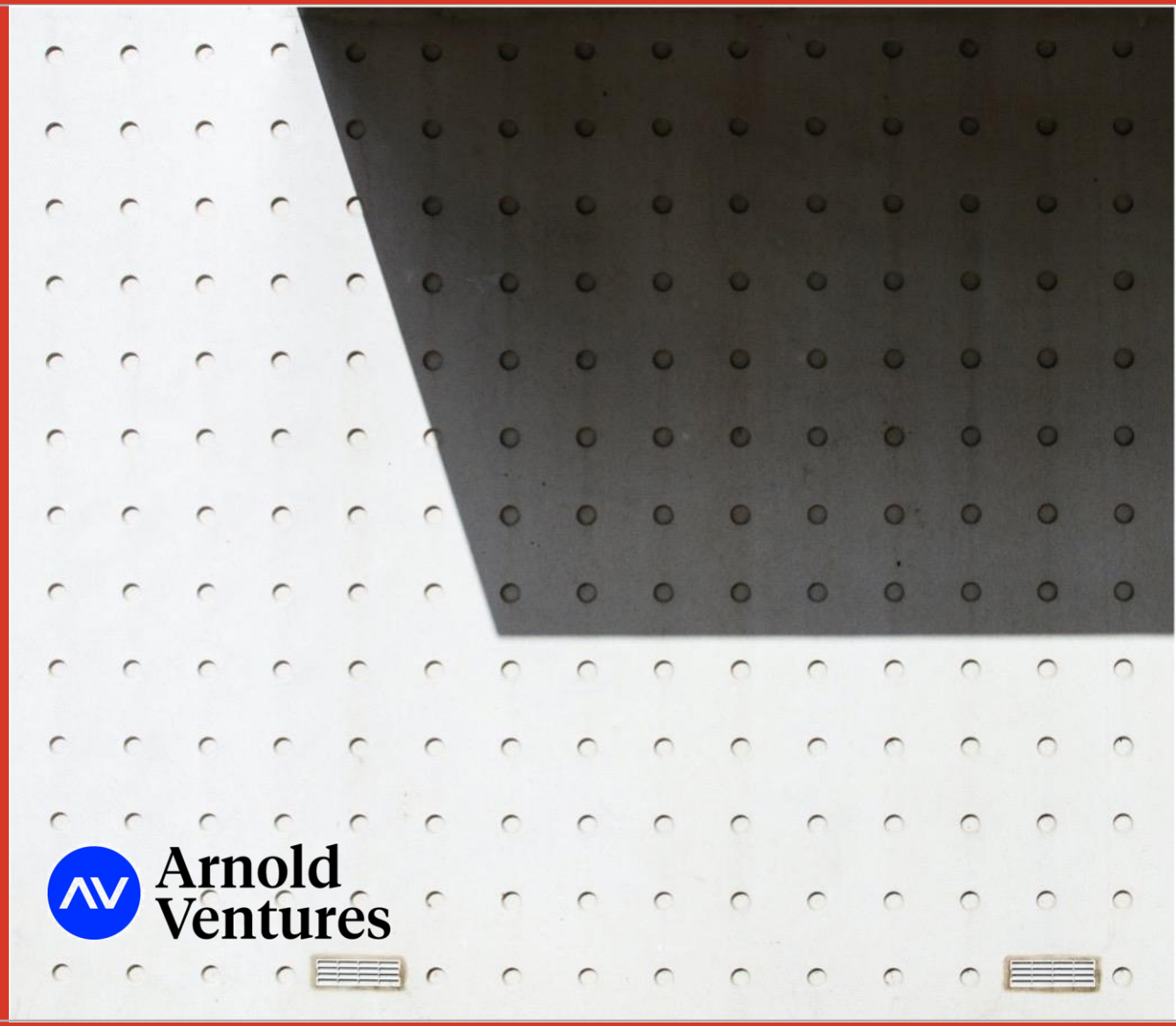
State Approaches to Increase Home and Community-Based Service (HCBS) Provider Capacity

June 2022

ATI Advisory



→ Background and Purpose

Home and community-based services (HCBS) allow people with physical and cognitive limitations to live in their home or a home-like setting and remain integrated with the community. As states prioritize person-centered care, beneficiaries are increasingly receiving long-term services and supports (LTSS) through HCBS rather than in institutional settings.

