



# **State Implementation of American Rescue Plan Act Initiatives to Increase Wages and Expand Career Opportunities for Direct Service Workers: Summary of a State Affinity Group**

**AUGUST 2022**

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AUGUST 2022

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**The American Rescue Plan Act (ARPA) Home and Community-Based Services (HCBS) Technical Assistance Collective** is made up of five organizations with deep expertise in HCBS systems: ADvancing States, Halperin Butera Consulting, the National Association of State Directors of Developmental Disabilities Services, Riverstone Health Advisors, and Ventech Solutions. The TA Collective's mission is to support states in achieving the objectives included in their ARPA HCBS Spending Plans to expand, enhance and strengthen their HCBS systems by March 31, 2025.

**ADvancing States** represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

**NASDDDS** assists member state agencies in building person-centered and culturally and linguistically appropriate systems of services and supports for people with intellectual and developmental disabilities and their families.

**Ventech Solutions** is a healthcare information technology company that uses the most advanced digital technologies to support new applications in the health care market, including government, employers, providers, health plans, and consumers. We develop Remote Monitoring Systems that support the ability of frail older persons and persons with disabilities to live in homes of their own choosing, while protecting their privacy and data security.

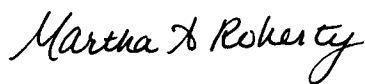
*Made possible with support from [The SCAN Foundation](#), [The John A. Hartford Foundation](#), [Arnold Ventures](#) and [The Milbank Memorial Fund](#).*

# Acknowledgments

**A**Dvancing States and our partners with the ARPA HCBS Technical Assistance Collective (TA Collective) are proud to release this paper that provides important and timely information about the activities to support direct service workers (DSW) that states are currently undertaking as part of their ARPA HCBS initiatives. Through the generous support of The SCAN Foundation, The John A. Hartford Foundation, The Milbank Memorial Fund, and Arnold Ventures, the TA Collective operated an Affinity Group to support state DSW improvement efforts, facilitate information exchange, and share innovations, promising practices, and other strategies to strengthen the DSW workforce across the country. We are grateful to these foundations for their support and also to the state officials who shared their expertise, challenges, and promising practices with peers across the country.

According to PHI, an organization that supports DSWs, annual turnover of the employees is estimated to be between 40 and 60 percent but can be higher in some areas. This turnover, coupled with the growing population of people who utilize LTSS, has resulted in millions of jobs that need to be filled.<sup>1</sup> The labor-intensive nature of the work, historically low wages, and increased competition from outside industries, is creating an environment where strategies to recruit, retain, compensate, and provide career advancement opportunities for DSWs will be crucial to ensuring that the health and social support needs of older adults and people with disabilities can continue to be met. While the strategies and promising practices discussed in the Affinity Group and recorded in this report are not necessarily sufficient to solve the entirety of the workforce crisis, we hope that the information will provide useful tools to states as they work to enact changes that lead to incremental improvements in the system.

State leaders are faced with enormous challenges at this critical juncture in LTSS across the country. As the TA Collective continues to support states to improve long-term services and supports for older adults and people with disabilities, we hope the lessons learned from this Affinity Group provide guidance and direction that supports better outcomes and better lives for the workers and the people they serve.



**Martha Roherty, Executive Director**  
*ADvancing States*

<sup>1</sup> <https://www.phinational.org/caringforthefuture/>

# Introduction

In March 2021, Congress enacted the American Rescue Plan Act. Section 9817 of the Act provided states with a 10% Federal Medicaid Assistance Percentage (FMAP) enhancement on Medicaid expenditures for Home and Community-Based Services (HCBS) provided between April 1, 2021 and March 31, 2022. In return for this one-time funding boost from the federal government, states are required to spend an amount equal to the enhanced FMAP on HCBS-related services between April 1, 2021 and March 31, 2025. The ARPA HCBS Funding Initiative represents the largest infusion of new

federal resources into the nation's HCBS system over the last 30 years, with an estimated \$35 billion in total spending between now and March 2025.

