DRIVERS OF SYSTEMS CHANGE AND PROVIDER READINESS FOR MICHIGAN'S HOME AND COMMUNITY-BASED SERVICES

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tbdSolutions

incompass MICHIGAN

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Executive Summary

Incompass Michigan engaged TBD Solutions Inc (TBDS) to explore the research on national trends and innovative practices in behavioral health-related services that may be used to prepare its members for systemic change and inform Incompass Michigan's technical assistance (TA) with its membership.

Project Objectives

- To support Incompass Michigan in capacity-building efforts to offer new types of TA to its membership, including around emerging reimbursement models.
- To identify national and state trends in the delivery of home and community-based services (HCBS) in emerging whole-person care models.
- To identify examples of data-driven approaches to service delivery.
- To identify practices related to services, quality, and payment models that have enabled providers to adapt and develop to meet the changing needs of behavioral health consumers.

Rationale for Engagement

In response to trends, including decreased public funding for services traditionally provided by its members, an increase in the number of beneficiaries served in home and community settings, a movement toward integrated managed care models, and potential payer restructuring, Incompass Michigan approached TBDS about completing a research project to understand better the return on investment (ROI) of services provided by its members as well as a landscape analysis to learn about practices outside of Michigan that demonstrated a strong ROI.

The scope of the project also includes an analysis of the trends in home and community-based services and the shifting provider and payer landscape to help inform Incompass Michigan's capacity-development strategy.

Focus

This report offers a broad survey of federal trends and examples of innovative state and provider HCBS practices. Those innovations have enabled consumers to make their own choices, to engage in activities that are personally meaningful to them, and to be an equal part of and participant in their community.

Introduction

As the demand for a diminishing pot of funding for behavioral health services increases, Incompass Michigan believes its members will benefit from being able to demonstrate the ROI of their services.

Strong quality outcomes not only benefit consumers but also justify public investment in those services. Understanding how other payers and providers have designed services to produce outcomes and expand services may also enable Incompass Michigan members to identify new partners and funding sources to expand services to new and/or underserved populations.

This report summarizes the drivers of payer initiatives and models across the county that align service design and financial incentives around the needs of the behavioral health consumer. It also identifies and summarizes innovative and effective practices in community-based services particularly related to service expansion, adaptation to new payment models, and quality outcomes.

Methodology

TBD Solutions used the following methodology:

1. 

   Conducted a literature review to identify how communities have developed or enhanced services in response to diverse stakeholder needs and emerging trends in managed care

2. 

   Reviewed state government publications and reporting on services within the scope of the report objectives

3. 

   Interviewed leaders engaged in innovative behavioral health projects across the country

DRIVERS OF CHANGE

Providers in Michigan who serve children and adults with behavioral health needs and/or developmental disabilities will continue to experience myriad shifts within the system.

National and Statewide Trends

Over the past decade, Medicaid financing models for behavioral health has increasingly shifted away from fee-for-service plans and carve-outs of specialty populations and instead have opted for integrated managed care financing of behavioral health services. The number of state Medicaid plans using primary carve-out models for behavioral health specialty populations have dropped significantly, from 15 states in 2011 to 8 states in 2022. Most states (33 of 51) have moved to having health care plans manage both behavioral health and physical health benefits. Michigan is no exception in considering these integrated care models. Former Michigan Governor Snyder introduced Section 298 as part of his FY2016-17 recommended budget. The Section 298 initiative would have required funding and administrative services currently provided through public prepaid inpatient health plans (PIHPs) be done by commercial Medicaid HMOs by the end of that year. This initiative was reignited in 2021 by then State Senate Majority Leader Mike Shirkey who, with co-sponsor Sen. John Bizon, M.D., introduced Senate Bills 597 and 598. Those bills proposed physical and behavioral health integration by replacing PIHPs with specialty integrated plans (SIPs) by 2026. Representative Mary Whitehead and others offered a competing proposal to Sen. Shirkey's, which would have replaced PIHPs but with an administrative services organization (ASO) model.

Concerns about the costs and quality of the "carve-out" system, particularly the perceived inefficiencies of the PIHP administrative level and lack of coordinated care at the points of service, were the reported primary drivers of those payor reform efforts. Challenges to the state's "carve-out" payor structure are likely to continue. While these political efforts to fundamentally change the state's payor structure stalled, a confluence of other external factors will continue to drive change at both the payor and provider levels.