Despite the growing reliance on HCBS, there is a shortage of available direct care workers (DCWs) to provide HCBS. As a result, state Medicaid agencies may struggle to connect beneficiaries in the community to adequate services. A recent MACPAC report identified "leveraging Medicaid managed LTSS programs" as a primary opportunity for addressing these challenges through contract requirements.

This tool is intended to provide State Medicaid agencies with examples of how to encourage or require managed care entities (MCEs) and Dual-eligible Special Needs Plans (D-SNPs) to support state HCBS capacity building efforts.

In partnership with Arnold Ventures, ATI Advisory produced this tool with examples for State Medicaid Agencies to consider as they seek to build HCBS and DCW workforce capacity.

Navigate directly to a section of this tool:

State	MLTSS RFP (Year)	MLTSS Contract (Year)	D-SNP Contract (Year)
Arizona		✓ (2021)	✓ (2021)
Florida	✓ (2013)	✓ (2020)	
Massachusetts		✓ (2021)	
Minnesota	✓ (2021)	✓ (2021)	
New Jersey		✓ (2020)	
Pennsylvania	✓ (2016)	✓ (2015)	✓ (2022)
Tennessee	✓ (2021)	✓ (2022)	✓ (2019)
Texas	✓ (2022)	✓ (2022)	✓ (2020)

ATI reviewed the most recent, publicly-available Medicaid managed care RFPs, Medicaid managed care contracts, and D-SNP contracts (State Medicaid Agency Contracts (SMACs)) for eight states. These states were selected as a representative sample with:

- → Mature managed LTSS (MLTSS) programs
- → Geographic diversity
- → Diversity in demographics of Medicaid population served

Publicly available documents were reviewed.

Overview of Levers to Increase HCBS Capacity

→ State Medicaid Agencies have three primary levers through which they can encourage HCBS capacity building investments by MCEs:

1

Managed Care Procurement

→ States with Medicaid managed care can evaluate prospective MCEs on the strength of their responses related to HCBS and HCBS providers through the **request for proposals (RFP)** process

2

Managed Care Contract

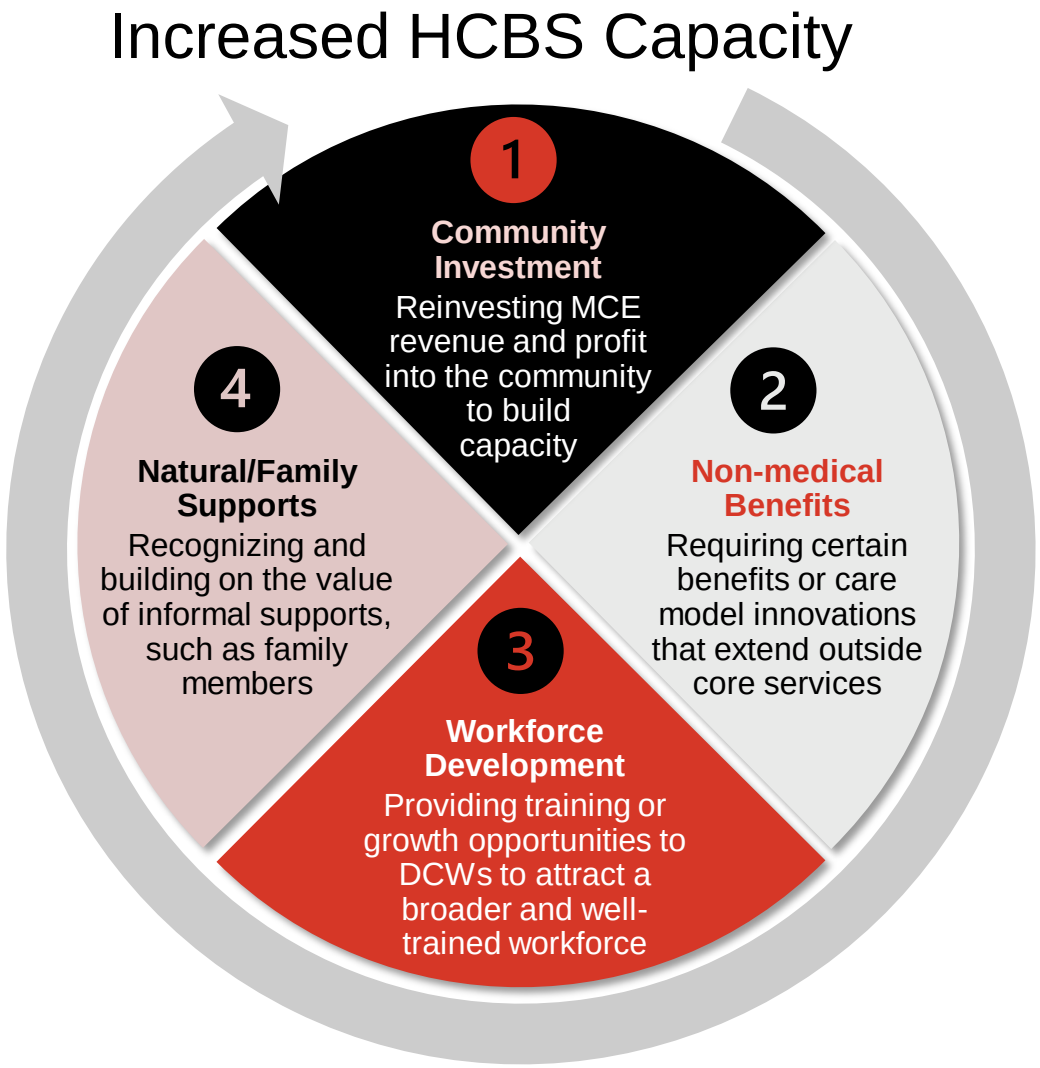
→ States with Medicaid managed care can include requirements in **MCE contracts** and program monitoring

