



***LONG-TERM SERVICES  
& SUPPORTS***

*Leveraging American Rescue Plan Act  
Investments to Drive Lasting Transformation  
for People with Complex Needs*



# TABLE OF CONTENTS

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<b>EXECUTIVE SUMMARY</b>	<b>1</b>
<b>ACKNOWLEDGEMENTS</b>	<b>3</b>
<b>CHAPTER I <i>The Opportunity To Transform LTSS</i></b>	<b>4</b>
<b>CHAPTER II <i>The Current Environment</i></b>	<b>7</b>
<b>CHAPTER III <i>Opportunities For Action</i></b>	<b>9</b>
<i>1. Build and Strengthen the LTSS Workforce</i>	<b>9</b>
<i>2. Assist and Strengthen Individuals' Natural Supports</i>	<b>13</b>
<i>3. Promote the Adoption of Telehealth and Assistive Technology</i>	<b>16</b>
<i>4. Advance Person-centered Outcomes and Quality</i>	<b>19</b>
<b>CHAPTER IV <i>Conclusion</i></b>	<b>22</b>

## Leveraging American Rescue Plan Act Investments to Drive Lasting Transformation for People with Complex Needs

The COVID-19 pandemic, its economic impacts, and the deep racial and ethnic disparities it exposed have highlighted the opportunity – and the urgency – for the nation to strengthen and transform the delivery of long-term services and supports (LTSS) to individuals. LTSS includes residential care that is provided in nursing facilities and intermediate care facilities. It also includes services and supports that allow people to live more independently and in their community, such as in assisted living facilities and in the home. Medicaid is a foundational element of the nation’s LTSS system. It provides these services to older adults with low incomes, children with complex health needs, children and adults with intellectual and developmental disabilities, and adults with complex physical and/or cognitive needs. These are vital services for millions of people to ensure their independence and wellbeing. In total, Medicaid provides more than half of the nation’s LTSS spending.<sup>1</sup> To meet the needs of those they serve, Medicaid programs across the country are grounded and driven by the principle of person-centeredness: Putting the person and their unique needs at the center of service planning and delivery.

In summer 2021, NAMD convened an Executive Working Group of state Medicaid LTSS experts and national thought leaders to identify a framework of options that states could use to respond to this opportunity to improve and strengthen these services. This framework explores how states can meet the needs of individuals so they can maximize their health and thrive in the community of their choosing. It focuses on four opportunities for action now:

### Four Opportunities for Action



**1. Build and strengthen the long-term services and supports workforce.**

**2. Assist and strengthen individuals’ natural supports.**



**3. Promote the adoption of telehealth and assistive technology to support independence, health, and safety.**

**4. Advance person-centered outcomes and quality through innovative payment approaches.**



The disruption caused by the pandemic, as well as new federal investments, have created an urgent opportunity for states to stabilize and transform service delivery and strengthen the systems that support long-term services and supports. Without urgent action, individuals may lack access to needed services and supports, and states could miss this opportunity for true transformation and the system could continue to be one that is institutional care-biased and fragmented.

<sup>1</sup> [2020 Medicaid and CHIP Beneficiary Profile: Characteristics, Health Status, Access, Utilization, Expenditures, and Experience](#). Centers for Medicare and Medicaid Services. August 2021. [Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Years 2017 and 2018](#). Centers for Medicare and Medicaid Services. January 7, 2021.

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# CHAPTER I

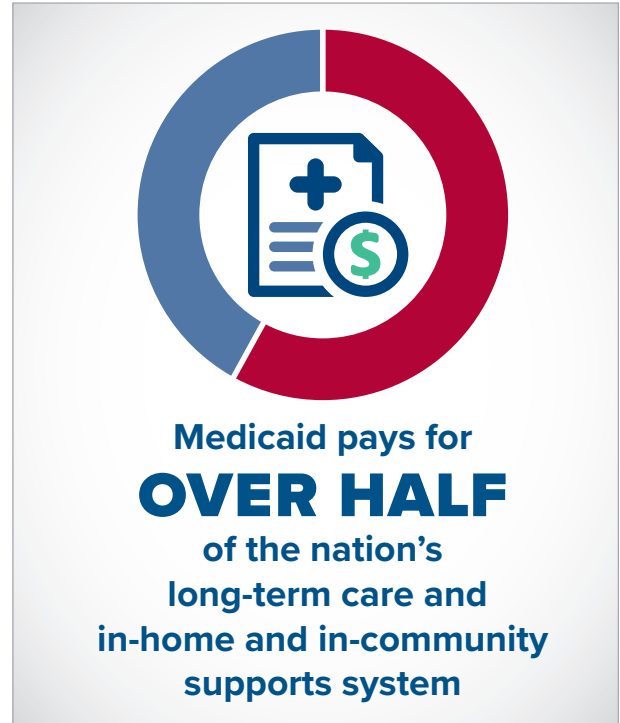
## *The Opportunity to Transform LTSS*

The COVID-19 pandemic, its economic impacts, and the deep racial and ethnic disparities it exposed have highlighted the opportunity and the importance for the nation to strengthen and transform the delivery of long-term services and supports (LTSS) to individuals. LTSS includes residential care that is provided in nursing facilities and intermediate care facilities. It also includes services and supports that allow people to live more independently and in their community, such as in assisted living facilities and in the home. Medicaid is a foundational element of the nation's long-term care and in-home and in-community supports system, providing vital services to millions of people to support their independence and wellbeing and paying for over half of the nation's spending on these services.<sup>2</sup> As the nation continues to respond to the COVID-19 pandemic and look toward recovery, state and national leaders are focused on efforts to stabilize and transform the long term-services and supports system.