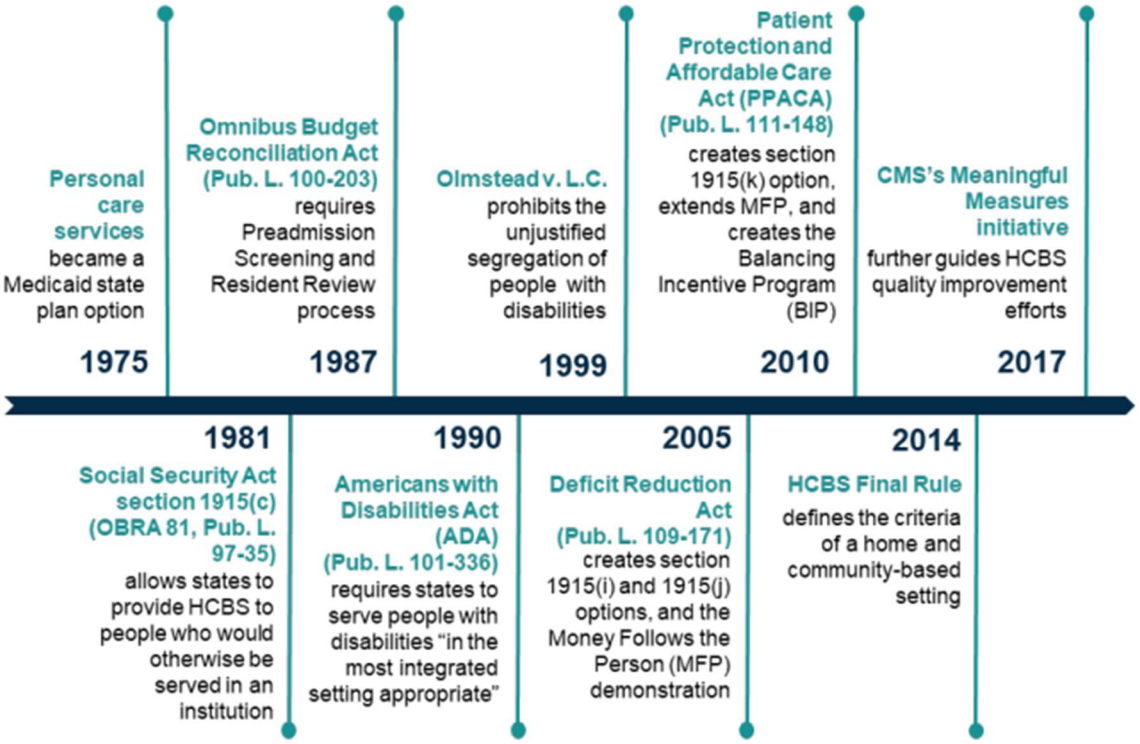
Regulatory Priorities for Home and Community-based Services

According to the Congressional Research Service (CRS), Medicaid-funded long-term services and supports (LTSS) recipients represent about one-twentieth (5.3%) of all Medicaid recipients and account for nearly one-third (32.1%) of the total Medicaid personal health care spending.[1]

Analysis from the Kaiser Family Foundation shows that of the 142,500 Medicaid enrollees in Michigan who used an LTSS in 2021, 75% used only a HCBS, while 2% used both HCBS and institutional LTSS. In comparison, several states with similar population profiles have higher HCBS-only rates, including Georgia (78%), North Carolina (94%), Virginia (81%), and Washington (91%).

"Over the past 40 years, a number of legislative and policy changes have worked to significantly increase the use and quality of HCBS." (See Figure 1)[2]

Figure 1.



[1] *Who Pays for Long-Term Services and Supports?* (September 19, 2023). https://crsreports.congress.gov/product/pdf/IF/IF10343

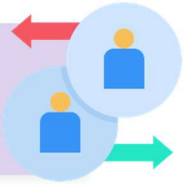
[2] Chidambaram, P., & 2022. (2022, September 15). *10 Things About Long-Term Services and Supports (LTSS)*. KFF. https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/

The Centers for Medicare & Medicaid Services (CMS) has prioritized rebalancing, that is, the expansion of services provided in home and community-based settings rather than institutions. CMS has published a toolkit to support states' efforts to expand and enhance home and community-based services (HCBS).[3] While CMS has given states broad discretion and flexibility in how they implement these services (i.e., often through demonstrations), the toolkit outlines hallmarks of an effective HCBS ecosystem:

PERSON-CENTERED PLANNING AND SERVICES

NO WRONG DOOR SYSTEMS

COMMUNITY TRANSITION SUPPORT



DIRECT SERVICE WORKFORCE AND CAREGIVERS

HOUSING TO SUPPORT COMMUNITY-BASED LIVING OPTIONS

EMPLOYMENT SUPPORT

CONVENIENT AND ACCESSIBLE TRANSPORTATION OPTIONS

[3] *Long-Term Services and Supports Rebalancing Toolkit*. (2020). https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

Levers of Healthcare Improvement: From a Triple to Quintuple Aim

The Institute for Healthcare Improvement (IHI) introduced the Triple Aim in 2007. The Triple Aim sought to identify the distinct but interdependent factors for healthcare improvement.

