March 20, 2023

Chairman Bernard Sanders
332 Dirksen Senate Office Building
Washington, DC 20510

Ranking Member Bill Cassidy
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to your request for information on the health care workforce.

As the nation emerges from the most acute phase of the COVID-19 pandemic, Medicaid Directors report that gaps in the health care workforce are one of their most serious challenges. **Workforce shortages represent an existential threat to the Medicaid program; without providers to deliver care, Medicaid agencies cannot create access to services for their members**. Addressing these shortages will require creative strategies and long-term investments.

Medicaid Directors report that workforce challenges span the continuum of providers, from physicians and nurses to nontraditional providers like peer support specialists, community health workers, and long-term care direct support professionals. Medicaid programs have led the way in expanding coverage of these nontraditional providers: as of 2018, for example, 32 states covered behavioral health peer support workers – a provider group that Medicare and private insurers have lagged behind in covering. Building a robust workforce of nontraditional providers, through multi-payer strategies aimed at ensuring these jobs are viable careers, will be crucial to ensuring Medicaid members can continue to access effective care.

Medicaid Directors are diligently preparing for the upcoming redeterminations of Medicaid eligibility as allowed under the Consolidated Appropriations Act of 2023. Because of the intensity of this work, our members have limited bandwidth to respond to requests for information. We did, however, want to highlight our previous positions on steps that Congress should take to support the health care workforce in behavioral health and long-term care. **Please find NAMD's previous comments on building out the health care workforce appended to this letter.** We recognize that several of these recommendations may require action from other Senate Committees, particularly the Senate Finance Committee given its jurisdiction over the Medicaid program.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

We appreciate the opportunity to share our previous health care workforce recommendations with you. Please do not hesitate to reach out to NAMD staff for further information on these critical issues.

Sincerely,

Allison Taylor
NAMD Board President
Director of Medicaid
Indiana Family and Social Services Administration

Cynthia Beane, MSW, LSCSW

Cindy Beane
NAMD Board President-Elect
Commissioner
West Virginia Department of Health and Human Resources

Appendix: Recommendations on Supporting the Long-Term Care and Behavioral Health Workforce

Long-Term Care Workforce

NAMD urges Congressional action to strengthen the long-term care workforce, including the home- and community-based services (HCBS) workforce. HCBS are unique Medicaid benefits which empower individuals with intellectual and developmental disabilities to achieve their full potential and live healthy, rewarding lives in their communities, in addition to supporting aging individuals who may wish to continue residing in their homes and communities rather than seeking institutional care. Workforce capacity is a significant barrier to providing these services to all people eligible for and interested in receiving them, and these challenges will only become more acute as aging demographics drive increased demand.

We encourage Congress to take a holistic view of supports needed to address this shortage. Although rates, wages, and benefits are important components of recruitment and retention, they are not the only factors impacting the workforce; states with robust wage and benefits structures in place today still struggle with HCBS worker retention. Short-term, time-limited wage increases may temporarily strengthen the workforce, but, for long-term retention, direct service positions must have a clear path for advancement.

Congress should:

- **Increase the FMAP for long-term care workforce training**. Currently, long-term services and supports workforce development activities are only matched at 50 percent from the federal government. This lower matching rate makes it difficult for states to invest their limited resources into workforce development activities.
- **Decouple HCBS costs from the institutional standard.** Currently, states must monitor and report on costs in HCBS to demonstrate that HCBS is a cost-effective alternative to institutional care. This reporting requirement is outdated, administratively burdensome, costly, and stifles investment in the HCBS workforce. Decades of experience have demonstrated that services delivered in the home and community are a cost-effective alternative to institutional care.
- **Create a new demonstration and best practices center focused on workforce development.** Congress or the Administration could create a new demonstration opportunity that builds the workforce capacity in the same way that the federal demonstration, Money Follows the Person, built the capacity for individuals to reside in the community. As part of this demonstration, the federal government could also create a center that facilitates the collection and sharing of best practices on LTSS workforce development and retention.

