National MLTSS Health Plan Association

Realizing the Vision of Medicaid-funded HCBS:

A Framework for Enhancing Access and Advancing Quality in HCBS Provision in Managed Medicaid LTSS

Overview

The COVID pandemic forced the nation to confront a harsh reality with respect to the consequences of various gaps in our long-term care system supporting older adults with complex medical needs and individuals with disabilities. The pandemic shed light on the need for more integrated, individualized home and community-based services (HCBS) options to assure that people can live, work, and thrive in the greater community based on their own individual preferences, interests, and needs.

Recognizing the critical importance of strengthening the HCBS delivery system as one component of federal infrastructure modernization efforts as well as in meeting the growing demand of the nation's care economy, the federal government has moved forward with proposals to stimulate significant funding and policy changes in 2021. If implemented, these forward-thinking investments and policy reforms could revolutionize the provision of HCBS in America and assure that all aging adults and individuals with disabilities get the individualized care they need to age in place in their own homes, fully participating in the greater community through work, recreation, social relationships, and civic engagement.

Recent Federal Response to Recognition for Increased Access to Higher-Quality HCBS Options

The American Rescue Plan Act of 2021 (ARP) provided short-term enhanced funding for States to access for the purposes of expanding or enhancing Medicaid-funded HCBS. The increased funding is intended to "assist States in leveraging federal resources to increase health equity in Medicaid beneficiaries' access to HCBS, positive health outcomes, and community integration" (CMS Press Release, 5-13-2021). Specifically, Section 9817 of the ARP provides States with a

temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid HCBS from April 1, 2021, through March 31, 2022, to improve HCBS under the Medicaid program. States then have until March 31, 2024, to continue to spend down any increased funding received because of the enhanced FMAP. The additional federal funding made available under the ARP allows States to tailor HCBS enhancements based on the needs and priorities of its residents, while protecting and strengthening the HCBS workforce, safeguarding financial stability for HCBS providers, and accelerating long-term services and supports reform and innovation.

On the heels of the ARP, Congress has introduced several legislative proposals that would significantly expand the capacity of state Medicaid programs to provide increased HCBS, and, for the first time, erase the institutional bias that persists in Medicaid-funded LTSS. The *Better Care, Better Jobs Act*[1], as well as the *HCBS Access Act*[2], are legislative proposals that both seek to create a mandatory Medicaid-funded HCBS option for all eligible individuals with disabilities and aging adults, thus eliminating waiting lists and increase access to HCBS across the country. The funding attached to these reform investments is substantial – as much as $400 billion in new money could be authorized by late 2021 to support capacity building efforts within state Medicaid HCBS systems to enact the ambitious aims of these legislative proposals.

As these efforts continue to roll out, it is imperative that the national dialogue around HCBS modernization begin to bridge the gap in both access to and quality of HCBS.

A Framework for Improving Network Adequacy & Quality of Managed HCBS

The National MLTSS Health Plan Association offers a framework for States who have managed LTSS programs to assure that state HCBS systems have a first-class provider network and HCBS

[1] The *American Care, American Jobs Act* was introduced as S. 2210 in June of 2021 by U.S. Senators Robert Casey (D-PA), Chairman of the Senate Aging Committee; U.S. Senator Ron Wyden (D-OR), Chairman of the Senate Finance Committee; and U.S. Senator Chuck Schumer, Majority Leader in the Senate. They were joined by U.S. Senators Murray, Duckworth, Brown and Hassan, and U.S. Representatives Dingell, Pallone, Schakowsky, and Matsui. The Better Care Better Jobs Act is intended to expand home and community-based services (HCBS) infrastructure, a key component of the Biden Administration's American Jobs Plan. The one-pager and section-by-section can be found here. The legislative text can be found here.

[2] The *HCBS Access Act*, which has not yet been introduced, aims to eliminate waiting lists for HCBS, promote independence by covering rehabilitation and other services, eliminate silos and streamline access to HCBS, increase the capacity of community services, support the unpaid caregiving workforce, improve the direct care workforce, and eliminate disparities in access services. In the spring of 2021, the original drafters of the HCBS Access Act, afforded stakeholders an opportunity to provide feedback and recommendations regarding the draft text. MLTSS Association's comments can be found here.

direct care workforce to successfully meet the individualized support needs of individuals with disabilities and older adults requiring long-term services and supports (LTSS) so that they may live in in the greater community with high social determinants of health and quality of life outcomes.

Key Principles of the Framework

The increased federal recognition for substantive HCBS expansion and reform necessitates strong attention to improving both access to and quality of HCBS options. Some preliminary recommendations for framing any network adequacy standards in the future were embedded into the Association's 2017 quality framework. Building from those initial recommendations and informed by five additional years of growth and evolution in HCBS demand and strategy, the Association offers the following ten principles in establishing a common vision and framework for managed HCBS in the future:

1. Through a strong person-centered planning process that is informed through exposure to a variety of experiences, service models, and HCBS setting options, and supported decision making, individuals with disabilities and older adults have the right and autonomy to develop a holistic, comprehensive plan that reflects their vision and desired goals for their life, preferences based on informed choice, and support needs necessary to accomplish goals related to full community inclusion, optimal independent living, and programming that addresses social determinants of health.

2. A qualified network of providers of services with a robust, culturally diverse, skilled, healthy, and reliable workforce serves as the backbone for any adequate HCBS delivery system.

