

Alaska Complex Behavior Collaborative

Investment in Alaska's workforce and services for individuals with cognitive disabilities and complex behavioral needs

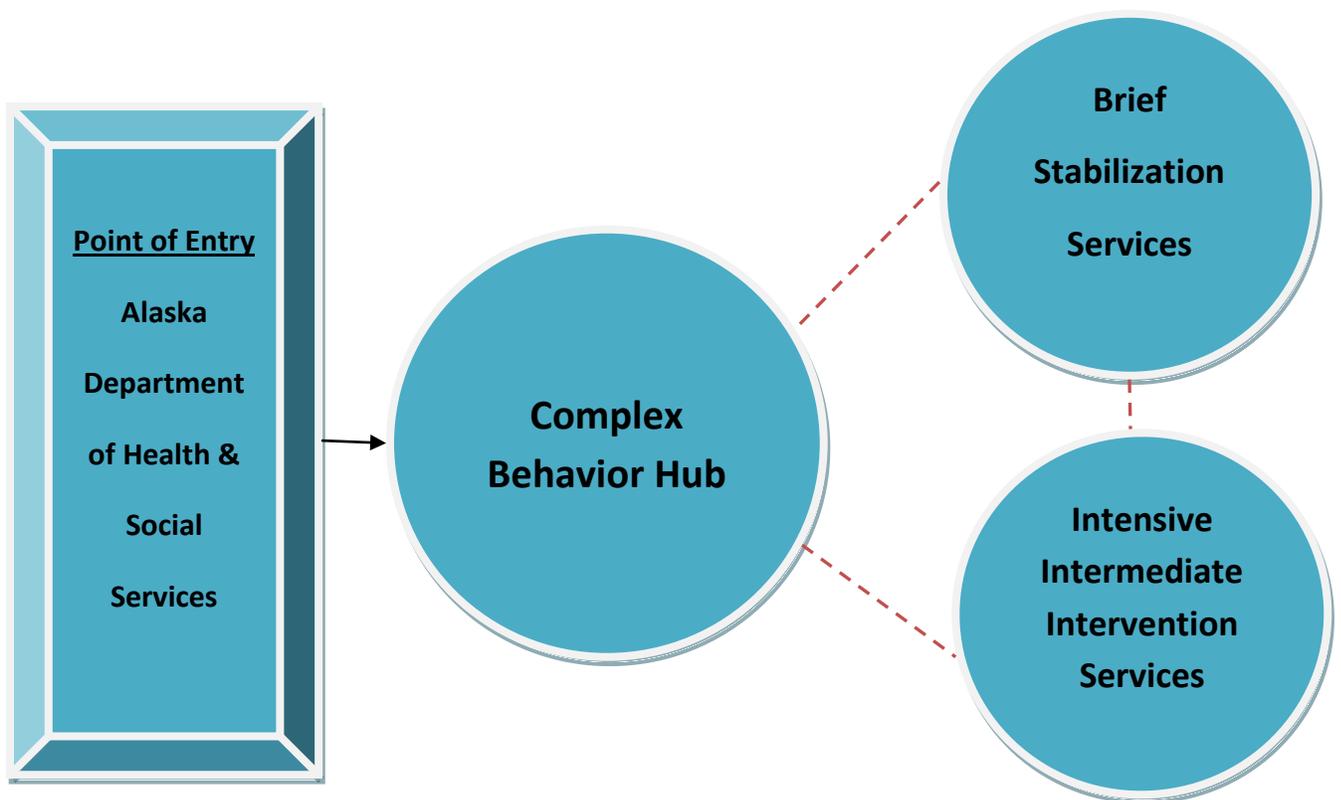


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Executive Summary

In partnership with the State of Alaska - Department of Health and Social Services (DHSS) and the Alaska Mental Health Trust Authority (Trust), the Western Interstate Commission for Higher Education (WICHE) led the second phase of a project intended to improve the system of care for a sub-population of vulnerable Alaskan beneficiaries. The initial work of Phase I completed by WICHE in July 2009 was reported in the Issue Analysis and Options Brief - Alaskans at-risk of out-of-home placement due to complex behavior management needs. After reviewing the initial report it was determined by the key stakeholders Workgroup within the DHSS that a Phase II to this project was necessary. Through partnership between the DHSS and the Trust, a Phase II contract was developed with WICHE to perform further analysis and specific systems recommendations for improving the current system of care for those individuals who are difficult to treat in community based programs due to complex behaviors and are thus at risk for out-of-State placement.

At the request of the Workgroup, WICHE agreed to the following for Phase II:

- Identify service options for the population to be served;
- Assess the Medicaid reimbursement rate structure; and
- Outline three (3) models for Alaska to consider, which will address serving individuals with complex behavior management needs.