3

D-SNP Contract

→ States with a D-SNP program can incorporate provisions in **D-SNP contracts**

Managed Care RFP		Managed Care / D-SNP Contract	
Opportunities	**Considerations**	**Opportunities**	**Considerations**
▲ Establishes MCE expectations early-on in procurement process ▲ Provides opportunity to evaluate MCEs on strength of response to requirement	▼ To avoid protest, need to ensure fair evaluation of all questions and responses across MCEs ▼ States must perform extensive oversight to ensure MCEs implement RFP promises	▲ MCEs and D-SNPs have legal obligation to fulfill contract requirements ▲ States can amend contracts annually and, in some instances, more frequently than annual approval timeframes	▼ SMACs are due to Centers for Medicare & Medicaid Services (CMS) for approval in the July prior to the Contract Year ▼ Establishing additional requirements creates additional contract compliance burden



States can deploy multiple approaches across each of the three levers (RFP, MCE Contract, D-SNP Contract) to build HCBS capacity. Underneath each approach are more granular mechanisms and tools that include:

- → Model of care
- → Oversight and reporting
- → Quality improvement
- → Data sharing

Approach 1:

Invest in Community Infrastructure

Community Investment Plans

- States can request RFP respondents to discuss their approaches to community and infrastructure investment.
- Three states asked RFP respondents to invest in the communities they were applying to serve. Two states, Florida and Pennsylvania, specifically called out HCBS capacity as an area for MCEs to address in responses:
  - Florida indicated that initiatives "should be proposed to help meet the need for affordable housing and other home and community-based services" (e.g. 1)
  - Pennsylvania asked respondents for their plans related to "increas[ing] access to affordable, accessible housing," "expand[ing] access to community-based integrated employment," and "develop[ing] the LTSS direct service workforce" (e.g. 2)

→ Example Language – Community Investment Plans

State	Example	Text
Florida	e.g. 1	The respondent shall describe how it will establish community partnerships with providers that create opportunities for reinvestment in community-based services... 'Reinvestment in community-based services' is defined as initiatives undertaken by the managed care plans (MCPs) that foster accountability to, and reinvestment in local communities. Initiatives should be proposed to help meet the need for affordable housing and other home and community-based services for elders and individuals with disabilities within the urban and rural local communities, as determined by the Managed Care Plan.
Pennsylvania	e.g. 2	Describe your plans for delivering comprehensive services that: → Increase access to affordable, accessible housing. → Expand access to community-based integrated employment. → Develop the LTSS direct service workforce. → Expand use of technology among LTSS providers.