3. Building a premier network requires ongoing investments from the state and federal government in ongoing training, professional development, technical assistance and ongoing mentoring support of providers and direct care workers in the delivery of high-quality HCBS using the best available evidence and focused on the desired outcomes of individuals based on robust person-centered planning.

4. There must be a balance between access and quality when looking at network adequacy. In other words, it is important to not only have enough providers across service options, but to make sure those providers meet high-level quality standards and are competent in the delivery of HCBS that are outcome-oriented and embed the best available evidence.

5. Systems must offer flexibility in how people receive the services they need to achieve their life goals as articulated through a person-centered process, with greater attention

being paid toward outcomes tied to the person-centered plan and member satisfaction over process.

6. Not all outcomes are equal. Public investments in HCBS provision should prioritize outcomes related to improved social determinants of health, quality of life standards, optimal independent living, socioeconomic advancement, and full community inclusion. A focus on such outcomes may result in a fading of certain services over time to support increased participant independence and control.

7. Consumers should always receive HCBS in the most integrated setting, and as individualized as possible to assure personal autonomy in choice and informed decision-making.

8. As partners in implementing the vision of state Medicaid HCBS programs, plans should be given greater autonomy in determining what providers are included in their network, offering incentives to reward high performers, and holding providers accountable for improving performance.

9. Plans should also be incentivized for producing higher priority outcomes for a larger percentage of individuals as part of network adequacy assessment.

10. Greater collaborations between states, plans, providers, and consumers to pilot and evaluate new models and strategies for offering individualized, fully integrated home and community based services should be prioritized as a pathway to stimulating further innovation.

Addressing Operational Challenges that Impede HCBS Network Adequacy & Quality

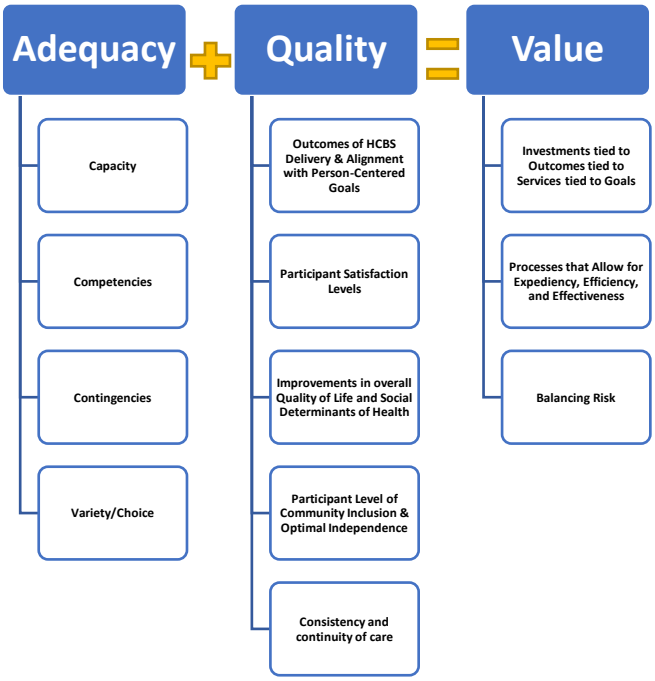
Rooted in aligning principles laid out in the 2014 federal HCBS regulation[3] as well as in federal civil rights law[4], the above-mentioned list of principles collectively establish a common national vision of the basic qualities that any managed HCBS system should possess. As such, current HCBS operational infrastructure, delivery systems, and processes should be evaluated through this lens. With respect to assuring an adequate network of providers capable of delivering high quality HCBS based upon the best available evidence[5], several challenges persist including:

[3] See 79 Fed. Reg. 2948 (Jan. 16, 2014), available at https://www.gpo.gov/fdsys/pkg/FR-2014-01- 16/pdf/2014-00487.pdf; see also 42 CFR Parts 430, 431, et. al.
[4] 28 C.F.R. § 35.130(d) (the "integration mandate").
[5] In its September 2016 report entitled, "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement," the National Quality Forum defines Systems Performance

- lacking a common national definition and mutual understanding of adequacy and value across States, systems, and provider types;
- having siloed approaches to adequacy v. quality;
- assisting current provider models and identifying new providers to better meet individual needs and focus on outcomes-based services; and
- building a competent, reliable, and healthy direct care workforce to meet quality expectations of service provision.

The following section provides greater detail about each of these challenges.

Figure 1. Value Proposition in Managed Medicaid HCBS



Defining Value (Adequacy + Quality) is difficult and varies across States, systems, and provider types.

Defining value in terms of network adequacy differs greatly across States, systems, and provider types. For example, establishing network adequacy in agency-directed service models is quite different than under self-direction, though States seldom offer a distinct set of milestones and metrics for each type of delivery system.

and Accountability as a key domain for assuring HCBS quality. The domain is focused on the degree to which the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Three subdomains were prioritized and defined under this domain, including Evidence-based Practices, or the level to which services are delivered in a manner that is consistent with the best available evidence.

The type of services and the providers offering various categories of services across different HCBS authorities also can be vastly different. For example, network adequacy for supported employment might be assessed by outcome and member satisfaction, while network adequacy for transportation may also factor in access and numbers served.

Some network adequacy standards overly rely on staff headcounts without assessing quality or user experience. This could be mitigated by applying a "Technology First" approach to supporting HCBS participants in achieving maximum self-sufficiency and independence. Under this concept, a State could develop standards that require providers to demonstrate that they are providing access to technological solutions desired by individuals as part of HCBS provision that do not require an increase in staff headcount.