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- **Create a Bureau of Labor Statistics category for direct care workers**. This would allow the federal government to monitor this workforce and provider greater insight into supply and demand challenges.
- **Allow federal dollars to be used to build HCBS provider infrastructure.** HCBS providers are typically small, operate on thin margins, and have limited information technology infrastructure. Federal flexibility is needed, including in the temporary enhanced federal funding for HCBS, to allow states to invest in the infrastructure of its HCBS providers.
- **Provide states with resources to develop partnerships between Medicaid, labor and training departments, and education providers to support robust data collection, programming, and policy change**. This should include targeted funding for investments to expand, enhance, or build data ecosystems within states. These ecosystems should match data sets, produce anonymized analysis and summaries, and inform future inform policy decisions, funding allocations, and targeted interventions.
- **Provide investments to support rate increases**, **develop training programs and pipelines, and help smaller HCBS providers secure health insurance and other benefits for their employees.** This could include creating reimbursement mechanisms and purchasing strategies to support independent contractors and small providers in securing liability insurance, health insurance, and other benefits. These small providers, particularly those serving high-risk populations, are often challenged to reach economies of scale for maximizing purchasing power and spreading risk across a larger risk pool. These purchasing strategies could potentially support training for these providers as well.
- **Require provider agencies to report annually on average rate of pay and benefits provided for their direct service workforce;** states could use this data to develop additional strategies to support the HCBS workforce.
- **Require provider agencies to pass through a given percentage of a rate increase directly to their HCBS workforce in the form of a wage and/or benefit increase.** Some states with experience implementing this type of strategy note that successful implementation requires administrative work on the state's part to collect and analyze necessary data from provider agencies. Federal support for this administrative work should be provided.
- **Invest in training programs and curriculums.** This could include:
    - Community college training opportunities and other similar community-based trainings to increase the professionalization of the HCBS workforce.
    - A National HCBS Curriculum modeled after the CMCS Direct Service Worker Core Competencies developed in 2014. Ensure such training is competency-based with required demonstration of competencies. Completion of the training could be further incentivized by linking wage

incentives for workers with value-based incentives to providers for employing higher qualified staff.
    - Continuing education programs and specialty training, with a specific focus on trauma-informed care, behavioral health care (including co-occurring behavioral health conditions and intellectual or developmental disabilities), Alzheimer's and dementia care, and chronic disease management.
    - Providing states with resources to maintain training offerings, such as covering online training platform hosting costs, site maintenance, ongoing curriculum development, tracking of student completion, etc.
- **Exempt any federally required wage, rate or benefit increase from states' 1915(c) waiver cost neutrality calculations and 1115 demonstration waiver budget neutrality calculations.** This exemption will ensure states retain maximal use of these authorities in provision of HCBS.
- **Consider a federally funded minimum childcare benefit for Certified Nurse Aides and below working in an HCBS setting.** This could potentially be paired with a choice between the childcare benefit and an employer contribution to a portable retirement account to maintain parity across workers of different demographics.
- **Ensure that direct care workers who currently receive public benefit programs, such as Temporary Assistance for Needy Families, do not lose access to these benefits (such as cash benefits, childcare, and transportation subsidies) until they have stabilized in their employment as a direct care worker.** One approach to meet this objective could be to exempt a portion of pay from counting towards income limits for public assistance eligibility.

These recommendations were previously articulated in:

- Letter on Home and Community-Based Services Access Act
- Letter to House Energy & Commerce Committee on Disability Policy
- NAMD's Medicaid Forward: Long-Term Services and Supports Report

Behavioral Health Workforce

States identify workforce shortages as one of the biggest – if not the biggest – challenges facing their behavioral health care systems. Although these issues span the continuum of care, states identified acute shortages among specific provider types (including psychiatrists, social workers, and psychiatric nurse practitioners), multi-lingual providers, and Black/Latino providers. These shortages are compounded by financial and regulatory barriers that discourage provider participation in Medicaid and CHIP, threatening the ability of Medicaid members to access behavioral health care.

Increasing Medicaid reimbursement rates to be more competitive with commercial rates is an important first step in addressing these challenges. However, we encourage Congress to craft a broader strategy to recruit, train, and retain behavioral health care providers, with a specific focus on diversifying the workforce and ensuring access in rural and underserved communities. We also encourage Congress to address the barriers (including lower reimbursement rates, higher administrative burdens, and higher rates of no-shows) that reduce provider participation in Medicaid and CHIP.