Community Investment Plan Compliance

→ States can establish contract provisions to monitor MCEs' progress on proposed community investment plans. For example, Tennessee's RFP requirements and corresponding contract provisions include:

MLTSS RFP	MLTSS Contract
CONTRACTOR shall demonstrate a commitment to the local communities in which it operates through community investment activities and shall commit to the dollar amount proposed as the Bidder's Investment Commitment to the RFP. This dollar amount proposed as the Bidder's Investment Commitment to the RFP will serve as the annual minimum investment. The initial dollar amount associated with the RFP response, the Bidder's Investment Commitment or any annual investment above the annual minimum investment shall not deduct from other expenses such as administrative and medical costs.	The CONTRACTOR shall submit annually, a Community Investment Report of actual expenditures as set forth in this Contract and in accordance with TennCare requirements. The Community Investment report should be submitted no more than sixty (60) days after the conclusion of the calendar year.

Approach 2:

Expand Access to Non-medical Benefits

Addressing SDOH needs

States are increasingly asking MCEs what steps they will take to ensure social needs are addressed, not just identified through screening. A similar approach can be taken with HCBS/other non-medical benefits. This includes asking:

- How MCEs will ensure timely access to social services (e.g. 3)
- How MCEs will address housing insecurity during a nursing home transition (e.g. 4)
- How MCEs will incorporate social needs into their community investment plans (e.g. 5)

→ Example Language – Addressing SDOH Needs

State	Example	Text
Arizona	e.g. 3	Describe how the Offeror will use existing Medicaid compensable services as well as non-covered services and supports to address social risk factors impacting AHCCCS members. Include how the Offeror will capture data related to Social Determinants of Health to ensure members are connected and have timely access to needed social services.
Pennsylvania	e.g. 4	Describe how you will approach nursing home transition (NHT) service delivery, including but not limited to how you will approach NHT for populations with barriers to housing.
Tennessee	e.g. 5	The Respondent shall provide a plan that outlines their community investment approach. The community investment plan shall aim to address health outcomes through targeting members' unmet non-medical risk factors and reflect adequate, data-driven approaches. The plan shall contain, including but not limited to, the non-medical risk factors to be addressed, population(s) of focus, and an evaluation plan.

Use of Care Coordinators to Address Non-medical Needs

Care coordinators play essential roles in providing or linking members to non-medical services such as housing, food assistance, and other community resources

→ States can further strengthen care coordinators' involvement and impact by working with MCEs to ensure that care coordinators reflect the diverse cultural and linguistic needs and preferences of their members. Examples of such provisions may include:

- Care model requirements that the MCE invest in recruiting and retaining a diverse care coordinator workforce
- Cultural and linguistic competency training requirements for care coordinators

→ States can also explore requirements related to MCE care coordinators collaborating with community organizations who already support members' SDOH needs, like Area Agencies on Aging (AAAs)

More information on care coordinators' essential roles in addressing dually eligible individuals' SDOH needs::

- Addressing Social Determinants of Health in Demonstrations Under the Financial Alignment Initiative
- Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans

Supplemental Benefits to Address Non-medical Needs

- States can leverage SMACs to require D-SNPs to coordinate with the state in the development of their supplemental benefits including those supporting community living (e.g., transportation, meals, caregiver supports)
- States vary in how general or specific requirements are for D-SNPs developing supplemental benefit offerings
  - Arizona lists example benefits and requires that plans collaborate with the state on their supplemental benefit offerings *(e.g. 6)*
  - New Jersey lists the types of benefits that align with the state's Medicaid goals *(e.g. 7)*
  - Pennsylvania requires that benefits are designed to fill a gap the current Medicaid benefit package *(e.g. 8)*
- New Jersey requires that D-SNPs use supplemental benefits to advance specific state goals (e.g., improving care experiences for enrollees with cognitive impairment and their caregivers) *(e.g. 22)*