Phase II occurred from March through September of 2010, with input and guidance from Alaska's Complex Behaviors Workgroup and has resulted in the development of a comprehensive recommendation for the effective care of Alaskan beneficiaries, specifically targeting individuals with cognitive disabilities and challenging behaviors who often present safety issues for themselves and, or others and therefore are at risk for institutional or out-of-State placement. It was recognized that beneficiaries other than those with cognitive disabilities may also have complex behaviors and could benefit from additional services; however, the Workgroup identified the target population for Phase II with the understanding that other population groups may benefit over time from the services that are developed and from the resultant enhanced workforce capacity.

Alaska's current system of care does not include the appropriate continuum and array of services for individuals with cognitive disabilities and complex behaviors. Because of this, many of these individuals are served by the Alaska Psychiatric Institute (API), where they languish in an unnecessarily restrictive environment for extended periods of time, or they are inappropriately held in places such as jails and emergency rooms. Many are ultimately sent out-of-State for care, where in many cases they remain indefinitely. Risk for out-of-State placement typically occurs when the individual exhibits behaviors that are so complex that they are

outside the range of expertise of local caregivers and providers, or the available treatment options in State have been exhausted without resultant success for the individual. The result of the lack of appropriate services in Alaska is significant financial cost to the State and personal cost to the individuals and their families.

This document identifies service options for the identified population, as well as the costs and benefits of implementing the recommended services. Additionally, it addresses the long-term fiscal incentives to the State relative to cost effectiveness and savings for DHSS. While the cost savings for DHSS and the State may not be immediate or substantial, the long-term benefits are significant. Investing in services and the workforce within Alaska through the proposed Complex Behavior Collaborative will have far-reaching benefits beyond individuals with cognitive disabilities. Developing a more competent workforce and the necessary infrastructure to support collaborative interventions and continuity of care is an important and overdue investment for vulnerable Alaskans, their families and their communities.

A risk assessment if the State is to take no action on this issue was performed. A few of the key risks identified include:

- ✓ Potential exists for Americans with Disabilities Act (ADA) violations; specifically regarding *Olmstead versus LC*. The Department of Justice expects states to demonstrate progress on their waiting lists to move individuals with disabilities to less restrictive, integrated community-based settings, to have a clearly defined method to manage movement on the waiting lists, and to demonstrate their methodology regarding how their lists are developed and tracked. It appears that while limitations in state budgets may affect states rate and scope of compliance with the ADA's integration mandate, budget limitations do not relieve the states of their obligation to take effective steps to end inappropriate institutionalization. Such lawsuits are quite costly to states due to imposed court mandates and while such lawsuits may result in the development of needed services, they are not the most effective or cost efficient way to develop them.
- ✓ Continued un-budgeted, non-Medicaid general fund expenses related to things such as the need to provide additional staff to manage and contain some individuals, cover out-of-State travel and related expenses.
- ✓ Continued escalating costs associated with providing an inadequate continuum of care, which currently adds additional expenses by bringing in extra staff to 'manage and contain' complex behaviors, instead of investing up-front in the workforce and programs to provide appropriate interventions and services.

An assessment of Alaska's Medicaid reimbursement rate structure as compared with two other states (Oregon and Colorado), which set rates for service provision based on an individual's support needs and acuity level, was conducted. Based on the results of this assessment, **it is recommended that Alaska consider using cost-based rate setting methodology combined**

with an acuity-based tier or level system when setting individual budgets or levels of care rates for persons receiving service from the Alaska's 1915(c) waiver for individuals with developmental disabilities. Detail of this analysis can be found in Appendix 5.

The service recommendation includes three models, which are presented in this document together as the Alaska Complex Behavior Collaborative. These models may be implemented together as a 'package' or incrementally; however, they are designed to be closely integrated regardless of how they are implemented. Three (3) models of care are identified to enable Alaska to better serve individuals with complex behavior management needs within the State. The positive and negative characteristics of each model are identified in the document and include the following parameters: fiscal environment, geographic and workforce challenges, environmental challenges, policy implications and a cost and benefit analysis of each model.

The proposed Alaska Complex Behavior Collaborative consists of three primary models or components: the Complex Behavior (Hub), Brief Stabilization Services, and Intensive Intermediate Intervention Services. **The Hub** is conceptualized as a point of entry into the Alaska Complex Behavior Collaborative (Collaborative). Individuals may be brought to the attention of the Hub when their behaviors are complex; presenting a high risk of danger to self or others and the interventions required to ensure the safety of those involved are outside the skill-set of the current program staff. The services provided by the Hub will be available for individuals who are already receiving services supported by the Department of Health and Social Services, and will not be considered a means of achieving eligibility for services. Additionally, designated staff within the Department of Health and Social Services will function as the 'gatekeeper' for access to the Hub to manage the appropriateness of referrals and timely access to these exceptional resources and services based on specific access criteria related to the determined level of care that is responsive to the needs of each individual.

