have confronted during the implementation process:

1. Size of the Wage Increase: At what level should the proposed wage increase be set to attract/retain workers to direct service jobs?
2. Equity: Will the wage increase be extended to workers across all health care settings? Only in LTSS settings? Or only within a subset of LTSS providers?
3. Universality: Is provider participation in the wage pass-through to be optional or mandatory?
4. Specificity: How flexible or specific should the guidelines be for use of the funds?
5. Accountability: What audit and enforcement procedures need to be in place, and how do they relate to existing payment and auditing systems?
6. Continuity: Will funding for the pass-through be a one-time wage adjustment or will it be built into the rate as a base for subsequent years?
7. Notice: How much time and education do providers need to implement the increase as envisioned by the state?

The aforementioned issues represent key criteria and determinations that affect the impact of wage pass-through programs on worker compensation. The researchers emphasized importance of increasing worker wages through rigorous pass-through design and effective implementation methods. However, it is important to note that procedures for auditing wage pass through programs are often necessary to make sure that employers pass on the wages to workers. The researchers concluded that, "Solving today's workforce shortages and meeting future demands will require policymakers and providers to examine not merely workers' wages and benefits, but also how they are educated, trained, supervised, and managed" (PHI, 2003, p. 7). This highlights the need to devise well-coordinated strategies to strengthen the direct service workforce.

How effective are wage pass-through programs?

There are a variety of challenges in analyzing wage pass-through programs. Most pointedly is the difficulty separating the effect of a wage pass-through from other DSW interventions (IOM, 2008). These challenges have contributed to a small and limited evidence base. Yet recent emerging evidence and evaluation data are compelling.

Baughman and Smith (2010) found that workers who worked in 20 states that had implemented pass-through programs earned as much as 12 percent more per hour than workers in states that had not implemented pass-through programs. The authors noted the significance of increased wage results yielded through pass-through programs, and their viability as a policy option. In conjunction, the Centers for Medicaid & Medicare Services (2001) estimated that worker wages would have to increase by 10 to 22 percent in order to reach minimum adequate staffing levels in LTSS.

Feng and colleagues (2010) reported that, in the years following adoption of a wage pass-through program, there was a 3.0 to 4.0 percent net increase of certified nurse aide (CNA) hours per resident day (or HPRD; the average daily hours worked by CNAs divided by total number of residents). In congruence, Foster and Lee (2011) found staffing was increased by 4.4 percent in nursing facilities after states' implementation of wage pass-through programs. In addition to increased staffing, these authors reported higher quality of care as a result of wage pass-through.

State evaluation data of wage pass-through programs demonstrate efficacy through increased worker wages and reduced turnover rates. The wage pass-through program in the State of Wyoming facilitated an increase of average worker wages from $7.38 to $10.74 over four years, and a subsequent dramatic reduction in turnover rates, from an average of 52 to 32 percent (Lynch, Fortune, Mikesell, & Walling, 2005; Sherard, 2002). Service recipients in the State of North Dakota also observed an18 percent decrease in turnover that was associated with implementation of smaller wage pass-through efforts over seven years (The North Dakota Association of Community Providers, 2010). On varying scales, these states and others are demonstrating marked trends of increased worker wages and reduced turnover directly associated with wage pass-through programs.

Wage pass-through programs present an advantageous framework for states to build an infrastructure supporting the compensation, retention, and education of the direct service workforce. The improvement of service delivery systems within each state is predicated on the implementation of viable policies and coordinated strategies.

For Critical Reflection

- ❑ Does your state have any innovative apprenticeship and/or locally driven competency based training program(s) to build upon?
- ❑ If so, who participates in those programs?
- ❑ How can your state build upon the successes and lessons learned to develop a statewide DSW training infrastructure?
- ❑ Do you know your workforce partners across all service sectors, settings and provider models?
- ❑ How are Medicaid provider rate increases passed on to direct service workers in your state, if at all?
- ❑ How does your state verify that Medicaid provider rate increases have been passed on to direct service workers?
- ❑ Did you know you can visit the National Direct Service Workforce Resource Center at www.dswresourcecenter.org for information, research, and promising practices in other states?

Purpose of Section	Section III

This section discusses the direct service workforce that is employed by Medicaid beneficiaries enrolled in participant-directed service programs. The majority of Medicaid beneficiaries enrolled in participant-directed service programs choose to hire friends, family members and other individuals who they know to provide their home and community based services. This section of the Toolkit discusses the potential effects of the participant-directed service delivery model on the worker, potential training needs and how training may be delivered while adhering to the principles of participant direction and the effect of providing this training on existing training programs.

Section III: Participant-Directed Supports and the Role and Financing of Training

A growing number of individuals receiving Medicaid-funded HCBS are receiving these services through a participant-directed service delivery model. A recent survey of participant-directed service programs conducted by the National Resource Center for Participant-directed Services (NRCPDS) identified 298 participant-directed HCBS programs operating in 50 states, with the majority implemented since 2000. Their research also reported approximately 810,000 individuals receiving participant-directed services; that all of the states have at least one participant-directed service program that offers employer authority; and that 44 states also offer budget authority to program participants (Sallow, 2011 slide, 13, 14, and 17). However to date, there is limited research on direct service workers employed by individuals enrolled in participant-directed service programs, core competencies related to the delivery of participant-directed services and the type of training needed and/or received by these workers

Key Premise of Participant-Directed Services

A key premise of PDS is based on the independent living philosophy that recognizes that an older adult or individual with a disability, or [their] representative, when appropriate, is the best judge of [their] own interests, needs and how [their] services should be provided.

Participant direction is a new paradigm of HCBS delivery that transfers decision-making and managerial authority from workers to individuals and their families while providing them with a variety of employer supports. Under participant direction, older adults and individuals with disabilities, and their representative, when appropriate, have greater choice and control over the HCBS they receive and the workers and organizations that provide them by either being the common law or managing employer of their workers. Based on the Independent Living philosophy and the premise that individuals with disabilities know best about the services they need and how they are best delivered; and the disability advocacy creed of “Nothing About Us Without Us,” the provision of services and the training of HCBS workers under the participant-directed service delivery model originates with, and are specific to, the individual (Flanagan, 2005, p.12).

A key design feature of participant-directed service programs is affording older adults, individuals with disabilities and their representative, when appropriate, the option to hire neighbors, friends, relatives and others known by the individual or representative as paid workers (including legally responsible family members, as allowed). This approach liberates a non-traditional direct service workforce and

expands the existing home and community-based direct service workforce to a certain extent. However, in the absence of a relationship with the individual in need of services, many neighbors, friends and relatives might never consider being workers (Flanagan, 2005, p. 26). The Cash and Counseling Demonstration Evaluation (CCDE) and a study conducted by Delp et al in 2010 found that the majority of individuals receiving participant-directed services under the Demonstration opted to hire relatives (including legally responsible relatives in some states) when given the opportunity to do so (Mahoney, 2005; Delp et al, 2010, p. 928). Moreover, in a 2011 survey conducted by PHI of workers serving individuals enrolled in the Michigan Choice Program's Self-determination Option, 49 percent of respondents reported being family and 24 percent reported being friends and/or neighbors (PHI, 2011, p.8).

Using a participant-directed approach, HCBS delivery has been found to increase access to, and the quality of, service delivery in addition to overall consumer satisfaction with services provided. The CCDE found that individuals using participant-directed services reported less unmet need for personal care, were more satisfied with their care, and were no more likely to have suffered a care-related health problem than those using agency-based care (based on the 11 measures examined) (Brown et al., 2007, p. xix).

A key characteristic of workers working in participant-directed service programs is frequently they work for only one individual. In 2010, Delp et al found that only 22.63 percent of 1,614 home care workers working for individuals enrolled in the California IHSS Program in Los Angeles reported working for more than one individual program participant (Delp et al, 2010, p.928).

Another key characteristic of workers in participant-directed service programs is often they receive little formal training. The CCDE reported that only 50-55 percent of the workers providing participant-directed services received training in the provision of personal care (Foster, Dale & Brown, 2007, p.523). However, even though only a limited number of workers reported receiving formal training, approximately 90 percent reported they felt well informed about the individual's condition and fully prepared to fulfill their responsibilities (Foster & Dale, 2005, slide 18).

In a 2004 study conducted by Benjamin and Matthias on work-life differences and outcomes for agency and participant-directed home care workers in California's In-Home Supportive Services (IHHS) program, it also was reported that participant-directed home care workers were less likely to receive formal training. However, the research suggested that participant-directed home care workers receive considerable informal training from various sources, including family physicians, home-health nurses and therapists, and that this training is targeted to the individual's specific care needs. From the participant-directed home care worker's perspective, it was reported that the absence of formal (agency or academy) training was far less of an issue than expected and findings on service satisfaction from recipients supported this view (Benjamin et al., 1998; Doty, 1999). However, Benjamin and Matthias concluded that whatever the service delivery model used, adequate training and pertinent information on the individual's condition were associated with more worker satisfaction and less stress (Benjamin and Matthias, 2004, p.486).

On November 16, 2011, the National Resource Center on Participant-directed Services (NRCPDS), in collaboration with ADAPT, the Center for Self-Determination, the Service Employees International Union and the Topeka Independent Living Resource Center, issued, and affirmed their endorsement of the document, *Guiding Principles for Partnerships with*

Unions and Emerging Worker Organizations When Individuals Direct Their Own Services and Supports ("Guiding Principles"). This document specifically addresses the provision of worker training under participant-directed service programs and provides guidance on the topic. It states that there is strong disagreement within the disability and labor communities regarding the provision of worker training when individuals direct and control their supports and the workers who provide them. In addition, it states that issues related to worker training are addressed on the local or state level as part of collaboration between disability advocates and labor (NRCPDS, 2011, p.5).

The *Guiding Principles* developed by NRCPDS et al in 2011, recommend that when training programs exist for participant-directed service programs, they should promote the acquisition of the basic values and skills needed to support the individual directing his/her services. The guiding principles also emphasize that individuals in need of long-term services and supports have diverse needs and thus, require workers who are able to provide these services in a manner that is determined by the individual receiving services (NRCPDS et al, 2011, p.5).

The *Guiding Principles* recommend that training programs for participant-directed service programs:

- Be funded independently of program participants' individual budgets unless an individual decides to supplement training beyond what is reimbursed by the state program.
- Recognize that individuals frequently hire family and friends who already have significant experience providing supports to the individual.
- Be implemented in a manner that expands the available source of workers and facilitates individuals hiring the worker of their choice (NRCPDS et al, 2011, p.5).

Finally, the *Guiding Principles* also recommend that "when training programs exist, the curriculum must":

- Be designed in collaboration with people directing their own services and supports and workers who support them.
- Reflect the values and practices of self-determination and independent living, including supporting individual rights and control, the ability to pursue competitive and supported employment, and the desire to live a life of dignity and meaning in their own communities.
- Reinforce that acquired skills need to be applied differently depending on the needs and preferences of the individual and at the direction of the individual.
- Include best practices for injury prevention for the worker and participant.
- Be delivered by experienced and competent instructors, including workers, program participants, and family members [representatives], who are familiar with the best practice of choice and control (NRCPDS et al, 2011, p.6).

Participant-directed services: A Snapshot

States may offer two basic participant direction opportunities to individuals enrolled in a Medicaid HCBS waiver or state plan amendment (SPA). Under *Employer Authority* individuals receiving services may function as either the common law or joint employer of their workers and carry out the employer responsibilities with supports. Under *Budget Authority*, individuals have the authority and accept the responsibility for developing and managing an individual-directed budget and may have the option to purchase approved individual-directed goods and services. CMS requires states to provide supports to individuals using participant-directed services. These include Information & Assistance (I&A) and Financial Management Services (FMS). Currently, CMS recognizes three types of FMS: Government or Vendor Fiscal/Employer Agent (F/EA) FMS or an Agency with Choice (AwC) FMS. Under the Government or Vendor F/EA FMS model, the individual or his/her representative is the common law employer of his/her direct service workers. Under the AwC FMS model, the individual or his/her representative and an agency are joint employers with the agency functioning as the primary employer and the individual or representative functioning as the secondary or "managing" employer of the individual's direct service workers. As "managing employers," individuals or their representatives perform or actively assist with performing direct service worker recruitment, training, scheduling, supervision and discharge. Another participant-directed service delivery model used by six states to implement collective bargaining is the Public Authority model. Under the Public Authority model, the individual or his/her representative is a joint employer of the individual's direct service workers with the public authority and possibly a government or provider agency (Flanagan, 2009). Most participant-directed programs do not require formal direct service worker training, however, a growing number of states are making training available to this subset of workers (Hewitt et al., 2008).

A case also can be made for states developing specific direct service worker competencies, training and Medicaid rate setting methods for participant-directed service programs where individuals, or their representative when appropriate, act as either the common law or managing employer of their relative or non-relative direct service workers (*Employer Authority*). They also may have the option to manage an individual budget and purchase individual-directed goods and services (*Budget Authority*). Relatives hired as direct service workers by individuals enrolled in participant-directed service programs often only work for their relative, may or may not perform complex health maintenance tasks, and provide services in one work place setting. In addition, they often have prior knowledge of the individual's condition and care needs, and have received some informal training from various health care professionals (i.e., family physicians, home-health nurses and therapists).

Training within a Participant-Directed Service Delivery Model

As the common law or joint employer, individuals or their representative, as appropriate, are responsible for either training or actively participating in training their direct service worker based on the level of direction and control they wish to exercise.

Under a participant-directed DSW competency and training model, the individual receiving care and/or his/her representative should actively be involved in determining the type of training provided and in training his/her direct service workers to the extent he or she wishes to participate. The direct service worker training needs and curriculum should be *customized* to the individual's specific needs and documented in the individual's service plan and along with any updates. In addition, the cost of training could be funded, as allowed, in the person's individualized service plan and budget.

In developing competencies and training for direct service workers working in participant-directed service programs, it is important that both the time and cost of training and meeting the competency requirements not be an undue burden to the worker (relative or nonrelative). Additionally, it is important not to discourage relatives from being a paid worker for their family member or friend and

possibly reduce the availability of this non-traditional direct service workforce.

An argument can be made that a participant-directed approach should be implemented in all long-term care service delivery models and included in the competencies and training of all workers regardless of service setting (i.e., facility-based and home and community-based service settings). In a best practice model for long-term care service delivery, one might argue that using a person-centered, participant-directed approach provides individuals with a level of choice, control and service *customization* that can result in less unmet need for services, increased satisfaction with their services and better health and quality of life outcomes (Brown et al., 2007, p. xix).

