# BPDD Caregiver Task Force Recommendations

## *Charge: Analyzing strategies to attract and retain direct care workers*

## *Charge: Supporting family caregivers through respite and other supports*

- Improve family leave act policies and work with private sector to create flexible options that can accommodate family caregivers and employer's needs.

## *Charge: accessing compensation & fringe benefits for caregivers (incl. health care)*

### Basic health plan model

*The Basic Health Plan is an option under the ACA that allows states to cover people with incomes between 133 and 200% FPL. States can create a different coverage option that is typically more affordable (lower cost-sharing and premiums) than Marketplace plans and does not require a waiver to implement.*[1]

*Minnesota and New York are the only states that have implemented Basic Health Plans. This is state administered coverage; however states receive significant federal match for expanding coverage. States receive 95% of what it would have cost the federal government to subsidize those people on the Marketplace.*

### Assist workers with deductible, coinsurance, copays costs

*States can explore a variety of approaches that offer relief from deductibles, coinsurance, or co-pays, which can be a significant cost burden and limit access to care, even if premiums are subsidized:*

- *Setting aside state funding or setting up a pass-through mechanism for the caregiver workforce that specifically covers deductible, coinsurance, and co-pay costs.*
- *Creating a fund similar to the Family Care direct care worker fund that providers can apply to that enables employers to pay the additional health insurance costs of their direct care workers*[2].
- *Restructuring Medicaid Premium Assistance programs to offer reimbursement the portion of coinsurance that is not covered by employer sponsored plans, deductibles, and co-pays for workers that meet narrow eligibility criteria*[3]

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[1] Kaiser piece on Basic Health Plans

[2] In 2008, Maine considered a state demonstration project to create such a fund and included legislative language in this memo from a state task force that was developed to find solutions to affordable health care for direct care workers

[3] PHI covers several state coverage models that may improve health care coverage for direct care workers https://phinational.org/wp-content/uploads/2017/07/PHI-StateModels-final.pdf

- *Explore Medicaid coverage of worker deductible/coinsurance/copayments under a social determinants of health approach.*

## Medicaid Buy-In approach (1332 waiver)

*A 1332 waiver authority may offer states a mechanism for offering a Medicaid Buy-In model[4]; currently the parameters of what states can do through 1332 waivers have not been clearly defined, which may be helpful to states looking to pursue innovative options. A variety of Medicaid Buy-In approaches are being considered by states including allowing people of any income level pay premiums for Medicaid coverage; using the Medicaid provider network, reimbursement, the Medicaid infrastructure and/or Medicaid-like benefits to offer a more affordable or accessible coverage option in the state; or creating a program that resembles a Medicaid benefit, a marketplace product or a hybrid of the two[5].*

## Use Income Disregards specific to caregiving

*States have flexibility to apply rules that disregard a portion of an individual's countable income or assets, which effectively expands Medicaid eligibility. Creative use of income disregards could be used to create a pathway for access to Medicaid health care for caregivers. For example, disregarding income that is derived from providing supports and services to participants in Medicaid funding long term care programs would lead to many caregivers that earn more than 100% of the federal poverty level meeting the income eligibility criteria for Badgercare.*

## Expansion of BadgerCare to 138% FPL or higher

*An estimated 30% of Wisconsin's paid caregiving workforce is already in BadgerCare, as are many family caregivers who reduced hours or left the workforce to take care of aging adults and people with disabilities. Increasing the amount a worker or can earn to 138% of the Federal Poverty Level (FPL) would result in the 30% paid caregivers already in BadgerCare being able to work an additional 457 hours annually (or an extra shift per week) without losing their BadgerCare health insurance. Collectively, that translates into millions more hours of caregiving for Family Care and IRIS participants. Expanding BadgerCare would allow an estimated additional 8,000 paid caregivers to have BadgerCare health insurance, helping to increase direct care worker retention.*

## Use Wisconsin's existing cooperative authority to create more direct care worker co-ops

*Wisconsin can use existing co-op authority to expand the number of caregiver worker co-ops[6] in the state. Co-ops can use their buying power can purchase health insurance, retirement plans, liability coverage etc. for members; contract with entities or individuals;*

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[4] Nevada in 2017 passed a billto allow people to buy into Medicaid regardless of income level or health status. New Mexico legislature a Task Force study committee and is advancing Medicaid Buy-In program legislation. Eight other states—Colorado, Connecticut, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Washington—are pursuing legislation; Delaware is conducting a task force study, and Missouri and New Hampshire have legislative proposals to establish a task force study group.