The need for transformation is urgent. These services have been significantly disrupted by the pandemic. Many nursing facilities across the country are struggling to maintain safe and financially sustainable homes for residents. Individuals and families that receive home and community-based

services to support their independence and participation in community have also been impacted by the shutdowns and staffing shortages brought about by the national health emergency. Congress has made an initial investment of more than \$9 billion in this transformation through the American Rescue Plan Act to expand access to home and community-based services and to strengthen the direct care workforce.<sup>3</sup>

Medicaid delivers LTSS to individuals with a diverse array of needs and circumstances, including children with complex health needs, children and adults with intellectual and developmental disabilities, and older adults with complex physical needs and/or cognitive needs. To meet the needs of those they serve, state Medicaid programs across the country are grounded and driven by the principle of person-centeredness: Putting the individual and their unique needs at the center of service planning and care delivery. This “person-centered planning is a facilitated, individual-directed, positive approach to the planning and coordination of a person's services and supports based on individual aspirations, needs, preferences, and values. The goal [...] is to create a plan that would optimize the person's self-defined quality of life, choice, and control, and self-determination through meaningful exploration and discovery of unique preferences and needs and wants.”<sup>4</sup>



<sup>2</sup> [2020 Medicaid and CHIP Beneficiary Profile: Characteristics, Health status, Access, Utilization, Expenditures, and Experience](#). Released August 2021. Centers for Medicare and Medicaid Services; [Medicaid Long Term Services and Supports Annual Expenditures Report](#). Federal Fiscal Years 2017 and 2018. Centers for Medicare and Medicaid Services. January 7, 2021.

<sup>3</sup> [Cost Estimate: Reconciliation Recommendations of the House Committee on Energy and Commerce](#). Congressional Budget Office. February 14, 2021.

<sup>4</sup> [Person Centered Planning and Practice Final Report](#). July 2020. National Quality Forum.



# CHAPTER I

## *The Opportunity to Transform LTSS*



### *What are Long-term Services and Supports?*

LTSS encompass a variety of health, health-related, and social services that provide assistance with activities of daily living for individuals who experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability.<sup>5</sup> The goal of LTSS is to ensure individuals have choice and control, including choice of where they live, as well as access to a full array of quality services that ensure optimal outcomes, such as independence, health, and quality of life.<sup>6</sup>

Medicaid programs have not just been on a journey to make LTSS more person-centered, but they have also been on a journey to rebalance where care is delivered by shifting expenditures from institutional settings to home- and community-based ones. Rebalancing is about ensuring individuals have the services and supports they need to live in the setting of their choosing safely and with community-based options. Federal law requires Medicaid to cover institutional settings, but states have the option to provide home- and community-based services. This creates the room and opportunity for program innovation in the rebalancing effort.

These services are unique from the rest of the health care system and the Medicaid program. For most people receiving Medicaid, the provision of health care coverage is centered on diagnosis and treatment, and Medicaid funds a set of clinical services: hospitalization, physician visits, prescription drug coverage and others. However, Medicaid programs have a unique relationship with persons who receive long-term services and supports, given that they qualify for coverage because of their complex health care and functional needs, and they receive a comprehensive array of clinical and support services. This difference requires that state Medicaid programs develop meaningful relationships with these individuals to understand the services they need and ensure those services adapt as the needs of the person changes. In addition, since many services are provided daily and are designed to maximize a person's functional goals and authentic engagement in the community, significant utilization and costs are expected.<sup>7</sup> Through decades of experience, states have demonstrated that providing these services in the home and in the community is more cost effective than providing care in a nursing facility.<sup>8</sup>

<sup>5</sup> Erica Reaves and MaryBeth Musumeci. [Medicaid and Long-term Services and Supports: A Primer](#). Kaiser Family Foundation. December 15, 2015.

<sup>6</sup> [Long Term Services & Supports](#). Centers for Medicare and Medicaid Services.

<sup>7</sup> While utilization and costs are generally higher for this population compared to other Medicaid enrollees, effective application of LTSS can prevent the need for unnecessary hospitalization, emergency department use, and the need for the individual to reside in a nursing facility.

<sup>8</sup> [Home- and Community-based Services](#). Centers for Medicare and Medicaid Services.



### *How States Organize the Delivery of LTSS Matters*

States organize the administration and delivery of LTSS in a variety of ways. It is important for Medicaid leaders to understand how their system is organized because this impacts the levers Medicaid leaders can use to transform and strengthen it. It is also important to note that the terminology used to describe components of the LTSS system can vary significantly across states and within a state's LTSS system.

**Partnership with sister state agencies.** In FY2016, services for individuals with intellectual and developmental disabilities (ID/DD) were operated or co-operated by agencies other than the single state Medicaid agency in 30 states, physical disability services were operated by another agency in 16 states, and LTSS for older adults were operated by another state agency or department in 20 states.<sup>9</sup>

**Service delivery model.** Twenty-five states deliver some portion of LTSS to individuals covered by Medicaid through a capitated managed care model.<sup>10</sup> Other states deliver LTSS through a fee-for-service delivery model where the state contracts with the home-and community-based provider agencies, nursing facilities, and other community support providers directly.

While person-centeredness is the driving goal of all LTSS, this principle often comes into tension with the realities of the administration of public programs and the need for clear and reliable policies and program structures and systems, which can lead to programs being overly rigid and inflexible. This challenges state Medicaid leaders and federal policymakers to constantly strive to balance the need for reliable program structures and systems with the goal of making sure they are flexible enough to meet individual needs. One approach states use to navigate this challenge is to center the person in the system and organize the program structures around the principles of access, choice, person-centered care, person/family-professional partnership, care/service coordination, person-specific outcome metrics, and quality improvement.