- **Allow states to generate federal match on workforce training programs,** including programs focused on developing career paths for peers and community health workers. This would give states the financial resources they need to create strong pipelines to careers in behavioral health. Alternatively, Congress could establish other funding models like grants to support the development of training programs.
- **Create funding mechanisms to expand training and technical assistance programs.** Congress could address workforce shortages by creating a model (similar to the Graduate Medical Education model in Medicare) to fund behavioral health education, fund teaching Community Mental Health Clinics directly, or create scholarships. Alternatively, CMS could approve 1115 demonstration waiver pathways or other mechanisms for state Medicaid programs to fund training and technical assistance; currently, state Medicaid programs cannot directly use federal funds for continuing education or advanced training, limiting their ability to address workforce issues. Training components may be embedded into a rate structure tied to a specific service, but this type of career-advancing training cannot be billed standalone and generate federal Medicaid match. HRSA could also help address workforce challenges by creating grant programs that specifically support workforce development and distribution efforts targeted at increasing the number of Medicaid-enrolled behavioral health providers.
- **Diversify the types of providers in the behavioral health workforce by creating incentives for the use of peer support professionals, community health workers, and health navigators and create pathways for these workers to become licensed providers.** These direct support professionals can fill existing gaps in care and create a more stable and resilient workforce. Congress should also create pathways for these types of workers to become licensed providers.
- **Expand scholarship and loan forgiveness programs and create incentives for practicing in rural or underserved communities.** Scholarship and loan forgiveness programs should explicitly aim to increase the number of multilingual and Black/Latino providers. Congress should also consider providing financial incentives like loan forgiveness programs, increased reimbursement rates, and

tax credits to providers who agree to practice in rural or underserved communities.

- **Reduce administrative burdens associated with Medicaid and CHIP participation.** This could include loosening documentation requirements like treatment planning, simplifying processes for enrolling as a Medicaid provider, and providing greater flexibility in reimbursement structures to allow for case rates or bundled payments for multiple services.
- **Provide technical assistance on developing a non-licensed professional workforce.** Peer support workers, community health workers, and other non-licensed professionals are a crucial part of the behavioral health workforce. CMS and SAMHSA could provide states with technical assistance on certification, coverage, and reimbursement of the peer support and non-licensed professional workforce, including mapping different types of non-licensed professionals (e.g., peer recovery coaches, youth and family peers, recovery specialists, community health workers) to potential Medicaid reimbursement pathways. These efforts could build on existing state-level initiatives to define and map different categories of non-licensed workers. CMS should also provide clarity on how criminal records may influence the ability of peer support workers to enroll as Medicaid providers. Substance use-related charges should not necessarily be considered disqualifying, as peer support workers are often effective providers *because* of their lived experience with substance use or mental health conditions.
- **Support behavioral health providers in participating in the Medicaid program.** Many behavioral health providers do not accept Medicaid or even private insurance, exacerbating workforce shortages. Congress could direct CMS to provide technical assistance on the Medicaid enrollment and reimbursement process, along with resources to implement electronic health records and other health IT, to support provider enrollment. Separately, HHS should encourage medical schools to include behavioral health (including the use of medications for opioid use disorder) in their curricula.
- **Remove administrative barriers to ensuring adequate reimbursement for behavioral providers, including state efforts to promote value-based and/or outcomes-based payments.** Most Medicaid members receive all or some of their benefits through managed care. States have reported that the review process for state-directed payments in managed care is administratively burdensome. Securing approval for minimum fee schedules for behavioral health providers can take many months, with much longer timelines for approval of value-based or outcome-based payment methodologies. CMS should consider simplifying this review process to support states in implementing innovative reimbursement methodologies, particularly when such methodologies are tied to adoption of an existing state fee schedule.

These recommendations were previously articulated in:

- Letter to Secretary Becerra on Behavioral Health
- Letter to Senate Finance Committee on Behavioral Health
- NAMD's Medicaid Forward: Behavioral Health Report

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