Illustrating the Effect of Participant Direction on Service Workforce Training

Given the nature of participant direction, states' Medicaid rate setting methods may afford individuals the ability to set wage and benefits rates for their direct service workers. These rates may or may not include the costs of ongoing training. A state may reimburse participant-directed services, including ongoing training, using an all-inclusive, average rate/unit of service approach. This rate setting method results in ongoing training costs being reimbursed for all workers regardless of whether ongoing training is provided. On the other hand, states that offer participant-directed services using Budget Authority may customized their rate setting approach by including ongoing training costs that are specific to an individual's needs in the person's individualized budget. This rate setting method ensures states that only the ongoing training, customized to the individual and provided to his or her direct service worker, and related costs are reimbursed.

The table below describes proposed training requirements for direct service workers working in participant-directed service programs. The rate setting model for participant-directed services enables a state to develop a payment method for ongoing training that upholds the philosophy of participant direction. Additionally, this kind of rate setting model supports the inherent value of the individual as employer while providing access to continuing education and training for workers that are needed and requested by the individual or representative-employer. In cases where states offer both Employer and Budget Authority under their participant-directed program(s), an individual could include continuing education and training and related costs in their individual budget. States that only offer Employer Authority inhibit individuals from providing continuing education and training due to the absence of an individual budget.

Table 3: Participant-Directed DSW Model

Participant-Directed DSW Model	
Provider Type	Participant-directed Direct Service Worker
Service Description	Same as the Base Service Description
Minimum Participant-Directed Worker Qualifications	***Minimum Qualifications to Work as a Participant-directed Worker:*** Prior to beginning work as a participant-directed worker the following minimum qualifications must be met. ❑ Minimum age of 18 ❑ Must pass criminal background checks and clearances as required by state participant-directed service program ❑ Often states require CPR/First Aide Certification ❑ Be able to successfully communicate with the individual in need of services and his/her representative, as appropriate. ❑ Be willing and able to perform the tasks, as required. ❑ May be a relative including a legally responsible relative (e.g., parent of minor child or spouse) when allowed by Medicaid law and state participant-directed service program. ***After hire and within 30 days of hire:*** ❑ Receive orientation/training on (1) participant direction philosophy and application to the delivery of HCBS, (2) individual's rights, confidentiality, dignity and respect for cultures and boundaries; (3) role and responsibilities of the individual receiving services, his/her representative, the worker, Financial Management Services and Information & Assistance type/organization being used, and state participant-directed service program; (4) ADLs, IADLs and health maintenance activities as identified by the individual and/or his/her representative for training, (5) recognizing incidences of abuse, abandonment, neglect, and exploitation and interventions to prevent or eliminate them; health and well-being, and state critical incident reporting procedures; (6) maintaining a safe work place and reporting work place injuries; (7) resolving conflict, (8) documentation and record keeping, and (9) other individual-specific issues as identified by individuals and representatives.
Minimum Worker Training Provided	❑ CPR/First Aide Certification ❑ Same as requirement under "after Hire and within 30 days of Hire" ❑ Other worker training as identified by individual/representative and who may seek advice from medical/rehabilitation workers and/or their Information & Assistance organization (e.g., service coordinator, supports broker), as needed.
Individual/Entity Responsible for Providing Worker Training	❑ Individual and/or representative either performs training directly (i.e. when the individual is the common law employer using G/V F/EA FMS or is the joint employer using AwC FMS), or assists in performing training (i.e. when the individual is the joint employer using AwC FMS), or arranges for training to be provided (under all three FMS models). May seek assistance from medical/ rehabilitation workers and/or their Information & Assistance provider (e.g., service coordinator, supports broker), as needed.
Individual/Entity Responsible for Verifying Minimum Worker Qualifications Have Been Met	❑ State participant-directed service program personnel or designee.

Participant-Directed DSW Model	
Development and Implementation of Performance Indicator(s) for determining whether Minimum Worker Qualifications Have Been Met	❑ State participant-directed service program personnel or designee.
Wages and Benefits	❑ As allowed by state participant-directed service program under the G or VF/EA FMS model, the individual or his/her representative may determine the worker hourly wages in compliance with federal and state department of labor fair labor standard act requirements for domestic service workers (both minimum wage and overtime requirements) and state self-directed service program rules. Under the AwC FMS model, the AWC FMS organization may have a role in establishing worker wages based on federal and state labor law and state self-directed service program rules. ❑ As allowed by state participant-directed service program, individual or his/her representative determines worker benefits (e.g., sick, holiday and vacation time; health, disability, or life insurance, family medical leave and/or pension/401-k). Under the AwC FMS model, the AwC FMS organization also may have a role in establishing a worker's benefits based on ERISA and state self-directed service program rules.

For Critical Reflection

- ❑ Does your state have one or more participant-directed service programs?
- ❑ Do you know the status of training within your state's participant-directed service program(s)?
  - ▶ How are participant directed workers trained? By whom?
  - ▶ How are participant-directed workers' skills and training verified? By whom?
  - ▶ How are training needs discussed in this Section addressed within your state's participant-directed program(s)?
- ❑ If Budget Authority is offered, may individuals include the cost of ongoing training within their individual budgets? If yes, do they?
- ❑ Do you know how satisfied participant-directed workers are with the training they receive?
  - ▶ Do they receive the training they feel they need?
  - ▶ Do individuals who hire and manage their workers receive State support in providing training to their workers?
  - ▶ Do you have any data or information that provides evidence that workers are adequately trained by individuals or their representatives?
- ❑ What improvements can your State make to its overall training policy, as well as coverage of continuing education and training, within your participant-directed service program(s)?
  - ▶ If yes, does your program(s) offer Employer Authority, Budget Authority or both?
- ❑ If your program only offers Employer Authority, how much flexibility does the individual have to include the cost of worker training within the payment rate?
- ❑ If your program offers Budget Authority, how much flexibility does the individual have to include worker training costs within his or her individual budget?
- ❑ Have you considered the inclusion of important contract language for managed care plans or other care organizations to ensure that the individual maintains choice and control over his/his services and the workers and organizations that provide them and over the training of workers?

Purpose of Section	Section IV

This section provides an overview of how Medicaid reimbursement rates are established and focuses on the inclusion of continuing education and training costs into the Medicaid rate-setting methodology. Medicaid programs and their rate-setting methodologies vary by state, so this section provides a general national overview.

Section IV: Medicaid Payment Reimbursement Basics

CMS promulgated regulations at 42 CFR 447.200-205 to meet the payment rate requirements at §1902(a)(30)(A) of the Social Security Act. Essentially, there are ***three core statutory requirements*** that apply to setting payment rates.

- Methods and procedures must lead to payments that are "consistent with efficiency, economy, and quality of care."
- Payment rates must "be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."
- Providers must accept the Medicaid rate of payment as payment in full and therefore, cannot seek payment from Medicaid recipients. However, there are a few exceptions to this rule (e.g. nominal deductibles, co-insurance, and co-payments).

Impact on Quality and Access

Reimbursement policies play a key role in access and quality of care because such policies influence provider behavior.

The Medicaid program is administered jointly by both federal and state governments. As a result, states have significant latitude in how they develop and implement payment methodologies for Medicaid services rendered and these methods can vary by state. State Medicaid Payment policies can affect access to and quality of Medicaid services by influencing provider behavior. Table 3 reflects examples of Medicaid payment methodologies.

Table 4: Medicaid Payment Methodologies

Examples of Medicaid Payment Methodologies	Description of Medicaid Payment Methodologies
Fee for Service	An established fee is paid for services provided by specific Medicaid provider types. Some fee for service rates are based on Medicare rates with geographic adjustors for the same service or are built using an independent rate model that takes into account market-based rates and a provider's cost of doing business.
Capitated	Actuarially sound rates based on comparable recipients and historical utilization and expenditures. Requires certification of actuarial soundness by CMS. Usually includes risk adjustment, enhanced benefits, and/or risk corridors. Capitation can be set administratively, through negotiation or through competitive bid.

Examples of Medicaid Payment Methodologies	Description of Medicaid Payment Methodologies
Retrospective Cost-Based	Fees are established periodically for provider types based on a provider's historic cost of providing services. Adjustments may be indexed to inflation factors. Rate ceilings may also be in place.
Prospective	Rates are set in advance (sometimes using peer groups, case mix or other historical payment information) and may or may not be related to the provider's actual costs.

Note: Merlis, M. (2004). "Medicaid Reimbursement Policy". CRS Report for Congress.

In addition to Medicaid regulations contained within the Code of Federal Regulations, additional guidance also can be found in §1915(c) of the Social Security Act and within CMS instructions to states developing and administering home and community based services (HCBS) waiver programs. Given the focus of this Toolkit, the guidance provided by CMS for HCBS waivers is helpful. See www.hcbs.org/moreInfo.php/doc/1752 for the waiver technical guide and application.

Table 5: Additional Guidance contained in the §1915(c) HCBS Waiver Application

Additional Guidance contained in the §1915(c) HCBS Waiver Application
Rates may be prospective, retrospective with some settlement of interim rates, or fee for service.
Rates set by states may incorporate "difficulty of care" factors to address the level of provider effort associated with serving individuals with different support needs.
Rates may include geographic rate adjustors to reflect differences in costs in different areas of the state.
Rates must be uniform across all providers for the same service description.
Supplemental or enhanced payments may be made within regulations (e.g. performance incentives)

Note: States may also find additional guidance through CMS on the 1915i, 1915j, and 1915k of the Social Security Act at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html.

For Critical Reflection

- ❑ Have you mapped out the Medicaid rate setting methodologies used by your state to reimburse direct care services (in general and to cover training) across your long-term services and supports programs? If not, try mapping out your state qualifications and training by program and service, as appropriate, discuss with key partners, and develop a plan of action to modify necessary waivers, state plan amendments, and/or regulations such as rules and procedures as necessary.
- ❑ Do you have consistent qualifications and training requirements across sectors (*i.e. service, setting and provider model as described in the Introduction Section*)? If not, developing consistent requirements is the first step in developing a foundation for a direct service worker training model.

Purpose of Section	Section V

This section provides an introduction to the "ground up" approach to rate setting and establishes a possible foundation for the inclusion of training costs within a basic rate-setting model. The section then illustrates payment methodologies with the inclusion of the continuing education and training. These models are expected to stimulate state policy and rate-setting and encourage the deliberation of potential changes that ultimately improve the direct service workforce infrastructure.

Section V. Fee for Service Rate-Setting Model: Building Continuing Training into Medicaid Rate-Setting

Each Medicaid program is required to establish service descriptions, provider types, and standards required for a service provider to be considered qualified to enter into a contract with the Medicaid agency. As mentioned in the introduction to this Toolkit, initial training and related costs are not allowable under Medicaid due to the requirement that providers only bill for, and receive Medicaid payment for, services rendered following execution of a provider agreement/contract with the Medicaid agency. Initial training is often a requirement for provider enrollment and therefore received prior to initiation of a contract. Therefore, this section focuses on continuing education and training within traditional and participant-directed service delivery models. The section:

- illustrates transparent rate-setting models which highlight how States could include continuing education and training costs within Medicaid rates of payment in traditional service delivery systems;
- provides insight into the impact of the traditional rate setting models on participant direction and integrated service delivery systems;
- discusses the potential development of incentive based service delivery; and
- describes continuing education and training within participant-directed service delivery models.

Medicaid Programs have great flexibility in establishing provider qualifications and training standards

Each state Medicaid program operates under different state laws and different Medicaid policy provisions.

According to a report issued by the Congressional Budget Office, determining the adequacy of payment rates often is difficult. This is due to a number of factors. For example, it is challenging to determine how to allocate the cost of training and overhead and how to address geographic differences in cost. It is for this reason that the Toolkit uses the "ground up" approach to rate setting to illustrate the critical components of a rate in a transparent manner. The "ground up" approach has a history of use within some programs in Ohio, Nevada and Arizona. It is important to note that this Toolkit does not include examples for every possible rate-setting or payment methodology available across state Medicaid programs. Rather, the Toolkit provides insight into how continuing education and training could be included using a "ground up," transparent approach.

This section attempts to illustrate different ways to allocate continuing education and training costs within different payment models. States have great latitude in defining Medicaid services and setting qualification standards for providers. The section is meant to provide the foundation to state dialogue. The National Direct Service Workforce Resource Center is available to offer technical assistance as states engage in this important dialogue.

Base Provider Type, Service Description and Provider Standards Necessary to Secure a Medicaid Contract: An Example

Each state Medicaid program operates under different state laws and different Medicaid program policy. The description below provides the foundation for the example "base" rate contained in this section. This example identified the initial requirements that might be necessary for an individual or agency to enroll as a Medicaid provider, and then the continuing education and training that could be included within a base rate. For illustration purposes only, the §1915(c) waiver definition of personal care is used as the service definition with one possible set of qualifications as an example foundation to each model.

Table 6: Base Provider Type, Service Description and Provider Standards

Base Provider Type, Service Description and Provider Standards	
Provider Type	Direct Service Worker
Service Description	Provides a range of assistance (e.g. Activities of Daily Living such as bathing, dressing, transfers, positioning, range of motion, toileting and Instrumental Activities of Daily Living such as homemaker/chore activities, community integration support, and health maintenance activities) to enable persons to accomplish tasks they would normally do for themselves if they did not have a disability. This assistance may take on the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the person to perform a task.
Provider Standards	Potential Initial Requirements to Obtain a Provider Agreement (*varies by state*): ❑ Minimum age of 18 ❑ Some states have requirements regarding whether a parent or spouse (legally responsible adults) can be a Medicaid provider. In addition, states may or may not allow legally responsible adults to enter into a Medicaid Provider agreement. ❑ Many states have policies and procedures governing confidentiality, satisfaction, service monitoring and protections (please note this may not be applicable to individual providers under participant direction). ❑ Some states require potential workers to pass a background check. A "Promising Practice" for states is requiring that a background check be conducted for all workers. It should be noted that under participant direction, a state may allow a program participant to hire a worker who does not pass the background check, however, it is not recommended. ❑ Often states require CPR/First Aide certification. ❑ Often states require training on Medicaid recipient protections and state critical incident reporting procedures.

Base Provider Type, Service Description and Provider Standards	
	Within 30 days of obtaining initial provider agreement, training requirements could include a state determined number of hours on: Training on tasks to perform to meet individual's needs as described in his/her care plan, individual rights, behavioral support (if applicable), medication administration, signs and symptoms of health and safety, and documentation and billing requirements, to name a few. ***Ongoing Requirements to Maintain Provider Agreement could include:*** ❑ 10 hours of continuing education (please note this may not be applicable to participant-direction programs).