In summer 2021, NAMD convened an Executive Working Group of state Medicaid LTSS experts and national thought leaders to identify a framework of options that states could use to respond to this opportunity to improve and strengthen these services. This framework explores how states can meet the LTSS needs of individuals so they can maximize their health and thrive in the community of their choosing. It was designed with the current realities in mind – particularly the opportunity Medicaid programs have with the American Rescue Plan Act funding which could plant the seeds for long-term, sustained improvements.

<sup>9</sup> [State Medicaid Operations Survey: 5th Annual Survey of Medicaid Directors](#). National Association of Medicaid Directors. December 2016.

<sup>10</sup> [Managed Long-term Services and Supports](#). Medicaid and CHIP Payment and Access Commission.





# CHAPTER I

## *The Opportunity to Transform LTSS*

### *A Person Centered Approach*







## CHAPTER II

### *The Current Environment*

While states continue to respond to the ongoing impacts of the pandemic on long-term services and supports, Medicaid programs are also focused on driving lasting transformation of these systems. The Medicaid Forward: LTSS Executive Working Group identified six realities of the current long-term services and supports environment that are creating the imperative for Medicaid programs to respond urgently.

**1. The pandemic fundamentally changed the landscape of LTSS.** Nearly 1 in 10 individuals who live in nursing facilities died during COVID.<sup>11</sup> Institutional settings, like nursing facilities, were not equipped to respond to a pandemic and implement the infection control processes needed to prevent the virus from spreading through their residents and staff. Hospitals, families, and individuals stopped or were not able to refer new residents for admission, and many families moved residents out of nursing facilities as soon as they were able to. These dynamics increased the demand for home and community-based services. At the same time, home- and community-based and other service providers were transforming their care model to find safe ways to provide services to individuals covered by Medicaid. Families and caregivers experienced great stress and strain as they worried about service providers coming into their homes and how to protect their loved ones from COVID-19.

**2. The LTSS workforce was insufficient before the pandemic, and it has only gotten worse.** Long-term care facilities and home- and community-based provider agencies were struggling to find staff prior to the COVID-19 pandemic, especially in rural and high-cost of living areas. Now, as more individuals are choosing to receive services in the home and community, the workforce challenges that were present before COVID have become even more acute. There are not enough direct care workers or direct service professionals, like personal care assistants, to meet the demand for home and community-based services. The economics of the service sector have long been a challenge, but they are more severe than ever.

**3. More Americans are going to need LTSS.** The number of Americans 65 and older is going to double in the next 40 years and the nation's oldest adults (age 85+) will quadruple in the same four decades.<sup>12</sup> In addition, advances in health care and technology have allowed individuals of all ages with complex health care needs and disabilities to live longer. These changes will further increase the need for LTSS and strain the system.

**4. There are known inequities in the provision of LTSS.** Data from states have shown that during the COVID-19 pandemic individuals living in nursing facilities located in communities of color were infected and died at disproportionately higher rates than their counterparts in white communities.<sup>13</sup> In addition, prior to the pandemic, states recognized and were working to ensure that the systems, processes, and service providers in their LTSS systems were accessible and culturally appropriate for diverse populations and communities in their states.

**5. Widespread adoption of telehealth and assistive technology may help solve some challenges.** A silver lining of the pandemic was that individuals, providers, and Medicaid policies adapted quickly to utilize telehealth and new assistive technologies for LTSS. And today, there is greater awareness and acceptance of the ways in which technology can increase access to person-centered services and supports.

**6. States have seed money to strengthen the capacity to provide LTSS in the community.** Congress provided a 10 percent increase in federal matching funds for one year under the American Rescue Plan Act, and states have three years to invest these additional federal dollars generated in the first year. This creates the opportunity for states to begin this transformative work, but Congress needs to take additional action, including providing continued funding, to support lasting and sustainable transformation.

<sup>11</sup> [The COVID Tracking Project: Long-term-care COVID Tracker](#). The Atlantic. March 2021.

<sup>12</sup> [The US Population is Aging](#). Urban Institute. Program on Retirement Policy.

<sup>13</sup> Derek Cantu. [Minority Residents in Illinois Nursing Homes Died of COVID-19 At Disproportionate Rates](#). NPR Illinois. May 3, 2021.



# CHAPTER II

## The Current Environment

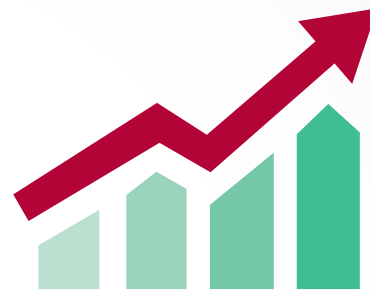


Nearly  
**1 in 10**  
individuals who live in  
nursing facilities died  
during COVID

Individuals living in nursing  
facilities located in communities  
of color were infected and died  
of COVID at disproportionately  
**HIGHER RATES**  
than their white counterparts



The number of  
Americans 65 and  
older is going to  
**DOUBLE**  
in the next 40 years



Congress provided a  
**10% INCREASE**  
in funds for one year and states  
have three years to invest these  
additional federal dollars



# CHAPTER III

## *Opportunities for Action*

The need for urgent action is clear. Without it, individuals may lack access to the services and supports they need to be safe, healthy, and thrive in the community of their choosing. In addition, a swift response is needed to truly transform the system to one that is person-centered. Without this, the system will continue to be institutional care-biased and fragmented. It is from this place of urgency that the Executive Working Group identified four key opportunities for immediate action to stabilize and transform the system.

- 1. Build and strengthen the LTSS workforce.**
- 2. Assist and strengthen individuals' natural supports.**
- 3. Promote the adoption of telehealth and assistive technology to support independence, health, and safety.**
- 4. Advance person-centered outcomes and quality through innovative payment approaches.**

This is not an exhaustive list, but they are places where state and national thought leaders see the need and the opportunity to support transformational change.