**During each 90-minute meeting, the states shared information, asked each other questions, and heard presentations from both national subject matter experts and other states with experience to share.**

Due to its time-limited structure, the ARPA HCBS Funding Initiative presents a significant challenge to states. With a substantial amount of funding made available to states, the Centers for Medicare & Medicaid Services (CMS) established a relatively short timeline to expend the funds, and many initiatives focused on expanding and reforming

benefits for HCBS recipients as well as modernizing HCBS infrastructure. These expansions in benefits and infrastructure initiatives often require extended periods of time to conduct stakeholder engagement around design issues, procure new types of vendors, and conduct detailed planning around implementation approaches. Most states did not have existing capacity to implement the new initiatives in their HCBS Spending Plans and therefore had to either hire new staff or procure outside assistance. Regardless of the approach, a substantial amount of time is required to either recruit new employees or secure contractual assistance.

Through the generous support of [The SCAN Foundation](#), the [Milbank Memorial Fund](#), and [The John A. Hartford Foundation](#), and [Arnold Ventures](#), the ARPA HCBS Technical Assistance Collective came together to provide quick-turnaround technical assistance to states on the implementation of their ARPA Spending Plans. A portion of the funding was allocated to establishing two state Affinity Groups (AGs) on topics of high interest to the

states. One AG focused on ARPA initiatives to Strengthen the Direct Service Workforce and the second focused on new Enabling Technologies to provide support to HCBS participants in their own homes.

This Issue Brief summarizes the work of the AG to Strengthen the Direct Service Workforce. States which applied and were accepted in the AG included: Arizona, Connecticut, Georgia, Illinois, Kentucky, Maine, Minnesota, Louisiana, Ohio, Oklahoma, Oregon, South Carolina, Virginia, Washington, and Wyoming. These states met six times over three months. During each 90-minute meeting, the states shared information, asked each other questions, and heard presentations from both national subject matter experts and other states with experience to share.



# Affinity Group Overview

The six sessions of the Direct Service Workforce (DSW) Affinity Group were broken into two parts. In the first three sessions, the Affinity Group discussed initiatives to use ARPA funding to increase wages and benefits for front-line DSWs. These workers, who have been chronically underpaid in State Medicaid Programs, are hands-on workers who assist individuals with Activities of Daily Living (ADLs) such as dressing, eating, bathing, toileting, and mobility, as well as Independent Activities of Daily Living (IADLs) such as shopping, meal preparation, housekeeping, money management, and transportation. DSWs also provide supports to HCBS participants in community-based settings, such as supported employment, adult day health and social supports, or similar non-residential programs. Due to low payment rates and lack of career development

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opportunities, the turnover of DSWs has been historically very high, and many agencies who employ DSWs have difficulty retaining enough workers to meet their contractual obligations with states or managed care companies. In many states, the annual turnover rate among DSWs is well over 50%.

The last three sessions of the Affinity Group were focused on Career Development Initiatives, which are designed to create opportunities for DSWs to advance professionally through increased training and experience. In state Medicaid programs,

Career Development programs for DSWs are rare, because they require states to develop and implement formal training programs and to link increased training levels and experience with increases in wages and/or benefits. In most states, the opportunity to increase one's salary as a DSW is extremely limited, and also highly subject to the rates which the state Medicaid program pays the agencies which employ DSWs for these services.



# Increasing Wages and Benefits for Direct Service Workers with ARPA Funds

A primary policy objective of Section 9817 of the American Rescue Plan Act is to provide states with the funding needed to raise wages and benefits for Direct Service Workers. Many HCBS Spending Plans submitted by states to CMS indeed adopted this policy objective, and a significant percentage of the total funding made available to states under the ARPA legislation is being used for that purpose. Table 1 presents data on the total amount of funding made available to each state in the DSW Affinity Group, the amount of ARPA funding that was allocated to DSW wage and benefit increases, and the percentage of total ARPA funding allocated to each state which was devoted to DSW compensation increases. This data shows that percentage of total ARPA funding allocated to DSW compensation increases ranged from 30% to 100%, and across all the states participating in the Affinity Group, 55% of all ARPA funding was devoted to DSW payment increases.

The details of how states made payment increases to DSWs are fairly complicated and were a major point of discussion within the DSW Affinity Group. States had a variety of options under different Medicaid authorities for increasing payments for DSWs and from the states' perspectives, there were advantages and disadvantages to each approach, as discussed in the following sections. There were energetic discussions as to why a specific state chose the pathway it did, and at the time of this writing, there were still some states that, while they have committed significant amounts of their ARPA funding to raising the wages and benefits of DSWs, are still deciding on the best approach for distributing these funds to maximize beneficial impacts on the direct service workforce.