Geographic differences also require a separate set of strategies – and standards – between rural and urban areas. For example, in less densely populated regions of the country, it is not cost-effective for plans to invest in the building of large provider options, but rather to look at more innovative, targeted models of service provision relying more heavily on self-direction or smaller, more nimble agency models.

Network adequacy standards seldom include a focus on quality.

Developing a common understanding across States, plans and providers about what adequacy is, what quality looks like, and what the relationship is between the two is a difficult feat in current HCBS systems. And yet, clear guidance on the interconnectivity and expectations of state Medicaid programs related to promoting both adequacy and quality in a parallel and combined path could result in stronger, more robust HCBS systems nationwide.

Current standards for establishing network adequacy undervalues efforts of MLTSS providers to require stronger quality among providers.

Currently, many States define network adequacy by how many licensed and/or credentialed providers are in the network. Becoming a licensed provider is relatively easy in most States but performing at optimal quality by providing services in alignment with the best available evidence and desired outcomes of each HCBS recipient outlined through person-centered planning, implementing integrated service delivery models, and increasing competency of direct care workers is more difficult. And given the lack of a comprehensive, federal set of tested and validated quality measures, there needs to be a continued investment in strengthening the robustness of state quality programs over time as more universal quality measures and standards become available.

MLTSS plans have little autonomy or control for instituting higher standards for provider participation in plan networks.

While there appropriately remains high expectations among State Medicaid agencies that MLTSS health plans will regulate the providers within their network, health plans are restricted

in making decisions about adding or removing providers from their network based on the plans' quality metrics. In States that have an "any willing provider" network adequacy requirement, plans typically must submit justification and receive State approval before terminating a provider, including offering a solution or strategy for addressing any network adequacy concerns created by the removal of the provider. Rather than requiring plans to allow any provider that meets minimal licensing requirements to participate in a plan's network, States should allow plans to implement more stringent requirements on providers and encourage plans to work with providers to improve quality of care.

Some States have not taken advantage of federal incentives and enhanced federal funding match programs to build the capacity of their provider systems. These States may lack a significant number of providers or direct care workers who are by providing services in alignment with the best available evidence and desired outcomes of each HCBS recipient outlined through person-centered planning in their HCBS service delivery models. Plans are expected to build a more robust, higher quality provider network, which may take more time to complete with fidelity in States whose HCBS service systems have not evolved through the benefit of more concentrated federal enhanced funding.

States' lack of commitment to individualized, integrated approaches to HCBS delivery limits the effectiveness of plans to reduce their reliance on larger facility-based congregate care models.

In most States, the focus of HCBS provision has continued to rely heavily on the contracting of service providers that can serve large numbers of HCBS participants simultaneously. However, to improve individual quality of life outcomes and social determinants of health overtime, HCBS systems need to evolve to allow for more targeted, individualized HCBS options offered in typical integrated community settings. As such, States should work with plans to support the creation of more innovative, individualized approaches to HCBS provision, allowing plans greater flexibility and financial incentives for offering more individualized service options as part of their overall network adequacy strategy.

The ongoing national crisis in front-line direct care workforce shortages are not being adequately addressed by States or the federal government.

Federal regulations, including the Americans with Disabilities Act (ADA), the federal Home and Community Based Services (HCBS) Settings Regulation, and the Workforce Innovation and Opportunity Act (WIOA), have set forth standards aimed at making optimal independent living and self-sufficiency, full community inclusion, competitive integrated employment, and socioeconomic advancement of people with disabilities a reality. The availability of a qualified, competent, and stable direct care workforce plays a critical role in supporting people to accomplish these goals. It is critical that direct care workers have the competence, confidence,

ethical decision-making skills, empowerment, guidance, and latitude necessary to provide quality support, receive compensation that is commensurate with job responsibilities and have access to a career path aligned with ongoing professional development.

Unfortunately, building and promoting an adequate, well-qualified, and competent direct care workforce has proven to be a particularly challenging task across HCBS systems, and a federal strategy is required to address what has become a national workforce gap crisis within America's Care Economy. Such a strategy could help propel direct care workforce development and retention and could assure that direct care workers have the capacity, competency, health, and ongoing supports to meet the growing demand for and provide the highest-quality of HCBS to Medicaid LTSS participants.

Any federal strategy should include, at a minimum, the CMS core competencies as well as recommended rate methodologies to reflect the diverse skills and duties of this workforce. One of the challenges is the lack of labor market data currently available in relation to direct support professionals (DSPs)[6] given the lack of any DSP-specific standardized occupational code (SOC). The establishment of a DSP-specific SOC would provide more data on underlying challenges in this space and further define the unique and interdisciplinary nature of the position.

In the short-term, data captured through state Electronic Visit Verification (EVV) systems (i.e., data on missed visits, late visits, and member satisfaction) may help identify trends in gaps with respect to DSP reliability and availability; however, EVV alone will not be able to capture outcomes-related quality data vital to informing the ongoing expansion of a strong, robust direct care workforce. The National MLTSS Health Plan Association provided detailed recommendations[7] to CMS during its 2020 Request for Information regarding a Recommended HCBS Quality Measure Set[8], which would help align network adequacy with longer-term quality and systems-improvement goals.

[6] A Direct Support Professional, or Direct Support Care Professional, cares for individuals experiencing developmental or intellectual disabilities. The role of a direct support professional is complex and requires a specific set of skills and value focused on supporting an individual with significant disabilities work, live and thrive in typical community settings. As such, the duties of a DSP are ever-changing, and could include assistance with activities of daily living (ADLs) as well as assistance accessing health care, transportation, employment, and social inclusion. The following represents what to expect in one's practice as a direct support professional. For a description of a Direct Support Professional, see: https://nadsp.org/wp-content/uploads/2020/03/DSP-job-description-NADSP2.pdf.