Experience of Care: Factors relating to satisfaction/dissatisfaction with services largely relate to the six factors identified by the Institute of Medicine (IOM), that is, safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

Population Health: The IHI recognized the growing research that whole-person health is largely determined outside of the healthcare service. Genetics, environment, lifestyle, and social factors play significant roles in the overall health of a population. Emphasis is placed on public health and prevention.

Cost and Value: As healthcare costs continue to rise, payors and healthcare consumers alike are incentivized to identify and avoid not only inefficiencies (i.e., unnecessary procedures and processes) but also value (i.e., outcomes relative to cost).

The Triple Aim has recently been expanded to **The Quintuple Aim** in recognition of the critical importance of both **workforce satisfaction** and **health equity** for healthcare improvement. Workforce satisfaction encompasses clear roles and responsibilities, supportive and collaborative team environments, professional development and career pathways, as well as burnout prevention and self-care. Health equity, the most recent addition to this framework, underscores differences in how healthcare has been accessed and delivered across different population groups.

These five aims have been and will continue to be leveraged by states in their efforts to expand and enhance HCBS implementation.

Workforce Satisfaction

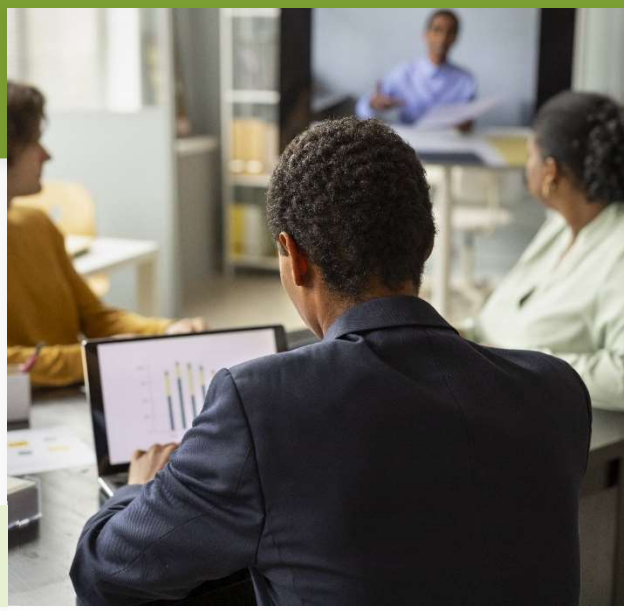
Behavioral health systems across the country have noted workforce-related capacity issues. States have begun directly addressing workforce constraints for HCBS programs. A recent Kaiser Family Foundation Survey showed that all responding states reported having adopted measures to address workforce shortages. The most common strategies have included the following interventions:

- increased payment rates to HCBS providers (48 states),
- developing or expanding education and training programs for behavioral health professionals (42 states),
- incentive payments to recruit or retain workers (41 states),
- raising the state minimum wage (20 states), and
- offering paid sick leave for workers (19 states).

"States also reported several other types of initiatives to strengthen the workforce, including creating platforms or support systems to connect job seekers with employers and positions, launching a social media campaign, and providing outreach to prospective employees.[4]

As part of its LTSS system transformation effort, TennCare, Tennessee's Medicaid program, in partnership the State of Tennessee Board of Regents, BlueCross Blue Shield (BCBS) of Tennessee, American Job Centers and others, has implemented several workforce initiatives that aim to address common workforce constraints.

- National Alliance for Direct Support Professionals (NADSP) E-Badge Academy (with bonuses for both the organizations and DSPs that pass competency-based coursework)*
- Paid Caregiver Career Pathways
- DSP Apprenticeship through higher education partnerships



Research suggests that ongoing professional development is the quality indicator with the highest correlation to reduced cost for LTSS services. Professional development included strong orientation to the organization and role, provided competency-based training (around the specific needs of the person(s) served), and on-the-job support.[5]

**An evaluation of TennCare's E-Badge program showed a statistically significant improvement in Job Satisfaction and Career Commitment as a result of this initiative.*

Chidambaram, P., & 2022. (2022, September 15). *10 Things About Long-Term Services and Supports (LTSS)*. KFF. https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/).

[5] Friedman, C., & Rizzolo, M. C. (2021). Value-Based Payments: Intellectual and Developmental Disabilities Quality Indicators Associated with Billing Expenditures. *Intellectual and Developmental Disabilities*, *59*(4), 295-314

Population Health and Health Equity

People living with a behavioral health condition or intellectual/developmental disability are more likely to experience social determinants of health (SDoH) and have Health-related Social Needs (HRSN) than other population groups.[6] People with disabilities experience higher rates of unemployment and underemployment, dependency on family and professional supports, unique challenges accessing safe and accessible housing, specialized education and employment accommodations, social isolation, mobility and transportation barriers, and shorter life spans.