### *1. Build and Strengthen the LTSS Workforce*

States have long grappled with shortages and high turnover of the direct care workforce and nursing professionals in LTSS. These workforce challenges have only been exacerbated by the physical and emotional challenges faced by these essential workers during the pandemic and the increased demand for home and community-based care. According to national modeling, the country is expected to need an estimated 3.4 million direct care workers in LTSS by 2030. However, there are no national estimates that project the supply of direct care workers.<sup>14</sup> For the nursing workforce prior to the COVID-19 pandemic, some models estimated that there was a sufficient national supply of nursing workforce, but that local population and health care dynamics can lead to localized nursing professional shortages.<sup>15</sup>

The U.S. is expected to need an estimated

3.4 MILLION

direct care workers in LTSS by 2030



<sup>14</sup> [Long-term Services and Supports: Direct Care Worker Demand Projections: 2015 – 2030](#). Health Resources and Services Administration. March 2018.

<sup>15</sup> [Supply and Demand Projections of the Nursing Workforce: 2014-2030](#). Health Resources and Services Administration. July 21, 2017; [Long-term Services and Supports: Nursing Workforce Demand Projections 2015 – 2030](#). Health Resources and Services Administration. March 2018.



## CHAPTER III

### *Opportunities for Action*

#### STATE OPPORTUNITIES

Medicaid leaders can take various steps to support the development of a well-trained, compassionate, diverse, and sufficient LTSS workforce. These options and levers include:

- **Finance and incent the professional development and a career ladder for service providers.** Working collaboratively with service providers, community colleges, universities, and vocational and technical schools, Medicaid programs can support professional development and career advancements for direct care workers and direct support professionals through incentives, payment, and quality improvement requirements. For example, states can provide an incentive payment for each worker who receives certain certifications or trainings, and if all (or certain percentages of) workers receive the training, the nursing facility or home and community-based service provider could also receive a bonus payment.
- **Evaluate and promote a diverse and culturally reflective workforce.** Some state Medicaid agencies are going beyond measuring if they have enough providers in their long-term care systems and are developing ways to measure the diversity of their provider networks and whether or not the providers are reflective of and culturally aligned with the person receiving the services.
- **Implement policies and standards that ensure all workers are practicing at the top of their licensure and training.** Although most Medicaid agencies do not have the authority over scopes of practice and provider certification and licensure, the Medicaid agency can play an educational and clarifying role for their provider networks. For example, Medicaid can clarify which services a provider may bill for, which will ensure all care providers are maximizing their skills and training in the services they provide. In addition, the Medicaid agency can educate their partners in state government who are responsible for scope of practice about the practical impact of restrictive scope of practice policies on those seeking to reside in the community.
- **Increase compensation, benefits, and other non-monetary supports for the LTSS workforce, and align this compensation with the level of tasks they are providing and the outcomes they help individuals achieve.** State Medicaid agencies face many challenges in addressing the low compensation that is a longstanding challenge in the service sector, including in LTSS. However, states can consider increasing compensation or other supports that can increase the attractiveness of these professions. A state could do this by taking a more deliberate approach to rate setting, such as by using the Bureau of Labor Statistics data to set rates that reflect the broader labor market. Alternatively, states could provide add-on payments based on a staff person's training, the complexity of care being provided, and/or based on the outcomes that they help individuals to achieve. Finally, states can create a wage passthrough requirement to ensure home and community-based service providers and other LTSS providers use increased rates to raise wages for the front-line workers.

#### *Dually Eligible Individuals*

In 2020, nearly 8 million individuals were insured by both Medicaid and Medicare.<sup>16</sup> These dually eligible individuals represent 15 percent of enrollees but their care accounts for 32 percent of Medicaid spending.<sup>17</sup> Dually enrolled beneficiaries will benefit from LTSS transformation opportunities states may pursue based on this report. However, an ongoing partnership between the states and federal government is required improve coordination across programs and reduce fragmentation in care delivery.

<sup>16</sup> [2020 Medicaid and CHIP Beneficiary Profile: Characteristics, Health status, Access, Utilization, Expenditures, and Experience](#). Released August 2021. Centers for Medicare and Medicaid Services

<sup>17</sup> [Dually Eligible Beneficiaries](#). Medicaid and CHIP Payment and Access Commission.



# CHAPTER III

## Opportunities for Action

- **Leverage self-direction.** Self-direction models allow individuals receiving Medicaid home and community-based services to have responsibility for managing all aspects of the services they receive, including the providers. This model has been shown to have high consumer satisfaction and can lead to more stable care provider relationships. Self-directed options have increased in popularity as home- and community-based provider agencies have been less and less able to provide needed hours.

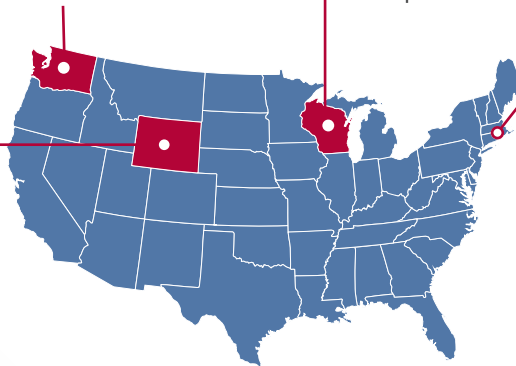
### State Examples: Build and Strengthen the LTSS Workforce

**Washington State** provides advanced training opportunities and wage increases based on cumulative career hours.

**Wisconsin** requires a certain portion of home health agency reimbursement to be passed on to the frontline worker.

**Wyoming** recently overhauled HCBS reimbursement rates using national data from the Bureau of Labor Statistics.

**Rhode Island** provides a payment bump for direct care workers who receive certain trainings or certifications, particularly in behavioral health. If all the home- and community-based provider agency's workers receive the training, the agency also gets an additional payment.