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**Table 1. State Investments in Service workers/DSW Wages and Benefits Under the ARPA HCBS Funding Initiative**

State	Total Estimated ARPA HCBS Spending (millions)	Estimated Spending on Service workers/ DSW (millions)	Percent of Total ARPA Spending Allocated to Service workers/DSW
Arizona	\$1,500.0	\$1,011.0	67.4%
California	\$3,026.8	\$912.2	30.1%
Colorado	\$501.4	\$241.5	48.1%
Connecticut	\$447.1	\$195.0	43.6%
Hawaii	\$51.5	\$23.2	45.0%
Illinois	\$559.5	\$444.0	79.4%
Kentucky*	\$308.8	\$308.8	100.0%
Louisiana	\$526.0	\$426.6	81.1%
Maine	\$230.9	\$134.1	58.1%
Minnesota	\$1,276.0	\$926.7	72.6%
Nevada	\$112.0	\$125.8	89.0%
Ohio	\$1,019.0	\$764.1	75.0%
Oklahoma	\$265.2	\$90.1	34.0%
Texas	\$964.5	\$721.2	74.8%
Wyoming	\$35.2	\$21.4	60.8%

*\*Note: Kentucky's original spending plan allocated funding across a variety of initiatives; however, subsequent legislative action shifted 100% of the ARPA funding to provider increases.*

## States Are Using a Variety of Medicaid Authorities to Increase Compensation for Direct Service Workers

Although CMS has approved many of the initiatives proposed by the Affinity Group states, CMS approval only provided states with the authority to utilize ARPA funding for those initiatives. If a state wants to receive Medicaid match for allowable services and activities, they must also submit a Medicaid “action,” to implement the activity. These actions are required to implement changes to “Medicaid authorities,” which are the specific statutory requirements under the Medicaid statute which permit states various options for expanding Medicaid coverage. Under the ARPA HCBS Funding Initiative, States have used a variety of Medicaid authorities to increase wages and other compensation for DSWs. A brief summary and the considerations for selecting a specific authority are presented in Table 2.

**Table 2. Medicaid Authorities Used by States to Increase Wages and Other Compensation for Direct Service Workers**

Authority	Summary of Option	Considerations
<b>1915(c) waiver amendment</b>	Standard process for implementing changes to HCBS waivers, such as new or expanded services, change in rate methodologies, or changes to eligibility.	A standard amendment may not be approved as quickly as other approaches, may require more comprehensive public input, and may not be approved with a retroactive implementation date.
<b>State Plan Amendment (SPA)</b>	Standard process for implementing changes to HCBS authorized by the state plan, such as 1915(i), 1915(k), and 1905(a)	A standard SPA may not be approved as quickly as other approaches and may require more comprehensive public input. SPAs can be approved retroactively to the first day of the quarter in which they are submitted.
<b>Administrative Claiming</b>	Certain activities, such as certain provider trainings, evaluations, rate studies, and similar projects, may receive Medicaid administrative match.	Claims must be directly related to the proper and efficient administration of the Medicaid State plan or waiver services and must be supported by an approved cost allocation plan at the state.
<b>Enhanced Funding for Information Technology</b>	Certain Medicaid technology projects, such as those related to claims, billing, and eligibility, may receive 90% Federal match for installation and 75% match for ongoing operations.	A state must submit an “Advance Planning Document” prior to accessing enhanced funding. This can be a lengthy process and may delay implementation of the project.

*(continues)*

**Table 2. Medicaid Authorities Used by States to Increase Wages and Other Compensation for Direct Service Workers** *(continued)*

Authority	Summary of Option	Considerations
<b>1915(c) Appendix K</b>	An option to implement emergency/disaster related changes to state HCBS programs.	Only applies to services delivered under 1915(c) waivers or certain LTSS services within pre-existing 1115 waivers. Additional flexibility around timelines and processes for receiving approval, including an option for a retroactive start date. COVID Appendix Ks may be extended to no more than 6 months after the public health emergency ends.
<b>Disaster SPA</b>	A state plan amendment that implements disaster-related changes to the Medicaid program.	Not applicable to 1915(c) or 1115, but can apply to state plan HCBS. Potentially allows for expedited implementation and less stringent public notice requirements. Ends when the public health emergency expires.