→ Example Language – Supplemental Benefits to Address Non-medical Needs

State	Example	Text
Arizona	e.g. 6	"The MAO shall collaborate with AHCCCS regarding discretionary health-related supplemental benefits to be offered through Special Supplemental Benefits for the Chronically Ill (SSCBI) . . . Such coordination shall include proposed prospective SSCBIs that have a reasonable expectation of improving or maintaining the health or overall function of such an AHCCCS Dual Eligible Member as tailored to the individual's needs, for those such who are enrolled with the MAO. AHCCCS seeks to improve Medicare-Medicaid program coordination of such SSCBIs so as to reduce service delivery fragmentation and promote improved health outcomes. Examples of such coordinated SSCBIs include, but are not limited to: home delivered foods/meals, home environmental modifications, transportation for non-medical needs, and other identified social determinant of health needs on a per identified and defined chronically ill Dual Eligible Member basis as documented in their care management/care treatment plan."
New Jersey	e.g. 7	"The Contractor shall develop a Cognitive Impairment Program, that with DMAHS prior approval may incorporate one or more targeted supplemental benefits and disease management programs under Medicare Advantage, or some combination thereof, designed to improve care for enrollees identified with cognitive impairments and incorporate such a program into its FIDE SNP Model of Care . . . The Contractor shall direct all available and appropriate benefits—traditional or supplemental—toward the relief of enrollee and caregiver disease and disease management burden. Likewise, the Contractor shall continuously identify opportunities to simplify and streamline the enrollee experience with the FIDE SNP."
Pennsylvania	e.g. 8	"The D-SNP will offer at least one Supplemental Medicare Benefit that is designed to fill a gap in Medicaid services for which full duals are eligible. These may include, but are not limited to, gaps in hearing or vision services. D-SNPs may not impose any cost sharing to the Supplemental Medicare Benefits offered."

Approach 3:

Grow the Direct Care Workforce and HCBS Provider Network

Network Adequacy and Development

- Managed care RFPs commonly ask MCEs to describe their methods of ensuring network adequacy across providers so that members can maintain access and choice
- In addition to network adequacy, some states inquire about network development efforts by the MCE, specifically for LTSS providers *(e.g. 9, e.g. 10)*
- Some states probe further on MCE network development strategies, including one state inquiring how MCEs will support the state in recruiting and retaining direct care workers *(e.g. 11)*

"…describe how the Responder ensures that Enrollees have a choice of providers, comparable access, high quality service expertise for special needs, and the option for an Enrollee in need of services to reside in or near their home community."

– Minnesota RFP

→ Example Language – Network Adequacy and Development

State	Example	Text
Tennessee	*e.g. 9*	The Respondent shall describe its proposed approach to Medicaid managed care network development, network management, and provider services for each TennCare program and population (including LTSS providers). The Respondent shall specifically identify strategies and programs the Respondent has implemented to support, strengthen and develop its provider network(s) in other Medicaid programs and how it would implement those strategies under this Contract to meet the needs of each population.
Texas	*e.g. 10*	Describe the Respondent's approach to developing a robust Network that ensures Covered Services, including LTSS, are available to enable Members to live in the least restrictive setting(s) possible.
Texas	*e.g. 11*	Describe financial and non-financial strategies the Respondent will implement to ensure the availability of Providers of in-home LTSS. Describe strategies the Respondent has used or will use to support the State's efforts to recruit and retain the direct care workforce.

Network Adequacy and Development

- States reiterate network adequacy requirements, inclusive of HCBS providers, in their MLTSS contract language. To regulate MCE access to HCBS providers, some states provide a minimum number of HCBS providers that MCEs must contract with *(e.g. 12)*, while others provide thresholds for percentages of members who must receive timely access to HCBS services *(e.g. 13)*
- Some states require MCEs to submit a Network Development Plan as part of the contracting process. States can include consideration of HCBS providers as a minimum required element of these Network Development Plans *(e.g. 14, e.g. 15)*
- States can also require that MCEs "oversee the development of its contracted provider workforce" as part of contractually obligated network management *(e.g. 16)*
- One state requires its contracted MCEs to ensure that MCE contracts with personal care agencies (PCA) clearly state overtime thresholds and requires MCEs to support enrollees in identifying additional PCA services are necessary *(e.g. 17)*
  - Given that retention and turnover are two critical issues plaguing the HCBS workforce, establishing MCE responsibility for identifying additional HCBS provider support if needed (versus relying on enrollees to do this themselves), is conducive to maintaining a HCBS workforce

