Developing the Long-Term Services and Supports (LTSS) System Infrastructure to Promote Greater Access to HCBS: A Strategy for Strengthening LTSS

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Fiscal pressures and increasing demand for consumer-preferred, lower cost home- and community-based services (HCBS) have driven and continue to drive states to invest in long-term services and supports (LTSS) system changes that promote rebalancing, better predict LTSS costs, and ensure greater access to HCBS. States have steadily used waivers and more recently, new and expanded state plan options to achieve this—increasing HCBS offerings and access to these services over time. However, implementing new programs does not immediately ensure that LTSS needs are met and HCBS are expanded. States also must ensure that their LTSS system infrastructure has adequate capacity to actually support timely access to services for individuals in the community who are eligible for these LTSS. Increasingly states are recognizing the need to have:

1. A workforce with sufficient capacity to deliver HCBS;
2. A streamlined way for beneficiaries to access information about services, as well as the services themselves;
3. A uniform way for providers to assess beneficiaries' LTSS needs to ensure equitable access;
4. The ability to respond to beneficiary problems and complaints;
5. The ability to define and measure outcomes; and
6. A communication and education vehicle to connect with stakeholders and providers on an ongoing basis.

Additionally, states' efforts to expand LTSS service offerings and to make corresponding improvements to the structural aspects of LTSS systems are influenced by:

1. A state's history and commitment to delivering HCBS;
2. The availability of federal funding and new flexibilities to target services; and
3. The impact of advocates who may push the state to expand services, or providers who, when engaged, can champion LTSS reform efforts.

More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million Americans to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than $154 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This LTSS reform strategy is part of a larger toolkit, *Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment*, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.

To learn more and view the full toolkit, visit **www.chcs.org/ltss-toolkit**.

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▶ Expiring Federal Funding Opportunities: Money Follows the Person and Balancing Incentive Program

Many states leveraged the federally-funded **Money Follows the Person** (MFP) demonstration and the **Balancing Incentive Program** (BIP) to significantly advance their rebalancing reforms. The programmatic changes that both opportunities promoted can serve as a template for other states thinking about rebalancing reforms. States will need to be creative to identify new funding to replace these sources and may even need to mix and match various federal, state, local, private, and foundation sources—and likely utilize 1115 waiver flexibility—to support rebalancing initiatives.

MFP: This national demonstration helped Medicaid enrollees transition from facility-based to community-based care, and may save money by shifting spending from more costly institutional care to potentially less costly HCBS. MFP program goals include: (1) increasing HCBS use and reducing institutionally-based service use; (2) eliminating barriers that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice; (3) strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and (4) putting procedures in place for quality assurance and improvement of HCBS.

BIP: Created under the ACA, BIP aimed to improve access to Medicaid LTSS in community settings by giving states an increased federal matching rate for community-based services. Eighteen states received BIP funding and were required to: (1) implement a "no wrong door" system, core standardized assessment, and conflict-free case management; (2) use the funds to improve access to LTSS in the community; and (3) spend a certain percentage of total LTSS funds on community LTSS. Based on states' reports, the no wrong door system had the largest impact on access to community LTSS by increasing entry points, streamlining the referral process, and improving awareness of services.

Under BIP, the 18 states received a total of $2.4 billion in grant funding to increase access to new or expanded services and infrastructure. Since 2007, 43 states and the District of Columbia have received over $4 billion in MFP funding. Although funding for MFP was recently extended in January 2019 for one year, the program has been dependent on temporary extensions and states have been looking to implement sustainability initiatives within their programs to prepare for potential program ending to maintain the gains they have achieved in improving their community-based LTSS infrastructure.

State MFP sustainability include efforts to continue to fund dedicated transition support staff along with MFP-like services. Several states are working to transfer staff currently funded by MFP into state-funded positions, which is crucial to maintaining transition efforts. States are also amending HCBS benefit design to include transition case management and housing supports via ongoing waiver programs (e.g., 1115 and/or 1915(c) waivers). A few states are leveraging comprehensive MLTSS programs to continue MFP activities, working with MLTSS health plans to ensure plans are dedicating care management resources to continue transition efforts and deliver transition case management supports. Some states have contract requirements that advance a greater focus on affordable housing and development of new housing partnerships at the health plan level. States can also examine flexibilities in newer HCBS authorities, such as CFC, as an option to fund pre-transition services essential to supporting individuals return to community housing.