A major decision point among the AG states was whether to make wage and compensation increases “permanent” through state plan amendments and/or 1915(c) waiver amendments, or whether to make wage increases temporary through time-limited payment increases, bonus payments, retention payments, signing bonuses, or supplemental payments. As shown in Table 2, there were significant advantages and disadvantages to each approach. Overall, the viability of ongoing payment increases was a major factor influencing state decisions. States that couldn’t guarantee ongoing increases (particularly those states whose legislatures would not commit to permanent rate increases) generally elected to provide one-time payments, or rate increases that had definitive end dates built into the rate increases. However, there were at least an equal number of states (at least in the Affinity Group) who believed that their legislatures had agreed to permanent rate increases, mostly by including rate increases in their future annual state budgets.

The decision to make rate increases more permanent or temporary was not always an either/or decision, as some states used both approaches across different HCBS programs. One common example was that states made one set of rate increases for DSWs support persons with intellectual and developmental disabilities (IDD populations) while another set of increases were applied through HCBS programs serving older persons and persons with disabilities. Another common example was for states to make one set of rate increases for DSWs employed by traditional Medicaid provider agencies and another set of increases for DSWs employed directly by HCBS participants in self-directed care models. Several states in the Affinity Group were making efforts to equalize

DSWs rates across HCBS populations and HCBS waiver programs and address historical wage inequalities. A more in-depth research study of how states used ARPA funding to increase payment rates across the full spectrum of programs and populations in each state is certainly warranted upon completion of the initiatives.

Finally, several states decided that increases in payments rates for Direct Support Workers and providers should be performance-based. These states were considering several metrics for performance-based increases, such as the number of critical incidents reports, outcome measures in quality reviews, or adherence to state reporting requirements. While performance-based bonuses were usually modest, they represented early attempts by states to implement value-based performance payments in HCBS populations.



# Implementation Challenges Encountered by States

States faced several implementation challenges in their efforts to raise wages and benefits for DSWs. One challenge was conducting a valid “rate study” as a prerequisite for gaining approval from CMS for a provider payment increase. A rate study, usually conducted by an independent contractor, provides a justification for a rate increase in terms of comparable wage rates in similar markets. The need to conduct a rate study before submitting a state plan amendment or a waiver amendment was a cause for delay in getting rate increases through CMS. Many states used alternative Medicaid authorities simply because a rate study was not needed to get higher rates approved via those mechanisms.

Another obstacle to increasing wages for DSWs is that rate increases usually go through a provider agency which employs the DSWs and, unless provided in self-direction programs, the payments do not go to the DSW directly. Thus, rate increases for agency providers must rely on the provider agency to pass through rate increases to their

DSW employees. Most states did not have any existing mechanism to make wage pass throughs mandatory and enforce the requirement. In some cases, a state might not even know how many DSWs a particular agency employs, since agencies generally bill states in aggregate for the total amount of service units provided, not the number of workers employed. In a few states, however, statutory mandates exist which specify the percentage of aggregate payments made to agency providers are passed through to DSWs. In direct responses to the ARPA Initiative, many states established new mechanisms to ensure that providers used the majority of their rate increases for paying DSWs increased wages and

benefits. For example, many states developed attestation forms which must be signed by the provider agency which legally binds the agency to pass through payment increases. Some states also began requiring agencies to provide annual cost reports to the state that document how total payments made to the agency were distributed across all categories of costs.

**In direct responses to the ARPA Initiative, many states established new mechanisms to ensure that providers used the majority of their rate increases for paying DSWs increased wages and benefits.**

A third obstacle to increasing wages and benefits to DSWs was simply that many state legislatures required both CMS and legislative approval before increases could be implemented. Since many states did not receive final approval of their HCBS Spending Plans until late 2021 or early 2022, they needed to wait until their legislatures approved their FY 2023 budgets before rate increases could be operationalized. Since FY 2023 did not begin until July 1, 2022, rate increases in many states did not go into effect until that date, 15 months after the enactment of the ARPA legislation. In some instances, however, by working closely with their state legislators, states were able to secure legislative approval and implement rate increases prior to March 31, 2022, which earned those states an extra 10% FMAP increase on those expenditures due to the mechanics of ARPA funding flow. Since these rate increases often totaled in the hundreds of millions of dollars, the extra 10% FMAP increase was not insignificant.