→ Example Language – Network Adequacy and Development

State	Example	Text
New Jersey	e.g. 12	The Contractor shall have adequate HCBS provider capacity to meet the needs of each MLTSS Member receiving HCBS services. At a minimum, the Contractor shall contract with at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county. For HCBS provided in a Member's place of residence, the provider does not need to be located in the county of the Member's residence but must be willing and able to serve residents of that county.
Texas	*e.g. 13*	MCOs must ensure that a minimum of 90% of Members who are authorized to receive community attendant care services have timely access to such services...The STAR+PLUS MCO must have workforce development capacity and make concerted efforts to assist agencies contracted to provide community attendant care services in the agencies' role to improve recruitment and retention of provider agency community attendant staff.
New Jersey	e.g. 14	Minimum elements [of the Network Development Plan] include: → Summary of HCBS provider network, including community-based residential alternatives, by service and county. → Report of HCBS network deficiencies by service and by county and interventions and timetables to address the deficiencies. → Ongoing activities for HCBS provider development and expansion taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in Membership and long term needs.
Tennessee	e.g. 15	Minimum elements of the MCO's LTSS network development plan must include: → Ongoing activities for CHOICES or ECF CHOICES HCBS provider development and expansion taking into consideration identified provider capacity, network deficiencies, and service delivery issues and future needs relating to growth in membership and long-term needs.

→ Example Language – Network Adequacy and Development

State	Example	Text
Tennessee	e.g. 16	The Contractor shall, as part of its network management responsibilities, oversee the development of its contracted provider workforce, and shall take specific and measurable actions to help ensure a qualified competent and sufficient workforce to consistently deliver needed services in a timely manner.
Massachusetts	e.g. 17	The Contractor must include provisions in its contracts with its PCM Agencies requiring that the PCM Agencies instruct Enrollees regarding appropriate utilization of PCA overtime requiring authorization pursuant to 130 CMR 422.418(C), in accordance with 130 CMR 422.421(B)(1)(b)(5). For the avoidance of doubt, any Contractor contracting with a PCM Agency to provide PCM Services shall require such PCM Agency to agree to: … d. Educate Enrollees that do or may need to schedule PCAs for more than 50 hours per week regarding the scheduling requirements pursuant to 130 CMR 422.420(A)(5)(b) and 130 CMR 422.418(C) and the potential consequences pursuant to 130 CMR 422.420(B)(5); e. Assist Enrollees that do or may need to schedule PCAs to work more than 50 hours per week by working with those Enrollees to identify additional resources to enable such Enrollees to hire additional PCAs to meet the scheduling requirements;

State Partnership

- Two states, Minnesota and Tennessee, acknowledge in their managed care contracts that they expect contracted MCEs to serve as state partners in addressing HCBS capacity
  - Minnesota encourages the participation of MCE representatives on the State's LTSS Quality Improvement workgroup, which is charged in part with "improving capacity to support individuals at home" (e.g. 18)
  - Tennessee requires MCE partnership in helping the state address a variety of goals related to capacity, competency, and consistency of the direct support workforce (e.g. 19)

→ Example Language – State Partnership

State	Example	Text
Minnesota	e.g. 18	The MCO is encouraged to appoint representatives to participant in the following STATE workgroups: → LTSS Quality Improvement. The STATE is seeking improvement in the following goal areas related to LTSS: returning persons to home from nursing homes, improving capacity to support individuals at home, improving the quality of life of HCBS participants and increasing the use of self-directed care.
Tennessee	e.g. 19	The CONTRACTOR shall partner with [the State] to: Increase the capacity, competency and consistency of the direct support workforce, including a reduction in workforce turnover and ability to consistently demonstrate compliance in the timely initiation of services and the ongoing provision of services; Develop and engage statewide HCBS provider networks, including workforce capacity, to serve people with IDD and co-occurring behavior support needs.

Network Development and Training

- Through managed care contracts, states can require MCEs to submit relevant data on HCBS rebalancing efforts with the intention of posting measure performance publicly via a dashboard to establish MCO accountability and promote transparency in progress toward LTSS rebalancing goals
  - States could ask MCEs to submit data on direct care workforce training offered and the utilization of those trainings, including:
    - Number of trainings available to direct care workers
    - Number of times trainings have been viewed or completed
    - Number of direct care workers engaged in training material
- States can establish similar requirements for D-SNPs; states can call for provision of and reporting on what training resources D-SNPs are providing to AAAs to help support and empower AAA staff workers

Approach 4:

Strengthen Supports for Informal and Family Caregivers

Emotional Support for Informal Caregivers

- Providing emotional support to informal and family caregivers indirectly impacts HCBS capacity by reducing burnout and extending the amount of time an informal caregiver can care for their loved one, thereby reducing reliance on HCBS providers

- While managed care RFP questions related to strengthening informal caregiver supports were not identified in any of the reviewed RFPs, states can ask such questions. An example might be:
  - Provide examples from comparable markets of how the Respondent has supported informal and/or family caregivers through addressing of financial, respite, or social needs.