Sources: *93.791 Money Follows the Person Rebalancing Demonstration.* Section 2403, 2010 Patient Protection and Affordable Care Act. 2010; *93.778 State Balancing Incentive Payments Program.* Section 10202 Patient Protection and Affordable Care Act. 2010; Texas Health and Human Services. "Money Follows the Person Demonstration Project." Available at: https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project.; CMS. "Balancing Incentive Program." Available at: www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html; Mission Analytics Group and New Editions Consulting, Inc. "State Reflections and Recommendations, Balancing Incentive Program." February 2016. Available at: www.medicaid.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf.; The Balancing Incentive Program. "Balancing Incentive Program, Summary Report." August 2015. Available at: www.balancingincentiveprogram.org/sites/default/files/BIP_Summary_Report_8_2015.pdf.; Mathematica Policy Research "Money Follows the Person 2015 Annual Evaluation Report." May 2017. Available at: www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf.; analysis of four state MFP sustainability plans: Louisiana Department of Health and Hospitals. "MFP Sustainability Plan." March 2015. Available at: http://laddc.org/files/Louisiana'sSustainabilityPlanMFP.pdf.; Vermont Department of Disabilities, Aging, and Independent Living. "Vermont Money Follows the Person Sustainability Plan." December 2017. Available at: https://dail.vermont.gov/sites/dail/files/documents/VT_MFP_Sustainability_Plan_02052018.pdf.; New York Department of Health. "New York State Money Follows the Person Rebalancing Demonstration." October 2017. Available at: www.health.ny.gov/health_care/medicaid/redesign/2016/docs/mfp_sustainability_plan.pdf.; "Massachusetts Money Follows the Person Demonstration Sustainability Plan." April 2015. Available at: https://www.mass.gov/files/documents/2016/09/sa/mfp-ma-sustainability-plan-posted-summary.pdf.; and "H.R.259 - Medicaid Extenders Act of 2019." 116th Congress. Available at: www.congress.gov/bill/116th-congress/house-bill/259/text.

▶ Strategy Description

States have focused LTSS infrastructure development on a number of key areas, leveraging BIP's funding opportunities and program requirements improve their LTSS infrastructure. These areas include: (1) creating a "no wrong door" single entry point to the LTSS system to streamline the maze of agencies, organizations and eligibility requirements for individuals and increase awareness and information about options (e.g., Massachusetts and Maryland); (2) implementing a uniform assessment tool to assess HCBS eligibility based on clinical and functional needs so that all eligible individuals are assessed in a comprehensive manner using the same standard (e.g., New York); and (3) implementing systems to require and support person-centered care plans driven by individuals' needs, goals and preferences rather than care coordinators' preferences (e.g., Massachusetts).

In addition to developing new infrastructure and tools, states also are building capacity among their formal and informal workforce to ensure a sufficient number of trained and qualified workers in the community-based system to provide needed care (e.g., New York, New Jersey, California, Washington, and Tennessee).

Although not a topic of discussion in this toolkit, several states and health plans are investing in technology to improve the reach of the LTSS workforce, such as tablet-based technology to support communication between care coordinators, family caregivers and direct care workers, remote monitoring systems, and Electronic Visit Verification systems.

▶ Implementation Mechanisms

Mechanisms to support development of HCBS infrastructure include both financial and regulatory options. Several states made financial investments in system infrastructure through the use of: (1) federal funds (e.g., BIP in Massachusetts and Maryland); (2) state funds (e.g., $5 million in New York for its standardized assessment tool), including state bond funding; and (3) private grants (e.g., Robert Wood Johnson Foundation funding for New Jersey's nursing delegation pilot).

Though there is no new BIP funding available for states, states' BIP experiences provide relevant templates in the event that the federal government appropriates future funding or states are able to leverage other funding sources to support similar goals and efforts, including private foundation grants and state appropriations. Other states have used federal and state authority to launch reforms in these areas, including: (1) 1115 waiver authority to retrain the LTSS workforce (e.g., New York); and (2) changes to state regulations and nursing practices to support workforce development and capacity efforts (e.g., New Jersey and California).[1] As New Jersey did with its nursing delegation initiative, states also can use pilot programs to test initial concepts and gain support to fund future reform efforts.