Once a state establishes the provider standards and requirements, the state sets the rate. The rate model below is an example of how a state can set a base rate using a simple "ground up" rate-setting method. This method incorporates training time, trainer costs and materials to cover the continuing education and training requirements. For the sake of illustration, this rate model is built using the 2011 median average hourly wage for personal care aides. It is widely known that the wages paid to workers vary considerably (Hewitt et al., 2008). Please visit http://phinational.org/policy/states/ for more information on average wages by state. Given that this rate model uses the average wage as a foundation for illustration purposes, states can modify this model by starting with a different average wage as determined appropriate for the state. The below base rate also assumes that employees have unbillable time during a typical year. Leave benefits, the unbillable time, is included to illustrate how a state could cover the lost time associated with training and other leave benefits. The below model DOES NOT include coverage of pension, health care or other fringe benefits. Please see section immediately following **Table 4** for a description of the calculations used throughout this Toolkit.

Table 7: Base Rate Model

Rate Component	Addition to Rate	Discount from Rate	Final Rate
Average Hourly Salary	$9.49[1]		
Total Annual Paid Hours	2080		
Less Holiday Hours		72	
Less Vacation Leave		80	
Less Sick Leave		40	
Less continuing education hours		10	
Net Hours for Billing		1878	
Percentage of Time Available for Billing		. 902	
Adjustment for Billable Time (Total Salary % of time available for billing)	$10.52		
Other Direct Costs	$3.65		
Transportation[2]	$6000		

Rate Component	Addition to Rate	Discount from Rate	Final Rate
Trainer and Supplies[3]	$1600		
Hourly Rate with Other Direct Costs[4]	$14.17		
Indirect (10%)[5]	$1.42		
Total Hourly Direct plus Indirect			$15.59

Assumptions for Illustration Purposes Only:

1. 2011 U.S. median hourly wages for personal care aides - http://phinational.org/policy/states/united-states/.
2. Assumes $6,000 annual transportation costs. States will need to determine the appropriate annual transportation costs.
3. Assumes 10 hours X $150 per hour + $100 total supplies per person. States will need to determine the appropriate cost of training time and supplies.
4. Direct costs generally include: Salaries or wages (including vacations, holidays, sick leave, and other excused absences), other employee fringe benefits allocable on direct labor employees, travel, materials, supplies and equipment and communication costs.
5. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation of the agency and the activities the employee performs. An indirect of 10% is used for illustration purposes only.

Description of the Base Rate-Setting Model Calculation:

The rate-setting model begins with an average hourly salary with the addition of hourly fringe benefits (paid time off). The rate-setting model does not reflect the actual wages a direct service worker could receive, but rather the rate paid for the service provided. State Medicaid agencies may want to consider establishing policies for wage pass-through as described in Section II to ensure that the employee also benefits from the training provided reflected through an increase in wages.

- *Step 1.* The model assumes 2,080 hours worked per year, which equals a 40-hour work week for 52 weeks of the year. The model then subtracts the hours of unbillable work associated with vacation, holidays, sick leave, and *training hours* which leaves a net of 1,878 for billing which equates to .902 percentage of time available.
- *Step 2.* To calculate billable time, the average salary is divided by the percentage of time available for billable activities resulting in a total hourly cost of $10.52.
- *Step 3*. The rate then takes into account the cost of transportation, a trainer, and training supplies calculated annually then distributed across 2,080 hours resulting in the addition of $3.65 to the hourly rate.
- *Step 4.* An indirect charge of 10% is then added with a final rate of $15.59 hourly.

Toolkit provides an illustration

The Toolkit uses the "ground up" approach to rate setting to illustrate critical components of a rate in a transparent manner.

The below base rate model DOES include fringe benefits such as pension and health benefits for illustration purposes only. States have flexibility to establish rates and may or may not choose to include fringe benefits within the calculation.

Table 8: Base Rate Model

Rate Component	Addition to Rate	Discount from Rate	Final Rate
Average Hourly Salary	$9.49[1]		
Fringe Benefits	$4.23[2]		
Total Salary and Fringe	$13.72		
Total Annual Paid Hours		2080	
Less Holiday Hours		72	
Less Vacation Leave		80	
Less Sick Leave		40	
Less continuing education hours		10	
Net Hours for Billing		1878	
Percentage of Time Available for Billing		.902	
Adjustment for Billable Time (Total Salary and Fringe/% of time available for billing)	$15.21		
Other Direct Costs[3]	($3.65)		
Transportation[4]	$6000		
Trainer and Supplies[5]	$1600		
Hourly Rate with Other Direct Costs	$18.86		
Indirect (10%)[6]	($1.89)		
Total Hourly Direct plus Indirect			$20.75

Assumptions for Illustration Purposes Only:

1. 2011 U.S. median hourly wages for personal care aides - http://phinational.org/policy/states/united-states/.
2. Fringe: Assumes some pension, health care, and other benefits at $8,800 per year. States will need to determine the appropriate fringe for workers.
3. Direct costs generally include: Salaries or wages (including vacation, holidays, sick leave, and other excused absences), other employee fringe benefits allocable on direct labor employees, travel, materials, supplies and equipment and communication costs.
4. Assumes $6,000 annual transportation costs. States will need to determine the appropriate annual transportation costs.
6. Assumes 10 hours X $150 per hour + $100 total supplies per person. States will need to determine the appropriate cost of training time and supplies.
7. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation of the agency and the activities the employee performs. An indirect of 10% is used for illustration purposes only.

Description of the Base Rate-Setting Model Calculation

The rate-setting model begins with an average hourly salary with the addition of hourly fringe benefits. The model follows the same calculation as Table 3 with the exception that fringe benefits are included prior to the calculation at *Step 1*.

The Value of Adding Fringe Benefits

Although atypical to how states likely calculate rates for this provider type, this base rate-setting model includes fringe benefits. The model assumes that the employee receives fringe benefits that are typical for most employees in other workforce sectors. Research conducted by the National Direct Service Workforce Resource Center (Hewitt et al., 2008) cites limited access to

fringe benefits for direct service workers. This example rate model illustrates not only how training costs could be included, but also how a state could more adequately cover the basic fringe benefits many employees in various occupational sectors receive. Health benefits are critical to establishing a sustainable workforce and can reduce employee turnover, increase the health care quality of workers and leader to a decrease in state costs associated with public assistance programs. U.S. data on direct service worker households reflect that 47 percent of the direct service workforce used public assistance programs between 2008 and 2010 with 38 percent enrolled in Medicaid and 32 percent in Food and Nutrition Programs. States that incorporate fringe benefits within rates may find a resulting decrease in state costs associated with providing public assistance benefits. See the PHI State Data Center at http://phinational.org/policy/states/ for your state's public assistance impact.

Illustrating Innovative Approaches to the inclusion of Continuing Education and Training within Medicaid Rate-Setting

Direct service workers spend more time with service recipients than any other Medicaid long term services and supports provider type and yet have the least education and training. Competency-based training is a tool that states can use to ensure that workers have the knowledge and skills to meet the unique needs of service recipients. Direct service worker competency development can lead to greater quality, reduce costs, and promote the development of career ladders and lattices industry-wide.

Table 9: Benefits of a Competency-Based Approach

A competency based approach benefits the…			
Individual Receiving Services	**Direct Service Worker**	**Employer**	**Policymaker**
As evidenced by…			
Increased quality of care and life in all settings Optimal training resources for informal caregivers Potential for increased ability for self-directing participants to guide the training based on competencies determined necessary to meet their individual needs	Increased competence and feelings of job satisfaction Increased responsibility and recognition, including promotional opportunities Connection to industry career pathway programs and career development pathways within university systems	Expansion and increased capacity and flexibility of a direct service workforce Decreased administrative and operational expenses (i.e. decreased turnover, training to reduce occupational injury) Reduced bureaucracy (one set of requirements across sectors)	Dissemination of training to reduce premature nursing facility admission and prevention strategies Potential for reduced administrative costs for services (i.e. marketing, interviewing) resulting in greater focus on direct services Streamlined administration across sectors Ability to connect rates to quality and training Address health and human service workforce shortages through the development of career ladder/lattice models

This section illustrates approaches to strengthen the direct service workforce using various competency-based models. The models illustrated within the following sub-sections reflect different ways a state can cover the cost of continuing education and training for the direct service workforce in compliance with Medicaid requirements using the same “ground up” approach illustrated earlier in this section.

> *This Toolkit presents a rate-setting approach that can provide a foundation to the development of a DSW infrastructure. States may take the examples*

presented in the competency-based models, build upon them, adapt and/or mix the ideas contained within, in order to meet state specific goals.

For example, a state could develop the acuity-based model and incorporate competency-based training systems based on an identified participant's needs within the acuity model. Once a state has determined the service recipient's needs (via assessment) and connected needs to service delivery structures (via person-centered planning), the state could build in any of the following competency-based training and development models, including the mentorship/supervisor model and statewide training and credentialing model. A state also could use the acuity-based model to determine provider qualifications and the number of training hours necessary to qualify providers to meet service recipient needs. The models contained in this section could provide a tool to translate training models into policy and practice.

The section concludes with a description of the impact of the various rate-setting models on participant direction programs and within an integrated service delivery system whether through a traditional managed care environment or through innovative care management programs.

Each model reflects varying value to the Individuals served and to the direct service workforce. When possible, limitations are noted and a value is assigned as follows:

Figure 2: Description of Value Icons

Individual Value

Low individual value

This model provides little support to individuals and is not directly linked to the needs and desired outcomes of individuals served.

Medium individual value

This model provides some support by connecting workers to necessary training that can lead to the provision of high quality services and supports.

High individual value

This model optimizes the quality of care delivery by connecting training directly to individual need and desired outcomes.

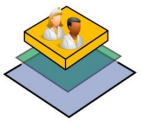
Low DSW value

This model is not likely to lead to greater recognition for the DSW, increased wages, improved retention and reduced turnover, and overall quality.

Medium DSW value

This model is directed toward greater recognition for the workforce and may lead to greater wages, improved retention and attainment of quality outcomes. The model reflects movement toward an optimal DSW infrastructure with potential for growth.

High DSW value



This model leads to greater recognition, improved wages and benefits, training directed to meet individual needs and desired outcomes, improved retention, higher quality, and potential to address the gaps within the broader health and human service workforce.

Value is assigned based on the model's ability to improve quality of individual's care and reduce turnover, increase skills and enhance wages of direct service workers.

For Critical Reflection

- ❑ Do you have any Medicaid rates of payment in your state, which are established using the "ground up" approach?
  - ► If not, can you envision the possibility of establishing Medicaid rates of payment using a similar transparent approach?
- ❑ Do you have a health and human service workforce strategy?
- ❑ If not, use the tool in Appendix B and develop one today!
- ❑ Have you reviewed your state's direct service workforce's wages and benefits?
- ❑ How many workers in your state are receiving public assistance? Visit the PHI Data Center to review these statistics. Conduct cost benefit analysis to determine whether your state could leverage efficiencies and potentially reduce overall state costs by adding fringe benefits to the rate-setting calculation.
- ❑ Can you think of ways to include continuing education and training costs within the Medicaid rate setting methods you currently have in place? What barriers prevent you from moving forward?
- ❑ Can you think of solutions to eliminate and/or mitigate any barriers to training and improving wages and benefits identified? The National Direct Service Workforce Resource Center can help you think this through. Contact us today! info@dswresourcecenter.org or 877-822-2647.

Acuity-Based Rate Setting Model

This sub-section illustrates a model that varies based on the acuity level of service recipients and the complexity of their service needs. Assigning acuity levels in advance could more easily promote a competency-based workforce system by determining/assigning specific training for workers based on the care needs/levels of people they support. An acuity model justifies how to implement competency-based training to meet the unique needs of service recipients.

The ***Acuity-based Model*** reflects a rate-setting model that varies based on the acuity level of service recipients and the complexity of their service needs. It is built upon the base service description and provider standards outlined earlier in this section.

Training within an Acuity-Based Model

In this model, the direct service worker receives enhanced reimbursement based on acuity and service need.

Table 10: Acuity Based Model

Acuity Based Model	 High Value  Medium DSW Value
Provider Type	Direct Service Worker
Service Description	Same as base
Provider Qualifications	Same as base
Base Rate	$15.59 (built on traditional model described in the introduction to this section)
Acuity-based Payments	The acuity-based model is a tiered direct service worker model based on acuity levels. This model requires increased competence in specific areas relevant to a particular group's needs. States may apply an acuity-based adjustment to the base rate using an instrument like MDS 3.0, which results in a Resource Utilization Group (RUG) score. The RUG represents the person's direct care resource requirement and is a possible method for adjusting the base rate based on acuity. States may develop similar instruments for community based settings with the intent to not only develop a person-centered care plan, but also assess the payment rate for meeting needs as outlined in the care plan. An acuity-based payment rate may be accompanied by state requirements for providers to meet certain quality standards with possible linkage to incentive-based payments as described below. An example of a tool for determining acuity is the "The Home Care Assessment System". The tool is known as InterRAI HC with 27 Clinical Assessment Protocols including a case-mix system that places persons into distinct intensity categories known as the RUG-III/HC. A State also could set provider rates based on levels such as "light, moderate, and heavy" associated with a threshold of need with activities of daily living (ADL), instrumental activities of daily living (IADL) and health maintenance. Such a rate system could then be tied to corresponding training requirements as illustrated below.

Acuity Based Model


High Value


Medium DSW Value

Light Level – Direct Service worker serves individuals with 'light' care needs such as two ADLs, 1 IADL, and receives basic training.

Moderate Level – Direct service worker serves individuals with 'moderate care' needs such as three ADLs, 2 IADLs and perhaps one health maintenance need such as medication administration. Worker receives basic and additional advanced competency-based training in an area of specialization such as medication administration.

Heavy Level – Direct service worker serves individuals with 'heavy' care and support needs such as three ADLs, two IADLs and more than two health maintenance needs such as medication administration, positive behavior support, and crisis intervention strategies. Worker receives basic training and full range of more advanced competency based training.

The acuity-based model provides value to both the individual service recipient or consumer and the worker. It more effectively reimburses the provider based on acuity and encourages the establishment of quality measures. Compared to the other models included in this Toolkit, this model provides a potential for direct service workforce quality improvement. The model customizes training to service needs and compensates the worker accordingly.

For Critical Reflection

- ❑ How well does this model fit within your current state infrastructure for the direct service workforce?
- ❑ What aspects of this model fit the state's goals for your state's direct service workforce?
  - ► States may wish to consider adapting this model and/or merge the aspects you value most from across all of the models contained in this Toolkit resulting in an infrastructure that best meets state goals and desired outcomes for your health and human service workforce. States also may wish to consider using the tools contained in Appendix B and C to guide development of a health and human service workforce initiative.
- ❑ How does this rate setting model interface, or not, with your participant-directed service programs?
- ❑ Consider how this rate setting model could be applied in an integrated care environment.