- States could also make informal and family caregiver supports a required element of MCEs' care models, including assessing and addressing caregivers' needs

Inclusion of Informal Caregivers in Care Planning and Education

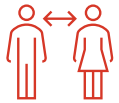
- Some states require inclusion of informal caregivers in care planning and providing education as necessary (e.g. 20, e.g. 21, e.g. 22)
- One state requires contractors to provide proactive health promotion and wellness information activities to not only enrollees but also family members and significant informal caregivers (e.g. 23)

→ Example Language – Inclusion of Informal Caregivers in Care Planning and Education

State	Example	Text
Minnesota	e.g. 20	Procedures for ensuring access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of Enrollees who are found to require a Nursing Facility Level of Care. These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources.
Minnesota	e.g. 21	The MCO must provide Case Management services that are designed to ensure access to, and coordinate the delivery of preventive, primary, acute, post-acute and rehabilitation services, (including discharge planning). The Case Management system must incorporate the following elements for all Community EW MSC+ Enrollees: . . . (12) The case management system must provide caregiver supports and facilitation of caregiver respite to assist Enrollees to remain at home.
New Jersey	e.g. 22	"The Contractor shall develop a Cognitive Impairment Program . . . designed to improve care for enrollees identified with cognitive impairments and incorporate such a program into its FIDE SNP Model of Care . . . The program shall include the following: iv. Develop an individualized written care plan that includes a plan for caregiver supports whenever an unpaid caregiver is involved; . . . vii. Ongoing educational programming for significant caregivers which emphasizes community. … The Contractor shall direct all available and appropriate benefits – traditional or supplemental – toward the relief of enrollee and caregiver disease and disease management burden…"
Massachusetts	e.g. 23	The Contractor must provide a range of health promotion and wellness informational activities for Enrollees, family members, and other significant informal caregivers. The focus and content of this information must be relevant to the specific health-status needs and high-risk behaviors in the senior population. Translation services must be available for Enrollees who are not proficient in English. Examples of topics for such informational activities, include, but are not limited to, the following: 1. Exercise; 2. Preventing falls; 3. Adjustment to illness-related changes in functional ability; 4. Adjustment to changes in life roles; 5. Smoking cessation; 6. Nutrition; 7. Prevention and treatment of alcohol and substance abuse; and 8. Coping with Alzheimer's disease or other forms of dementia.

Innovative Informal Caregiver Support Programs

→ States can encourage MCEs and D-SNPs to test innovative informal caregiver programs, like those currently implemented in Hawaii:[1]



Senior Companion Program

A program for low-income, volunteer seniors age 55+ to provide respite for caregivers of frail older adults through in-home companionship and limited personal care services

Respite Companion Program

An employment and training program for low-income seniors age 55+ who can work 19+ hours per week to serve frail homebound elders on Oahu

1 https://atiadvisory.com/wp-content/uploads/2021/05/HCBS-and-Emerging-Approaches_Research-Bibliography_April2021.xlsx

Cross-Approach Opportunities

Quality Withhold Measures

States can establish one or more quality withhold measures related to LTSS rebalancing tied to Medicaid dollars. MCEs, in their desire to meet the established measure threshold, could leverage any or all of the HCBS goals to do so. Possible measures for consideration include:[1]

- → LTSS Minimizing Institutional Length of Stay (MLTSS Quality Measure)[2]
- → LTSS Successful Transition after Long-Term Institutional Stay (MLTSS Quality Measure)[2]
- → Percentage of People Who Have Adequate Support for Everyday Activities (NCI-AD)[3]
- → Percentage of People Who Have Adequate Support for Self-care (NCI-AD)[3]
- → Percentage of People Whose Services Meet Their Needs and Goals (NCI-AD)[3]
- → In mature LTSS markets, states could consider implementing a more direct measure of HCBS network capacity, like "Home Health and Personal Care Aides in-network per 100 member population"[4]

[1] Understanding What Works: Measuring and Monitoring Quality in Medi-Cal's Home and Community-Based Services (chcf.org)
[2] Measures for Medicaid Managed Long Term Services and Supports Plans: Technical Specifications and Resource Manual
[3] NCI-AD_Indicators_w_NCI_and_PCP.pdf
[4] This measure inspired by a current measure utilized by the LTSS Scorecard