The Brief Stabilization Services component of the Collaborative is one of two intervention arms included in the proposed model. The Brief Stabilization Services will consist of three small units of approximately five beds each that may be used for brief crisis stabilization of generally less than a week but no more than 30 days, if deemed clinically appropriate following consultation by the Hub. These units will be located in Anchorage, Juneau, Fairbanks, and potentially other regions with existing bed space that may be dedicated for this purpose. Reasonable attempts will be made to keep individuals in or near their home communities. Brief crisis stabilization may be utilized when individuals experience an escalation in behavior that is too difficult to manage within their current level of care, or when individuals' behaviors create a danger for themselves or others. These units should be secure (either by staff, delayed egress or door locks) in order to provide maximum safety for the individual, staff, and public.

The Intensive Intermediate Intervention Services component of the Collaborative will provide a residential option for individuals who require longer-term services prior to returning to previous or lower-acuity placements. This Service will be community-based and will provide a high level of structure and active behavioral intervention. The Intensive Intermediate Intervention Services will consist of three small units of approximately five beds each, located in Anchorage, Juneau, Fairbanks, and potentially other regions with existing bed space that may be dedicated for this purpose.

The Cost Comparison section of this document compares the fiscal costs of the current services model, including the current costs of out-of-State placements and in-State placements, with the costs of the proposed Collaborative services. Although frequently utilized in the current model, the costs of non-treatment placements, such as jails and emergency rooms, are not included in the comparison. The table below provides a summary of the information detailed in this section of the document.

Summary - Cost Comparison - Based on Annual Estimates				
Current Services	The Hub	Brief Stabilization Services	Intensive Intermediate Services	Cost of Proposed New Service Models
\$2,874,375 (in-State estimate)+ \$3,449,250 (out-of State estimate) = \$6,323,625	Total Cost: \$650,000	Total Cost for 3 Sites: \$3,900,000	Total Cost for 3 Sites: \$3,000,000	Total Cost: \$7,550,000
	\$650,000	Estimated NEW Cost to Alaska for 3 Sites: \$1,170,000 [\$1,300,000 x .30* = \$390,000 per site x 3 sites = \$1,170,000]	Estimated NEW Cost to Alaska for 3 Sites: \$ 900,000 [\$1,000,000 x .30* = \$300,000 per site x 3 sites = \$900,000]	Estimated Total NEW Cost to Alaska: \$3,070,000 ** (\$2,720,000 programs + \$350,000 start-up and training: \$50,000/program/site)
Total Estimated New State General Funds (GFMH) with start-up costs (year 1)				\$2,302,500
Total Estimated Continued State General Funds minus start-up costs (out-years)				\$2,040,000

Notes:

* The proposed services will be provided to existing beneficiaries, therefore, there are already costs associated with treating these individuals. Therefore, the estimates for the Brief Stabilization Services and the Intensive Intermediate Services assume that 70% of the costs are already being incurred by State, including through Medicaid funds. Therefore the analysis uses a factor of .30 to estimate the additional new costs.

** Of the \$3,070,000 needed, some of these costs are not Medicaid reimbursable - such as some of the technical assistance and distance consultation as well as the start-up costs, however, most of them will be. Conservatively assuming only 50% of the services are Medicaid reimbursable, the necessary State funds would be \$767,500 for State Medicaid match (50% State match) plus \$1,535,000 for the State General funded services for a total of \$2,302,500 for the first year and \$2,040,000 for subsequent years (sans start-up costs).

Additionally, start-up costs are estimated at \$50,000 per program/site for the first year of operation for a total of \$350,000 for the Collaborative. These costs are intended to cover necessary infrastructure and initial staff training and development activities.

The following recommendations are included in this report for consideration by DHSS and the Trust:

General Recommendation

It is recommended that a comprehensive continuum of care be developed for the identified population. To this end, the three components of the Alaska Complex Behavior Collaborative may be adopted and developed. The Collaborative supports Alaska's *Olmstead* plans as it broadens the continuum of services through the development and enhancement of integrated community-based services. A decision will need to be made regarding the implementation timeline, and whether the development should occur in phases. A commitment to providing the requisite support to ensure this development will need to be made at the State level and it is suggested that the Workgroup continue to meet to prioritize and track progress on the accepted recommendations from both Phase I and Phase II of this project; and to identify opportunities to implement and evaluate elements of the Collaborative for high-risk individuals, while the components are being developed and made fully operational.

Mentally Retarded / Developmentally Disabled (MRDD) Waiver Recommendation

The Department should track the number of Health and Safety Requests received by the Program Managers and the percent approved, along with denial information to assist the providers with understanding the request criteria and process and to promote uniformity of approvals across the State.

Rate Setting and Acuity Recommendation

Consider using cost-based rate setting methodology combined with an acuity-based tier or level system when setting individual budgets or levels of care rates for persons receiving services from the Alaska's 1915(c) MR/DD and possibly other waivers.

Licensing Fees Recommendation

Alaska should evaluate their licensing fee structure and the intent of these fees, and if so determined, increase these fees to support program oversight and development.