Mentorship Rate-Setting Model

This section reflects a rate-setting model that enables the worker to enter the system with minimal training with mobility across a "lattice" over time. States can use the ideas contained within this model to develop an innovative and supportive approach to DSW development. Assumptions are used to illustrate the rate model that may or may not be applicable or desired. The benefit to the "ground up" approach is the ability to modify the assumptions to meet state specific goals.

Training within a Provider-Based Tiered Model

In this model, the direct service worker enters the system with minimal training and has a "lattice" in which to grow across the direct service workforce.

The mentorship rate-setting model builds upon the base service model description and provider standards. Under the mentorship rate-setting model, the worker enters the system with minimal training and climbs the employment "ladder" based on increased training and competence resulting in reaching a higher rate tier. The individual receiving services has access to the same scope of work activities regardless of tier. The level of skills a worker has varies depending on the tier the worker attains. Additionally, this model could be coupled with an acuity-based system matching the needs of service recipients to the workers meeting specific skills.

The mentorship rate-setting model can be modified to match state specific data. States can determine the appropriate ratio of mentor to worker to meet desired workforce outcomes. States can provide policy guidance and develop audit controls to ensure that providers receiving the enhanced rate associated with mentor and supervisor pass a portion of the enhancement to employee wages thereby recognizing the value of education, training, and job shadowing on employee career mobility.

Table 11: Mentorship Model: Tier 1

Mentorship Model TIER ONE  Low Value  Medium DSW Value	
Provider Type	**Tier 1: Direct Service Worker Entry Level**
Service Description	Same as the Base Service Description
Provider Qualifications	Same as the Base Provider Qualifications
Tier 1: Base Rate	$15.59 Note: Using the base rate in Table 4.

Table 12: Mentorship Model: Tier 2

Mentorship Model TIER TWO	 Low Value	 Medium DSW Value
Provider Type	**Tier 2: Direct Service Mentor**	
Service Description	This rate setting model uses the same service definition as noted within the base. A mentor could be assigned to at least two entry level workers at any one time. The Mentor coaches the worker on techniques and skills and facilitates/challenges the worker to grow in accordance with pre-established goals.	
Provider Qualifications	For illustration purposes, this rate setting model uses the entry level base rate and provider qualifications and assumes that the Mentor will have twenty additional hours of continuing education per year in mentoring skills and twelve additional hours in consultation with supervisor and entry level staff per year.	

Table 13: Tier 2: Mentor Rate

Rate Component	Addition to Rate	Discount from Rate	Final Rate
Average Hourly Salary	$9.49[1]		
Total Annual Paid Hours		2080	
Less Holiday Hours		72	
Less Vacation Leave		80	
Less Sick Leave		40	
Less continuing education and consultation hours[6]		42	
Mentorship Hours[7]		200	
Net Hours for Billing		1646	
Percentage of Time Available for Billing		.791	
Adjustment for Billable Time (Total Salary and % of time available for billing)	$12.00		
Other Direct Costs	($4.01)		
Transportation[2]	$6000		
Trainer and Supplies[3]	$2350		
Hourly Rate with Other Direct Costs[5]	$16.01		
Indirect (10%)[4]	($1.60)		
Wage Increase to Meet Enhanced Worker Qualifications	($.40)		

Rate Component	Addition to Rate	Discount from Rate	Final Rate
Total Hourly Direct, Indirect, and Wage Increase			$18.01

Assumptions for Illustration Purposes Only:
1. 2011 U.S. median hourly wages for personal care aides - http://phinational.org/policy/states/united-states/.
2. Assumes $6,000 annual transportation costs. States will need to determine the appropriate annual transportation costs.
3. Assumes 10 hours from the base rate calculation plus an additional 5 hours X $150 per hour + $100 total supplies per person. States will need to determine the appropriate cost of training time and supplies.
4. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation of the agency and the activities the employee performs. An indirect rate of 10% is used for illustration purposes only.
5. Direct costs generally include: Salaries or wages (including vacations, holidays, sick leave, and other excused absences), other employee fringe benefits allocable on direct labor employees, travel, materials, supplies and equipment and communication costs.
6. Added an additional 32 hours non-billable for mentorship training and consultation to the base. States will need to determine the appropriate amount of time for mentorship training and consultation.
7. Added an additional 200 hours across the year for mentoring workers to the base. States will need to determine the appropriate amount of time for mentorship.

Table 14: Mentorship Model: Tier 3

Mentorship Model TIER THREE  Low Value  Medium DSW Value	
Provider Type	***Tier 3:*** ***Direct Service Supervisor (The Frontline Supervisor)***
Service Description	For illustration purposes, this model uses the same definition as Mentor with the addition of an estimated four to six workers to supervisor ratio and at least one mentor. The supervisor manages implementation of individual care and support plans and assures quality in service delivery.
Provider Qualifications	For illustration purposes, this rate setting model assumes that provider qualifications are the same as the Mentor with the exception that the Supervisor is estimated to have at least forty additional hours per year of continuing education and training and fifteen hours of consultation with leadership per year. The model also assumes 260 hours (10 hours bi-weekly) away from billable activity necessary to supervise the staff and mentor. This rate setting model does assume that the supervisor also performs direct service activities in the course of his/her duties. Please note that the state could choose to modify the average salary by aligning the supervisor with a supervisor classification as opposed to building off the base rate of a worker.

Table 15: Tier 3: Supervisor Rate

Rate Component	Addition to Rate	Discount from Rate	Final Rate
Average Hourly Salary	$9.49[1]		
Total Annual Paid Hours		2080	
Less Holiday Hours		72	
Less Vacation Leave		80	
Less Sick Leave		40	
Less continuing education hours[6]		65	
Supervisory Hours[7]		260	
Net Hours for Billing		1563	
Percentage of Time Available for Billing		.751	
Adjustment for Billable Time (Total Salary and Fringe/% of time available for billing)	$12.64		
Other Direct Costs	($4.38)		
Transportation[2]	$6000		
Trainer and Supplies[3]	$3100		
Hourly Rate with Other Direct Costs[5]	$17.02		
Indirect (10%)[4]	($2.28)		
Wage Increase to Meet Enhanced Worker Qualifications	($.80)		
Total Hourly Direct, Indirect and Wage Increase			$20.10

Assumptions for Illustration Purposes Only:

1. 2011 U.S. median hourly wages for personal care aides - http://phinational.org/policy/states/united-states/.
2. Assumes $6,000 annual transportation costs. States will need to determine the appropriate annual transportation costs.
3. Assumes 10 hours from the base rate calculation plus an additional 10 hours X $150 per hour + $100 total supplies per person. States will need to determine the appropriate costs of training time and supplies.
4. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation of the agency and the activities the employee performs. An indirect of 10% is used for illustration purposes only.
5. Direct costs generally include: Salaries or wages (including vacations, holidays, sick leave, and other excused absences), other employee fringe benefits allocable on direct labor employees, travel, materials, supplies and equipment and communication costs.
8. Added an additional 55 hours non-billable for mentorship training and consultation to the base. States will need to determine the appropriate amount of time for mentorship training and consultation.
6. Added an additional 260 hours across the year for mentoring and supervising workers to the base. States will need to determine the appropriate amount of time for mentorship and supervision.

This model provides value to both the individual receiving services and the worker. The individual receiving services gains greater oversight of workers by peer mentors and supervisors. The worker gains the ability to grow within a matrix environment gaining skills and higher pay as experience builds. Compared to the other models in this Toolkit, however, this model has limited worker growth potential. Once the worker attains the supervisory level, growth in skills and wages hypothetically diminish over time.

For Critical Reflection

- ❑ How well does this rate setting model fit within your current state structure for the direct service workforce?
- ❑ What aspects of this rate setting model fit the state goals for the worker?
- ❑ Consider adapting this rate setting model and/or merge the aspects you value most from across all of the models contained in this Toolkit resulting in an infrastructure that best meets state goals and desired outcomes for your health and human service workforce. Use the tools contained in Appendix B and C to guide development of a health and human service workforce initiative.
- ❑ How does this rate setting model interface, or not, with your participant-directed service programs?
- ❑ Consider how this model could be applied in an integrated care environment.

State Training and Career Pathway Model: An Exemplar Direct Service Worker Certificate Program

This section illustrates a rate-setting model that corresponds with the implementation of a state certification system for workers. The section provides an overview of a tiered Direct Service Worker Certificate Program (or career path) that may be developed within a state, with further program design information presented in Appendix E. This worker certificate program is considered an exemplary model for coverage of DSW training within Medicaid policy and rate setting, as it represents a competency-based, coordinated approach to address workforce challenges while successfully meeting the wide range of support needs of participants.

Individuals receiving support through Medicaid HCBS Waivers, state plan amendments (SPAs) and traditional personal care state plan services have a wide range of needs. National apprenticeship and credentialing programs are designed to provide training and increase competence in a wide range of community-based support areas as well as more specialized training and competencies needed to meet the unique needs of specific population. Implementing a state certification program that corresponds with national apprenticeship and credentialing programs will demonstrate the increased competence of the workforce to provide high quality, specialized support to individuals based on nationally recognized standards.

The state training and career pathway rate-setting model can be modified to match state specific data. States can determine the appropriate number of training units/hours to meet desired workforce outcomes. States can provide policy guidance and develop audit controls to ensure that providers receiving the enhanced rate associated with certification pass a portion of the enhancement to employee wages thereby recognizing the value of education, training, and job shadowing on employee career mobility.

Training within a State Training and Career Pathway Model

This model outlines the strategies and methods for covering the costs of providing training and increased wages based on the achievement of increasing competencies of direct service workers through credentialing or apprenticeship programs.

Table 16: Competency Based Training & Credentialing/ Apprenticeship Model

Competency Based Training & Credentialing/ Apprenticeship Model  	
Provider Type	Direct service worker
Service Description	Same as the Base
Provider Qualifications	Same as the Base

Competency Based Training & Credentialing/ Apprenticeship Model

Base Rate:	Rate at Hire
Level 1 Wage	***Worker Level 1/Registered Apprentice Training Based on State and Organization Requirements –*** Considered initial training for illustration purposes, and therefore not included within the rate model as a covered Medicaid cost.
Level 2 Wage = Worker Level 1 Rate + increase based on % of journey worker wage (state) – See Table 8 for the Rate Model	***Worker Level 2 /Initial Certificate*** Total Training Hours = 112 Total On the Job Learning (OJL) Hours = 1200 Portfolio work samples based on 4 competency areas submitted and approved
Level 3 Wage = Worker Level 2 Rate + increase based on % of journey worker wage (state) – See Table 8 for the Rate Model	***Worker Level 3/Advanced Certificate*** Total Training Hours = 220 Total OJL Hours = 3000 Portfolio work samples based on 4 competency areas submitted and approved
Added Benefit to the Model	An added benefit to developing a rate within a career lattice model is the concept of establishing partnerships with community colleges and universities. These entities would award credit hours for work experience providing direct service workers with the opportunity to grow not only within the direct service workforce sector, but also possibly within a health and human service sector.

Table 17: Worker Level 1 Rate-Setting Model

Worksheet for Worker Level 1 Rate			
Rate Component	***Addition to Rate***	***Discount from Rate***	***Final Rate***
Average Hourly Salary	$9.49[1]		
Total Annual Paid Hours		2080	
Less Holiday Hours		72	
Less Vacation Leave		80	
Less Sick Leave		40	
Net Hours for Billing		1888	
Percentage of Time Available for Billing		.908	
Adjustment for Billable Time (Total Salary and Fringe/% of time available for billing)	$10.45		
Indirect (10%)[2]	($1.05)		

Worksheet for Worker Level 1 Rate			
Total Hourly Direct plus Indirect			$11.50

Assumptions for Illustration Purposes Only:
1. 2011 U.S. median hourly wages for personal care aides - http://phinational.org/policy/states/united-states/.
2. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation of the agency and the activities the employee performs. An indirect of 10% is used for illustration purposes only.

Table 18: Worker Level 2 Rate-Setting Model

Worksheet for determining the Level 2 Wages associated with enhanced training under Worker Level 2			
Worker Level 2			
Rate Component	***Addition to Rate***	***Discount from Rate***	***Final Rate***
Worker Level 1 Hourly Salary	$11.50		
Total Annual Paid Hours		2080	
Less Holiday Hours		72	
Less Vacation Leave		80	
Less Sick Leave		40	
Less continuing education hours for Worker Level 2 Time 112 hours [1]		112	
Net Hours for Billing		1776	
Percentage of Time Available for Billing		.854	
Adjustment for Billable Time (Total Salary and % of time available for billing)	$13.47		
Other Direct Costs	(.34)		
Transportation[2]	$500		
Purchase of Related Blended Instruction (per person cost estimate)[3]	$200		
Hourly Rate with Other Direct Costs	$13.81		
Indirect (10%)[4] for Worker Level 2	($1.38)		
Wage Increase to meet Enhanced Worker Qualifications	($.80)		
Total Hourly Direct, Indirect, Training Costs and Wage Increase for Worker Level 2			$15.99

Assumptions for Illustration Purposes only:
1. Includes 56 hours spent taking online courses, and 56 hours of related on the job instruction. Amount of time for online courses and on the job instruction is for illustration purposes only. States will need to determine the appropriate amount based on the competency-based training/credentialing model chosen.
2. Assumes $500 annual transportation costs given online training curriculum. States will need to determine the appropriate annual transportation costs.
3. Assumes the organization purchased the online curriculum. If state purchases and offers to all providers, less than $200 per person.
4. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation the agency and the activities the employee performs. An indirect of 10% is used for illustration purposes only.

Table 19: Worker Level 3 Rate-Setting Model

Worksheet for determining the Level 3 Wages associated with enhanced training under Worker Level 3			
	Worker Level 3		
Rate Component	***Addition to Rate***	***Discount from Rate***	***Final Rate***
Worker Level 2 Hourly Salary	$15.99		
Total Annual Paid Hours Minus Holiday, Vacation and Sick Leave	1888		
Less continuing education hours for Worker Level 3 Time 220 hours[1]		220	
Net Hours for Billing		1668	
Percentage of Time Available for Billing		.802	
Adjustment for Billable Time (Total Salary and % of time available for billing)	$19.93		
Other Direct Costs	(.34)		
Transportation[2]	$500		
Purchase of Related Blended Instruction (per person cost estimate)[3]	$200		
Hourly Rate with Other Direct Costs	$20.27		
Indirect (10%)[4] for Worker Level 3	($2.03)		
Wage Increase to meet Enhanced Worker Qualifications	($1.00)		
Total Hourly Direct plus Indirect for Worker Level 3			$23.30

Assumptions for Illustration Purposes Only:

1. Includes 110 hours spent taking online courses, and 110 hours of related on the job instruction. Amount of time for online courses and on the job instruction is for illustration purposes only. States will need to determine the appropriate amount based on the competency-based training/credentialing model chosen.
2. Assumes $500 annual transportation costs given online training curriculum. States will need to determine the appropriate annual transportation costs.
3. Assumes the organization purchased the online curriculum. If state purchases and offers to all providers, less than $200 per person.
4. Indirect costs are expenses of doing business that are not readily identified services, but are necessary for the general operation the agency and the activities the employee performs. An indirect of 10% is used for illustration purposes only.