▶ Results to Date

According to a February 2016 evaluation of BIP-funded states, of the three required BIP structural changes, implementing a single entry point system for access to community LTSS is expected to result in the greatest impact on access to services.[2] This no wrong door system increases entry points to the LTSS system for individuals (i.e., physical locations, websites, and toll-free numbers), streamlines the information and referral process for services, and increases overall awareness of the available community LTSS options.[3] The same evaluation found that only nine of 18 states that responded reported that implementing a uniform assessment tool significantly improved the state's ability to conduct accurate assessments and improve care plans, though states' responses largely varied based on what assessment infrastructure was already in place.[4]

For instance, New York reported limited impact because efforts to create a uniform assessment tool were already underway, though the state did note that BIP funding helped expedite the tool's automation.[5] The BIP evaluation also found that many states had already introduced conflict-free case management, though some states like New Jersey reported that BIP funding prompted the state to include conflict-free language in its managed care contracts.[6] Results related to workforce investment are difficult to measure and limited as most states are just beginning these efforts. New Jersey's nursing delegation pilot led it to revise its nursing regulations and improved quality of life for pilot program participants—although nursing delegation is not widely used within the state. Despite some strides, most states still have considerable needs for investments in LTSS infrastructure, particularly for building beneficiary awareness, ensuring equitable access to services across populations, recruiting and retaining the direct care workforce, and supporting overburdened and overwhelmed informal caregivers.

▶ Key Lessons

- **Engage leadership across state agencies.** Gubernatorial or executive support and direction is crucial to moving reform efforts forward, building relationships across agencies, and engendering support for new program or system changes. Maryland identified that having the support of its Secretary of Health and Mental Hygiene, Governor's office, and Medicaid director was instrumental to advancing its rebalancing efforts. More broadly, states reported that one of the key impacts of their LTSS system redesign work was to increase coordination and collaboration across often siloed state agencies, and strong leadership was essential to pushing rebalancing initiatives forward.[7] Notably, New York reported that the departure of its uniform assessment tool's administrative champion and other staffing changes slowed momentum for rolling out the tool across programs, demonstrating how critical state leadership is to strategy design and execution.

- **Engage all relevant stakeholders early and build lasting partnerships**. All states interviewed identified the importance of stakeholder engagement and buy-in, particularly among beneficiaries and their advocates, during all phases of reform—design, implementation and ongoing monitoring. New Jersey noted the importance of gaining support from the executive director and board members of the New Jersey Board of Nursing to promote nursing delegation efforts, as well as ensuring attorneys within in the Department of Law and Public Safety, which houses the Board of Nursing, understood

the program's intent. New Jersey also developed an advisory council that included provider representatives—such as home care workers, hospital associations, and experts in nursing delegation—to assist with problem solving.[8] Tennessee echoed the importance of engaging stakeholders early and often, using stakeholder feedback to drive initiatives and identifying key areas of the process for stakeholders to own. Not only can meaningful and lasting partnerships help advance a state's strategy, but also they can prevent potential challenges by providing early warnings about implementation and transition issues.

- **Collect program data and ensure staff capacity to analyze and monitor its impact**. States identified the importance of measuring and analyzing program data and the consequences of not having the necessary staff resources to do so. Massachusetts, having learned from past experiences, suggested ensuring data collection strategies are in place prior to program launch and that strategies are consistently designed and enforced across related programs. Key program measures include access to services, beneficiary experience, and outcome measures that assess beneficiaries' satisfaction. New York highlighted a challenge with implementation of its uniform assessment tool, noting that it has not had sufficient staff resources to analyze the data collected from the tool to inform policymaking. It suggested that other states implementing a similar model make staff resources available to meaningfully analyze and utilize the information that is collected from their assessment tools.

- **Leverage existing LTSS infrastructure.** To ensure efficient use of existing capabilities and reduce duplication, it is helpful to have a clear understanding of the state's existing LTSS infrastructure landscape at the outset to leverage existing funding and systems wherever possible. For instance, in Texas, the state used existing workforce capacity (i.e., community transition teams) to understand regional institutionalization trends, including where the greatest community transition needs were and to work with relocation contractors on housing issues.

