

# Making a World of Difference In People's Lives

www.nadsp.org



## Using Medicaid Home and Community Based Services or ICF/MR Funding to Pay for Direct Support Staff Training and Credentialing Programs

### Purpose and Background

Many states are facing significant challenges in assuring the availability of sufficient numbers of direct support practitioners with adequate professional preparation to promote the health and well-being of Medicaid recipients. In some states, inadequate support resources including in-home staff, have resulted in lawsuits on behalf of Medicaid recipients who are not receiving adequate services.<sup>1</sup>

Workforce adequacy is diminished by turnover rates among direct support professionals (DSPs) that average 50%, persistent difficulty with hiring new workers, and the demand for this group of workers that continues to increase across all areas of long term care. To meet these challenges, some states are investing in the development of educational, training and credentialing programs for the direct support workforce to create career paths and retention incentives for new and incumbent workers.

A number of states have statewide workforce development plans that identify the need to raise wages, improve access to benefits, and increase the availability of quality educational, training and career paths. These state efforts are congruent with the goals that the National Alliance for Direct Support Professionals (NADSP) has put forward as important systemic workforce development strategies:

- Increasing access to high quality training and lifelong learning;
- Supporting policy change regarding DSP wages and benefits;
- Improving partnerships between DSPs, people with disabilities and their families;
- Improving the status and image of DSPs; and,
- Implementing a national credentialing program for this workforce.

A persistent barrier to implementing effective workforce development programs is the ability for states, and human services organizations to pay for training programs and related wage incentives. One promising strategy to confront this challenge is the structuring of Medicaid reimbursement rates to support the human resource development interventions essential to a stable and competent workforce.

The NADSP has developed a national credentialing program. This program provides administrative support, structure and oversight for the implementation of a tri-tiered credentialing program. The program has three levels: 1) *Direct Support Professional - Registered (DSP-R)*: This is the most basic credential offered. It is intended to recognize people who have entered the profession and desire to have careers in the field of community human services for people with disabilities.; 2) *Direct Support*

---

<sup>1</sup> See "Rosie D."

(<http://www.mass.gov/?pageID=eohhs2subtopic&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2>) in Massachusetts and other related cases across the country that represent a national legal strategy to improve in-home supports and Early Periodic Screening and Diagnostic Treatment (EPSDT) Medicaid requirements

*Professional – Certified (DSP-C):* This credential recognizes DSPs that have demonstrated competence (measured and approved by the NADSP). This credential sets this group of DSPs apart from other DSPs in that they have demonstrated skills that typical entry level DSPs would not have acquired; and 3) *Direct Support Professional – Specialist (DSP-S):* (in four possible areas *Positive Behavioral Support, Health Support, Inclusion and Supervision and Mentoring*). The specialist certificate is designed to recognize DSPs who have obtained specialized training and have demonstrated competence in providing specialized support to individuals with disabilities. The NADSP website has specific guidelines and instructions about how to develop and implement the NADSP program, including all of the required elements for each level of the credentialing program.

### **Cost of Training Program Reimbursement**

Many states have been able to strengthen their capacity to support relevant educational and training activities by claiming some of the costs as Medicaid related activities that are eligible for federal participation (FFP). This can be accomplished by claiming related training expenditures as either **administrative** costs covered under the Medicaid State plan, that are identified and included within the state’s Medicaid administrative cost allocation methodology, or as a component of the costs that are reimbursed through the state’s payment rates for **services**. In order to fund professional preparation activities in this way, states will need to work with their Single State Medicaid Agency to review the options, select either the “administrative rate” or “services rate” approach and establish a sound basis and methodology for making claims for training and educational activities.

#### *Claiming FFP at the administrative rate*

States can create a cost allocation plan to claim training expenditures such as those related to the College of Direct Support, other NADSP accredited educational programs, or other state defined educational requirements as a Medicaid administrative cost. States may claim expenses for what the Centers for Medicaid and Medicare Services deems are necessary, “for proper and efficient administration of the State plan..”(42 CFR 433.15(a)(7)). Medicaid administrative claims are reimbursed to states at the 50% FFP (Federal Financial Participation) rate. In claiming federal financial participation, states must employ an allocation methodology approved by the U.S. Department of Health and Human Services (DHHS) to document the portion of time or, of the project activity, which is directly related to the administration of the state Medicaid plan.