### FEDERAL LEVERS TO SUPPORT LONG-TERM TRANSFORMATION

The 10 percent enhanced Federal Medical Assistance Percentage (FMAP) that Congress provided in the American Rescue Plan Act can jump-start strategies to strengthen the LTSS workforce. However, sustaining these efforts will require bold congressional action to fundamentally transform LTSS and remove the institutional bias in it, provide ongoing investments in these services, and address broader economic challenges in the caregiving workforce.

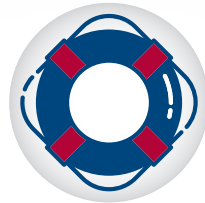
- **Expedite approval of Home and Community-based Services (HCBS) spending plans and offer maximum flexibility for the use of these dollars.** The Centers for Medicare and Medicaid Services (CMS) can help states maximize the current federal investment by expediting the review and approval of state HCBS spending plans and other authorities needed to implement them. CMS can also maximize the impact of these investments by giving states maximum flexibility to make meaningful investments that will address LTSS workforce challenges.
- **Extend the enhanced FMAP for HCBS.** Congress can continue the 10 percent enhanced FMAP beyond one year. This will allow states to implement innovative strategies to shore up and strengthen the workforce. Without sustained investments from Congress, states will have to focus on one-time investments in HCBS, rather than tackling ongoing and systemic challenges.



## CHAPTER III

### *Opportunities for Action*

- **Increase the FMAP for LTSS workforce training.** Currently, LTSS 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 innovation and 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.
- **Create a Bureau of Labor Statistics category for direct care workers.** This would allow the federal government to monitor this workforce and provide greater insight into supply and demand challenges.
- **Provide maximum state flexibility around HCBS providers' ability to pool dollars and purchase benefits.** The recent proposed rule from CMS is a helpful step forward, but additional flexibility is needed for states in this area. CMS should ensure that states have the maximum flexibility so that they have the option to permit their small HCBS providers to pool dollars and purchase training, health insurance, and other benefits for direct care workers.



### *American Rescue Plan Act Investments & Strengthening the LTSS Workforce*

States are exploring how to use the 10 percent enhanced FMAP for home- and community-based services under the American Rescue Plan Act to strengthen the LTSS workforce. Examples of how states are proposing to do this include:

- Funding workforce training and career development, including training on equity
- Increasing rates to home and community-based providers requiring those dollars to be passed on to front-line workers
- Paying out retention and/or recruitment bonuses
- Developing credentialing or certification for direct care workers or direct service professionals
- Conducting a workforce quality and structure study
- Providing tuition assistance for direct care workers or direct support professionals
- Developing direct care worker or direct support professional registries
- Offering a workforce transportation incentive





### *2. Assist and strengthen individuals' natural supports*

Individuals with complex and significant health care needs receive support from many people in their lives and from the communities in which they reside. These natural supports – family, friends, schools, faith-based organizations, neighbors, and others – are essential to allowing them to live safely and thrive in the setting of their choosing. Historically, Medicaid programs have not played a major role in supporting and strengthening these natural supports; the program has instead focused on formal structures and systems. To meet the growing need for home- and community-based services and deliver person-centered care, it is essential for Medicaid programs to consider strategies to strengthen natural supports and to do so in ways that recognize the unique realities of each state.

#### **STATE OPPORTUNITIES**

State Medicaid programs have multiple levers and pathways they can use to strengthen the natural supports for individuals receiving home- and community-based services. The primary challenge for Medicaid programs in doing this is to find ways to strengthen and increase the resiliency of natural supports, and not supplant them.

- **Ensure the authentic inclusion of families and natural supports in the person-centered planning process.** The first step to assisting and strengthening natural supports is to include a more deliberate focus on families and other people who serve as natural supports in the person-centered planning process. Technology can facilitate this more authentic inclusion at care conferences, which is when an individual and their caregivers meet to develop and update their person-centered care plan.
- **Increase the use of self-directed models of LTSS.** Self-direction programs allow individuals to manage their own supports and services, rather than having services managed by an agency. Many of these models allow an individual to hire someone who is known to them. It can leverage and strengthen natural supports and ensure that the person receives culturally and linguistically competent care. In expanding the use of these models, it is important to be mindful of unique realities within each state and the need to strengthen and increase the resiliency of natural supports, and not supplant them.
- **Provide assessment, training, support, and/or pay for family caregivers.** Assessing family caregiver needs is an important first step to person-centered service delivery. States may also offer training, like certified nursing assistant training, to unpaid or paid family caregivers to ensure they feel competent and confident to provide needed support. In addition, states and health plans may offer support services to family caregivers or connect them to non-Medicaid social services and supports to ensure their wellbeing and stability, like counseling, peer supports, or respite care. These types of mental health supports may be particularly helpful, given recent data from the Centers for Disease Control and Prevention found that family caregivers are experiencing increased levels of anxiety, depression, post-traumatic stress disorder, and suicidal thoughts.<sup>18</sup> Finally, states may elect to directly pay for family caregivers for the services that they provide to individuals.

<sup>18</sup> [Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24-30, 2020](#). Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. August 14, 2020.





## CHAPTER III

### *Opportunities for Action*

- **Ensure case managers provide culturally competent case management and empower them to assess the needs of family caregivers.** Case managers' engagement and intimate knowledge of about an individual is critical to ensuring the goal of strengthening and increasing the resiliency of natural supports, and not supplanting them. It is also critical to ensuring that individuals receive person-centered, culturally competent care. In particular, states may empower case managers to work in partnership with the individual and their caregivers to determine what supports are needed. In order to do this, states must ensure case managers receive the training needed to play this role and ensure payment is aligned with these expectations.
- **Incentivize Managed Care Organizations (MCOs) to buttress natural supports.** In managed LTSS programs, MCOs have significant flexibility to strengthen natural supports. States can create requirements and/or financial incentives for MCOs to assess the needs of family caregivers and provide support that responds to those needs, like caregiver training, peer support, respite care, mental health services, or even pay for caregiving.