In Lieu of Services (ILOS)

States can leverage ILOS to afford MCEs greater flexibility to invest in non-medical services and supports promoting community living

- Two reviewed states (Minnesota and New Jersey) include ILOS language in their managed care contracts, with both states providing specific examples of authorized services and settings (e.g. 24, e.g. 25). MCEs can also voluntarily submit additional services for approval to the states
  - New Jersey authorizes, among other ILOS, home modifications (e.g., ventilation or accessibility) and assistance with finding or keeping housing (not inclusive of rent)
- States can provide guidance to MCEs to consider leveraging ILOS such as caregiver respite, home modifications, or in-home supports

→ Example Language – In Lieu of Services

State	Example	Text
Minnesota	e.g. 24	The services and settings that are authorized by the STATE to be provided by the MCO as in Lieu of Services under this Contract are: (1) Waiver Services that are approved by the MCO, for Enrollees who are not enrolled on a waiver. (2) Additional and Alternative Devices and Services. This includes non-State Plan devices and services meeting criteria for in lieu of services, and designed to ensure maintenance of health status, such as services or devices provided to meet Enrollee needs during periods of transition from one device to another or additional services or devices to provide higher quality of life; for example, a durable medical device that allows the Enrollee to better advocate for himself or herself, in place of interpreter services . . . The MCO may voluntarily provide or arrange to have provided services in addition to the services described in Article 6, as permitted by CMS under Title XIX, §1915 of the SSA, for Enrollees for whom, in the judgment of the MCO's Care Management staff, the provision of such services is Medically Necessary. The provision of any such services shall not be included in the calculation of capitation rates pursuant to Article 4. [42 CFR §438.3(e)(1)]
New Jersey	e.g. 25	1.The Contractor may cover the services or settings that are in lieu of the services or settings included in the New Jersey's Medicaid State Plan that the Contractor is responsible to provide as part of any benefit package provided by the Contractor under this contract. Over the counter medications; Smoking cessation assistance; Residential treatment in an Institution for Mental Disease (IMD) for a covered mental health service. Only treatment for a month in which the number of resident days does not exceed 15 days can be considered an ILOS; Treatment in a Long Term Acute Care facility (LTAC); Residential modifications (such as ventilation or accessibility); Assistance with finding or keeping housing (not to include rent) 2.These services and settings have been determined by the State to be medically appropriate and a cost effective substitute for the Medicaid State Plan or MLTSS covered service or setting. To the extent the Contractor would like to offer additional in lieu of services, it must submit a written request to the State for such service or setting to be included in the In Lieu of Services.

American Rescue Plan Act (ARPA) HCBS Spending Plan Goals

States can incorporate language in their D-SNP SMAC that supports goals established in the state's ARPA HCBS spending plan to encourage D-SNP support of state HCBS capacity building goals

→ CMS encouraged states to use HCBS spending plan funds to support similar goals to those enumerated in this tool, including[1]:

- Making long-term investments in HCBS infrastructure
- Strengthening the direct service workforce
- Addressing SDOH

For more information on how states can leverage D-SNP contracts to support HCBS spending goals, see ATI's resource, "HCBS Spending Plans and the Untapped Potential of D-SNPs"

1 Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817 Spending Plans and Narratives | Medicaid

The issues below are not addressed explicitly in the levers detailed in this tool. States should consider additional opportunities to make the role of a DCW more attractive to the potential workforce:

- **Paying for travel**. DCWs typically are paid for the time spent in a person's home but not for the time and distance required to get to the person's home. This results in costs for DCWs that are not reimbursed by a state or MCE (e.g., gas, transportation, the time associated with travel between client's homes), and creates a disincentive to serving Medicaid recipients.
- **Culture**. Access barriers include a lack of providers who understand cultural norms and preferences of diverse individuals with HCBS needs. In addition to a general increase in DCWs, it is important to ensure alignment in DCWs and the cultural needs/preferences of the individuals receiving HCBS.
- **Stigma**. There may be a stigma associated with caring for individuals with certain needs (e.g., serious mental illness), or concerns among DCWs about their ability to safely render care in a person's home or community. De-stigmatization training would help bolster access for individuals with particularly complex care needs.
- **Systems and Requirements**. DCWs face administrative burdens that may disincentivize them from serving Medicaid recipients. For example, states should make access and use of electronic visits verification (EVV) easy and free for DCWs.

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