There are several advantages for states that implement the direct service worker certificate program. First, the program ensures a cadre of well-trained workers who have the necessary skills, competencies and ethical practices to support individuals receiving services in a state. Second, it provides a systematic structure in which to devise and implement rate/wage increases within a state's services (constituting a coordinated approach to addressing workforce challenges). Third, the certificate program requirements have been specifically designed to align with the requirements of the U.S. DOL DSP Apprenticeship Program and the National Alliance of Direct Support Professionals (NADSP) Credentialing Program (see Figure 2). This potentially

allows for the development of a state's direct service workforce within established and portable national workforce program standards.

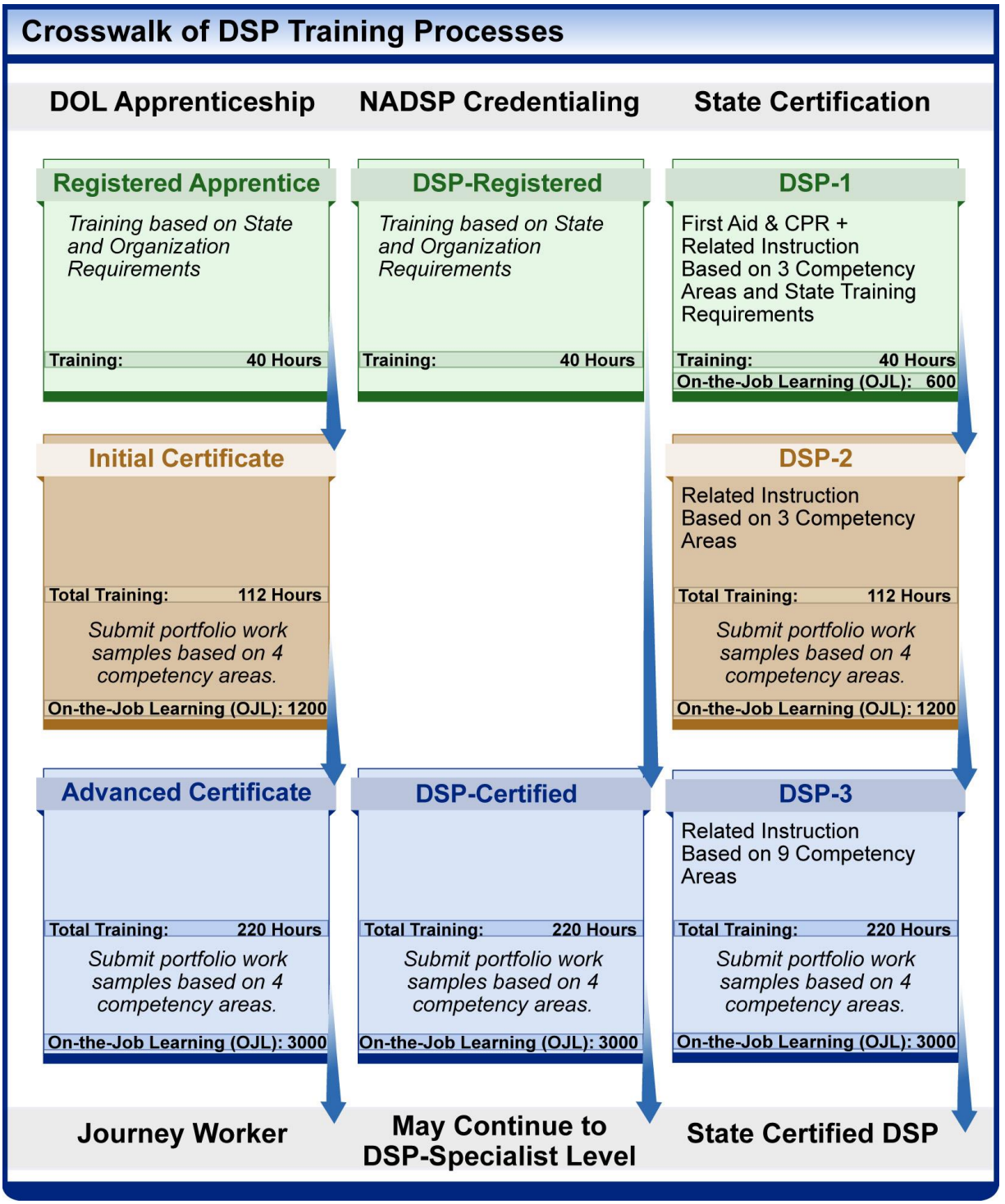
It is important to note that, when implementing this model, organizations will incur training costs before a worker becomes certificated at the Worker Level-1 level (first tier). With this rate-setting methodology, organizations can bill Medicaid at a higher reimbursement rate only after the Worker Level-1 becomes certificated. On average, workers may be expected to fulfill requirements for each tier during one calendar year cycle.

There are several strategies that states may explore in order to offset this initial training cost incurred by organizations, particularly within the first year of implementation. States may offset these costs by purchasing training curriculum, and making it available to service providers for free or lesser charge. This would negate or lessen tuition and training material expenses accounted in the current model. It is important to note that organizations may only be implementing continuing education and training for a percentage of their employees, based on acuity and/or other determinations.

Appendix D outlines components of a state certification system that is in alignment with national credentialing and apprenticeship standards for the occupation, as illustrated in Figure 2. This certification model entails a rigorous training and education program to be delivered through state community colleges in collaboration and partnership with employers of direct service workers. This model also may be applied within other contexts, such as training organizations or agencies in the public workforce system (*such as Department of Labor apprenticeship programs and Work Investment Act programs*) or programs offered through trade unions. States may utilize this training and career pathway model and adapt it based on specific mandated training requirements for workers.

The information in this section as well as Appendix D titled "State Direct Service Professional Certificate Program Educational Program Components and Requirements" outlines methods for covering the costs of providing training and increased wages based on the achievement of increasing competencies of workers through a tiered certification program. As mentioned previously, the proposed design for this certification program corresponds with standards of external national credentialing and apprenticeship programs. ***Figure 2 illustrates*** how the DSP Certificate Program requirements have been specifically aligned with the requirements of the U.S. DOL DSP Apprenticeship Program and the National Alliance of Direct Support Professionals (NADSP) Credentialing Program. This allows for the development of a state's direct service workforce within established—and importantly, portable—national workforce program standards. To review further information about certification, credentialing, and apprenticeship programs (including distinctions between these programs), please refer to the sub-section Credentialing and Apprenticeship Programs in ***Section II***.

Figure 3: Requirements of the State Certification Program in Context of National Apprenticeship and Credentialing Systems



For Critical Reflection

- ❑ How well does the State Training and Career Pathway rate setting model fit within your current state system for the direct service workforce?
- ❑ What changes would need to be made to adapt this model into your current rate setting methodology?
- ❑ What aspects of this rate setting model fit the state goals for developing its direct service workforce?
  - ► States may wish to consider adapting this rate setting model and/or merge the aspects you value most from across all of the models contained in this Toolkit. Doing so may result in an infrastructure that best meets state goals and desired outcomes for your health and human service workforce. Use the tools contained in Appendix B, C and F to guide development of a health and human service workforce initiative.
- ❑ Are there advantages for your state to require a commitment from the provider to work with individuals under Medicaid a minimum amount of time after receiving training?
  - ► Consider adding language to the waiver/state plan and associated administrative rules to indicate a commitment to serve following the state's commitment to provide training.
- ❑ How does this model interface, or not, with your participant-directed service programs?
- ❑ How could this model be applied in an integrated care environment?

Implementing the Competency Based Models within a Participant-Directed Service Delivery System

An ***Acuity*** Model establishes wage ranges and/or provider rates that link the cost of care to varied levels of individuals' need. In addition, an acuity based wage and/or rate setting model also can reflect varied worker qualifications and include the cost of ongoing training.

Under participant-directed service programs, some states allow individuals receiving services or their representative to establish their direct service workers' wage rate within established wage ranges. These wage ranges may or may not include benefits and the cost of ongoing training. Individuals or their representative often are allowed to determine the type and amount of initial and ongoing training their direct service worker will receive depending on state program rules. The explanation of wage ranges and/or rate components should clearly state how the cost associated with receiving ongoing training is included. Then during workers orientation, it should be clearly stated that the workers are personally responsible for receiving and paying for all required ongoing training and that the cost of such training, including the time in attendance, are included in their rate of payment. States may consider developing wage ranges and provider rates that are acuity-based and reflect worker qualifications and ongoing training costs in order to accommodate participant choice, link the cost of care to individual need, and to ensure the delivery of quality care.

The ***mentorship*** model is not applicable within a participant-directed service delivery system. The role of a mentor or supervisor is not applicable given that the individual receiving services or his/her representative is the supervisor and mentor of all workers they hire directly as a common law employer using Government or Vendor Fiscal/Employer Agent (F/EA) FMS organization. As a joint employer using an Agency with Choice (AwC) FMS organization, the AwC FMS organization and the individual or his/her representative are jointly responsible for training the individual's workers per Medicaid program and provider requirements. A state choosing to adapt all or part of the mentorship model may want to consider developing exceptions to workforce policy to enable individuals participating in participant-directed programs using Government or Vendor F/EA FMS or AwC FMS to exempt training requirements

for their workers. When implementing a mentorship model, it is recommended that workers be required to work as provider for the Medicaid program for a minimum amount of time after completing the program and related training.

Within the ***State Training and Career Pathway Model***, a state could set policy requiring workers to meet competency standards with exceptions allowing individuals enrolled in participant-directed programs to have the option to hire a worker who meets state competency requirements or not. A participant should have the option to use a worker that meets state required competencies or establish their own individualized training requirements. A state might consider establishing a core set of competencies that all direct service workers must meet with the individual having flexibility over specialized training. Additionally, a state may consider implementing an exception process that enables workers hired by individuals (i.e., family caregivers) to have flexibility in meeting competencies and training requirements within a competency-based system. There are multiple possible strategies to implement a career pathway model within a participant directed service delivery model. A career pathway model offers the same degree of flexibility to individuals and their representative, while potentially offering them a more qualified worker candidate pool.

Implementing the Rate Setting Models within an Integrated Service Delivery System

(e.g. traditional managed care organization, accountable care organization or integrated care organization for the dual eligible population)

States interested in implementing a version of the ***Acuity***, ***Mentorship*** and/or ***State Training and Career Pathway Rate Setting Models*** first need to determine what long-term services and supports will be included within the integrated delivery system. If all or part of the direct service workforce will be included within the integrated delivery system, it is recommended that the state include language within the managed care contract requiring the managed care organization to establish training requirements and rate setting operations consistent with state policy. States also should consider the following:

1. including training costs within capitated rates; and
2. establishing a set-aside of funds that managed care organizations could use to meet contractual requirements; or
3. requiring managed care organizations to meet training requirements through an agreement with a pre-determined entity specified in the contract with funds exchanged between the state and the pre-determined entity. For more information, visit http://www.medicaid.gov/mltss/index.html.

Building Incentives into your State Model

Better care, better health and lower costs can be achieved through system change that focuses on universal models of care which includes developing the role of direct service workers to meet the growing care needs and challenges faced by older adults, persons with disabilities and their families.

Developing an Incentive-Based Rate Setting System

This sub-section provides basic information regarding "pay for performance" and encourages the addition of incentive-based payments within a rate setting model to establish a quality direct service workforce. The goals of such a rate setting system should include improving the health of the population, enhancing the patient's experience of care, and reducing the cost of care—the Institute for Healthcare Improvement's "Triple Aim". Triple Aim has been described as:

> "Improving the U.S. health care system requires simultaneous pursuit of three aims: (1) improving the experience of care, (2) improving the health of populations, and (3) reducing per capita costs of health care."
>
> (The Triple Aim: Care, Health and Cost", Berwick, Donald M., Nolan, Thomas W., and Whittington, John, *Health Affairs*, 27, no. 3 (2008): 759-769).

It is critical to develop and enhance the quality of the direct service workforce to meet the needs of older adults and persons with disabilities. Better care, better health and lower costs can be achieved through system change that focuses on universal models of care which includes developing the role of direct service workers to meet the growing care needs and challenges faced by older adults, persons with disabilities and their families. In addition, developing the direct service workforce can result in the provision of quality care and cost-savings for the Medicaid program, the largest purchaser of health care.

According to CMS at www.cms.gov/MedicaidCHIPQualPrac/01_Overview.asp#TopOfPage, quality-based purchasing (also known as value-based purchasing or pay for performance) is a reimbursement methodology providing incentives for person-centered and high quality service delivery. A 2009 Report in ***Health Care Financing Review*** described a conceptual framework adapted from previous studies that payment systems are successful when quality is in the best financial interest of providers. "Pay for Performance" reimbursement methods seek to provide such incentives and are more common in hospital, physician and some nursing facility service lines of business. Typically, measures for increased payment include patient satisfaction, worker retention, worker turnover, and reduction of patients' clinical symptoms, facility/program occupancy, service utilization, person-centered care, and other quality measures found in valid and reliable instruments (e.g. minimum data set).

In 2009, CMS initiated a three-year *Nursing Home Value Based Purchasing Demonstration Project*. The goal of the Project was to provide financial incentive to nursing facilities to provide quality care to Medicare beneficiaries. Nursing facilities in Arizona (41 homes), New York (79 homes), Wisconsin (62 homes) are participating in the Demonstration. Performance scores are derived from data in the following domains; Staffing levels and turnover (30 points), Avoidable hospitalizations (30 points), Minimum Data Set (MDS) quality measures (20 points), and select Survey domains (20 points). More information on the design of this demonstration can be found at: www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/NHP4P_FinalReport.pdf.

In summary, incentive-based supplemental payments may amplify the rate methods described in this Toolkit and are worth further exploration. In particular, competency-based training as outlined in the previous models can lead to greater service quality and higher performance. For example, a state could establish a competency-based system that includes a supplemental payment structure requiring a wage pass-through to the worker when a worker and/or provider agency is able to meet pre-established benchmarks. These benchmarks could include review of agency turnover rates (not applicable to individual providers), satisfaction scores, quality of

training programs, number of incidents reported, workers' compensation insurance claims, and number of emergency room and hospital visits, to name a few. Quality equals the right care at the right time by the right (and qualified/trained) people.