# Shared Learning Among States

States participating in the DSW Affinity Group had the opportunity to share their experiences in raising wages and benefits for DSWs. Two states—Connecticut and Nevada—shared their experiences as a state that had made permanent increases in DSW wages with ARPA funds (Connecticut) and a state that had elected to make one-time payments for DSWs with their ARPA funding (Nevada).

## Connecticut's Experience



Connecticut is one of the wealthiest states in the country, has more resources to work with, and made some significant investments to strengthen its direct service workforce. For example, the state had contracted with the University of Connecticut to measure the overall demand for Direct Service Workers versus the supply of DSWs providing care to individuals under Medicaid. The data dashboard developed in this project showed a gap of 10,000 workers between the supply and the demand, which helped the state justify new rate increases for HCBS workers. Connecticut also used its data dashboard to show differences in payment for DSWs working in HCBS settings versus those working in institutional settings to convince the Governor's office to support parity in payment rates across all LTSS settings. Connecticut was also able to convince its legislature to make a commitment that rate increases enacted with ARPA funding would be maintained after the ARPA funding was depleted. The presentation made by Connecticut stimulated other states in the Affinity Group to explore similar investments in data collection to monitor the DSW shortage in their own states.

## Nevada's Experience



Nevada also presented to the Affinity Group and discussed its more temporary approach to raising wages for DSWs. First, under Appendix K authority, Nevada made two Supplemental Payments to all DSWs who were providing Medicaid-funded personal care services in the state. The first payment was a \$500 bonus to all workers who were currently employed. The second payment, also \$500, was a retention bonus to all DSWs who had worked at least six months during a specified time period. Individual DSWs were identified through the state's Electronic Visit Verification (EVV) system as the state did not have a record or registry



of all DSWs employed by provider agencies. The opportunity to participate in the bonus payment program was made voluntary to personal care service providers through an application process and 63 percent of the eligible providers participated in the program. Also, providers encouraged the state to address the need to withhold necessary taxes from the bonus payments but the agency determined that it was a too difficult task and decided to remain silent on those implications. Nevada intends to address tax implications if subsequent payments are made directly to DSWs.

Nevada also gained Appendix K authority to provide supplemental payments for a few different provider types of HCBS services. These supplemental payments are made by summing the total net paid claims for each provider during a three-month period, and then paying the provider a supplemental payment for the entire period. The supplemental payments range from 14 percent to 27 percent, depending upon the type of provider. These Appendix K payments only last until six months after the end date of the Public Health Emergency (PHE), which is currently extended through October 13, 2022. Nevada is hoping to maintain these supplemental payments for HCBS providers after the PHE expires but will need both legislative and CMS approval to do so.



# Innovative Approaches by States to Strengthen the DSW Workforce

**W**hile most states focused on wage and compensation increases as the major strategy to strengthen the DSW workforce, a few states adopted innovative approaches. For example, Minnesota adopted a strategy to expand the provider network of personal care providers. The state initiated a grant program to establish employee-owned cooperatives. Through the grants, Minnesota intends to support increased wages, increased benefits, and retention of DSWs by providing them with control over their jobs and ownership of the provider agency. The state first selected a vendor to manage the program and provide technical assistance to direct care workers who were interested in establishing an employee-owned cooperative provider

agency. In September 2022, the state will issue an RFP eliciting direct care workers to submit applications for the program. It plans to award 10 start-up grants of \$90,000 each to establish new employee-owned cooperatives over a two-year period.

**Minnesota intends to support increased wages, increased benefits, and retention of DSWs by providing them with control over their jobs and ownership of the provider agency.**

The State of Connecticut has developed several data dashboards to measure the performance of state programs across the entire spectrum of state government. One of the dashboards includes a variety of metrics for monitoring the state's LTSS programs. For example, with this tool, the state was able to track COVID's impacts on individuals in nursing homes as well as in the community. Through this tracking, Connecticut

was able to understand the trends in LTSS and identified specific discrepancies between institutional and community outcomes. In Connecticut, 10% of all nursing home residents died of COVID, whereas the impact in HCBS was significantly less pronounced. This has led to increased awareness and a corresponding shift among individuals seeking community-based services.

Importantly, the dashboard also tracks the supply needed and demand for HCBS workers. According to current data, Connecticut has a shortage of 10,000 workers based on the existing workforce and the current demand for HCBS services. Due to the relatively significant increase in individuals seeking community-based services, coupled with the identified workforce shortage, Connecticut has been able to identify the role of unpaid caregivers filling the gaps in services. Connecticut used this information to inform their ARPA spending plan, which resulted in substantial ARPA funding being targeted to support unpaid caregivers in addition to efforts to stabilize formal care providers.