Telemedicine Recommendations

Take necessary steps to allow for identified telemedicine claims to be reimbursable through Medicaid and State funds. Appendix 6 includes an example of this from Colorado.

Seek federal or other grant funding to support the expansion of telemedicine capacity across providers in Alaska, including having sufficient capacity at the DHSS.

Staff Competence Recommendations

Specific staff competence requirements should be developed and adopted. Requirements may include minimum educational achievement levels, specialized training, and continuing education. Detailed recommendations for staff competence can be found in Appendix 7.

Workforce Training and Development Recommendation

Consider having rates adjusted to include a portion specifically for staff training (such as ten cents per billing code) and that the Department, potentially through the Hub, ensures providers are aware of training opportunities and monitors training participation.

Assisted Living Home Program Expectations / Licensing Recommendation

Consider either adding more population-specific minimum intervention program expectations to the Assisted Living Home regulations or create more population-based regulations for individuals able to benefit from structured services and active interventions, such as individuals with developmental disabilities or Alzheimer's.

Facility Security Recommendation

Make a policy decision about which approach to facility security will be chosen for use within the Brief Stabilization Services and the Intensive Intermediate Intervention Services. If a decision is made to use building security, an official opinion of the current regulations is needed and depending on the findings, any necessary changes should be incorporated. However, if the preference is to use the staff secure option, an investment in adequate staffing and staff training will be necessary. Additionally, depending on the physical plant of each facility, there may be some building modifications that can be made to improve the line-of-sight and other safety and security matters.

Licensing Recommendation

Designate at least some of the facilities that serve individuals with complex behaviors and complex management needs as more intensive and comprehensive; using the Centers for Medicare and Medicaid Services (CMS) regulations as guidelines, focusing specifically on facilities that become Intensive Intermediate Intervention Services.

Request for Interest Recommendation

Submit a solicitation of interest to determine the current desire and capacity of providers and potential providers to manage all of parts of the Collaborative. This effort will help inform next steps, including the roll-out of services to various parts of Alaska.

Closing Comments

While developing the Collaborative requires an investment in services for vulnerable Alaska beneficiaries with cognitive disabilities and complex behavioral needs, providing intensive services to individuals within the State allows for more control of the costs over time. Currently Alaska has some reasonable rates established for care provision within Idaho and a few other states; however, this can change at any time and if these other states no longer have capacity to serve Alaskans, it is unclear what could be negotiated with additional states. What is clear based on trends in recent years is the need for more intensive services with behavioral supports for individuals with cognitive disabilities. Through the work of the Trust, DHSS, and the Complex Behaviors Workgroup, Alaska has begun taking steps to develop capacity in-State to appropriately serve such individuals, investing locally in the infrastructure and workforce necessary rather than choosing to continue separating individuals from their families and communities for indefinite periods of time.

WICHE would like to offer thanks to all of the individuals both within and outside of Alaska for their contributions and input and would especially like to thank the Workgroup for providing their direction and support throughout the process.

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Purpose of the Alaska Complex Behavior Collaborative

In partnership with the State of Alaska Department of Health and Social Services (DHSS) and the Alaska Mental Health Trust Authority (Trust), the Western Interstate Commission for Higher Education (WICHE) Mental Health Program has developed a comprehensive recommendation for the effective care of Alaskans with cognitive disabilities and challenging behaviors who often present safety issues for themselves and, or others and therefore are at risk for institutional or out-of-State placement. Risk for out-of-State placement typically occurs when the individual exhibits behaviors that are so complex that they are outside the range of expertise of local caregivers and providers, or the available treatment options in State have been exhausted without resultant success for the individual. The recommendation includes three models, which are presented here together as the Alaska Complex Behavior Collaborative. These models may be implemented together as a 'package' or incrementally, however are designed to be closely integrated regardless of how they are implemented.

Description of the Alaska Complex Behavior Collaborative Components

The Hub

-  *Comprehensive diagnostic and testing capacity*
-  *Individualized triage services*
-  *Technical assistance to providers throughout Alaska*
-  *Case-specific consultation and training services*

The proposed Alaska Complex Behavior Collaborative consists of three primary components: the Alaska Complex Behavior Collaborative Hub (Hub), Brief Stabilization Services, and Intensive Intermediate Intervention Services. The Hub is conceptualized as a point of entry into the Alaska Complex Behavior Collaborative (Collaborative). Individuals may be brought to the attention of the Hub when their behaviors are complex; presenting a high risk of danger to self or others and needed interventions to ensure the safety of those involved are outside of the skill-set of the current program staff. The services provided by the Hub will be available for individuals who are already receiving services supported by the Department of Health and Social Services, and will not be considered a means of achieving eligibility for services.