ECU MOBILITY PROGRAM

Anne E. Dickerson, Professor of Occupational Therapy at Eastern Carolina University, developed a Driving and Community Bootcamp for Teens and Adults with Autism Spectrum Disorder. The 5-day training program uses driving simulation, visual recognition through the Drive Focus app, and didactic hands-on learning, including role-playing traffic stops with law enforcement. This program prepares young adults with ASD for driver training programs and, ultimately, mobility independence.

People with disabilities are often served in multiple systems, which can result in uncoordinated care and poor outcomes. Some states have begun targeted coordination across different administrative departments. The State of Washington, for example, has incentivized counties to ensure coordination between its Developmental Disabilities Administration, Department of Education, and the Division of Vocational Rehabilitation for students with significant support needs who are exiting school.[7]

[6] Friedman, Carli. (2024). Disparities in Social Determinants of Health Amongst People with Disabilities. International Journal of Disability Development and Education. 71.

[7] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/iap-hcbs-ltss-factsheet.pdf

Experience of Care

Based on the current measure set for HCBS, CMS is prioritizing experience of care in ways that extend the standard IOM categories of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The measures are primarily taken from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Functional Assessment Standardized Items (FASI), the National Core Indicators (NCI), and Personal Outcome Measure (POM).[8] Autonomy, choice, and community integration are the salient themes in this measure set, reflecting the prioritized experiences of care for individuals with disabilities in HCBS. These themes also point to unique principles for outcomes measurement for this population.

It will be imperative for states and their provider networks not only to collect this information as part of their ongoing assessment and planning efforts but also to use this data to understand how it relates to SDoH/HRSN outcomes. The Virginia Costs and Outcomes project is an example of an innovative use of available but disparate data sources to understand outcomes at the person and systems levels. The project mapped Medicaid expenditures for HCBS services using claims and encounter data, the SIS-A, and the NCI-IPS to identify patterns. One of the findings was that the strongest predictors of employment included having employment as a goal in a service plan and the ability of the individual to make meaningful daily choices. The project plans to use Medicaid Managed Care acute encounter data to better understand the relationship between these factors.[9]

[8] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents//cib041124.pdf

[9] Bogenschutz, M., Dinora, P., Lineberry, S., Prohn, S., Broda, M., & West, A. (2022). Promising Practices in the Frontiers of Quality Outcome Measurement for Intellectual and Developmental Disability Services. *Frontiers in Rehabilitation Sciences, 3)*. https://doi.org/10.3389/fresc.2022.871178.

Cost and Value of Care

The Health Care Payment Learning and Action Network (HCPLAN) developed its Alternative Payment Model (APM) Framework in 2017 based on CMS' payment model classification system. The Framework is frequently used to understand value-based payment reform efforts. (See Figure 2)

Figure 2.

Value-based payment metrics in healthcare commonly focus on follow-up after hospitalization, hospital readmission rates, emergency department, and access to care measures. These metrics are related to episodic access to (acute) care and can be most directly associated with reducing healthcare expenditures. LTSS, on the other hand, is by definition long-term in focus rather than episodic. "LTSS go beyond health and wellness, and cover quality of life and social determinants of health more broadly, often including not only traditional acute care but also wrap-around services, such as personal care, residential supports, employment supports and many more services."[10]

The focus of services for behavioral health and I/DD populations is distinct even within LTSS, as the goal is developing personal skills that improve opportunities for community integration rather than simply delaying higher-cost services. Research suggests that people in supported employment are not only more likely to be better integrated in their communities, but that people with IDD who have meaningful work and activity choices show fewer emergency department visits, injuries, and behavioral challenges. Rather than simply focus on driving down costs, research has shown that LTSS providers that score high on measures of consumer dignity and respect as well as autonomy and independence have lower associated billing, which along with positive outcomes, is desirable within a value-based environment.[11]

[10] Friedman, C., & Rizzolo, M. C. (2021). Value-Based Payments: Intellectual and Developmental Disabilities Quality Indicators Associated With Billing Expenditures. *Intellectual and Developmental Disabilities*, *59*(4), 295-314

[11] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/iap-hcbs-ltss-factsheet.pdf

Provider Readiness

Incompass Michigan and its membership can take strategic steps to prepare for and even influence potential changes to the payor structure, payment models, investment in workforce development, and quality initiatives through research-based advocacy, coordinated quality improvement, human resource innovation, and service innovation and expansion. The adaptive flexibility required for readiness for unknown systems change will require a cooperative rather than a competitive approach. A single organization is less likely to identify and assess larger trends, advocate for change, trial new strategies, and identify effective quality benchmarks. Collaboration within the association structure not only provides economies of scale, it also allows innovations to be tested in different markets and collective lessons learned.

Research-Based Advocacy

A proactive approach to systems changes involves research-based advocacy. Learning lessons from other states' attempts at payor restructuring and approaches to value-based purchasing will enable the association to identify trends that represent risks as well as those that may present opportunities.