[7] http://mltss.org/2020/11/30/plan-associations-comment-letter-hcbs-quality-measures-rfi/

[8] https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf

Creating a New Vision for Network Adequacy based on Quality

To adequately address the issues presented in the previous section, the Association offers a three-tiered approach:

Figure 2. Three-Tiered Approach to Improving Federal Network Adequacy in Managed HCBS

Align Quality and Network Adequacy Objectives

Getting network adequacy right in the managed HCBS requires a lot more than simply counting the number of providers by service type in an area. Placing a combined focus on quality metrics and access to supports is imperative to building a first-class HCBS provider network. Focusing solely on the number of providers by service type in a geographic area drives the need to grow the number of providers but does not necessarily lead to a network of highly-qualified providers who are providing services in alignment with the best available evidence and desired outcomes of each HCBS recipient outlined through person-centered planning or focusing on models of optimal individualization and integration. Instead, focusing just on how many providers plans have in their network can ultimately lead to a fragmented, and fragile, network fighting over the same resources without a clear vision of what the priority in service delivery and outcomes should be. Additional providers do not necessarily increase the adequacy rate for direct care workers. If the goal is to develop as many high-performing agencies with skilled and competent direct care workers as possible, then evaluating, building, and improving the capacity of provider agencies and tying capacity building efforts to quality in the delivery of services in alignment with the best available evidence and desired outcomes of each HCBS recipient outlined through person-centered planning is imperative.

Promoting quality while building a sufficient supply of HCBS providers can be accomplished if States are in partnership with plans and other stakeholders toward this common vision, and if plans are provided greater autonomy, flexibility, and incentives to achieving solid results toward assuring access to high quality HCBS options. States should also provide plans some latitude to expand the capacity of existing providers while developing new provider options over time that

meet higher quality standards. For example, states have the option now as part of their statewide transition plans for implementing the 2014 federal HCBS regulation to apply a "tiered standards" approach to any category of HCBS to (a) reduce the reliance on a former model by reducing the number of available slots for the model, eliminating new entries into the model, or decreasing the reimbursement rate for the model; and (b) introducing a new service delivery model within that service that reflects best practice and increased integration of older adults and people with disabilities. Several states have utilized the tiered standards model to introduce new provider options in the areas of assisted living (Indiana and Illinois); day programming for individuals with I/DD (Ohio); and individualized supported living (Minnesota).

Plans should have the ability to require higher quality metrics among providers as a condition of remaining in the network and be allowed to put low-performing providers of services onto performance improvement plans, place temporary restrictions on them until key metrics are achieved, or terminate their contracts without penalty, so long as the plan has established a solid transition plan for impacted participants. Unfortunately, without a national framework for HCBS quality measures, the nature of how States measure quality of Medicaid HCBS and use this information to strengthen their systems overall. The Association provided comments to CMS in 2020 in response to its *Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services*, and encourages CMS to not only issue its Recommended HCBS Measure Set but also to afford plans greater autonomy to negotiate with States on what measures are most appropriate to appropriately assess access to and quality of HCBS across plans and providers.

States should allow health plans committed to implementing higher quality metrics/standards for providers to build or increase their network over time in a more methodical way that focuses on the evolving and expanded development of a higher quality provider network and direct care workforce. This would assure a stronger outcome toward the goal of improving access to numerous high-quality HCBS provider options for Medicaid HCBS participants. And while providing such latitude to health plans may result in a smaller network of providers across participating health plans initially, such flexibilities could be designed based on specific timeframes and milestones.

Support Ongoing Provider Transformation and Direct Care Workforce Development

With a strong federal focus towards infusing large amounts of additional funding into Medicaid HCBS over the next several years, it is imperative that these increased investments lead to a continued expansion of services provided in alignment with the best available evidence and desired outcomes of each HCBS recipient outlined through person-centered planning and stronger options for more individualized and targeted HCBS delivery integrated into the community. Health plans can play a critical role in the development and evolution of HCBS

providers and the larger direct care workforce. States, however, must provide a balanced direction in terms of defining and prioritizing specific services over others. Services that lead to improved levels of integration, social determinants of health, and quality of life outcomes should be the Priority. Competencies and qualifications of front-line workers should be required across the board as well as more specialized workforce requirements for targeted populations and service types; and the expectations of providers to modernize their approaches to HCBS delivery over time. And there must be a shared responsibility and collective accountability across HCBS systems, spearheaded by States and inclusive of health plans and other stakeholders as collaborative partners, to tackle the challenges of and promote the transforming of provider organizations and building of a robust direct care workforce.

In the short-term, there are precursory steps that all state Medicaid managed LTSS programs should take to assure baseline improvements in the expectations of all providers coming into an HCBS system.

Increase the standards required of providers to be licensed and credentialed to provide HCBS.

Minimal standards for certification and licensing of HCBS providers may allow providers into HCBS systems who lack the capacity or competency to offer higher-quality HCBS to diverse populations of people with disabilities using the best available evidence and focused on the desired outcomes of each HCBS recipient outlined through robust person-centered planning . Ideally, States would implement higher standards as part of re-certification or licensing renewals in the future for existing providers to demonstrate that they can provide all services they are currently approved to provide, coupled with an automatic requirement for new providers coming into the system to already possess the higher standards and demonstrate their readiness. At the same time, States need to make stronger investments in supporting plans and providers to offer increased training and skills development opportunities and improve career paths and benefits for workers.

