Association of Rehabilitation Facilities
Florida ARF
A Voice for Community Agencies

Florida's Direct Care Workforce Crisis

Why there is a workforce crisis

- A recent National Core Indicators staff stability survey found a 45% average DSP turnover rate nationally.
- A survey by the American Network of Community Options and Resources (ANCOR) found 1 in 3 DSPs leave employment in their first year of employment.
- Each vacancy costs agencies between $4,200 and $5,200 in costs in separation, training and replacing employees (Medisked Connect, 2016).
- There simply are not enough staff to meet the steadily growing demand for direct support professionals, also known as direct care aides, home care workers, etc.

Who the workforce crisis affects

- The workforce crisis affects all members of the community:
  - Providers struggling to maintain stable services and meet regulatory requirements;
  - Professionals performing this emotionally rewarding but difficult work with insufficient relief; and,
  - Consumers and families for whom services are a matter of life or death.

Factors leading to the workforce shortage

- ANCOR has identified the following factors leading to the workforce shortage:
  - Low rates to providers that do not support a living wage for DSPs (#1 reason DSPs leave).

- Insufficient benefits such as health insurance or paid sick leave (often a factor of low reimbursement rates).

- Lack of a career path and the perception that direct care service is a low-skilled profession.

- Insufficient access to technologies necessary for employee safety, improved outcomes, or streamlined documentation;

- Workforce demographics that are not keeping up with the demand. According to PHI, *Demand for New Direct Care Workers Outstrips Numbers of Women Entering Labor Force*: From 2010-2020, an estimated 612,350 women between ages 25 and 55 (the main DSP demographic) are expected to enter the direct care labor force, but the workload demand will be for 1,615,100 employees.

Are low provider rates creating Medicaid access issues?

Per Medicaid law, states are to ensure that their reimbursement rates are adequate to ensure sufficient numbers of providers exist to meet the needs of eligible individuals needing services. This provision is referred to as access.

As enacted into law, the equal access provision requires that state Medicaid provider payments be "consistent with efficiency, economy, and quality of care and . . . 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."

A federal access rule that went into effect on January 4, 2016, takes a small step towards creating a stronger process for evaluating the adequacy of state Medicaid payments. However, the rule excludes access reviews for Medicaid managed care plans. CMS said the equal access standard applies only "to state payments to providers and not to capitated payments to managed care entities." (80 Fed. Reg. 67582.)

The access rule also does ***not*** include Medicaid waiver services and demonstration programs. According to CMS, the agency uses separate waiver and demonstration specific standards for these programs. The exclusion of Medicaid waivers from the rule means there are no objective standards for evaluating or measuring access concerns.

The rule delegates to states the responsibility for setting standards and access measures and access measurement analyses. It prescribes no remedial actions that will be required—whether before or after rate changes take effect—in the event access reviews identify problems. CMS acknowledges the rule "does not prescribe specific state actions to address access to care issues. The rule instead requires procedures that will inform states and CMS of access concerns before (state plan amendment) approval and on an ongoing basis."

In Florida, we hear access related questions in the form of: *Are there enough providers to meet individuals' service needs, and how many providers have closed their doors*? Since 07-08, we have seen a 35% drop in the number of providers who provide iBudget waiver services. We also hear repeatedly that individuals are having difficulty locating providers particularly in rural areas – or that choices are limited.

Stakeholders may need to be more attentive to the State Plan Amendment process.

CMS Guidance to States on Rate Setting:

Since 2013, CMS has encouraged states to:

- Conduct analyses of how the home care industry relates to the larger marketplace within a state when forming their rate-setting methodologies.
- Consider the requirements of the DOL rule, Application of the Fair Labor Standards Act to the Domestic Service Act of 2013 when setting rates.
- Consider provider business costs associated with the recruitment, retention, and training of skilled workers.
- Build providers' cost of maintaining status as qualified Medicaid providers.
- Consider other provider costs such as staff tuition payments, higher wages for shift work or performance-based bonuses.
- Consider "difficulty of care factors" to address the level of provider effort associated with serving individuals with different support needs.
- Consider ground up models of rate setting as described in the CMS state toolkit for Medicaid agencies created in August 2013.

How do we address the problem?

- Support Medicaid rate reform initiatives to include indexing Medicaid reimbursement rate increases with cost of living increases. Florida could begin by reinstating its provider reimbursement rates to the 2003 level for key services (11% increase).
- Support a standard occupational classification of the Direct Support Professional (DSP) position by DOL and work with CareerSource Boards to identify the need for this classification, collect data, and standardize reimbursement rates that result in fair living wages for DSPs.
- Educate lawmakers and state entities on the need for adequate funding to ensure that Florida's HCB waiver services are funded adequately to ensure quality care.