### *State Examples: Assist and Strengthen Natural Supports*<sup>19</sup>

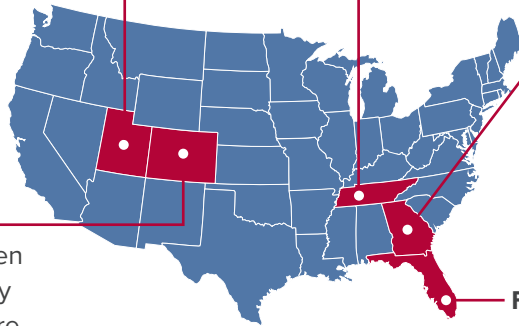
**Utah** offers training to unpaid family caregivers so they can carry out their responsibilities as outlined in the person-centered care plan.

**Tennessee's** MCOs must assess caregivers' needs and provide support that responds to those needs.

**Georgia** offers a service that supports family caregivers and provides a stipend to family caregivers who live with and provide support to a qualified individual receiving Medicaid LTSS.

**Colorado** provides family counseling to families of children with life-limiting illnesses. They also pay family members to care for their loved ones if they become Certified Nursing Assistants.

**Florida's** MCOs provide behavioral health services for family caregivers as a value-added benefit.



<sup>19</sup> Neva Kaye and Salom Teshale. [Medicaid Supports for Family Caregivers](#). National Academy of State Health Policy. October 29, 2020.



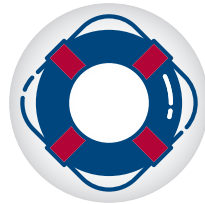
## CHAPTER III

### *Opportunities for Action*

#### FEDERAL LEVERS TO SUPPORT LONG-TERM TRANSFORMATION

Medicaid programs have options to strengthen natural supports under existing federal rules. However, there are opportunities for the federal government to come alongside states in strengthening this core component of LTSS.

- **Expand the opportunities to provide supportive housing.** The federal government can ensure states have the necessary flexibility to ensure individuals receiving LTSS and their caregivers have stable housing. This is essential to ensure natural supports can continue to provide care and the individual can live in the setting of their choosing.
- **Partner with states to refine and strengthen HCBS authorities.** Each authority used to deliver HCBS has its own set of opportunities and limitations. For example, 1115 authority provides significant flexibility to states, but the current application of budget neutrality prevents states from making significant investments in HCBS. States would welcome the opportunity to partner with CMS in examining all HCBS authorities and addressing the limitations of each one that prevent states from strengthening natural supports.
- **Allow states to offer a limited set of services to individuals and their family caregivers before the individual becomes Medicaid eligible.** This strategy is being employed by some states through an 1115 waiver pathway. Making this option more readily accessible to states could delay individuals' need for Medicaid LTSS over the long-term, resulting in greater independence and quality of life for individuals and cost savings to the federal and state government. It does this by supporting family caregivers and empowering them to provide natural supports longer, delaying the need for the full complement of Medicaid services.



#### *American Rescue Plan Act Investments & Natural Supports*

Many states are planning to leverage the 10 percent enhanced FMAP for home- and community-based services under the American Rescue Plan Act to buttress natural supports. Examples of how states are proposing to do this include:

- Expanding non-financial supports for family caregivers
- Providing pay for family caregivers
- Offering respite services to family caregivers
- Providing additional assistance to families with youth transitioning into adulthood



### *3. Promote the Adoption of Telehealth and Assistive Technology to Support Independence, Health, and Safety*

A silver lining of the pandemic is that it accelerated the use and acceptance of technology as a vehicle to deliver health care and home- and community-based services safely, foster social connection, and access other services and supports. State Medicaid leaders have an opportunity to seize this moment to leverage technologies that already exist to increase access to LTSS, and support independence, health, and safety in a variety of settings. In addition, expanding the use of technology can mitigate the workforce challenges facing the nation. It is important to note that this is an emerging area of opportunity, and work is still underway to develop a common definition and understanding of assistive technology in LTSS.

#### **STATE OPPORTUNITIES**

Medicaid programs can support the use of telehealth and assistive technology by removing policy barriers to the use of these technologies, and ensuring individual Medicaid recipients, plans and providers have clarity about state coverage policies. States can also re-evaluate and reduce their prior authorization process and other administrative requirements for individuals and providers. Finally, states can use payment to incentivize the use of these technologies by home and community-based providers, health plans, and institutional providers. This will allow states to maximize the use of technologies that promote:

- **Authentic independence.** Virtual job coaching and employment supports can increase access to training that supports community engagement and independence. In addition, technology, like environmental controls, automatic stove shutoff, fall alert systems, and even remote supports can support a safe home environment and allow individuals to choose to live safely in their own home.
- **Clinical care delivery.** Traditional telehealth can increase access to office-based physicians and behavioral health providers for individuals receiving LTSS. Other clinical technology, like remote patient monitoring, medication management tools, electronic visit verification, and on-demand clinical assistance (“red button technology”) can also provide timely access to needed care, avoid potential emergency department visits and/or hospitalizations, and improve health outcomes for individuals receiving LTSS.
- **Care planning and care coordination.** Technology can also improve care planning and care coordination. Virtual care planning conferences enable more members of the care team to participate in the planning process. This is particularly valuable for children with special health care needs who have many individuals involved in the delivery of services and supports. It can also make it easier for individuals and their caregivers to access care coordination services. Finally, electronic visit verification systems can engage in-home care providers as important persons of the team in providing information about the person’s needs or changes in needs or conditions that might warrant timely intervention.