Additionally, designated staff within the Department of Health and Social Services will function as the 'gatekeeper' for timely access to the Hub to manage the appropriateness of referrals and access to these exceptional resources and services based on specific access criteria related to the determined level of care that is responsive to the needs of each individual. The Hub will offer comprehensive assessment and diagnostic services by drawing on a pool of identified experts. These experts will be local as well as from out-of-State, when a particular expertise is not available locally. Short-term contracts with expert consultants may be utilized to fill this

workforce need. Individualized triage services will be available, in order to direct each individual to the appropriate level of care within the Collaborative or outside of it. In some cases, individuals may require brief stabilization or longer-term support through one of the two intervention arms of the Collaborative, which, based on the needs of each individual, could occur within their current placement or may require transfer to specialized services. In other cases, individuals may be able to return to their previous care setting, with individualized consultation services provided by Hub experts to caregivers and/or providers. Case-based consultation and technical assistance will be provided through the Hub to providers throughout the State of Alaska. This assistance will be made available by direct contact locally as well as virtually through telemedicine technology. Additionally, travel to other parts of the State to provide consultation may be indicated in some situations.

The technological and research capacities are central elements of the Hub. Because the Hub will be a center of expertise for the identified population(s), accessibility by providers throughout the State is paramount in order to ensure the most effective use of this resource. Therefore, it is expected that the technological capacity of providers across the State will need to be better developed over time, requiring additional dedicated resources. This is further discussed under the Environmental section of the Comparative Challenges and Opportunities, later in this document.

It is also likely that provider training will be necessary in order to prepare community providers to utilize the technology and to incorporate the consultation and technical assistance provided by the Collaborative effectively, which will require an investment in resources for training and possibly to back-fill direct care providers while they receive training. In terms of research, the Hub will have the capacity to collect data including demographic, assessment, diagnostic, and services data. These data may be used to facilitate research that will inform the understanding of promising interventions for individuals with cognitive disabilities and complex behavioral needs. Outcomes of research may be used to inform future policy decisions and service development.

The potential for workforce development opportunities through the Hub, and even more directly through the two intervention arms of the Collaborative, is significant. As a locus of expertise as well as a clinical setting, the Collaborative provides a natural opportunity for formal advanced training as well as on-the-job and off-site training and family/caregiver psychoeducation. The Collaborative may partner with such training programs as Psychiatry Residencies, Psychology Pre-Doctoral Internships, Social Work Practica, etc. in order to offer clinical training to these behavioral health professionals. On-the-job training may also be offered to staff members of residential facilities and other providers who serve the identified population. The Collaborative may partner with these facilities to provide on-the-job and off-

site training to new staff members as a condition of employment prior to placement in the employer's facility.

Community providers may also receive training through case-specific consultation opportunities with Hub experts. Training opportunities such as these will help ensure the development of a more competent workforce over time with proficiency in managing the specific needs of individuals with cognitive disabilities and complex behavioral needs, while also providing earlier interventions to minimize the risk of individuals developing more complex behaviors. Additionally, psychoeducational training may be provided to families of individuals within the identified population in order to teach family members to recognize warning signs of and provide intervention for escalating behaviors. It is anticipated that over time, the Collaborative will develop the workforce capacity and expertise to provide consultation and technical assistance for a variety of individuals with complex behaviors, beyond those identified in the targeted population for the initial implementation. However, this will not occur without an investment in the workforce. This is discussed in greater detail in the Workforce section of the Comparative Challenges and Opportunities, later in this document.

Brief Stabilization Services

- *Dedicated brief stabilization services*
- *Alaska Psychiatric Institute (API), emergency department and jail diversion*
- *Secure capacity - when clinically indicated for client and, or public safety*
- *Utilization of existing bed/space capacity (approximately 5 beds - possibly more, especially in Anchorage)*
 - *Locations in Anchorage, Juneau, Fairbanks and other regions with bed capacity*
- *Anticipated average length of stay of less than a week but no more than 30 days*
- *Crisis respite services*
- *Individualized triage services*
- *Community transition with a planned, well-coordinated, collaborative transfer of individuals back to their original residence and services*
- *Support services - follow-up consultation as needed*
- *Workforce development - training opportunities for community providers*

The Brief Stabilization Services component of the Collaborative is one of two intervention arms included in the proposed model. The Brief Stabilization Services will consist of three small units of approximately 5 beds each that may be used for brief crisis stabilization of generally less than a week but no more than 30 days, if deemed clinically appropriate following consultation. These units will be located in Anchorage, Juneau, Fairbanks, and potentially other regions with existing bed space that may be dedicated for this purpose. Reasonable attempts will be made

to keep individuals in or near their home communities. Brief crisis stabilization may be utilized when individuals experience an escalation in behavior that is too difficult to manage in their current level of care, or when individuals' behaviors create a danger for themselves or others. These units should be secure (either by staff, delayed egress or door locks) in order to provide maximum safety for the individual, staff, and public.

Prior to admission into a Brief Stabilization Services unit, the referring provider will receive approval from DHSS for case-specific consultation from the Hub and potential strategies for managing the problematic behavior within the current placement will be discussed. If the provider is unable to manage the behavior with consultation, the individual may then be referred to a Brief Stabilization Services unit. Referring providers will hold each individual's bed until their behaviors are stabilized and they are ready to return.