Many states have adopted an incremental approach to introducing commercial MCOs to manage HCBS. Kansas and Iowa were the first states to contract with large national commercial MCOs with statewide mandatory enrollment for HCBS.[12] Iowa shifted the management of its Medicaid program to three managed care organizations (MCOs) on April 1, 2016 with the creation of IA Health Link. Home and Community-Based Services (HCBS) were included in IA Health Link. The goal of privatization was to reduce the growing costs of the state's $4 billion Medicaid program. Disability Rights Iowa filed a lawsuit in 2017, alleging systemic service cuts affecting disabled service recipients.

Kansas launched KanCare in 2013, contracting with three MCOs, Amerigroup, Sunflower State Health Plan, and UnitedHealthcare. KanCare promised to save its Medicaid program $1 billion over 5 years, from 2013-2017. As noted in a 2013 issue brief by the Kansas Health Institute, "the largest savings will be in care for the elderly and people with disabilities."[13] As in Iowa, the wholesale conversion of LTSS to commercial MCOs in Kansas has also been plagued by costly missteps.

Researchers have noted that the MCO arrangements in both Iowa and Kansas have been marred by case management challenges, service cuts, wait lists, and denials. They identified limited consumer engagement throughout the process, insufficient oversight and protections, and misaligned goals as contributing factors in poor outcomes related to the transition of Medicaid programs to MCOs. In contrast, Tennessee has implemented an incremental approach to commercial MCOs. It has allowed existing service recipients to remain in the HCBS waiver program, while new enrollees to supported employment work with one of 3 MCOs.[14] Incompass Michigan is well-

[12] *Lewis, S., Patterson, R., & Alter, M. (2018). Current Landscape: Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities PREPARED FOR AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES (ANCOR). https://www.ancor.org/wp-content/uploads/2022/09/Current-Landscape-Managed-Long-Term-Services-and-Supports-for-People-with-IDD.pdf*

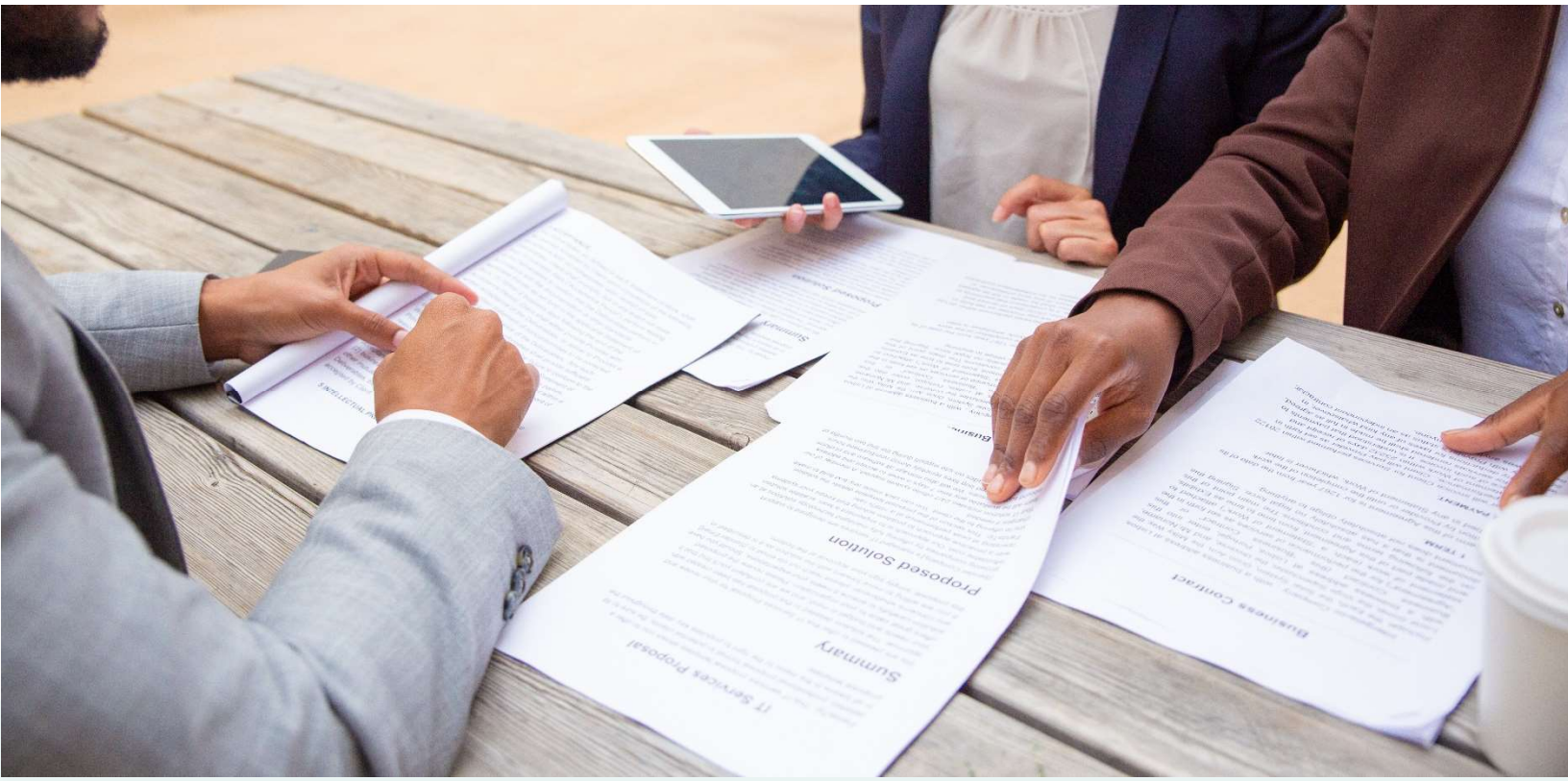
[13] https://www.khi.org/wp-content/uploads/2013/08/KanCare_Managed_Care_Contracts.pdf