# CHAPTER III

## Opportunities for Action

- **Social and emotional health.** Individuals with significant health care needs often face social isolation and loneliness, but particularly during the pandemic. According to one study, 40 percent of nursing home residents exhibited a sense of loneliness even prior to COVID,<sup>20</sup> and this social isolation can result in premature death for older adults.<sup>21</sup> Loneliness and isolation have also impacted individuals living in home and community-based settings during the pandemic, like families of children with complex needs. Technology, like video chat and email, can reduce the feelings of isolation and loneliness, particularly for older adults.<sup>22</sup>

**State Examples:**  
**Promote the Adoption of Telehealth and Assistive Technology to Support Independence, Health, and Safety**

**Washington State** expanded the use of assistive technology during the public health emergency.

Many states, such as **Connecticut** and **Maine**, are permitting virtual assessments and person-centered planning meetings during the public health emergency.

**Kentucky** leverages a virtual care coordination process for children with special health care needs.

**Tennessee** is leveraging enhanced FMAP funds under the American Rescue Plan Act to ensure that individuals served in all HCBS programs have access to a broad array of enabling technologies, flexibly designed to help maximize safety and independence in the person's home.

### FEDERAL LEVERS TO SUPPORT LONG-TERM TRANSFORMATION

There are three key opportunities for the federal government to support and sustain the adoption of assistive technologies in LTSS:

- **Allow Medicaid to pay for broadband access.** Many individuals receiving Medicaid LTSS lack access to broadband internet. This makes it impossible for these individuals to benefit from technologies that can improve access and outcomes. In the absence of a national effort to increase broadband availability, the federal government should provide flexibility for states to pay for broadband access for these individuals so they can access telehealth and assistive technologies.
- **Remove provider enrollment barriers.** Federal requirements around provider enrollment make it difficult for states to allow and incentivize the use of assistive technologies. For example, these requirements stipulate that states must enroll technology vendors as Medicaid providers – many of which are not equipped or willing to go through that process.

<sup>20</sup> Dorota Trybusinska and Agnieszka Saracen. [Loneliness in the Context of Quality of Life of Nursing Home Residents](#). Open Medicine. April 24, 2019.

<sup>21</sup> [Social Isolation and Loneliness in Older Adults](#). National Academies of Sciences, Engineering, and Medicine. 2020.

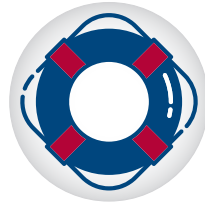
<sup>22</sup> [The Link Between Loneliness and Technology](#). May 2019, Vol. 50, No. 5. American Psychological Association.



## CHAPTER III

### *Opportunities for Action*

- **Provide technical assistance.** States would benefit from technical assistance from the federal government on which technologies and service systems are evidence-based in LTSS. In addition, states need technical assistance on how to price the technologies and set reimbursement rates for them, as well as how to safeguard individuals' privacy while using them.



### *American Rescue Plan Act Investments & Assistive Technology*

Many states are planning to leverage the 10 percent enhanced FMAP for home- and community-based services under the American Rescue Plan Act to promote the adoption of telehealth and assistive technology. Some of the ways states are proposing to do this include:

- Purchasing devices for HCBS recipients and providers so they can access and use assistive technologies
- Providing remote tech support
- Building an enhanced assistive technology benefit
- Providing broadband installation and equipment
- Training individuals receiving LTSS, home- and community-based providers, and direct care workers on assistive technologies
- Purchasing adaptive devices, like cooking equipment



### *4. Advance person-centered outcomes and quality through innovative payment approaches*

Payment is one of the main ways Medicaid programs can incentivize and transform LTSS towards a system that is higher quality and more person-centered. However, it is challenging for Medicaid leaders to use this lever in LTSS due to the lack of person-centered outcome measures. Currently, there are limited measures of patient safety, program compliance, and the National Core Indicators, which include standard measures of person experience in key areas, such as service, planning, choice, community inclusion and others. But long-term transformation will require new measures of quality and person-specific outcomes, such as person-reported outcome measures (PROMs).

#### **STATE OPPORTUNITIES**

Better quality and person-centered outcome measures will be critical to states' efforts to use payment to transform LTSS. In the absence of these measures, Medicaid leaders can still begin to explore innovations in payment to make the system one that is more person-centered. Some examples include:

- **Incentivizing right-sized institutional care.**

Rebalancing care and choice of setting are key principles in Medicaid LTSS. There will always be a role of institutional care, but states have an opportunity to strengthen the quality of person-centered care in these settings. Increasingly, the evidence is pointing to smaller, more innovative institutional settings that can provide more home-like environments, increase staff retention and control infections through private bedrooms and baths, like the Green House Model. Medicaid can create financial incentives for nursing facilities and intermediate care facilities to provide more privacy and to operate smaller facilities. For example, states could provide a rate enhancement for facilities with less than a certain number of beds. States can also incentivize right-sized institutional care by creating financial incentives for MCOs to rebalance care towards the community and support individuals who wish to reside in the community in moving into those settings.

#### *Person-Reported Outcome Measures (PROMs)*

To advance a person-centered LTSS system, Medicaid programs need to recognize and value what matters to the individual receiving services. Person-reported outcome measures are a promising way to do this. These measures allow individuals to report on their own health and well-being in a structured way. To date, the development and use of these measures is limited. Medicaid leaders should stay attuned to this measurement work and begin to explore how to bring these measures into their LTSS strategy.