For Critical Reflection

- ❑ How can your state build incentives into the direct service workforce infrastructure? Consider establishing benchmarks for direct service workforce quality (i.e. decreased rate of "no-shows") and performance (i.e. turnover rates).
- ❑ If in a managed care environment, consider the potential for bonus payments to the managed care organization and the provider entity for meeting shared benchmarks with a wage pass through (or benefits) requirement for those benchmarks related directly to direct service workforce training and quality.

Purpose of Section	Section VI

This section outlines the goals for this Toolkit and encourages states to think critically about current workforce status and potential for growth.

Section VI: Conclusion

Training is a foundational element in workforce development. Moreover, training influences the foci of services and supports, and therefore, the quality of outcomes. This Toolkit represents a targeted strategy to address and resolve systemic challenges of the Direct Service Workforce (DSW). The Toolkit presented strategies and methods for covering the cost of continuing education and training for direct service workers and provided insight into the potential role of core competencies and credentialing in supporting a high quality and cost-effective direct service workforce infrastructure. The goal of the Toolkit is to:

- Provide an overview of national trends in direct service;
- Highlight selected strategies for addressing direct service workforce challenges and improving service outcomes;
- Encourage investment in the most important state resource – direct service workers, whether paid or unpaid, who provide long-term services and supports to older adults and people with disabilities; and
- Stimulate critical thinking about developing Medicaid rate setting and payment methods that address the provision of continuing education and training, wage increases, leave time and health care benefits that are implemented in a transparent manner and that can apply to a participant-directed service delivery system and within an integrated care environment.

Training influences quality outcomes

Direct Service Workers are critical to a State's ability to meet the changing needs and desires of older adults and persons with disabilities.

Investment in this workforce leads to quality and cost savings.

Invest now!

Why is developing your direct service workforce infrastructure so important? As mentioned in the Introduction of this Toolkit, changing demographics (i.e. greater number of older adults) and greater demand for home and community-based services stress an already burdened health care delivery system. The direct service workforce exists within the broader context of the health care delivery system creating a need to develop a unified approach to education and training, career advancement and overall quality. The tools contained in Appendices B and C are meant to emphasize the need to think beyond the direct service workforce to the needs of your state within the larger health and human service workforce.

- How do direct service workers fit within your current health and human service workforce?
- What are your gaps in direct service and in worker health care sectors?
- What can your state and national data tell you about the workforce capacity and needs?

These are critical questions to understanding your workforce and necessary to building a direct service workforce strategy.

- What strategies, including the inclusion of continuing training within rates or the development of a "ground up" rate methodology across systems, can your state pursue to meet your specific state vision for long term services and supports and overall healthcare delivery?
- What resources are needed to get started versus to continue development (e.g. time, knowledge, skills, ideas and money)?
- Who are the critical state and local partners and how do you engage them?

These are critical questions that need to be addressed in order to develop an action plan for your direct service workforce.

The National Direct Service Workforce Resource Center is ready to provide technical assistance to meet your state's unique needs and to help you to answer the key questions that lead to action.

The National Direct Service Workforce Resource Center was created by the Centers for Medicare and Medicaid Services in 2005 to respond to the large and growing shortage of workers who provide direct care and personal assistance to individuals who need long-term supports and services in the United States. The Resource Center supports efforts to improve recruitment and retention of workers who assist people with disabilities and older adults to live independently and with dignity in the community. This includes direct service workers, personal care attendants, personal assistance providers, home care aides, home health aides, and others.

It is our hope that this Toolkit provokes critical thought and useful insights into your current workforce status and potential for growth. To learn more about the National Direct Service Workforce Resource Center or to request technical assistance, please visit our website: www.dswresourcecenter.org, email us at info@dswresourcecenter.org or call us at 1-877-822-2647.

Appendix A: July 13, 2011 CMS Bulletin

Department Of Health And Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Center for Medicaid, CHIP, and Survey & Certification
CMCS Informational Bulletin
DATE: July 13, 2011
FROM: Cindy Mann, Director
Center for Medicaid, CHIP and Survey and & Certification (CMCS)

Inclusion of Training Costs in Rate Development

In light of questions we have received, CMCS is providing this information regarding the mechanism by which provider-related training costs may be considered in the development of the rate of payment for medical services. Questions have come up particularly in the area of home health services.

Medicaid statute and regulations (§1902 of the Social Security Act and 42 Code of Federal Regulations 430 and 447) allow reimbursement for covered services delivered by a qualified provider to an eligible beneficiary. Costs associated with requirements that are prerequisite to being a qualified Medicaid provider are not reimbursable by Medicaid. However, costs associated with maintaining status as a qualified provider may be included in determining the rate for services. Specifically, if as part of its provider qualification requirements, a State requires a provider to acquire a certain minimum number of hours of specified types of continuing education (CE) each period (annually or quarterly, for example), the State may recognize such CE expenses as a cost to the provider of doing business and may consider such costs in developing the rate paid for the service. The cost of CE may only be included as part of the rate paid for the service and may not be claimed separately by the Medicaid agency as an administrative expense.

For example, a State's provider qualification standards could require the direct service provider to: 1) have a high school diploma (or its equivalent) and be at least 18 years of age, and 2) complete a certain number of specified CE hours or credits during the calendar or fiscal year (or quarter) in order to maintain eligible provider status. The State could not pay, or include in its rates, costs for individuals to obtain a high school diploma or its equivalent. However, the State may include the estimated costs of meeting ongoing CE requirements in determining the rate paid for the service. If the provider fails to acquire the minimum required number of CE hours or credits, the provider would no longer be qualified, and no Medicaid payment could be made either for services or for the CE that would be needed as a prerequisite to regaining status as a qualified provider.

Similarly, should a State wish to promote advanced provider skills training to increase the availability of providers qualified to serve beneficiaries with more complicated or difficult medical needs, costs associated with that advanced training could also be included in the development of rates paid for services requiring more complex levels of care. The State could set provider qualification requirements at a separate and distinct level for those advanced level providers, and pay rates commensurate with their higher skill levels. The qualifications and rates could be higher than those for services furnished by less skilled individuals such as family members.

Appendix B: Developing a Health and Human Service Workforce Strategy Checklist

This checklist is a tool to help state agencies to develop a health and human service workforce strategy through streamlined efficiency, goal setting, and project management. States seeking to engage in a workforce strategy need not start from scratch. This checklist is a tool to encourage states to go through a series of steps to prevent duplication and inefficiency in state efforts. As states embark on integrated care management, an adequate workforce is key to success. This checklist is meant to provide access to a seamless approach to development of an integrated health (e.g. the medical specializations) and human (the social and behavioral specializations) service workforce strategy.

Health and Human Service Workforce Strategy Checklist	Completed
Conduct Environmental Scan: Gather documents related to your state's health and human service workforce including, but not limited to, state workforce statistical reports on the health and human service workforce, strategic planning documents, current workforce policies and procedures as well as national data for comparison purposes. Conduct a review of journal articles relevant to workforce issues as well as occupational information network files.	☐ Date:__/__/__
Summarize Information and/or Develop Cross-Walks: Review all Medicaid and non-Medicaid policies and procedures and summarize for use during implementation of the communication plan. Determine commonalities across systems when applicable and develop cross-walks.	☐ Date:__/__/__
Perform a Workforce Gap Analysis and Establish Workforce Baselines: Review national reports, analyze state trends and establish baselines across workforce elements. This includes turnover rate calculations, retention rates, and a cost analysis related to these rates.	☐ Date:__/__/__
Identify Workforce Partners: Identify all state workforce partners including, but not limited to, employers, workforce and health care economists, adult basic education, post-secondary education, TANF providers and human service agencies, community colleges, specialty disciplines (e.g. gerontology, mental health, developmental disabilities), state and local workforce agencies and boards, minority health, medical workers through Boards/Commissions and relevant state agencies.	☐ Date:__/__/__
Establish an Integrated Workforce Vision: Determine scope of workforce strategy (e.g. occupations included within the integrated vision), define sectors applicable to state strategy and establish a unified vision to focus strategic effort.	☐ Date:__/__/__

Health and Human Service Workforce Strategy Checklist	Completed
Explore Workforce Opportunities: Review national and state funding opportunities for workforce growth through grants and other sources. Engage state workforce partners in exploration of workforce need as well as funding available through other sources such as the workforce investment act.	☐ Date:__/__/__
Develop and Implement a Communication Plan: A communication plan is helpful in building buy-in of necessary workforce partners. The project leads and/or the core project team should establish a position paper and associated tools such as a fact sheet or PowerPoint slides to communicate the possible vision and engage necessary partners in dialogue leading to buy-in. If buy-in is already established and supported by state leadership, a communication plan and associated tools remain helpful for stakeholder engagement. Moving the strategic effort forward is dependent on key partnerships that cross disciplines and sectors.	☐ Date:__/__/__
Build Core Project Team: The core project team could include only state agency staff or could include a much broader group with select workforce partners necessary to establish buy-in for the strategic plan. Regardless, a core project team is necessary to refine the strategic plan and monitor implementation enabling change when needed to move the system toward pre-established workforce goals.	☐ Date:__/__/__
Convene Strategic Kick-Off: Once the majority of key partners are formed and the vision is clearer, consider convening a strategic kick-off meeting to establish a more formal charter, refine the vision, and develop strategies.	☐ Date:__/__/__
Develop Strategic Plan: A strategic Plan should a clear vision, objectives, ground rules, action items, measurement and timelines. Consider using the Health and Human Service Workforce Strategic Planning Tool as a guide.	☐ Date:__/__/__
Engage Cross-Sector Stakeholders: Consider holding information sessions and focus groups to gauge stakeholder feedback on the establishment of the strategic plan and on implementation buy-in. Focus groups could include business roundtables and a focus on the impact of strategies on employers as well as on recipients of service delivery. Components of focus group consideration could include impact of strategies on cost-efficiency for employers and administrators, cross-sector innovations, educational/training resources, recruitment and retention, reimbursement policies, state regulations and support services.	☐ Date:__/__/__
Establish a Workforce Dashboard: Determine state specific workforce measures, establish a baseline including possible comparison to national data, establish frequency and form a dashboard for internal as well as public use.	☐ Date:__/__/__
Develop a Research Platform: A review of data often results in the need to understand more. Consider a partnership with public universities to conduct research in areas of limitation to provide clarity and/or establish baselines for strategic goals.	☐ Date:__/__/__

Appendix C. Health and Human Service Workforce Strategic Planning Tool

Health and Human Service Workforce Strategic Planning Tool
Insert State Name
Insert Date Developed and/or revised
Insert Project Sponsor Name and Contact Information

Vision/Values

Insert integrated workforce vision and values

Core Project Team Members

Insert cross-discipline and sector core project team representation

Insert cross-discipline and sector core project team representation

Name	Title/Agency	E-mail Address
First Name Last Name	Agency Name	name@agency.com
First Name Last Name	Agency Name	name@agency.com
First Name Last Name	Agency Name	name@agency.com
First Name Last Name	Agency Name	name@agency.com
First Name Last Name	Agency Name	name@agency.com
First Name Last Name	Agency Name	name@agency.com
First Name Last Name	Agency Name	name@agency.com

First Name Last Name	Agency Name	name@agency.com

Brief Description

Insert brief description of strategic plan

Boundaries

Insert all boundaries that impact implementation of strategies
(e.g. state and federal laws)
Insert all boundaries that impact implementation of strategies
(e.g. state and federal laws)
Insert all boundaries that impact implementation of strategies

Strategies

<strategies could include .... Establish a health and human service lattice, establish competency based training, align policies and programs, clarify roles and responsibilities, Engage employers, conduct a workforce gap analysis>

Strategy	Action Step(s)	Lead(s): Person(s) responsible for initiating and monitoring action steps	Strategic Partner(s): Persons responsible for supporting lead(s) in completing action steps	Timeline	Expected Outcomes
#1					
#2					
#3					
#4					
#5					
#6					
#7					
#8					

Appendix D: State Direct Service Professional Certificate Program Components and Requirements

This document highlights just one example of a training and education program that includes both continuing training components and requirements. The program uses the DirectCourse: College of Direct Support (CDS) curriculum as an example of a tool that fulfills related instruction requirements. While relevant to IDD, this training program is adaptable and is not meant to reflect all that is available in the market.

This document describes the specific design of a state certification/credentialing model that may be used as an exemplar for projects within states. It is referred to here as the Direct Support Professional (DSP) Certificate Program. The purpose of the program is to provide an opportunity for workers to advance professionally and economically along a career pathway related to the provision of direct services.

The DSP Certification Program entails a rigorous training and education program that is delivered through state community colleges in collaboration and partnership with employers of direct service workers. Under this program, State community colleges and academic institutions provide the infrastructure and resources that support the implementation of certification and credentialing systems for direct service workers. This program also may be implemented by other entities, such as training organizations or agencies in the public workforce system (i.e., Department of Labor apprenticeship programs and the Work Investment Act programs).