[5] https://www.shvs.org/wp-content/uploads/2018/05/Medicaid_Buyin_-FINAL.pdf

[6] Existing personal care worker co-op successfully operating in Wisconsin **(**Cooperative Care)

*and provide a mechanism for consistent training and continued professional development of the workforce*

## Allow provider agencies or co-ops to buy into the state health insurance and retirement system

*Many provider agencies do not have the funding to offer health care or other benefits. In some cases, provider agencies are not required by the ACA to offer health insurance at all because they have a low number of full-time employees. Even larger provider agencies that are required to offer health care coverage are often unable to provide plans that offer the coverage workers need at a price they can afford. In previous sessions, Wisconsin has had legislative proposals that would allow small businesses to participate in the Wisconsin health insurance or retirement system, which would allow them to extend benefits to their employees at a much lower cost. Direct care worker co-ops should also be included as an entity that can participate.*

## Include direct service workforce providing care to Medicaid beneficiaries in the state health insurance and retirement system

*In previous sessions, Wisconsin has considered various proposals to include certain classes and types of workers to be state employees for purposes of state health insurance or other state benefits. Many family caregivers and workers hired by individual IRIS participants do not work for a provider agency. Allowing individual direct care professionals to participate in the state health insurance and retirement system extends private sector employer sponsored benefits (that require employee contributions) that have ongoing value and can be a recruitment/retention strategy.*

## Require private insurers to cover direct services in insurance plans

*Medicaid funds—with a low, fixed rate structure—are the primary source of payment for services provided by the long-term care workforce, and lack of diverse funding limits workers' compensation. Income and asset limits ensure that Medicaid coverage is available only to those at or below the federal poverty line. Many people are forced to divest or keep their incomes/assets low in order to access the Medicaid long term care and personal care services they need.*

*Requiring private insurance plans to include long term care supports as part of base coverage can broaden the demographics and number of people in the insurance pool financially supporting private sector long term care service coverage, diversify and increase the funding base for direct care provider agencies, prevent or delay divestment for the purposes of qualifying for Medicaid coverage, and save the state Medicaid dollars.*

## Create a Medicaid 1115 Demonstration waiver for caregivers

*Section 1115 Medicaid demonstration waivers[7] allow states to test different approaches that are "experimental, pilot, or demonstration project" that "is likely to assist in promoting*

[7] https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/

*the objectives of the [Medicaid] program." While there is no precedence for states receiving a waiver to cover a population that shares specific roles/responsibilities, 1115 waivers have been used to expand coverage to populations that have specific health needs[8].*

*An 1115 waiver could be structured to allow higher income eligibility (such as 300% FPL) limits to capture the majority of low-income caregivers, include additional deductions or income disregards, and/or allow workers to earn more in exchange for increased cost-sharing based on income. Using Wisconsin's unique SeniorCare waiver as a model, the state could explore a waiver that covers private insurance deductibles/coinsurance/copays for other populations.*

### Transportation benefits

*Access to transportation is a limiting factor especially for Home and Community Based workers who must commute to client's homes. Many workers may not be able to afford to obtain or maintain a personal vehicle or may have a range that is limited by the boundaries and reliability of public transportation.*

- *Reimburse HCBS workers for transportation costs associated with commuting to client homes. These costs should at minimum include gas, millage, and public transit system fares. Currently, the workforce is only reimbursed for travel time and not mileage. Travel time reimbursement often does not cover the cost of gas and wear and tear on the vehicle.*
- *Provide a fund for providers to acquire and maintain a fleet of loaner cars direct service staff can access when their transportation falls through.*

### Housing assistance

*Many low income care workers face housing instability or are in substandard housing and do not have the capital to move.*

- *Create a fund for workers that allows them to obtain matching funds to put a down payment down on a house or enough funds to meet 1st/last month's rent and deposit requirements.*

## *Charge: registries of home care providers and referral or matching services*

### Establish a statewide contract with a proven registry

*Establish a statewide contract with a proven registry that enables long term care participants and available workers to find each other, hire and schedule workers, expand*

[8] Direct care workers and caregivers are at higher risk of infection and injury than other workers. Ensuring that these workers have access to comprehensive health care 1) may prevent occupationally acquired infections, illnesses, and injuries 2) lead to quicker treatment and recovery for workers 3) may prevent transmission of illnesses and infections to the Medicaid long term care clients served by caregivers. A demonstration waiver could test: 1) how access to Medicaid health insurance results in a healthier workforce that can contribute more caregiving hours to Medicaid long term care recipients 2) how access to health care benefits improves recruitment and retention and of skilled caregivers 3) how improvements in workforce stability and caregiver health results in improved services and outcomes for Medicaid long term care recipients.