Individuals will receive active behavioral intervention by experts trained at the Master's and Doctoral level during the crisis stabilization period. Individualized triage services will be available in order to refer the individual to the appropriate level of care following stabilization. Referrals back to previous community services will include active consultation with receiving providers/caregivers and *planned well-coordinated, collaborative transfers of individuals back to their original residence and services*. Continued follow-up services to the previous community will follow, in order to provide ongoing support and consultation as needed.

Brief Stabilization Services units have the potential to serve as hospital, emergency department, and jail diversion and, or as a step-down from more intensive and, or restrictive services, reducing the burden on these systems. Additionally, the units may be utilized for respite services for caregiver systems when local community resources are not available. Because the units include active clinical services, the workforce development opportunities discussed above will be available, including on-the-job and off-site training for community providers and formal training programs for professionals and para-professionals.

Intensive Intermediate Intervention Services

-  *Community-based intensive intermediate intervention services*
-  *Structured, active intervention model with individualized behavioral interventions*
-  *Utilization of existing bed/space capacity (approximately 5 beds)*
 -  *Locations in Anchorage, Juneau, Fairbanks and other regions with bed capacity*
-  *Anticipated length of stay of 1-18 months, with discharge planning initiated at admission*
-  *Secure capacity - when clinically indicated for client and, or public safety*
-  *Community transition with a planned, well-coordinated, collaborative transfer of individuals back to their original residence and services*

- *Technical assistance to providers throughout Alaska*
- *Crisis respite services*
- *Support services - follow-up consultation as needed*
- *Workforce development - training opportunities for community providers*

The Intensive Intermediate Intervention Services component of the Collaborative will provide a residential option to individuals who require longer-term services prior to returning to previous or lower-acuity placements. This Service will be community-based and will provide a high level of structure and active behavioral intervention. The Intensive Intermediate Intervention Services will consist of three small units of approximately 5 beds each, located in Anchorage, Juneau, Fairbanks, and potentially other regions with existing bed space that may be dedicated for this purpose.

The units will be staffed by highly-trained specialists capable of providing intensive behavioral interventions. These units will also be secure (either by staff, delayed egress or door locks) in order to provide maximum safety for the individual, staff, and public when it is clinically indicated. The anticipated length of stay will be between one and eighteen months, with comprehensive discharge planning and consultation with receiving providers/caregivers initiated at admission and continuing throughout the specialized interventions. Transition back to community services will include continued active consultation with receiving providers/caregivers and *planned, well-coordinated, collaborative transfers of individuals back to their original residence and services*. Ongoing follow-up services to the community will occur, in order to provide ongoing support and consultation with a goal of mitigating the need for return to more intensive placements.

Because these units will be staffed by highly-trained specialists, the Intensive Intermediate Intervention Services component of the Collaborative includes the capacity to provide technical assistance and consultation to providers throughout Alaska. As with the Hub, the Intensive Intermediate Intervention Services units will utilize direct contact as well as telemedicine technology to provide these services as needed to providers and caregivers locally and statewide.

The Intensive Intermediate Intervention Services units may be utilized as respite services for caregiver systems, when local community resources are not available, in order to mitigate staff burnout due to ongoing stress and to encourage the utilization of available supports. The units will additionally provide psychoeducation to family caregivers for this purpose. Due to the inclusion of active clinical services by specialists, on-the-job training and off-site training opportunities for community providers and formal training programs for professionals will also be included in order to help address workforce development needs throughout Alaska.

Comparative positive and negative characteristics of the proposed models and the current services model

As noted previously, the three models presented above, together termed the Alaska Complex Behavior Collaborative, may be implemented together as a 'package' or incrementally, however are designed to be closely integrated regardless of how they are implemented. The intervention arms of the Collaborative may be combined such that both levels of intervention occur within one unit; however the physical plant will need to support milieu management and clinical interventions to appropriately address the diverse needs of these individuals. There are numerous positive and negative characteristics related to the potential adoption of these models, as well as to the option of making no changes to the current care system for individuals with cognitive disabilities and complex behavioral needs. These characteristics are discussed in the paragraphs below and summarized in tabular format in Appendix 4. The option of retaining the status quo for care of the target population is referred to below as the “current services”, fourth model.

Fiscal Environment

Each of the four models being compared includes negative characteristics with regard to the fiscal environment. The three models comprising the Collaborative will each require the investment of new funding in order to develop the described services. For the two intervention arms as well as the Hub arm of the Collaborative, there is the need for adequate reimbursement rates for service provision as well as fiscal resources to support active, individualized behavioral interventions. Within the Hub, flexible funding will be required in order to support as-needed contractual services. The fourth model is Alaska's current system and its fiscal challenge is the ongoing and indefinite cost of continuing to send individuals out-of-State for services. This cost will likely continue to increase over time, creating an ongoing outflow of funding with little to no in-State benefit.