- **Take a long view**. Overwhelmingly, state officials reflected on the long-term commitment needed to develop and support LTSS infrastructure. As New York noted, having state leadership at the forefront of these efforts is critical to maintaining momentum, but so too is a robust sustainability plan and funding source after federal funding runs out (e.g., Massachusetts has developed a sustainability plan for each of the ongoing programs which received BIP funding). Many states, including Tennessee, secured planning funds using 1115 waivers, BIP planning grants, and CMS Center for Medicare and Medicaid Innovation grants to create and sustain cross-agency meeting structures to deliberate on the design, implementation, and ongoing operation of their LTSS system reforms. Looking ahead to sustainability planning, states may be able to leverage enhanced federal funding for eligibility and enrollment systems to reduce the cost of information technology system development and improve sustainability.

▶ Case Studies

Massachusetts Creates a One-Stop Information and Referral Network and Expands Access to HCBS.

Massachusetts has a long history of prioritizing "community-first" LTSS, and has provided a generous scope of community-based LTSS benefits under its Medicaid state plan and through ten HCBS waivers. In state FY 2017, 74 percent of MassHealth LTSS spending was for community-based services, up from 44.8 percent in 2009.[9,10]

Massachusetts embarked on several efforts to further expand the availability of services to people in need of LTSS, and continues to improve the structural aspects of its LTSS system. In April 2014, the state received $135 million in BIP funding. In addition to expanding access to HCBS—specifically for children under age nine with autism—Massachusetts also used the funding to: (1) expand choice counseling through the state's Aging and Disability Resource Consortia (ADRCs); (2) improve eligibility assistance through co-location of Medicaid eligibility counselors and ADRCs; (3) support training of direct care workers; and (4) develop and raise awareness of the MassOptions information and referral website and call center.[11]

To help connect and coordinate the entire LTSS system—including 120 Councils on Aging, 11 ADRCs, 26 Aging Services Access Points, 11 Independent Living Centers, and multiple state agencies involved in coordinating and delivering LTSS—the Massachusetts Executive Office of Health and Human Services developed MassOptions, a website and call center that serves as a free resource for individuals (and their family members or caregivers) seeking information on LTSS. This single access point provides information about and connections to community services and supports, including caregiver support services, day services, financial assistance services, and housing, among many others. Individuals (or their families and caregivers) can communicate directly by phone, email, or online chat with trained specialists who can assess individuals' needs and make a "warm transfer" to an expert (e.g., an Independent Living Center or Aging Services Access Point) to minimize the frustration of calling multiple agencies and navigating various networks. MassOptions' phone line and online chat features are available 8 am to 8 pm, seven days a week. The website, available 24 hours a day, seven days a week, provides a referral form that directs an individual to an agency or organization in their community that can best meet his or her needs. Individuals can also request a "call back" and a trained specialist will respond within 24 hours.

New York Develops Uniform Assessment System to Standardize HCBS Needs Assessments.
In the 2008-2009 state fiscal year budget, New York State Department of Health (NYSDOH) secured a $5 million state appropriation to develop its uniform assessment system (UAS-NY). Using a uniform data set, NYSDOH's goal was to standardize and automate a comprehensive assessment for its home- and community-based programs. The NYSDOH procured a vendor to build the UAS-NY to support development activities: (1) first releasing a request for information to inform tool development; (2) then releasing a request for proposals to select a tool; and (3) ultimately, field testing the tool. The state selected the interRAI suite of assessment instruments as the basis for the tool. Using a standardized tool increases reliability and improves consistency of the assessment processes facilitating more equitable access to programs and services and eliminating duplication.

It took the state approximately three years to rollout the system statewide to all the different programs. Today, the tool is used in the state's mainstream managed care, MLTSS, and certain fee-for-service and adult waiver programs, including Traumatic Brain Injury and Nursing Home Transition and Diversion. The state seeks to expand the use of the tool for use in state policy and service planning.

Some challenges noted in the initial launch and continued operation of the UAS-NY include maintaining NYSDOH's focus and resources for the tool amid staffing changes, including loss of administrative champions and competing state agency priorities. Additionally, NYSDOH has experienced difficulty with acquiring the resources for comprehensive analysis of data collected, restricting its ability to use the data to inform policymaking.

▶ Using 1915(c) Waivers to Support Family Caregivers

Informal caregivers provide the majority of LTSS in the United States and experience tremendous physical, emotional, and financial stress in doing so. Yet, their numbers are dwindling as the average family size decreases, relatives are more geographically dispersed, and more women, who typically serve as primary caregivers, are in the workforce. States are recognizing the importance of developing systems to support existing and future caregivers. In a recent AARP survey, 15 states reported including a family caregiver assessment as part of their 1915(c) waiver programs. These assessments are intended to connect informal caregivers to local support services in their communities based on their identified needs. In addition, some states, such as Washington, have implemented specific programs for unpaid caregivers who are caring for a person receiving Medicaid LTSS.