The requirement that administrative claims for FFP be related to the “proper and efficient” administration of the state’s Medicaid plan is operationalized by CMS in accordance with the following principles as identified in a letter to state Medicaid directors from Sally Richardson, then the director of the Medicaid Bureau at CMS dated December 20, 1994 (see copy attached), and in the *CMS Medicaid School-Based Administrative Claiming Guide* released in May 2003.<sup>2</sup> Although some provisions of these rules have changed under the 2005 Deficit Reduction Act with regard specifically to school-based services and case management, the general provisions described below are still in effect for Medicaid programs.

Administrative costs are allowable for FFP claiming if they:

- Are directly related to Medicaid state plan or waiver services;
- Are included in a cost allocation plan approved by CMS and supported by documentation isolating the costs related to the support of the Medicaid program from other costs incurred by the agency; and

---

<sup>2</sup> Note: The “Guide” includes an explanation of CMS policy on procedures for claiming FFP for administrative costs, even though the focus is on the provision of Medicaid funded school-based health services. The document can be accessed from the CMS Web site at: <http://www.cms.hhs.gov/medicaid/schools/clmguide.asp>.

- Reflect an identifiable fraction of the activities of a non-Medicaid governmental agency that are exclusively directed to Medicaid administrative purposes and meet all other criteria for administrative claiming.

Administrative costs generally are not eligible for FFP matching funds if they:

- Include the costs of providing direct medical or remedial service;
- Are an integral part or extension of a direct medical or remedial service;
- Include funding for a portion of general public health initiatives;
- Include overhead costs of operating a provider facility;
- Reflect operating costs related to the operation of non-Medicaid related programs and
- Are incurred pursuant to services provided to “inmates of a public institution.”

To properly allocate the costs of the training provided to staff supporting Medicaid beneficiaries the state must work with its Single State Medicaid Agency to identify the number of people in HCBS waiver programs, ICF/MR program (and other applicable Medicaid funded services) and state-only funded programs whose DSPs will be trained. Once the state has identified these numbers, they use percentages of Medicaid-eligible service recipients receiving Medicaid funded services as the basis for claiming FFP on a portion of the cost. This is done at the administrative rate (50%) rather than the service FFP rate. As an example, for a state where 80% of service recipients are Medicaid eligible and receiving Medicaid funded services where trained DSPs provide services with a Medicaid administrative FFP rate of 50%, the effective federal share of their overall training costs would be  $.80 \times .50$  or a 40% federal contribution to the overall training program costs. The state is responsible for paying the required state match in order to claim the FFP.

#### *Claiming FFP through service rate*

Claiming Medicaid at the services rate may increase the funding for training as the service rate in many states exceeds the 50% limit of the Medicaid administrative claiming rate. Using the service rate approach, a state would need to establish or identify an entity to provide the specific training and technical assistance that the state desires. The identified educational/training provider(s) could contract with College of Direct Support or other accredited training provider to provide the desired training, and, in turn contract with provider (employer) agencies to deliver the requisite training to DSPs. The entity could be an existing provider agency such as the state’s University Center on Excellence in Developmental Disabilities (UCEDD) or a separate training organization (i.e. Oregon Technical Assistance Corporation).

In establishing the appropriate service rate, the costs for training furnished through the College of Direct Support (or other accredited training provider) and any additional state requirements would be built into the billing rate for each Medicaid service. The state would designate or approve a curriculum of required training that matched that provided by College of Direct Support (or other accredited training program). Providers would then be required to secure training from the qualified entity at the rate set by the state to cover the specific curriculum. Providers would pay the entity on a regular basis, which would, in turn purchase the service from College of Direct Support (or other accredited training program).

In most instances, states cannot compel private entities to purchase goods or services from specific vendors. States may however establish a rule that provider training meets specific requirements, addresses a specific curriculum or is secured from certified vendors. In establishing such rules, consultation with the Single State Medicaid Agency or legal counsel is advisable to assure compliance with Medicaid regulations.