The positive fiscal characteristics involved with the three models included in the Collaborative are numerous and additive. The fiscal characteristics related to workforce development within Alaska are primary. Each model within the Collaborative allows for on-the-job and off-site training as well as post-secondary and graduate level training. Developing a workforce that is specifically qualified to effectively serve the identified population will have long-term positive financial effects for the State, because the use of high-cost, high-acuity services will be limited and individuals may be more effectively maintained for longer periods of time in lower levels of care. The active intervention components of the Collaborative will also support leveraging more billable opportunities for in-State providers, and will allow for better cost management within the State.

Workforce

Negative characteristics related to the Alaska workforce exist across all four models. Implementation of the Alaska Complex Behavior Collaborative will require new workforce resources, because each of the three models will require highly-qualified staff. This will require an initial and ongoing investment in the workforce. Additionally, staff members who provide services within the Brief Stabilization and Intensive Intermediate Intervention Services will merit additional compensation due to the high clinical acuity of the population they will serve.

The primary workforce challenge associated with the current services model is that it creates no incentive to improve the current Alaska workforce serving the identified population. Training opportunities for workforce in the current services model are scarce and will likely continue to be scarce if current services are continued. Such training opportunities will need to be funded, including the possible need for travel, lodging and back-fill of direct care staff time. Some specialty provider agencies in other states provide intensive staff training prior to staff engaging with residents, which mitigates the need for some back-fill; however this remains an issue for ongoing provider training and in-services that are necessary to build and maintain a competent and confident workforce. Web-based training opportunities can be quite valuable in providing periodic training for providers, especially those in more remote areas and those who work evenings, nights and weekends.

Developing a competent provider network is paramount to the successful management of individuals with complex behaviors in Alaska, and incorporating the cost of training into Medicaid billing rates will help support this effort. For example, Alaska could identify the billing codes for each service for which training would be required in order to competently provide the service. A predetermined amount, such as ten cents, could then be added to the billing rate per encounter to compensate for the training and workforce development costs incurred by providers. This approach would help incentivize workforce development and improve provider competence across Alaska over time.

Another consideration would be to reimburse the providers of the specialized Collaborative services with a negotiated higher rate that is bed-based, instead of being negotiated separately for each individual served. This would offer these specialized providers greater financial predictability for staffing and general operations. While all of the specialized service recipients may not be Medicaid eligible, this approach will still help develop and support the specialized workforce needed for these individuals and other vulnerable Alaskans across the State.

The positive workforce characteristics created by the Collaborative models were alluded to in the above section. The three proposed Collaborative models will provide opportunities to develop a more competent workforce across all skill levels, from untrained or informally trained

caregivers and family members to graduate level professionals. The Hub will allow for the development of highly trained experts by partnering with graduate programs. The Brief Stabilization Services and Intensive Intermediate Intervention Services units will provide training opportunities for both professional and paraprofessional staff. Each of these components will allow for on-the-job training and consultative outreach for untrained or informally trained providers and caregivers. Improved staff retention at each level of service is an expected outcome of the Collaborative, because staff will have the skills and resources needed to work effectively with the target population, reducing stress and potential burnout. Workforce development, including training as well as appropriate resources and support for staff, is a key component of successful in-State services for this population.

Geographic

The negative geographic characteristics to be considered with regard to the three proposed models are primarily the same as those associated with the current services model. The current services model frequently creates a burden on community providers across Alaska as well as API when the target population is served in-State, because the system is not adequately prepared to maintain the individuals at an appropriate level of care. The individuals are frequently sent out-of-State for services, which creates the need for transportation. Since the out-of-State placements are often for indefinite periods of time, this also creates geographic and financial challenges for the families of the individual who wish to visit their family member.

The three models of the Collaborative each include positive geographic characteristics. The Hub is planned to be based in Anchorage, with telemedicine connectivity across Alaska and in other states. This allows for a central point of entry into clinical services as well as a locus of expertise that can be easily accessed by providers not based in Anchorage. The Brief Stabilization Services unit will also initially be developed in Anchorage, with potential for expansion to other parts of the State including Juneau and Fairbanks, as well as other possible locations. This allows for brief crisis stabilization in-State with consultation to providers outside of Anchorage and an increased ability to provide *planned, well-coordinated, collaborative transfers of individuals back to their original residence and services* and to other local community providers, when indicated. The Intensive Intermediate Services units will initially be developed using existing underutilized or converted bed space in Anchorage, Fairbanks, and Juneau, with the option of expanding to other parts of the State subsequently. These three initial sites allow for the individuals requiring this level of longer-term intensive residential services to be served as close to their home communities as possible.