In addition to receiving respite care and other services through the state HCBS waiver, caregivers through the national Family Caregiving Support Program receive service information and assistance, caregiver educational programs, support groups, and referral to other community service programs. Some states with MLTSS programs have built these initiatives into their health plan contract requirements, to more effectively and consistently provide these supports to all family caregivers.

Source: AARP Public Policy Institute. "Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home- and Community-Based Service Waiver Programs." December 2013. Available at: www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf.; and AARP Public Policy Institute. "Emerging Innovations in Managed Long-Term Services and Supports for Family Caregivers." November 2017. Available at: www.longtermscorecard.org/~/media/Microsite/Files/2017/2017%20Scorecard/AARP1202_EI_EmerInnovationLTSS_Oct31v2.pdf.

New York Uses 1115 Waiver Funds to Recruit, Retrain and Retain Its Long-Term Care Direct Care Workers.

In April 2014, CMS approved New York's Medicaid Redesign Team (MRT) amendment to the state's 1115 waiver, making $245 million available through March 2020 for initiatives to retrain, recruit, and retain direct care workers in the long-term health care sector. This initiative, referred to as the "Workforce Investment Program," was implemented in early 2018.

The NYSDOH requires its managed long-term care plans to contract with NYSDOH-designated workforce training centers (Long Term Care Workforce Investment Organizations, [LTC WIOs]) to: (1) invest in initiatives to attract, recruit and retain long-term care workers; (2) develop plans to place these workers in medically underserved communities; (3) analyze the changing

training and employment needs among workers served by the centers; (4) seek stakeholder input and engagement; and (5) support the expansion of home and respite care.
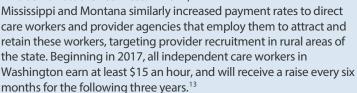
In October 2017, NYSDOH released its LTC WIO application and launched the process of designating LTC WIOs that met the state's minimum criteria. NYSDOH distributes waiver funds to its managed long-term care plans, which, in turn, provide payments to the LTC WIOs for delivering workforce development initiatives that provide training, and support recruitment and retention efforts to address the needs of plan, providers and healthcare workers in long-term care sector.[12]

Direct Care Workforce: The Need for Better Wages and Training

The direct care workforce is poorly paid with home health workers averaging just $10 to $13 per hour. The LTSS home care workforce experiences a 45 to 66 percent annual turnover rate, with nearly 25 percent of nursing assistants and home health aides reporting actively looking for another job. Private home care aides report one of the highest workforce injury and illness rates of all occupations, while home health aides experience a higher rate than the national average. Both increased pay and better training are needed to address the high turnover among the direct care workforce and to ensure sufficient numbers of workers to meet the projected demand for HCBS.

States are starting to take action. Massachusetts used BIP funding to set an enhanced minimum wage standard, increasing home care wages by five percent. In New York, the 1199 SEIU health care workers union joined the *Fight for $15*, a national movement to increase the minimum wage to $15 an hour. Additionally, 80,000 unionized city home health aides are among those who are benefiting from legislation that

Governor Cuomo signed in April 2016 enacting a statewide $15 minimum wage plan. In July 2018, Vermont finalized a Collective Bargaining Agreement with AFSCME, guaranteeing a minimum wage to Independent Direct Support Workers, who provide HCBS to LTSS participants who self-direct their services. In 2017, Mississippi and Montana similarly increased payment rates to direct care workers and provider agencies that employ them to attract and retain these workers, targeting provider recruitment in rural areas of the state. Beginning in 2017, all independent care workers in Washington earn at least $15 an hour, and will receive a raise every six months for the following three years.[13]