### **Direct Support Staff Wage Incentive Reimbursement Options**

Setting a higher Medicaid service rate for providers/staff that meet higher credentials is fairly simple and straightforward. States need to calculate what they think the extra credentials are worth and then establish a provider code for billing that will indicate the higher rate. Anything related to wages and benchmarked against education and qualifications is completely within the state's authority to design. The National Alliance for Direct Support Professionals (NADSP) has developed a credentialing program that has three levels: DSP-Registered, DSP-Certified and DSP-Specialist. Each level of the NADSP credential has requirements for completed training from an accredited program and skill demonstration. Using the NADSP's credentialing program levels as an example, here are a few ways to think about how staff wage incentives could be built into rate structures in states

#### *Option One*

In states that bill by units (usually by the hour) the state could set out several different rates based on the level of credentialed staff. Using the NADSP credential levels for example, the state could structure rates for credentials ranging from \$9.00 for an entry level DSP; DSP-R 10.00; DSP-C 11.00 and DSP-S 12.00. This puts some burden on providers because they have to bill by the unit and have to know what level of credential each DSP had per hour of delivered service. But some states have already moved to the system where they bill by the unit and have staff tracking their hours in this manner making such a method more feasible. Of course the state would have to work with their vendors that process billing and payments to ensure new codes are developed for the billing at different rates. Another option would be based on the total FTE billed by an organization at each level of the credential. So if an organization bills for 1,000 total hours at a typical rate of \$25 hour, they would specify what percentage is at each level (1000 hours billed, 100 at no certification billed at \$25; 700 billed at the @ 25 +1 DSP-R level; 100 @ 25 +2 DSP-C level ; and 100 @ 25 +3 DSP- S level).

#### *Option Two*

The state could offer incentives to providers for reaching benchmarks related to having credentialed direct support staff. In this situation the providers would work to get certain percentages of their staff to the various credentialing levels and as long as they achieved and maintained their percentages then they would have higher rates. For example using the NADSP credentialing levels, the benchmark might initially be set at having 50% DSP-R; 30% DSP-C and 10% DSP-S; if the providers met this benchmark their daily rates would be increased a certain percentage (to cover the cost of increased salaries of the staff who have achieved the credential levels – for example, \$1.00 for DSP-R; \$1.50 for DSP-C and \$1.50 for DSP-S). State's would need to integrate this approach into their other quality assurance/improvement procedures used to validate the fulfillment of Medicaid services for specific rates. One option would be to conduct random audits of some percentage of providers who bill at these higher rates. These audits would simply check the billed rates against personnel records or the state could get routine reports from the NADSP on the direct support workers in that state who are at various levels of certification.

#### *Option Three*

Individual service plans could be used by states to identify the level or type of staff qualifications that would most benefit the service participant. These levels could be based on the NADSP credentialing levels (DSP-R; DSP-C and DSP-S) and would be billed and reimbursed at higher daily or unit rates based on individual consumer need. The challenge with this is developing a method for pairing service participants with staff of varying qualifications. . Some states may like this because it aligns with movement toward individual budgets. This would require providers to ensure that direct support workers meet the requirements spelled out in the support plan. In order to monitor this an audit of a small sample would be needed that looked at the service authorization in the support plan, the services billed and a verification that the DSP who delivered the service was certified at the level billed.

**Conclusion**

Maintaining quality of services and supports to people with disabilities who receive support through the state's Medicaid Home and Community Based Services (HCBS) waiver and other Medicaid funded programs is a major concern for government, providers, consumers and families, and therefore an essential priority of a state's quality assurance/improvement program. To fulfill the commitment to these stakeholders of providing high quality support, it is vital that state's build the capacity to prepare direct support professionals (DSPs) with the competencies and skills necessary to deliver effective direct support. The federal HCBS program and the Medicaid state plan offer a number of options for states to obtain reimbursement for the cost of training programs and wage incentives for direct support workers who have attained the National Alliance for Direct Support Professionals (NADSP) credential levels or other state identified educational programs making these education and training programs affordable within the existing policy frameworks. As the primary source of funding for people with disabilities in the United States, it is crucial that state's lay the groundwork for using these options to assure an adequate and educated direct support workforce.

**Acknowledgement**

The NADSP would like to acknowledge the support of NASDDDS in the preparation of this document.