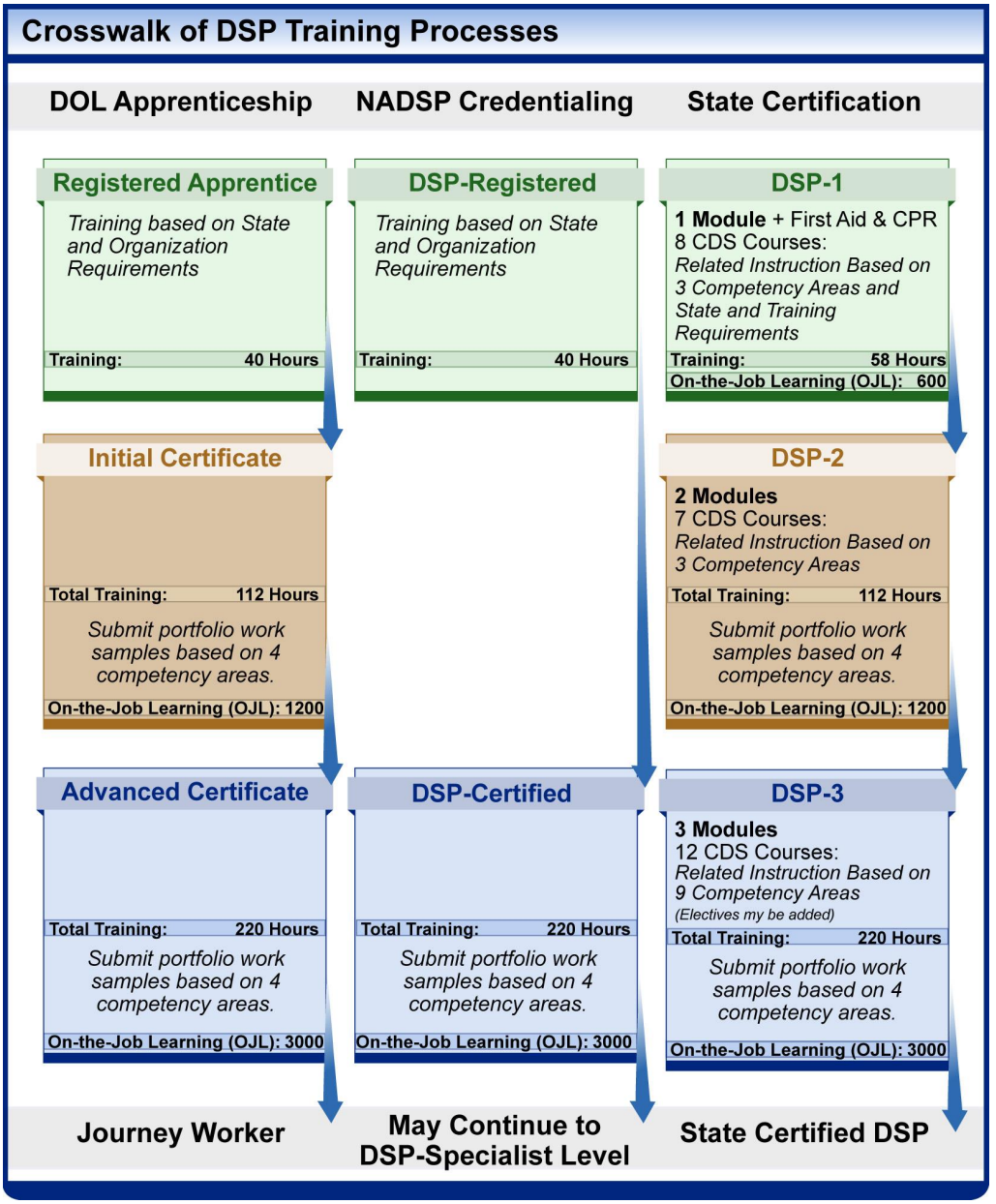
The DSP Certificate Program establishes a recognized and portable credential within a state for direct service workers. Under the proposed design for a DSP Certificate Program, direct service workers would earn college credit that could be applied towards earning an Associate in Applied Sciences (AAS) human service related degree. Thus, it is proposed that workers receive instruction that may be approved by the state community college system in fulfillment of AAS degree requirements. This requires partnership between community colleges and employer training programs, as workers would receive course instruction (implemented through both the college and employer systems) and on-the-job learning (implemented through the employer system) in order to fulfill the program and degree requirements.

There are several advantages to states that implement the DSP Certificate Program. First, the program ensures a cadre of well-trained workers who have the necessary skills, competencies and ethical practices to support individuals receiving aging and disability services in a state. Second, it provides a systematic structure in which to devise and implement rate/wage increases within a state's aging and disability services (constituting a coordinated approach to addressing workforce challenges). Third, the DSP Certificate Program requirements have been specifically designed to align with the requirements of the U.S. DOL DSP Apprenticeship Program and the National Alliance of Direct Support Professional (NADSP) Credentialing

Program (see **Figure 3**). This allows for the development of a state's direct service workforce within established and portable national workforce program standards.

For further information about these national programs, please see: http://nadsp.org/apprenticeship.html.

Figure 4: Requirements of the State Certification Program in Context of National Apprenticeship and Credentialing Systems



The DSP Certificate Program is a blended program that includes on-the-job learning and structured, consistent and transferable-related instruction. Instruction provided is specifically

designed to teach workers the information, skills and ethical practices required of their profession. This model program's related instruction utilizes materials from the DirectCourse online curricula, College of Direct Support (CDS) as the primary curriculum in the delivery of continuing education and training, which may implemented in partnership through state community colleges and employer training systems. CDS provides an effective web-based educational opportunity to thousands of workers throughout the United States and other countries. Appendix E provides information about additional DSW competency sets and training curriculums that may be applied in developing a certification model.

There are three levels built into the DSP Certificate Program: DSP–1, DSP-2 and DSP-3, or Registered, Initial and Advanced if using the Apprenticeship Program (Ladd, 2010). Each of these levels requires a unique combination of related instruction and supervised on-the-job learning. On-the-job learning entails tasks learned while providing services and support. These are tasks that workers are expected to become proficient in. Learning must be achieved through structured, supervised work experience. The supervisor of the worker is designated by a program sponsor and is responsible for supervising or having charge and direction over a worker.

In this model, training modules comprised of CDS courses have been developed specific to mandatory state training requirements at level DSP- 1, and the apprenticeship competency development requirements at levels DSP-2 and DSP-3 (see Figure 4). All workers must participate in mandatory pre-service training (before having contact with service recipients) per state requirements, but the costs associated with this training are not considered allowable Medicaid costs. Levels DSP-2 and DSP-3 are considered continuing education and training for workers. The costs related to continuing education and training are considered Medicaid allowable costs and can be included in a provider agency's expenses related to the provision of a service.

In order to fulfill national apprenticeship and credentialing requirements at levels DSP-2 and DSP-3, workers are required to demonstrate competence based on competencies established by the National Alliance of Direct Support Professionals (NADSP; see Figure 4). These competencies have been rigorously developed and widely applied in the field, and standardized by the national U.S. DOL Apprenticeship Program for DSPs (Ladd, 2010). Further, the CDS curriculum used within this model provides courses and coursework that are specifically based on the NADSP competencies. Since the NADSP includes 15 competency areas and 167 skill statements, the DSP Certificate Program is designed with instructional modules that group and target learning and mastery of certain competencies. Figure 5 outlines competency areas that workers would fulfill upon completion of each module.

The NADSP competencies provide standards for measurement of workers' skill attainment. This measurement is mainly operationalized through portfolios, as all learners in the program are required to create and submit a portfolio. Portfolios consist of work samples and activities that illustrate a worker's skills and competencies. The portfolio serves as one of the primary assessments of competency and acquired knowledge, which may count toward community college credit. The CDS curriculum includes relevant content and specific assessment tools to guide worker portfolio development in alignment with the NADSP competencies. As workers complete the Direct Support Professional Certificate Program exemplified in this Appendix, they will have received training within all 15 competency areas established by the NADSP. They also will have successfully completed assessments confirming that they have demonstrated competency within at least eight competency areas.

Figure 5: An Example of DirectCourse CDS Requirements meeting the State DSP Certification Program with Distinction between Mandatory Training and Continuing Education

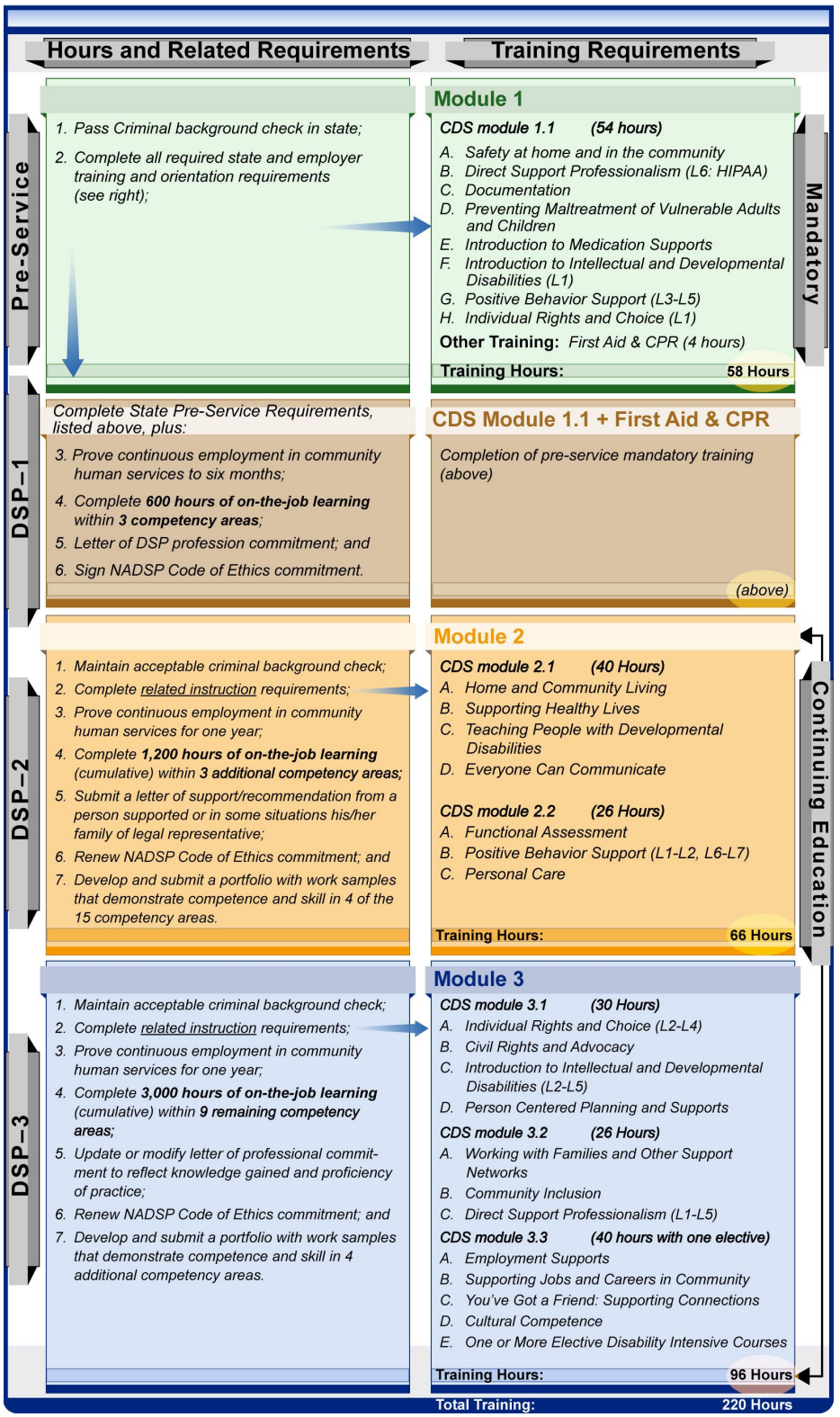
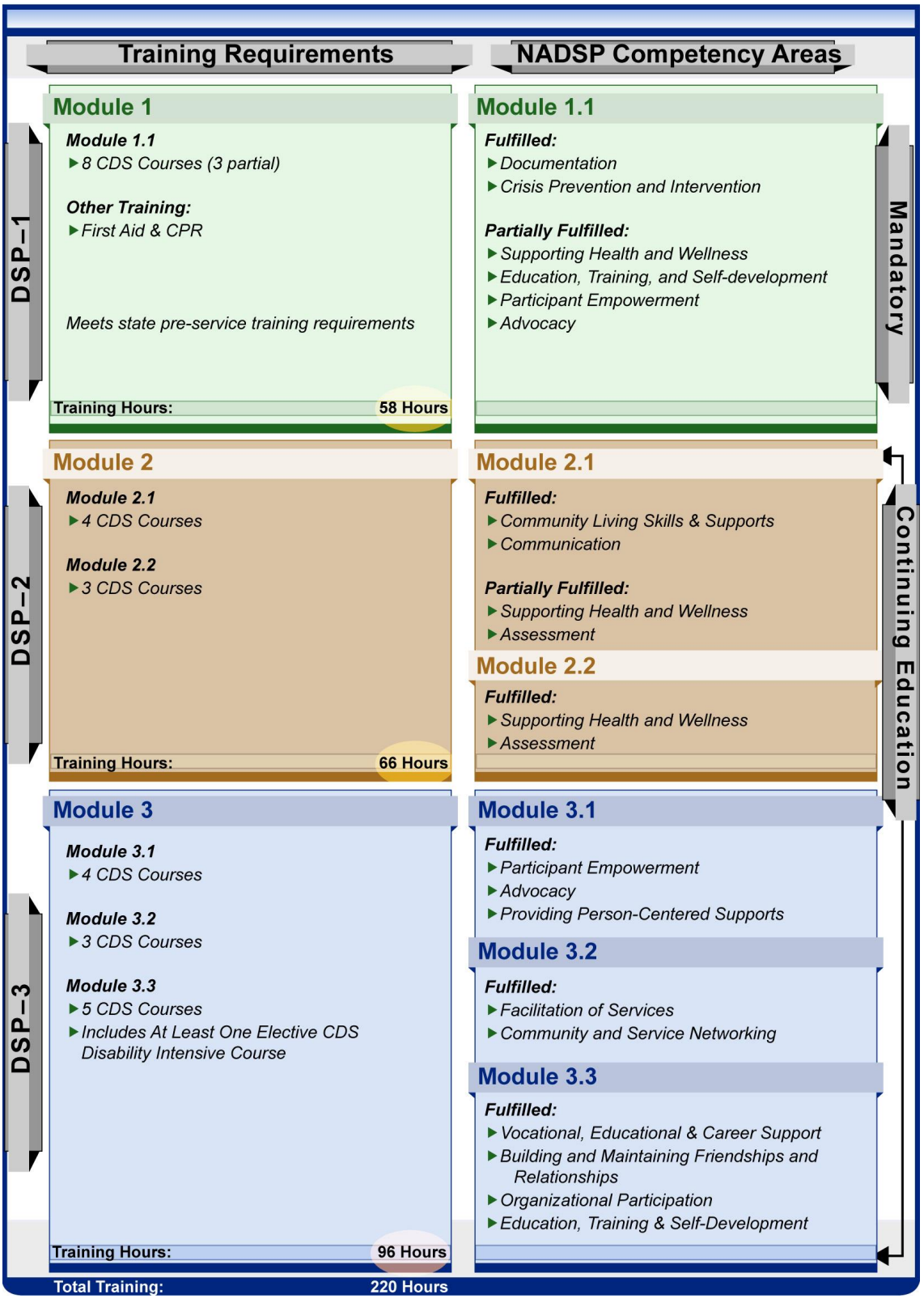


Figure 6: An Example of DirectCourse CDS NADSP Competency Areas Targeted Within Training Modules



Appendix E. Competency Sets that Inform DSW Credentialing and Certification Systems

Please note the following DSW competency sets, which provide foundation for training curriculum and requirements of credentialing and certification systems, as noted in Table 2 in Section II. For more information about curricula developed for this workforce, or to identify an appropriate curriculum, please contact the DSW Resource Center at www.dswresourcecenter.org.