Sources: "2017 Home Care Benchmarking Study." Home Care Association of America. April 25, 2017. Available at: https://benchmarking.homecarepulse.com/; "Personal and Home Care Aide State Training (PHCAST) Demonstration Program Evaluation: Report to Congress." Department of Health and Human Services Health Resources and Services Administration. July 12, 2016. Available at: www.hrsa.gov/sites/default/files/about/organization/bureaus/bhw/reportstocongress/phcastreport.pdf.; "Paying the Price: How Poverty Wages Undermine Home Care in America." Paraprofessionals Health Institute. 2017.; Center on Budget and Policy Priorities. "Medicaid Cuts in House ACA Repeal Bill Would Limit Availability of Home- and Community-Based Services." May 2017. Available at: www.cbpp.org/sites/default/files/atoms/files/5-18-17health.pdf.; Mission Analytics Group, Inc. "Innovations in the Balancing Incentive Program: Massachusetts." CMS, February 2017. Available at: www.medicaid.gov/medicaid/ltss/downloads/balancing/mass-case-study.pdf; G.A. Otis. "Home health workers join 'Fight for $15' to increase minimum wage." *Daily News*, April 13, 2015. Available at: www.nydailynews.com/new-york/exclusive-home-health-workers-join-fight-15-pay-war-article-1.2183024.; New York State. "Governor Cuomo Signs $15 Minimum Wage Plan and 12 Week Paid Family Leave Policy into Law." April 2016. Available at: www.governor.ny.gov/news/governor-cuomo-signs-15-minimum-wage-plan-and-12-week-paid-family-leave-policy-law.; Case study update from Vermont, September 14, 2018.; and Government Accountability Office. "Medicaid Home- And Community-Based Services: Selected States' Program Structures and Challenges Providing Services." October 2018. Available at: www.gao.gov/products/GAO-18-628.

New Jersey's Nurse Delegation Pilot Increases Access to HCBS. As part of its ongoing commitment to serve eligible residents with HCBS, New Jersey has consistently advanced innovative initiatives. Specifically, in the mid-2000s the state looked to implement nursing delegation—the process by which a registered nurse "directs another individual to do something that that person would not normally be allowed to do."[14] This plan was designed to expand access to HCBS by increasing the availability of the direct care workforce to meet beneficiaries' needs.

At that time, the New Jersey Nurse Practice Act permitted registered nurses to delegate *some* tasks, such as temperature taking and blood pressure reading, but they were not permitted to delegate medication administration to certified home health aides (CHHA) in home settings. Further, nurses reported that they were generally unaware of their ability to delegate health-related tasks or reticent to do so because of liability concerns. Therefore, from November 1, 2007 to October 30, 2010 the New Jersey Department of Human Services, with permission from the New Jersey Board of Nursing and a $300,000 grant from the Robert Wood Johnson Foundation, launched the New Jersey Nurse Delegation Pilot to expand the list of delegable health care related tasks among nurses, pilot the delegation of medication administration, and ultimately, increase access to HCBS. Under the voluntary pilot, nurses from 19 agencies trained, supervised, and delegated certain health maintenance tasks, including medication administration, to CHHAs.

The CHHAs were able to provide delegated services only to select Medicaid beneficiaries in a "triad" model that included the nurse, the CHHA, and the individual. Nurses had to meet documentation requirements that demonstrated CHHAs had the ability to provide medication to beneficiaries during training to reduce nurse liability risks. The CHHA's training was not transferrable, which required them to retrain for each client. An evaluation of the pilot was positive, with high levels of beneficiary satisfaction with the program and no evidence of adverse health outcomes.[15] The pilot established evidence of best practice and provided the necessary policy momentum for the Board of Nursing to change its regulations to permit delegation of medication administration by CHHAs in January 2017.[16]

Tennessee's LTSS Workforce Strategy. As a central component of its Quality Improvement in LTSS (QuILTSS) program, which promotes the delivery of high-quality LTSS through payment reform, Tennessee created a comprehensive LTSS workforce development program. This effort complements the state's value-based payment strategies for LTSS by aligning the opportunities for direct service worker training and degree attainment with LTSS quality measures and rewarding providers that employ a well-trained workforce.

Prior to QuILTSS' launch, TennCare—Tennessee's Medicaid agency—conducted extensive stakeholder engagement activities to identify program elements that have a large reported impact on LTSS quality and beneficiary experience. Having a well-trained, competent, and reliable workforce was one of the highest priorities reported by individuals who use LTSS. The LTSS workforce development program provides targeted training to direct service workers who participate in TennCare, coupled with an educational initiative that creates a new career path for workers to earn credits for a post-secondary certificate and/or degree program.