[14] https://www.thevbpblog.com/looking-at-states-managed-care-programs-iowa-and-tennessee/

positioned to track and use case examples like these from other states to advocate for structures that will effectively serve the populations and communities represented by its membership.

Regardless of the payor structure, Incompass Michigan and its membership can anticipate more push for value-based purchasing models in behavioral health services. Research on payment models and outcomes will be useful to the association as it considers how value-based models will impact healthcare consumers and their families. Recent analysis has shown, for example, that "the primary motivating factor behind managed care and VBP should be improving quality and outcomes; our findings suggest, cost savings will likely follow"[15]

VBP arrangements for LTSS have typically focused on chronic care outcomes in nursing home settings, acute care utilization including readmissions, and supported employment. As costs continue to rise, states are expected to scrutinize outcomes as a marker of value for LTSS and HCBS, which often represent high-cost services to people with high support needs.



[15] Friedman, C., & Rizzolo, M. C. (2021). Value-Based Payments: Intellectual and Developmental Disabilities Quality Indicators Associated With Billing Expenditures. *Intellectual and Developmental Disabilities*, *59*(4), 295-314

Quality Improvement

A statement from the Medicaid Innovation Accelerator Program captures the tension of value-based payment initiatives and the HCBS population:

"Heretofore, much of the VBP experience has been in clinical arenas in which a positive outcome may be uniformly defined and accepted. Because of the nature of HCBS, the definition of a positive outcome may vary by individual depending on what is important to the person as well as for the person. This requires a clear-cut articulation of (1) desired areas of impact, (2) available objective data to assess the current "as is" state, (3) metrics for success, and (4) all individuals and entities who may have a hand in affecting the outcomes.

This increased complexity requires strong collaboration across systems and a structured approach to ongoing and regular communication to ensure appropriate identification of goals and objectives as well as to infuse a continuous quality approach to review and revise strategies as needed."[16]

Incompass Michigan and its membership have the opportunity to develop a set of service outcomes that define success before external definitions are offered. One route the association could explore is the set of HCBS measures developed by The University of Minnesota's Institute on Community Integration, Rehabilitation Research and Training Center of HCBS Outcome Measurement (RTC/OM). RTC/OM has developed a series of measures based on the eight domains used by the National Quality Forum's (NQF) Framework for HCBS: 1) Choice and Control, 2) Freedom From Abuse and Neglect, 3) Person-Centered Planning and Coordination, 4) Transportation Measures, 5) Consumer Leadership in System Development, 6) Employment, 7) Meaningful Community-based Activity and 8) Social Connectedness. Each measure package has been developed and validated.[17]

[16] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/iap-hcbs-ltss-factsheet.pdf

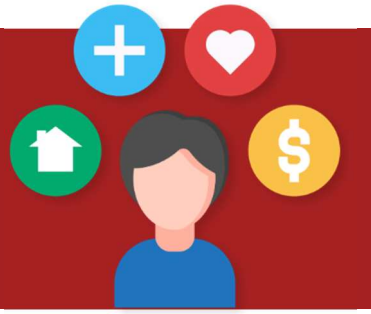
[17] https://rtcom.umn.edu/rtcom-measures

Human Resource Innovation

The nationwide direct support professional (DSP) workforce shortage is related to systemic funding issues with LTSS. The Arc's position statement on LTSS reflects both the reliance on DSPs to provide these critical services and the underinvestment in supporting sufficient wages, benefits, standard credentialing, and competency standards.[18]

While advocacy for increased funding for DSP wages and benefits remains a primary priority, providers do not have the luxury of waiting for change. Human resource innovation is needed to support the current workforce within the current reimbursement context. Low wages for the current DSP workforce has created a range of social needs for these professionals. Organizations that help their workforce identify and navigate solutions to these needs will be better positioned to retain employees. Beyond wages and social needs, DSPs roles are emotionally demanding, which can lead to burnout. There are a wide range of proactive steps employers can take to mitigate workplace stress and prevent burnout. Employees often value the same sense of autonomy, choice, and predictability that organizations ask DSPs to provide in the people with whom they work.