- Addiction Counseling Competencies (TAP 21)
- Adult Psychiatric Rehabilitation/Recovery-Oriented Mental Health Services for Adults Competencies (CPRP)
- Competency Standards for Physical Health and Aging
- Infant Mental Health Competency Guidelines
- National Alliance for Direct Support Professionals (NADSP) Competencies

References

American Network of Community Options and Resources [ANCOR]. (2001). *State of the state report*. Alexandria, VA: Author.

Baughman, R. A., & Smith, K. (2010). *The effect of Medicaid wage pass-through programs on the wages of direct care worker*. Medical Care, 48(5), 426-432.

Benjamin, A.E.; Matthias, R., and Franke, T. (1998). *"Comparing Consumer-directed and Agency Models for Providing Support Services at Home."* Final Report to the U.S. Department of Health and Human Services, Washington, DC, University of California, Los Angeles School of Public Policy and Social Research. September.

Benjamin, A.E. and Matthias, R.E., (2004). *"Work-life differences for agency and consumer-directed home-care workers".* Gerontologist. 44(4):479-88. August.

Braddock, D., & Mitchell, D. (1992). Residential services and developmental disabilities in the United States: A national survey of staff compensation, turnover and related issues. Washington D.C.: American Association on Mental Retardation.

Brown, R. Carlson, B.L. Dale, S., Foster, L., Philips, B. and Schore, J. (2007). *Cash and Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or Home and Community-based Services. Final Report.* Princeton, NJ. Mathematica Policy Research, Inc. August.

Castle, N. G., & Engberg, J. (2007). *The influence of staffing characteristics on quality of care in nursing homes.* Health Services Research, 42(5), 1822-1847.

Centers for Medicare & Medicaid Services. (2001). Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final. Baltimore, MD: US Center for Medicare and Medicaid Services.

Delp, Linda, Wallace, Steven, P., Geiger-Brown, Jeanne, and Muntaner, Carles, (2010). *"Job stress and job satisfaction: home care workers in a consumer-directed model of care."* Health Services Research 45:4, 922-940. August.

Doty, P. (1999). "In-Home Support Services for the Elderly and Disabled: Comparison of Client-directed and Worker Management Models of Service Delivery." Non-Technical Summary Report. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Feng, Z., Lee, Y. S., Kuo, S., Intrator, O., Foster, A., & Mor, V. (2010). *Do Medicaid wage pass-through payments increase nursing home staffing*? HSR: Health Services Research, *45(3), 728-747.*

Flanagan, S. A. (2009). Chapter 7: Fiscal/Employer Agent Services, in *Developing and Implementing Self Directed Programs and Policies: A Handbook.* Prepared by the RWJ National Cash and Counseling Project Office at Boston College Graduate School of Social Work. Published by the Robert Wood Johnson Foundation, Princeton, NJ (February).

Flanagan, S.A. (2005). *Consumers' Perceptions of Consumer-directed Personal Assistance and Intermediary Services: Eight States' Experience.* Ph.D. dissertation. UMI Number 329704, Ann Arbor, MI: UMI Dissertation Services/ProQuest.

Foster, A. D., & Lee, Y. S. (2011). Staffing Subsidies and the Quality of Care in Nursing Home. Retrieved from http://www.econ.brown.edu/students/Yong_Suk_Lee/nh_v071411.pdf

Foster, L., & Dale, S. (2005). *How Caregivers and Workers Fare in Cash and Counseling* {Power Point Slides} presented at the AcademyHealth Annual Research Meeting by Mathematica Policy Institute, Boston, MA, June 26th.

Foster, L., Dale, S.B. and Brown, R. (2007). *"How Caregivers and Workers Fared in Cash and Counseling."* Health Services Research. 42(1, part 2): 510-32.

Harris-Kojetin, L., Lipson, D., Fielding, J., Kiefer, K., & Stone, R. I. (2004). Recent findings on frontline long-term care workers: A research synthesis 1999-2003. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Retrieved from http://aspe.hhs.gov/daltcp/reports/insight.htm

Hawes, C. (2002). Elder abuse in residential long-term care facilities: What is known about prevalence, causes, and prevention. Testimony before the U.S. Senate Committee on Finance, Washington, DC. June 18, 2002.

Hewitt, A., & Lakin, K.C. (2001). Issues in the direct support workforce and their connections to the growth, sustainability and quality of community supports. Minneapolis, MN: Research and Training Center on Community Living, University of Minnesota. Retrieved from http://rtc.umn.edu/docs/hcfa.pdf

Hewitt, A., & Larson, S. (1994). *Training issues for direct service personnel working in community residential programs for persons with developmental disabilities.* University of Minnesota, Institute on Community Integration, College of Education and Human Development. Minneapolis: Research and Training Center on Community Living.

Hewitt, A., Larson, S., Edelstein, S., Seavey, D., Hoge, M. A., & Morris, J. (2008). A synthesis of direct service workforce demographics and challenges across intellectual/ developmental disabilities, aging, physical disabilities, and behavioral health. National Direct Service Workforce Resource Center. Retrieved from http://www.dswresourcecenter.org/tiki-index.php?page=Reports

Hewitt, A., O'Nell, S., & Larson, S. (1996). Overview of direct support workforce issues. In W. Ebenstein, *Opportunities for excellence: Supporting the frontline workforce* (pp. 1-18). Washington, D.C.: President's Committee on Mental Retardation.

Hoge, M. A., McFaul, M., Calcote, R., & Tallman, B. (Eds.). (2008). *The Alaskan crosswalk: Exploring competencies and credentialing for the state's direct care workforce: A report of the Credentialing and Quality Standards Subcommittee (CQSS).* Anchorage, AK: The Alaskan Mental Health Trust Authority. Retrieved from http://www.annapoliscoalition.org/resources/1/The%20Alaskan%20Crosswalk%20-%20Phase%20I%20Report.pdf

Howes, C. (2006). Building a high quality home care workforce: Wages, benefits and flexibility matter. Better Jobs Better Care. Retrieved from http://www.directcareclearinghouse.org/download/HowesSummaryFinal.pdf

Howes, C. (2005). *Living wages and retention of homecare workers in San Francisco.* Industrial Relations, 44(1), 139-163.

Institute of Medicine [IOM]. (2008). *Retooling for an aging America: Building the health care workforce.* Washington, DC: The National Academies Press. Retrieved from http://www.nap.edu/catalog/12089.html

Johnson, Richard, W., Toohey, Desmond, and Wiener, Joshua, M.(2007). *Meeting the Long Term Care Needs of Baby Boomers. How Changing Families Will Affect Paid Helpers and Institutions.* Discussion Paper 07-04 in The Retirement Project series. Urban Institute, Washington, DC. Retrieved on 10/7/12 at http://www.urban.org/url/cfm?ID=311451&renderforprint=1.

Keenan, T. (2010). *Home and Community Preference of the 45+ Population*. AARP, November. Available at http://assets.aarp.org/rgcenter/general/home-community.

Ladd, J. V. (2010). *National Guidelines for Apprenticeship Standards Developed by The National Alliance for Direct Support Professionals (NADSP) and The American Network of Community Options and Resources (ANCOR) for the Occupation of Direct Support Professional (Direct Support Specialist*). US Department of Labor Office of Apprenticeship.

Larson, S.A., Doljanac, R., Nord, D. K., Salmi, P., Hewitt, A.S. & O'Nell, S. (2007*). National Validation Study of Competencies for Front Line Supervisors and Direct Support Professionals: Final Report*. Minneapolis, MN: University of Minnesota, Research and Training Center on Community Integration.

Larson, S., Hewitt, A., & Anderson, L. (1999*). Staff recruitment challenges and interventions in agencies supporting people with developmental disabilities.* Mental Retardation, 37 (2), 36-46.

Lynch, R., Fortune, J., Mikesell, C. & Walling, T. (2005). Wyoming demonstrates major improvements in retention by enhancing wages and training. *Links, 35*(9). Retrieved from http://www.directcareclearinghouse.org/download/WY_2005_Wage.pdf

Mahoney, K. (2005). "Cash and Counseling: Part of the long-term care answer? "Congressional Hearing Presentation (July, 29th).

Merlis, M. (2004). "Medicaid Reimbursement Policy". CRS Report for Congress.

National Alliance for Direct Support Professionals. (2001). *Code of ethics.* Minneapolis: University of Minnesota, Research and Training Center on Community Living.

National Resource Center for Participant-Directed Services, Adapt, Center for Self-determination, Service Employees International Union and Topeka Independent Living Resource Center (2011). *Guiding Principles for Partnership with Unions and Emerging Worker Organizations When Individuals Direct Their Own Services and Supports.* http://web.bc.edu/libtools/details.php?entryid=271. November 16th.

The North Dakota Association of Community Providers (NDACP). (2010). Recruitment and Retention of Direct Support Workers in North Dakota: Analysis of 2010 NDACP Data. Retrieved from: http://www.ndacf.org/ND%20Direct%20Support%20Worker%20Workforce%202010%20Dec-Final.pdf

O'Neill, S.N. & Hewitt, A.S.(2005). "Linking training and performance through competency-based training." In S.A. Larson & A.S. Hewitt (Eds), *Staff Recruitment, Retention and Training Strategies for Community Human Services Organizations* (pp.125-143). Baltimore, MD: Paul H. Brookes Publishing Co.

PHI. (2012). *The PHI State Data Center: Comprehensive state-by-state data on the direct-care workforce.* Bronx, NY: PHI. Retrieved from http://phinational.org/policy/states/

PHI. (2011). The State Data Center: A new resource for workforce monitoring [PowerPoint presentation]. Retrieved from http://www.dswresourcecenter.org/tiki-download_file.php?fileId=433

PHI. (2003). State wage pass-through legislation: An analysis. Retrieved from http://www.directcareclearinghouse.org/download/WorkforceStrategies1.pdf

PHI. (2006). Subsidizing health insurance coverage for the home care workforce in two Wisconsin counties: An analysis of options. http://www.directcareclearinghouse.org/download/ HealthInsCovWIreport.pdf (accessed February 21, 2008).

PHI Michigan (2011). Self-determination and the MI Choice Medicaid Waiver Program: A survey of direct care workers serving people using the MI Choice self-determination option. Prepared for the Michigan Department of Community Health. October.

RTI International & Urban Institute. (2010). A Descriptive Analysis of the US DOL Long Term Care Registered Apprenticeship Programs. July 2010.

Scala, E. (2008). Home and Community-Based Services: Workforce and quality outcomes. *A Compendium of Three Discussion Papers: Strategies for Promoting and Improving the Direct Service Workforce: Applications to Home and Community-Based Services.* New Brunswick, NJ: Rutgers Center for State Health Policy. Retrieved from www.cshp.rutgers.edu/Downloads/7740.doc

Schalock, R., Gardner, J., & Bradley, V. (2007). *Quality of life for people with intellectual and other developmental disabilities.* Washington, DC: American Association on Intellectual and Developmental Disabilities.

Seavey, D. (2004). "The cost of frontline turnover in long-term care. Washington, DC: Better Jobs Better Care; Institute for the Future of Aging Services." Retrieved from http://phinational.org/sites/phinational.org/files/clearinghouse/TOCostReport.pdf

Selkow, I. (2011). "Growth and prevalence of participant direction: Findings from the National Survey of Publicly Funded Participant-Directed Service Programs [Power Point Slides] presented at the 2011 FMS Conference, November 14, 2011, Baltimore, MD.

Seavey, D., & Salter, V. (2006). *Paying for quality care: State and local strategies for improving wage and benefits for personal care assistants.* Washington, DC: AARP. Retrieved from http://assets.aarp.org/rgcenter/il/2006_18_care.pdf

Senecal, J. K., Livingston, J. A., & Reback, D. (2008). Legislative study of the direct care workforce in Vermont. Retrieved from http://dail.vermont.gov/dail-publications/publications-legis-studies/dcw-report-exec-summary

Sherard, B. D. (2002). Report to the Joint Appropriations Committee on the impact of funding for direct staff salary increases in adult developmental disabilities community-based programs. Retrieved from http://www.pascenter.org/documents/WY_2002.pdf

Spillman, B., & Lubitz, J. (2002). *New estimates of lifetime nursing home use: Have patterns of use changed?* Medical Care, 40(10), 965-975.

State of Washington Department of Social and Health Services (2009). *Revised Fundamentals of Caregiving Training Manual,* version 2, Module 5, Lesson 1, May

Stearns, S.C., & D'Arcy, L.P. (2008). *Staying the course: Facility and profession retention among nursing assistants in nursing homes.* Journal of Gerontology, 63B(3), S113-S121.

Taylor, M., Bradley, V., & Warren, R. J. (1996). *The community support skill standards: Tools for managing change and achieving outcomes.* Cambridge, MA: Human Services Research Institute.

Test, D., Flowers, C., Hewitt, A., & Solow, J. (2004). *Training needs of direct support staff.* Mental Retardation, *42*(5), 327-337.

University of Minnesota (UMN), Research and Training Center on Community Living in partnership with The Lewin Group. (2006). CMS Direct Service Workforce Demonstration Promising Practices in Marketing, Recruitment and Selection Interventions. Retrieved from http://www.dswresourcecenter.org/tiki-download_file.php?fileId=11

University of Minnesota Research and Training Center on Community Living (2011a). *Road Map of Core Competencies for the Direct Service Workforce, Phase I: Direct service worker Competency Inventory*, with input from the Lewin Group, PHI and the Annapolis Coalition for Behavioral Health Workforce. Prepared for the Centers for Medicare and Medicaid Services, May 31st.

University of Minnesota Research and Training Center on Community Living (2011b). *Road Map of Core Competencies for the Direct Service Workforce, Phase II: Direct service worker Competency Analysis* with input from The Lewin Group, PHI and the Annapolis Coalition for Behavioral Health Workforce. Prepared for the Centers for Medicare and Medicaid Services. May 31st

Velgouse, L., Sciegaj, M., & Sanders, C. (2011). "Core competencies for implementing a person-centered and participant-directed culture in the Aging Network" [Power Point Presentation] presented at the n4a Conference, Washington, DC. July. Retrieved from http://web.bc.edu/libtools/details.php?entryid=225.

Wong, A., Kaye, H. S., & Newcomer, R. (2007). *State legislation regarding wages and benefits of home care workers: Thirteen promising practices*. Retrieved from http://www.pascenter.org/pas_workforce/promising_practices.php

Wright, B. (2009). *Strategies for improving DSW recruitment, retention, and quality: What we know about what works, what doesn't, and research gaps.* National Direct Service Workforce Resource Center; The Lewin Group. Retrieved from http://www.dswresourcecenter.org/tiki-index.php?page=Reports