Given the work of States to implement the federal HCBS regulation in recent years, States should theoretically already be incorporating the settings criteria into their licensing and certification requirements. While this is a positive step in the right direction toward modernizing HCBS licensing and certification, more could be done during these processes to further assess the capacity of providers to (a) accept new clients; (b) support immediate transition needs of managed LTSS participants shifting from nursing home or institutional care to HCBS; and (c) gap-filling to address anticipated staff shortages. Two states, Arizonia and Tennessee, have both invested in comprehensive approaches toward increasing and improving their direct care workforces. In 2012, AHCCCS instituted training and testing requirements for Direct Care Workers (DCW) who provide direct care services (Attendant Care, Personal Care and Homemaker) to Arizona Long Term Care System (ALTCS) members residing in their own home. All AHCCCS provider agencies of direct care services must utilize DCWs who have passed the required competency tests within 90 days of hire unless otherwise exempt from the training and testing requirements (e.g., Registered Nurse,

Licensed Practical Nurse and Certified Nurse Aide). A direct care service agency has discretion whether to allow the DCW to provide care during the 90-day training period. The testing records are portable or transferable from one employer to another. DCWs do not have to pass the tests again unless they have experienced a lapse from working in the direct care field for a minimum of two years. AHCCCS has created an online testing records database (https://dcwrecords.azahcccs.gov/) to serve as a tool to support the portability or transferability of DCW or DCW Trainer testing records from one employer to another. An entity that wants to train and test DCWs must become an Approved Training and Testing Program (Approved Program).

SPOTLIGHT ON INNOVATION:

Arizona Health Care Cost Containment System's (AHCCCS) Training & Testing Requirements of LTSS Direct Care Workers

In 2012, AHCCCS instituted training and testing requirements for Direct Care Workers (DCW) who provide direct care services (Attendant Care, Personal Care and Homemaker) to Arizona Long Term Care System (ALTCS) members residing in their own home. All AHCCCS provider agencies of direct care services must utilize DCWs who have passed the required competency tests within 90 days of hire unless otherwise exempt from the training and testing requirements (e.g., Registered Nurse, Licensed Practical Nurse and Certified Nurse Aide). A direct care service agency has discretion whether to allow the DCW to provide care during the 90-day training period. The testing records are portable or transferable from one employer to another. DCWs do not have to pass the tests again unless they have experienced a lapse from working in the direct care field for a minimum of two years. AHCCCS has created an online testing records database (https://dcwrecords.azahcccs.gov/) to serve as a tool to support the portability or transferability of DCW or DCW Trainer testing records from one employer to another. An entity that wants to train and test DCWs must become an Approved Training and Testing Program

SPOTLIGHT ON INNOVATION:

Tennessee's DSP Apprenticeship Program via the QuILTSS Institute

Multiple organizations have come together to form a public-private partnership to help address two crises in the state of Tennessee – how to get unemployed and under-employed Tennesseans back to work while addressing the shortage of individuals trained to provide long-term services and supports to individuals with intellectual and developmental disabilities (I/DD). The partnership includes the QuILTSS Institute; Tennessee state government, led by the Department of Labor and Workforce Development; UnitedHealthcare Community Plan of Tennessee, a managed care organization (MCO) that serves the state's Medicaid population. State agencies, including the Bureau of TennCare and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD), are committed to partnering with and growing opportunities for DSPs. Through this collaboration, the goal is to set the standard across the country for a higher skilled workforce. More information can be found about the Tennessee model at: https://quiltss.org/apprentice/.

Allow MLTSS health plans greater autonomy to build stronger, higher quality provider networks.

States must provide health plans greater flexibility and autonomy to build the quality of their provider network while simultaneously focusing on improving network adequacy standards. For example, States should allow plans to:

- Initiate higher quality standards for providers to meet to remain part of a plan's network [these could include timely delivery of services and claims filing, contract compliance, employee retention, electronic visit verification (EVV), and consumer satisfaction].

- Evaluate providers on their ability to absorb new members, which is a critical component of network adequacy, especially for smaller providers that may not be able to absorb additional members on a regular basis.

- Remove a provider from the network who is not maintaining the plan's quality requirements as can be done on the acute care side.

- Prohibit rules requiring plans to contract with "any willing provider" be included in a network by a managed care plan. .

- Put in place an assurance process for growing a strong high-quality provider network while decreasing concern around limiting or minimizing choices in provider options.

Create additional incentives and flexibilities (via waiver options, new systems-change transformation investments, etc.) that could stimulate an accelerated growth in the development of a competent DSP workforce.

Federal investments focused solely on supporting state DSP workforce development goals connected to improving both access to and quality of HCBS is critically important and timely. Some key elements that should be expected of any State Medicaid Agency (SMA) that is receiving additional federal funding to support accelerated workforce development reform efforts should include:

- Investments in expanded, advanced training or specific accreditation for direct care workers and provider agencies.
- A state career pathway for direct care workers as well as manager development programs, which includes an implementation strategy (in collaboration with adult vocational education, local workforce investment system, community college system, professional trade schools, worker unions, provider entities, and health care plans) and creates

opportunities for early exposure in high school to the myriad of careers available within the direct care workforce.