Because Connecticut has been collecting, tracking, and publishing data from its dashboard on its DSW workforce, it has been able to document the increasing challenges with securing a sufficient DSW workforce. The data was extremely helpful to inform and educate policymakers and to advocate for additional financial resources to support HCBS services. While the state has not always achieved its agenda in the legislature, the information has generated support in the administration for their ARPA activities and will hopefully continue to provide value as the state seeks to sustain wage increases in HCBS after the ARPA funding ends.



# The Future Sustainability of Wage Increases for DSWs

CMS recently extended the deadline for states to expend all of their ARPA HCBS funding to March 31, 2025. However, the limited nature of the funding has created state concerns with sustainability, particularly as it relates to the ability to finance rate increases on an ongoing basis. A number of States expressed guarded optimism about the ability to extend the payment increases beyond the expiration of the ARPA funding; however, we note that the DSW Affinity Group discussions occurred prior to more recent economic news regarding rising inflation and a potential forthcoming recession. The overall fiscal health of State governments will no doubt play a large role in the viability of ongoing rate increases for the HCBS providers and the ability to sustain wage and compensation increases to DSWs.

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# Career Development Initiatives for DSWs

**W**hile nationally, states' approaches to addressing the workforce crisis using compensation strategies were relatively consistent, HCBS Spending Plans that included concomitant investments in career workforce development chose a variety of solutions. Primary among these was a focus on the development of career ladders and workforce training initiatives. All were aimed at elevating the professionalism of the direct service worker role and retaining field staff by establishing a tangible career path. State initiatives ranged from the creation of apprenticeship and internship programs, to investments in learning management systems, to the design of training curricula, to the development of supervisory toolkits and DSW public relations campaigns. All states' efforts to develop retention solutions are meant in some way to bend the trajectory of the mounting workforce crisis.

## State Challenges & Strategies to Overcome Challenges with Career Ladders

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The Affinity Group states agreed that there is no single moonshot strategy when it comes to using training and career ladders to bolster the direct service workforce. A common theme among the states is improving the recruitment pipeline through higher education and career or technical education programs. While seemingly simple, fostering partnership with colleges, universities, and high schools comes with challenges. One state's approach to this issue was to start at the top by conducting targeted meetings with college and university presidents. Surprisingly, many states are experiencing challenges from the disability advocacy community who question states' investments that do not involve rate or pay increases. In these situations, states find the most effective strategy to allay concerns of advocates and garner their support is to include them from the beginning and at all stages of initiative decision-making and implementation. A third common challenge for states is waning human resources within their own ranks. The shortages in state employees hinders the ability to readily launch and manage training and career ladder initiatives. Those effectively addressing this problem do so by leveraging inter-agency and interdepartmental collaboration by working outside of traditional siloes to accomplish the work.

## State Learning about Career Ladders

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The DSW AG afforded states the opportunity to share their spending plan ideas and discuss challenges with initiative implementation. While the biweekly sessions revealed a great deal of leading practices and cross-pollination of ideas, there were three significant points of learning among the participating states. Several states are grappling with the decision to develop their own career ladder curriculum or procure existing training programs such as the College of Direct Supports, the National Association of Direct Support Professionals (NADSP) E-Badge Academy, or the QUILTSS Institute, among others. States were able to hear from field experts regarding established training programs and think about the importance of emphasizing the necessary competencies when developing or procuring training programs. Another key take-away for Affinity Group participants was the need to offer training resources that are accessible for marginalized segments of the workforce, including those who use English as a second language. It is increasingly necessary for states to assure that information for DSWs is easily readable, translated into multiple languages, and available in a variety of formats. The third lesson learned for states is that it is not sufficient to focus solely on DSP wages or solely on training and career ladder development. Successfully influencing DSP recruitment and retention requires a coupling of workforce development strategies with actions to increase wages and offer payment incentives.