The Source in Grand Rapids, Michigan is an example of this type of HR innovation. The Source started with a small group of manufacturers who recognized employee issues were often related to social needs rather than a lack of work ethic. The then small collective organized resources to help employees with childcare, transportation, and other social needs (https://www.grsource.org/).



[18] The Arc. (n.d.). *Long Term Supports & Services Position Statement*. The Arc. https://thearc.org/position-statements/long-term-supports-services/).

Service Innovation and Expansion

HCBS spending: "In 2023, 29.4% of Medicaid LTSS spending in Michigan went towards home and community-based services (HCBS), compared to the national average of 53.3%..."[19] That discrepancy may point to opportunities for Michigan HCBS providers to be part of solutions that enable more people with behavioral health and/or developmental disabilities to be served in the community, especially as the population ages. Traditional models of care may need to be adapted to fit the needs of new or changing population groups.

The Value Proposition Canvas, developed by Strategyzer Group and published in, "Value Proposition Design," is often used by organizations to ascertain fit between their products or services and their target consumer segment. Organizations that use this approach can see where additional iteration may be needed, especially for a new market segment.

Thresholds, a community mental health provider in Chicago, Illinois, saw a need for a service that would enable transition age youth with mental health conditions to prepare for competitive employment. Thresholds developed and later manualized and adaptation of the evidence-based practice Individual Placement and Support (IPS) model, which they called The Carrer and Occupational Readiness Experience (CORE), a 15-week cohort-based approach that included an internship, soft skills training, and peer support.

Several states have incorporated the **Shared Living model** (also known as "Life Sharing" and "Host Home") into their LTSS benefit. While the service models and reimbursement structures vary across states, Shared Living uses Medicaid funding to enable adults with an I/DD disability to live in the community with an individual or family. In some states, Medicaid covers costs associated with rental assistance but not services (Virginia); and in other states Medicaid reimburses for authorized services provided by the host (Minnesota). The Virginia Costs and Outcomes project has shown preliminary evidence that socialization and community integration outcomes are stronger in Shared Living arrangements compared to residential settings (including 4-bed homes).

Pennsylvania expanded the **Community Autism Peer Specialist (CAPS) program** in 2021, a unique program developed 5 years earlier in Philadelphia through a multi-agency collaboration. CAPS is currently being studied by researchers from the A.J. Drexel Autism Institute for outcomes related to social connectedness, self-efficacy, and communication using a variety of measures.

Young adults with neurodevelopmental and acquired cognitive disabilities (NCD) can experience a "service cliff" when transitioning out of public school systems. The **Cognitive Skills Enhancement Program (CSEP)**, a clinical rehabilitation transition program designed for young adults with NCD, promotes work readiness and employment. The program is funded by a community-academic partnership between a university and the state vocational rehabilitation (VR) program.

[19] *Medicaid in Michigan*. (n.d.). Retrieved November 24, 2024, from https://chrt.org/wp-content/uploads/2024/09/MichiganMedicaidLegislativePrimer_Final.pdf

Conclusion and Recommendations

As cost containment efforts continue to drive policy related to healthcare generally and LTSS specifically, it is imperative for providers to understand their cost of care. Understanding the precise cost of care will enable providers to not only manage processes related to care but also negotiate rates that cover actual costs. It is equally as important for providers to show value for these high-cost services. Value may include lower episodic costs, but it must include improved quality of life for the person receiving services.

1. Research-based Advocacy

As healthcare systems adapt to meet the growing needs of consumers eligible for HCBS with funding that is unlikely to keep pace, advocacy will be needed to help to establish boundaries around services for people with a mental health condition or intellectual/developmental disability. Advocacy will be most effective when it can point to peer-reviewed studies as well as practice-based research. LTSS services that reflect best practices will be less vulnerable to external pressures to change.

Incompass Michigan can play a role in identifying unique payer programs, trends, and outcomes in other states. It can facilitate proactive conversations with policy-makers as well as other advocacy and interest groups in the state about examples of effective Medicaid programs—as well as those that have had outcomes that adversely impacted consumers.

2. Human Resource Innovation

HCBS providers are not in a position to compete for its workforce based on compensation. Inadequate pay can in fact be a driver of dissatisfaction and result in high turnover rates. As providers continue to advocate for funding to ensure competitive compensation for direct support professionals (DSP), innovative approaches to human resource management will be needed to address the effects of low relative wages. DSPs are often asked to provide care at work and at home (and may have to work additional jobs). Ensuring their workload is manageable, the work environment is safe and supportive, they are recognized for their specific contributions (rather than general affirmation), and the impact of their work (e.g., consumer outcomes) is reinforced will help to mitigate burnout. Employee Assistance Plans (EAPs) can be helpful but are by themselves inadequate to support DSPs. Intentional, supportive, and assertive management structures are be needed cultivate the best possible work environment.