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The curriculum for the workforce development component of the program was developed using CMS' Direct Service Workforce core competencies, and modified based on input from stakeholders and subject matter experts to better align with the state's workforce needs. It will be used in colleges of applied technology and community colleges. The state also plans to embed courses at the high school level to allow students to earn college credits in this field, targeting their recruitment into the industry, while also preparing them to enter the workforce with the competencies they need to be successful. The program includes mentoring, coaching and career planning, and a state-developed registry that will link participants together and track training and educational achievement. The state focused on the development of a career path, as opposed to limited certification opportunities not linked to a degree program, to encourage new workforce entrants and worker retention. Lastly, the program is competency-based, requiring workers to demonstrate learning and capacity outside of a classroom or an online course. As part of implementing the program, TennCare plans to implement an incentive structure that will reward participants with higher compensation as they advance in their completion of courses and the certificate.

Tennessee had a grant from the Robert Wood Johnson Foundation to support initial research and stakeholder engagement for the development of QuILTSS, and is now using a combination of state and federal funding (including the CMS State Innovation Model grant) to support curriculum and infrastructure development. TennCare staff noted that the LTSS workforce development program was bolstered by an overarching state priority to make post-secondary education and other job training more accessible to those who want it. However, the state anticipates that the program will become self-sustaining. TennCare staff is creating a business plan to support additional program components including ongoing curriculum development that is translatable across different settings, the online registry of direct support professionals, and accessible assessment centers to demonstrate competency-based learning.

TennCare also plans to address the direct service workforce shortage by using existing Money Follows the Person (MFP) funds to engage national subject matter experts to develop a workforce survey on direct service worker hiring, retention, and compensation practices to develop and measure improvement efforts over time. Providers will receive incentives to complete the survey, and TennCare will use the data to inform value-based payment strategies. Providers will also receive technical assistance from national subject matter experts on proper data collection and submission, how data analysis can be used to address workforce issues, and workforce recruitment and retention best practices.

ENDNOTES

[1] Though BIP funding is no longer available, its requirements (see sidebar *Goals of the Balancing Incentive Program* in full toolkit: www.chcs.org/ltss-toolkit) provide examples to other states of the critical importance of establishing infrastructure to support community-based services.

[2] Mission Analytics Group, Inc. "State Reflections and Recommendations, Balancing Incentive Program." Centers for Medicare & Medicaid Services, February 2016. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf.

[3] Mission Analytics Group, Inc. "State Reflections and Recommendations, Balancing Incentive Program." Centers for Medicare & Medicaid Services, February 2016. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf.

[4] *Ibid.*

[5] *Ibid.*

[6] *Ibid.*

[7] Mission Analytics Group, Inc., op. cit. (2016).

[8] State of New Jersey, Department of Human Services, Division of Disability Services. "FINAL NARRATIVE REPORT, There's No Place Like Home: New Jersey Nurse Delegation Pilot Project." May 21, 2011. Available at: http://www.state.nj.us/humanservices/dds/documents/DDS%20FINAL%20NARRATIVE%20REPORT.pdf.

[9] Mission Analytics Group, Inc. "Innovations in the Balancing Incentive Program: Massachusetts." Centers for Medicare & Medicaid Services, February 2017. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mass-case-study.pdf.

[10] Correspondence with Massachusetts, November 21, 2017.

[11] Mission Analytics Group, Inc., op. cit. (2017).

[12] New York State, Department of Health, Office of Health Insurance Programs. "MRT Waiver Amendment: MLTC Workforce Investment." Presentation, May 25, 2017. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/2017/docs/2017-05-25_workforce_investment_program.pdf.

[13] "Our 2017-2019 IP Contract Is Our Best One Yet!" SEIU 775. August 11, 2016. Available at: http://seiu775.org/category/home-care/.

[14] J. Farnham, H.M. Young, S. Reinhard, N. Petlick, T. Reinhard, V. Santillan. "New Jersey Nurse Delegation Pilot Evaluation Report." Rutgers Center for State Health Policy, April 2011. Available at: http://www.state.nj.us/humanservices/dds/documents/Report%20Formatted%2010may11%20with%20covers.pdf.

[15] *Ibid.*

[16] New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing. N.J. Admin. Code §§ 13:37-1.1 through 14.17 (June 19, 2017). Available at: http://www.njconsumeraffairs.gov/regulations/Chapter-37-New-Jersey-Board-of-Nursing.pdf.