- Given the diversity of the direct care workforce profession, there needs to be various career path options based on training milestones, and career lattices focused on promoting specializations based on current labor market needs and future projections in the HCBS space.
- States must increase investments in agencies to provide direct care workers with adequate wages, benefits packages for full-time employees, intentional overtiming, as well as for ongoing training, professional development, and mentoring/coaching. Agencies in many parts of the country do not receive enough funding through State, Federal or managed care organization (MCO) reimbursement to cover benefits for employees (personal time off, health care, etc.). Most provider agencies cannot afford to offer these without being properly reimbursed. When other sectors are providing not only higher wages but also benefits, direct care workers leave the HCBS workforce.

SPOTLIGHT ON INNOVATION:

Joining Forces: Working with Unions to Build the Capacity & Competencies of Direct Care Workers

PA Health & Wellness is piloting an advanced training program for direct care workers in cooperation with SEIU. Direct care workers who complete the advanced training curriculum receive a higher hourly rate for providing services to our members.

Requiring state Medicaid agencies to revisit reimbursement rates that may be inconsistent in adequately paying providers for DSP labor rates that are consistent with the federal minimum wage.

States need to examine parity with other industries that compete for the direct care workforce to ensure the ecosystem can effectively attract workers. Many States have not increased rates in many years, making it difficult to compete with increasing number of manufacturing jobs as well as other unskilled labor opportunities that pay more. Additionally, it is not enough just to attract workers with a higher initial wage, but to build in the additional costs associated with training, supporting, and retaining workers over time. Thus, assuring capitation payments reflect reimbursement that supports living wages, benefits for direct care workers at or above what the market is at for the labor pool, elevated wages for services requiring advanced competencies and specialization, peer-to-peer mentoring, and intentional overtime, is crucial to not only maintaining but building a stronger, more stable direct care workforce.

On the converse, rate setting must not become so stringent as to dilute the creativity of the managed care model, particularly with respect to building in greater incentives for high performers, accelerating payments based on desired outcomes, and introducing new value-based payment methodologies. Ideally, plans would benefit from a minimum fee-schedule that was coupled with flexibility to set value-based payments for select providers to pay higher rates based on performance. Value based payment strategies, combined with robust state quality programs that evolve over time, are key to building the caliber of HCBS provider networks expected of not only States and plans, but individual beneficiaries and their families.

Implement Metrics for Plans to Evaluate Trends in the Delivery of Services

Typically, state Medicaid agencies hold health plans accountable for assuring an adequate workforce that shows up for scheduled HCBS provision. Plans, in turn, must hold service providers accountable assuring that all requests for in-home services to members are fulfilled, even when there are gaps in available caregivers. For example, if a direct care worker calls in sick or simply does not show up, then providers must be able to provide a back-up staff person unless otherwise directed by the member. Alternatively, a member may opt to select an informal family caregiver to assist rather than have a backup fill-in. A few States have begun to pilot different strategies for improving efforts to address gaps in service delivery in real time and guarantee continued seamless service provision:

- In Arizona, for example, personal care agencies have overnight electronic systems in place to replace a scheduled caregiver who might not be available to do their morning shift.
- In Wisconsin, there is an incentive built in for fading of certain services (job coaching in supported employment, for example) as a metric to promote and reward providers focusing on skill development and independence.
- States can also utilize technology to support providers in addressing gaps as well. For example, PA could include a mix of tele-visits and visits from DSPs.

To adequately track and measure progress in addressing gaps in available workforce, metrics should be recommended at a federal level to support the ability of plans to evaluate trends in service delivery over time. Some metrics include tracking the proportion of services delivered as compared to the proportion of services authorized; tracking the effect, impact, and client satisfaction level of gap-fill mitigation strategies; and the timeframe around initiation of new services once they are requested (particularly if they are services related to transitions from institutional care to HCBS, or from congregate HCBS to more individualized, integrated service options).

Require States to report data on reinvestments of funds received as a part of any current or future systems-change incentives initiative in partnership with CMS to build a stronger provider quality network.

While health plans may serve a critical role as contracted partners to State Medicaid agencies in expanding and strengthening state HCBS provider networks, it is still the responsibility of SMAs to ultimately assure a strong, qualified provider network that is prepared to deliver HCBS through the best available evidence and informed by desired outcomes of the system and the individual participants. Given the myriad of financial options states have right now to access enhanced federal rates to support provider transformation and workforce development objectives, it is important for there to be transparency in how States are taking advantage of these funding opportunities to improve and modernize their HCBS delivery systems. Thus, CMS should require States to annually report data on the objectives, milestones, and projected outcomes of targeted investments focused on expanding and improving the quality of their HCBS provider networks and direct care workforce.

SPOTLIGHT ON INNOVATION:

State Leadership Modeling Strong Collaboration in Data Collection to Measure Progress in Advancing Provider Transformation & Direct Care Workforce Development

In Tennessee, health plans are contractually required to have a workforce development strategy and to work collaboratively with the state and with other plans to implement their strategies. For example, in 2018, the plans were tasked with collectively developing a single provider survey for all their providers (since many are duplicative between plans) to support data collection efforts. In 2019, TennCare implemented a new contract requirement to have designated staff for workforce development.