## CHAPTER III

### *Opportunities for Action*

- **Ensuring a sufficient, well-trained workforce.** Medicaid programs can use payment to incentivize MCOs, home and community-based providers, and institutional providers to have a well-trained and adequately staffed workforce. For instance, in institutional settings states can set minimum staffing standards. These minimum staffing standards can set expectations for institutional settings to have staff with skills to serve the more complex set of individuals who need this high level of care, such as individuals with dementia or those with co-occurring developmental disabilities and mental illness.
- **Establishing value-based payment for institutional care.** There are more robust quality measures available for institutional care, including the Medicare Minimum Dataset, which can be used to tie payment to quality and the person's experience of care. In using this data, states must be mindful to set up a system for validation of this largely self-reported data.
- **Implement a portfolio of value-based payment arrangements in HCBS.** It is more difficult to implement innovative payment arrangements in HCBS, given the limited infrastructure, capacity, and operating margins of HCBS providers, as well as limited quality and outcome measures. Nevertheless, states can still advance payment models that help providers build the capacity for transformation and deliver more person-centered, high-quality services and supports. Some examples include:
  - *Acuity-based payment.* This type of rate add-on or kicker payment recognizes and incentivizes providers to care for individuals with a more complex set of needs, such as co-occurring physical or developmental disabilities and mental illness.
  - *Pay-for-performance.* This payment model may be particularly well suited to help small HCBS providers make incremental improvements in service delivery, and states can use this model to focus on measures that matter to consumers. For example, states could measure timeliness of visits as part of their electronic visit verification system and link payment incentives to such measures.
  - *Fading model.* This model re-aligns incentives for LTSS providers that are typically disincentivized to achieve desired outcomes. For example, coaching and career development service providers can continue to get paid the same rate for a period of time after a person achieves their career goals and needs fewer coaching services.

### *State Examples:*

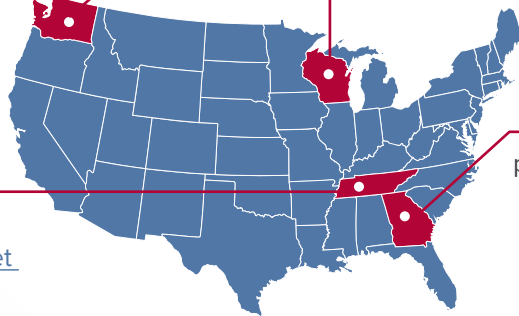
#### *Advance Person-centered Outcomes and Quality through Innovative Payment*

**Washington State** provides a payment add-on based on the complexity of the individuals being served.

**Wisconsin** provides an incentive payment to MLTSS plans for home- and community-based providers that achieve the Wisconsin Coalition for Collaborative Excellence in Assistive Living ([WCCEAL](#)) certification.

**Tennessee** nursing facility payment is linked to the facility's performance on a [set of quality measures](#).

**Georgia** provides an incentive payment to home health agencies when an individual meets certain benchmarks and goals laid out in their individual care plan.







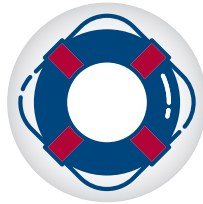
## CHAPTER III

### *Opportunities for Action*

#### FEDERAL LEVERS TO SUPPORT LONG-TERM TRANSFORMATION

Federal policymakers can work with states to define quality and support accountability for quality and innovative payment in LTSS. This partnership is essential to strengthening and transforming LTSS in the country. Key federal opportunities include:

- **Partnering with states to strengthen HCBS quality measurement.** CMS and its partners at the Department of Health and Human Services need to work closely with states, consumers, and the stakeholder community to develop patient-reported outcome measures in LTSS, especially in HCBS. While work is underway to strengthen quality measurement, the urgency of this work – and the need to transition away from relying solely on process and compliance measures toward for robust outcome measures – has increased.
- **Address misaligned incentives in Medicare.** For dually eligible beneficiaries, there are misaligned incentives in Medicare that prevent Medicaid from incentivizing high-quality, person-centered care. For instance, nursing facilities are incentivized to allow a dually eligible nursing facility resident to go to the hospital. When the individual returns from the hospital, Medicare pays for that individual's care at a higher rate than Medicaid payment.
- **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.



#### *American Rescue Plan Act Investments & Advancing Person-centered Outcomes and Quality through Innovative Payment Approaches*

States are exploring how to use the 10 percent enhanced FMAP for home- and community-based services under the American Rescue Plan Act to advance person-centered outcomes and quality through innovative payment approaches. Some examples of how states are proposing to do this include:

- Creating grant programs focused on quality improvement and systems transformation
- Creating grant programs focused on health-related social needs, including housing
- Developing innovative care delivery models, such as a Clubhouse-like model
- Establishing PACE licensure for oversight and compliance



# CHAPTER IV

## Conclusion

Medicaid programs are uniquely positioned to lead the nation in stabilizing and transforming LTSS to a system that is more person-centered. This framework outlined four of the most immediate opportunities for Medicaid to do this, including:

### Four Opportunities for Action



**1. Build and strengthen the long-term services and supports workforce.**

**2. Assist and strengthen individuals' natural supports.**



**3. Promote the adoption of telehealth and assistive technology to support independence, health, and safety.**

**4. Advance person-centered outcomes and quality through innovative payment approaches.**



Ultimately, to sustain these efforts, federal policymakers must come alongside states and take bold action to support this work. For instance, Congress can address the fact that institutional care, not home- and community-based services, is baked into law as the default option for LTSS. Congress can also provide sustained investments in states' transformational work by continuing the enhanced funding for HCBS, and the Administration can provide maximum flexibility around its use. The nation has a once-in-a-generation opportunity to transform the delivery of LTSS, and now is the time for federal and state policymakers to work together to help millions of individuals achieve their best health and thrive in their communities.