*the available worker pool for workers not affiliated with a provider agency, and helps provider agencies to improve administrative efficiency[9].*

*Applications have been developed that match participants and workers by via profile information (care needed, geography, availability), enable participants to self-direct and hire workers that fit their needs and personality, enable personal care agencies and workers to track hours to prevent incurring overtime expenses, and enable provider agencies and managed care organizations to reduce administrative overhead while tracking workflow and billable Medicaid expenses. CMS guidance[10] allows states to use, and Medicaid administrative match to implement open registry of workers for public use and pay for ongoing operating costs*

## *Charge: recruitment and retention programs to expand pool of providers*

*Ensure policies encourage and reflect individual direct care workers and family caregivers who are not working for provider agencies, but who are providing care for one or more people or relatives.*

- *Encourage MCOs to incorporate workers not affiliated with a provider agency-- including willing family members--into their provider networks. See also, Use Wisconsin's existing cooperative authority to create more direct care worker co-ops.*
- *Allow individuals who self-direct to pool their budgets to jointly hire staff and offer wage incentives.*
- *Continue allowing IRIS participants to hire workers--including relatives and friends—who are not affiliated with provider agencies.*

## *Charge: other solutions to support/strengthen workforce, increase access, improve quality*

### Adjust the Medicaid reimbursement rate structure

*Medicaid rates can be used as a mechanism to implement pay progression and career advancement for workers as well as a funding source for additional training and quality improvement for workers.*

- *Implement tiered Medicaid reimbursement rate structure "that provide enhanced reimbursement for services rendered by workers who are able to serve beneficiaries with more complex needs or have other advanced skills"[11].*

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[9] My Support (http://www.mysupport.com/) is an example of a platform currently operating in California, New Jersey, Iowa, and preparing to launch in Delaware and Maryland. My Support can be used as an the CMS suggested open registry of workers for public use, and Medicaid administrative match can be used by states to implement the My Support system and pay for ongoing operating costs (see page 2, CMS Guidance, Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce August, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf)

[10] See page 2, CMS Guidance, Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce August, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf.

[11] See CMS Guidance, Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce August, 2016, page 3 https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf

- *Build into the Medicaid rate structure provider's costs for other benefits offered to workers, such as tuition assistance, performance-based bonus payments or higher wages for shiftwork.*

- *Any increases to wages, extension of benefits, or other flexibilities given to agencies to increase worker retention be applicable to the entire Home and Community Based workforce. Many people with I/DD rely on many types of workers—including job coaches, respite care workers, certified nursing assistants, dementia specialists, behavioral support specialists, integrated day service staff, companions, mentors and other individuals someone might hire while self-directing etc.—to achieve care plan goals and outcomes.*

## Add Remote Support Technologies service definition and individual care plan requirements

*Ensure supportive technology waiver service definitions are flexible enough to be inclusive of current and future cutting-edge technologies that can maximize independence, privacy, and improve overall quality of life for Medicaid-funded long-term care participants. Technology can help reduce costs and address the shortage of direct care workers. Within the individual's care plan, require that:*

- *Participants are presented with options for use of supportive technologies in their individual support plans **before** assuming paid staff are necessary to enable independence in people's homes, workplaces, and communities.*

- *Supportive technology is evaluated as a viable resource to maintain a safe and quality lifestyle, particularly for people experiencing severe direct care staffing shortages.*

- *Supportive technology is encouraged and used in conjunction with traditional staffing is used to create a cost-effective method to ensure support needs are met.*

## Adjustments for IRIS participants

- *recommend DHS facilitate the ability for IRIS participants to connect and network with each other for purposes of braiding funding or banding together as a unit to demonstrate to providers that there is a volume of work that is worthwhile.*