Given the low relative wages, especially in an inflationary environment, DSPs often experience social care needs similar to those they provide care to. Human resources may need to adopt a proactive case management function in this environment to identify and facilitate connection to resources that directly address the social care needs experienced by the people providing care. This is not our grandparents' human resources. It is compassionate and imaginative in the ways it adapts to meet the needs of its workforce. Similar to services that seek stakeholder input,

providers that can enable meaningful engagement, autonomy, and choice in its workforce will be more likely to see positive outcomes. This is not a simple undertaking with a well-worn road map.

Incompass Michigan or a designated member could facilitate a regular human resources forum to discuss novel approaches, lessons learned, and strategies for implementing new HR-related laws (e.g., Michigan's Earned Sick Time Act).

3. Coordinated Quality Improvement

Human service organizations often report data showing *that* a service happened. Structural and process outcomes rely on data that are usually more accessible. As a result, many quality programs focus on outcomes that describe the number of referrals made, time to service, and the number of people served. Structural and process measures do not describe the impact a given service has had in the life of the service recipient. There is a need at the provider level to understand person-level outcomes.

HCBS providers occupy a unique position in the healthcare landscape. As discussed above, episodic outcomes such as emergency department visits or hospital (re)admissions may be less relevant to LTSS services given the nature of long-term needs. In order to demonstrate value, providers will need the capacity to collect and analyze relevant data. EHR systems that are customizable may enable data collection on a broad set of measures.

The literature shows a diverse range of scales used to measure aspects of care at the provider-level. A research project associated with an autism peer specialist program (CAPS) is using 14 different scales to measure impact[20]. The University of Minnesota's Institute on Community Integration's (ICI) Rehabilitation Research and Training Center of HCBS Outcome Measurement (RTC/OM) will be releasing updated versions of its measure sets. The RTC/OM measures have the advantage of being validated for HBCS services. The updated versions of these measures are expected to be published Summer 2025. ICI will be offering training and technical assistance for providers or groups of providers interested in using these measures.

Given the high rates of social care needs among the LTSS/HCBS populations, it may also make sense for providers to measure social care needs. The PRAPARE screening tool[21] is free to use and has been implemented by federally

[20] General Self-Efficacy Scale (GSES), Internalized Stigma of Mental Illness (ISMI-10), COPE, Questionnaire on Disability Identity and Opportunity (ODIO), Patient-Reported Outcomes Measurement Information System (PROMIS), Camberwell Assessment of Need, The Social Responsiveness Scale 2nd edition (SRS-2), Behavior Rating Inventory of Executive Function-Adult Version (BRIEF-A), The University of California Los Angeles Loneliness Scale Version 3, The PROMIS Meaning and Purpose, The Connor-Davidson Resilience Scale-10 (CD-RISC), The Adult Hope Scale, The Temple University Community Participation Measure (TUCP), and the WHOQOL-BREF.

[21] *The PRAPARE Screening Tool*. (n.d.). PRAPARE. https://prapare.org/the-prapare-screening-tool/

qualified health centers (FQHCs) and community health workers (CHWs) in Michigan. The Accountable Health Communities (AHC) Health-Related Social Needs from CMS[22] is also well-researched and widely adopted.

Incompass Michigan or a designated member could facilitate a regular quality forum to identify standard metrics and benchmarks for services commonly delivered by the membership, discuss implementation strategies and lessons learned, and develop reporting strategies. Incompass Michigan could serve as the clearinghouse for outcomes data for analysis and consolidated reporting, which could in turn inform its advocacy efforts.

4. Service Innovation and Expansion

As noted above, the Value Proposition Canvas[23] is a tool that can help organizations understand unmet needs of their (potential) consumers. The process of evaluating the extent that current program design aligns (or not) with the needs of the people the organization wants to serve can spark service innovations and improvements. It can also help to inform process and outcome measures that connect to the real needs and concerns of the population(s) the organization is serving.

As more services are provided in home and community settings, there are opportunities for providers to identify new services or new populations for existing services they could offer. Payers throughout the country have experienced "logjams" in connecting people to HCBS. Understanding local and regional logjams—especially high-cost logjams such as hospital (re)admissions—can also be a key to effective service development.

[22] Centers for Medicare and Medicaid Services. (2017). *The Accountable Health Communities Health-Related Social Needs Screening Tool What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool? What's in the AHC HRSN Screening Tool?* https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

[23] Osterwalder, A., Pigneur, Y., Bernarda, G., & Smith, A. (2014). *Value Proposition Design*. Wiley, November.