## State Career Ladder Innovations

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Three states participating in the Affinity Group are working on innovative approaches to DSW retention through career paths and training. Washington has successfully launched a high school technical program in one of its education districts. They celebrated their first graduates in the spring of 2022 attaining certificates of completion. Washington plans to add a practicum component and apprenticeship program through its ARPA investments. Illinois is enjoying some early success through a community college partnership to offer standard courses for mental health direct service workers. Illinois also is focused on developing a training program that will enable DSWs to be cross-trained and work within any type of HCBS setting. Ohio has a governor's task force aimed at establishing partnerships with universities, career and technical schools, and community colleges. The task force is charged with developing a variety of solutions including scholarships, internships, and supplemental payments to reward skill acquisition.

## Future Plans for Career Development Initiatives

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All states were presented with a key challenge at the outset of ARPA. This unprecedented infusion of financial resources in states to enhance HCBS comes with the pressure to honor the long-term commitment and sustainability of professional development for the direct service workforce. The creative strategies of states can only be maintained by funding and resource growth. States are already thinking about and building bridges to that sustainable future by collaborating with local workforce investment boards, fostering legislative champions around workforce issues and solutions, and including mechanisms to collect data and analyze the efficacy of the workforce development strategies they are implementing.

# Future Risks and Opportunities for Strengthening the DSW Workforce

This issue brief is being written in July 2022, approximately 15 months after the effective date of the ARPA Section 9817 HCBS Spending Initiative. At this time, states have 32 months remaining to spend an amount equal to the 10% FMAP savings they received in the first year of the initiative. States have made significant progress towards using the new federal funds available through the ARPA Spending Initiative to raise wages and other compensation for DSWs. Most states have gotten the necessary approvals from within their own agencies, from CMS, and from their legislatures to raise payment rates for personal care providers who employ DSWs. However, less progress has been made in actually operationalizing increased payment rates through claims payment systems. In some states, payment rate increases are only being made to personal care providers who voluntarily apply for increased payments, and in some cases, providers have not sought payment rate increases.

Much of the discussion in the AG focused on how states planned to distribute approved rate increases to providers and to DSWs directly. This was particularly true in states that did not raise Medicaid payment rates across the board but instead planned to make one-time payments to DSWs through bonus payments, retention payments, signing bonuses, recruitment bonuses, supplemental payments, or temporary rate increases that were only in effect for a few months. More operational resources were required in these states to determine the payment amounts that should be made to each individual provider agency depending upon the composition of their DSW employees. In some of these states, the distribution of payments to DSWs had still not occurred because the mechanics of distribution was still being determined.



A second challenge still facing many states is how to make sure that increased payments made to providers are being passed through to the paychecks of DSWs. Most participating states do not require cost reporting for Medicaid personal care providers, since many providers are very small businesses with limited accounting systems and historic price-based fee-for-service reimbursements. However, Affinity Group states recognized that they would need to develop an auditing process or cost reporting process which could assess the degree to which state mandates for DSW wage increases and/or one-time payments were being adhered to.

Finally, the issue of the sustainability of wage increases after the ARPA HCBS Funding Initiative ends in March 2025 looms large on the Medicaid horizon. The ARPA HCBS Funding represents a huge infusion of new Federal dollars into the Medicaid HCBS system, but there is no assurance, at least for now, that that level of investment by the Federal government will continue beyond the March 2025 end date. If the level of Federal investment in HCBS services declines after March 2025, states will have to sustain DSW wage increases with increased state dollars. Even states which committed to “permanent” wage increases through State Plan Amendments or 1915(c) waiver amendments might have to reduce payment rates in an economic downturn, as they have done many times in the past. In other words, there is no hard and fast guarantee that the wage increases which DSWs have achieved as a result of the ARPA HCBS legislation will be maintained after March 2025.





## Next Steps

**T**he ARPA HCBS Funding Initiative made a huge investment in the nation's capacity to provide HCBS to frail elderly persons and persons with disabilities who have functional needs. A major policy objective of that investment was to stabilize and professionalize the DSW Workforce of employees who provide hands-on care on a daily basis to Medicaid-eligible individuals with significant functional impairments. Given the amount of investment that the federal government made in the HCBS system, it is imperative that a comprehensive, objective, and rigorous evaluation be conducted of the return on that investment. Has the durability and capacity of the DSW workforce improved? Are DSWs staying in this labor market for longer durations? Has the quality of care provided to persons receiving HCBS services measurably improved? As the demand for HCBS services among the nation's aging population inevitably increases over the next 30 years, the level of commitment which the nation makes in a Medicaid-funded HCBS system will be a major policy concern.

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# Notes







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