Stimulate Creation of Innovative Solutions to Meet Ongoing Demand

The ongoing direct care workforce crisis, coupled with an ever-growing aging population, will continue to perpetuate challenges with respect to both supply and demand. Strategies are required at all aspects of the direct care workforce development process, whether it be in educating and training potential workers, accelerating recruitment and hiring processes, implementing reforms to enhance the competencies and quality of life outcomes of direct care workers to improve retention, etc. Additionally, as we have experienced over the past 18 months during the COVID pandemic, plans, providers, and participants must have the latitude and flexibilities to experiment with different low-cost, high-impact technologies to support individuals more efficiently and effectively with disabilities live, work, and thrive in the community. The development of models that take into consideration geography, level of need, individual preferences, and person-centeredness are the wave of the future in Medicaid HCBS provision.

INNOVATION SPOTLIGHT

Using Technological Solutions to Streamline Recruitment & Hiring Processes

Centene has partnered with ADvancing States to develop, build, and launch ConnectToCareJobs.com, an online portal that connects job seekers with employers, allowing clinical and non-clinical care workers to identify job openings and providing employers with a way to fill critical staffing gaps quickly. **ConnectToCareJobs.com** promotes the opportunity for registered facilities, agencies, organizations, and providers to identify the specific staffing needs they have for a short-term or on-going basis. At the same time, individuals who are licensed and/or trained for the various roles in these facilities and identified settings can register their availability and willingness to fill shifts. An algorithm then matches the workers and the openings – in real-time. States and Territories can manage which facilities, agencies, organizations, and providers are included to enable those in crisis to get preference and to monitor the matching efforts.

Create innovative models for addressing network inadequacy in rural, frontier, and tribal areas.

The experiences, options and cultural parameters of rural living necessitates a different approach to HCBS network adequacy than what is utilized in more densely-populated areas. Normal time and distance standards, or pure quantity metrics simply do not work in a rural environment. Models for rural HCBS provision should include compliance standards focused on access, stabilization of providers, and quality of the outcomes individuals are experiencing through the supports they receive. Several states, including New Mexico and others, already allow for different models of network adequacy and corresponding standards for urban versus rural or frontier areas. Similar strategies need to be put into motion to effectively address the unique needs of tribal populations as well.

INNOVATION SPOTLIGHT

Supporting the Growth of Smaller Providers and Unique HCBS Solutions for Rural Communities

Inclusa is working with State of Wisconsin Residential Quality Program (WCCEAL) on data collection and collaboration around the Assisted Living Pay for Performance and other innovative ways to recognize providers who are meeting and exceeding quality standards. Inclusa also has partnerships with Disability Service Provider Network (DSPN) to encourage/allow 1-2 bed owner-occupied homes to be included in their association, which qualifies them for access to WCCEAL. Inclusa has a focus on incorporating provider quality, adequacy, and capacity measures as part of upgrades. This includes, but is not limited to, proactive provider approaches supported through the system; provider feedback opportunities to improve communication; provider recognition within the system; availability of provider reports that encompass quality; improvement of Statements of Deficiencies (SOD) and incident management processes; and best practice reviews as part of system upgrades. Inclusa also partners with providers, through system design, to reduce duplicative documentation requirements; most specifically as they related to document of reporting incidents/events to Inclusa in a manner that facilitates export to meet the provider's documentation requirements.

Leverage technology and telehealth as part of meeting network adequacy standards.

Leveraging technology within individuals' homes to support outcomes and reduce the reliance on unnecessary (or unwanted) direct care professional staff is an area of tremendous growth given the impact of the COVID pandemic. When technology can be leveraged to support individuals with disabilities in place of staff, resources can be reallocated to support other individuals with support needs that may need more intensive staff supports or who are currently waiting to receive services. While the desires and preferences of participants should always drive the decision of when and whether to use technological supports in lieu of or in addition to staff, there are participants in Medicaid HCBS programs who have expressed preferences to using technology to grow their own independence and reduce their reliance on paid staff.

INNOVATION SPOTLIGHT

Accelerating Telehealth Options through Strategic Partnership Development

Centene has pursued strategic partnerships and vendor relationships with several key telehealth vendor solutions to expand access to care, both before and during the COVID-19 pandemic. Notable partners/vendors include Teledoc, Babylon, Hazel, and StationMD. These represent a portfolio of telehealth solutions that address health disparities and access for an array of populations that Centene serves.

There are lots of examples of technologies that have enabled HCBS participants to maximize their personal autonomy; for example, using sensory technology to monitor when someone with cognitive limitations or memory loss leaves their bed and returns to bed in the middle of the night; or, "Med Minders", which capture data on individual medication uptake and contacts a family member or neighbor when a medication has not been taken as scheduled.

Some plans are also working with SMAs to advocate for greater flexibility in empowering residential setting providers to support increased use of technology. One plan has been piloting the increased use of technology to support individuals at home while reducing the reliance on additional staff and have seen the same or better outcomes with supporting individuals versus having paid staff continuously onsite. Similar strategies could be deployed overtime for supporting individuals to be more actively engaged in typical community activities when staff shortages are an issue, and to support provider compliance with the federal HCBS settings criteria.[9] Other technologies that offer alternative transportation options could also be utilized to support greater flexibility in participants' schedule and access to the community.

[9] Many day programs and residential settings offering Medicaid HCBS have been challenged in meeting specific settings criteria outlined in the federal HCBS regulation due to staffing challenges. Most notably, staffing restrictions in congregate settings can prevent individuals from having control over their schedules, taking full

INNOVATION SPOTLIGHT

Partnering with Tech Industry to Pilot New Ways of Monitoring Participants

Centene successfully piloted a passive sensor and monitoring program with Best Buy Health that allows for continuous monitoring for member change in condition, allowing high-risk members to achieve a greater level of independence through a technology-forward monitoring solution. The program is currently being expanded into multiple markets across the enterprise.

Support efforts to expand, enhance, and scale self-direction as an option for the provision of LTSS.

Health plans often embrace self-direction as a tool for effectively addressing network adequacy issues in rural and frontier areas; in situations where provider organizations become insolvent and HCBS participants wish to hire existing staff within the organization directly; in instances where individuals prefer to identify, recruit, train and hire their own support staff rather than going through a provider agency. However, CMS and SMAs should still promote similar access to and completion of training on effective practices for DSPs and adherence to the CMS core competencies for direct care workers regardless of whether they are working under an agency or self-direction model. Additionally, health plans would benefit from greater flexibility and autonomy for monitoring and managing potential risks of waste/fraud within self-direction.

There are successful models for offering and supporting self-directed services (SDS) in a managed HCBS program. The creation of internal controls and intentional investments in up-front training options and resources for individuals self-directing their care and their employees helps to mitigate SDS implementation challenges. Plans have confirmed that SDS results in only a small percentage (if any) of waste or fraud and is a model that correlates with improved participant satisfaction and quality of life outcomes.

advantage of the opportunities that interest them in the community, and or being fully integrated in the community or being engaged with non-HCBS participants. Instilling new technologies to assist in providing support that may not require direct staff could create more opportunities for participants to access the community on their own terms (when they want, how they want, and with whom they want).

Looking Ahead: Policy Recommendations for Congress and The Biden Administration

Health plans play a pivotal role in executing the vision of State Medicaid Agencies to increase access to and improve the quality of Medicaid-funded HCBS. Much of what is discussed in this paper are strategies that SMAs could implement today without additional guidance. However, strong Federal guidance from is needed to assure that States focus on stronger network adequacy standards that focus on both quantity and quality of service and provider options. Additionally, strategic, targeted investments that require states to work in partnership with plans, providers, participants, and other stakeholders toward scaling and sustaining innovative solutions to provider transformation, workforce development challenges, and barriers to full integration would result in both a stronger HCBS system overall and in improved individual participant outcomes.

The following section outlines specific recommendations for the Biden Administration and Congress to consider in its policy efforts to modernize the provision of managed HCBS and improve individual quality-of-life outcomes.

Recommendations to Assure Network Adequacy is Aligned with Quality

1. Require state Medicaid agencies to increase the standards required of providers to be licensed and credentialed to provide HCBS to, at a minimum:
   - align with the 2014 federal HCBS regulation[10], as well as
   - demonstrate provider readiness to adequately provide any HCB-specific service that it is being licensed to provide.
2. Allow health plans to:
   - incorporate additional requirements for provider enrollment and participation in plan network beyond state licensing requirements.
   - count self-direction DSPs/providers as part of their network adequacy projections.
   - contract and terminate providers or determine what providers should be in-network v. out-of-network, as defined by the quality standards defined by the health plans.

[10] See 79 Fed. Reg. 2948 (Jan. 16, 2014), available at https://www.gpo.gov/fdsys/pkg/FR-2014-01- 16/pdf/2014-00487.pdf; see also 42 CFR Parts 430, 431, et. al.

Recommendations to Support Direct Care Workforce Development & Capacity

1. Ensure direct care workers and front-line supervisors have opportunities for needed training, mentoring and professional development to effectively assist people with disabilities to be fully included, valued, and members of their communities.
    - Require States to pay for the competency-based training that leads to certification of direct care workers from an accredited educational program, and to be able to use increased FMAP dollars to fund this requirement.
    - Require States under self-direction options to pay for competency-based training available outside of individual's self-direction budgets in parity with TA/training funded by the state for direct care workers within provider agencies.
    - Require States implement educational requisites to direct care front-line supervisors to demonstrate proficiency in core competencies developed for supervisors. Also allow States to use increased FMAP resources to fund the training and education involved in implementing this requirement.
2. Provide credentialing opportunities, career pathways, and ongoing competency-based training and mentoring, embedded in public policy and sufficiently funded to create incentives for direct care worker participation.
    - Encourage the development of statewide career advancement pathways for direct care workers based on the completion and demonstration of CMS' core competencies, with career lattices (with corresponding increased wages) for individuals who have been deemed by a neutral third-party as proficient in demonstrating competency areas.
    - Allow States to reimburse MLTSS health plans for front-line peer mentoring to allow seasoned direct care workers deemed proficient in demonstrating competency areas to work with less experienced direct care workers in learning how to effectively implement services using the best available evidence in direct support provision in real-time.

3. Provide MLTSS health plans latitude in working with providers to improve the quality of direct care workers and require States to incorporate costs associated with ongoing training, certification, mentoring and professional development of direct care workers in validated competency areas within capitated rates negotiated with health plans.

4. Require states to revisit reimbursement rates (including managed care capitation rates) to assure direct care workforce labor rates consistent with the labor market, and are inclusive of benefits, intentional overtime, training, and ongoing professional development and mentoring supports.

Recommendations to Incentivize Innovative Solutions to Meet Ongoing Increased Demand

1. Allow States to reimburse plans for virtual communications and technologies to support service provision and address direct care workforce shortages under certain circumstances based on specific quality and outcome standards. [NOTE: The use of virtual communications and technologies should not substitute necessary in-person supports that lead to inclusion.

2. Provide Additional Federal Guidance and Incentives for Supporting HCBS participants in Self-Directing Services under managed HCBS.

3. Establish Innovation Grants to Support New Models of Provider Transformation and Direct Care Workforce Development and Career Advancement