Environmental

The growing negative environmental characteristic of the current services model is that limited care options exist when the out-of-State placements do not have the capacity to accommodate Alaska's referrals. Related to this issue, other states may have a responsibility to serve their own residents and may begin to experience the demand to serve Alaska residents as an unwelcome burden, especially when the lengths-of-stay are extended because Alaska lacks the necessary program capacity to successfully return these individuals back to the State. Of the eleven individuals who had been placed outside of Alaska as of the Spring of 2010, only one has returned and only one other is working toward transition back to Alaska. The history of out-of-State placement of Alaskan residents predicts that these placements will continue to be utilized for lengthy periods for each individual in need. Almost half of the individuals who have left the State for services have been out-of-State for over two years, with the longest placement lasting over three years. Information from key informant interviews suggests that the low return rate of individuals to Alaska services is due to a lack of placements in Alaska with the ability or willingness to manage these individuals following unsuccessful intervention attempts prior to the individual leaving the State.

The primary negative environmental characteristic presented by the Collaborative is that it requires some investment in technology in order to effectively and efficiently provide the consultation and technical assistance included in the model. The technology capacity of the providers will be an important consideration in the selection of sites for the Brief Stabilization Services and the Intensive Intermediate Intervention Services; however, since the scope of the services that will be available extend to providers beyond those directly associated with the Collaborative, the technology capacity of providers across the State will need to be better developed over time, requiring additional dedicated resources.

While some consultation and technical assistance can occur through telephonic and electronic correspondence, more advanced technology such as telemedicine and video-conferencing enhance the ability to observe behaviors and exchange valuable information. Also, depending on what Alaska desires to have in its State Medicaid Plan and what is approved by the Centers for Medicare and Medicaid Services, the type of technology used may or may not be included as a billable service provision. For example in Colorado telemedicine services must be provided live; and the individual receiving services and the distant provider/consultant must interact with one another in real time through audio-video communications, not solely audio or another form of electronic communication. Additionally, action may be needed in Alaska to revise State Medicaid regulations to ensure that both the expert consultant and the provider receiving the specialized consultation are able to bill for such services in Alaska. As an example,

Colorado's provider information for Medicaid Telemedicine reimbursement is included in Appendix 6.

That being said, Alaska has the advantage of having many technology resources already in existence. Alaska is well positioned to expand their existing telemedicine network rather than having to develop one from the ground up. Expanding this network is an opportunity associated with the Hub and there may be federal grant funding opportunities to help develop and expand technology across the State.

An additional environmental characteristic of the Collaborative models is the opportunity to create a culture change around active interventions in Alaska for individuals with cognitive disabilities and complex behaviors. The intervention arms of the Collaborative will be influential in that shift as they provide high quality active interventions and support training to disseminate effective management strategies, in lieu of the current common practice of adding an additional staff to simply 'contain' behaviors. This will also allow for a reduced reliance on systems such as corrections, emergency departments, medical units in private hospitals and the Alaska Psychiatric Institute (API), which are often the interim provider by default because of gaps in the current service system.

Policy Implications

While there may not have been a deliberate policy decision made to send individuals with complex behaviors out-of-State, there will need to be a policy commitment to stop, or to at least significantly limit this practice. The most significant policy implication of supporting the three proposed models of the Collaborative is that it will require an ongoing commitment to dedicate resources to build and sustain a well-trained competent and confident workforce along with the development of an adequate continuum of care for vulnerable Alaskan beneficiaries. Additionally, as noted previously, a commitment to provide adequate rates for the services provided will be necessary in order to develop and sustain the level of care and consultation services needed.

If it is desired to have secure or at least lockable facilities, statutory or regulatory changes may be needed. Many states have been able to treat high-risk populations through the provision of structured interventions and adequate staffing levels without locking facilities; however, having a secure capacity is important as it allows the facility staff to provide for their own safety and the safety of each resident until the individual's behavior can be successfully deescalated. In the case that an individual is admitted who has an elopement history, which creates a danger for the individual, locking the facility until the individual can be stabilized may be helpful to ensure that individual's safety. Specific staff training would be required in order to ensure that staff members are competent in the appropriate use of locks and emergency evacuation, and that

each use is documented to prevent unwarranted restriction of individuals. Facility security is a policy decision that warrants further exploration and discussion.

Failure to develop integrated community-based programs and services in Alaska places the State at risk for an *Olmstead*-related lawsuit. On June 22, 1999 the United States Supreme Court determined in *Olmstead vs. L.C.* that the unnecessary segregation of individuals with disabilities in institutions may constitute discrimination based on disability. The Supreme Court ruled that the Americans with Disabilities Act may require states to provide community-based services rather than institutional placements for individuals with disabilities. Therefore, placing individuals in institutions in Alaska, or sending them to be institutionalized in other states, because appropriate community-based alternatives do not exist, places the State at risk for a lawsuit. Also, the Obama Administration is intensifying its efforts to enforce this mandate for community integration, with an emphasis on supporting individuals with disabilities as they live in the least restrictive community-based settings possible.

Costs

The overall picture of costs associated with the three models of the Collaborative highlight the issues of staff composition, staff development and training, the need to expand telemedicine capacity, and site and program development. Funding will be required in order to adequately staff each of the three components of the Collaborative, acquire additional technology, and to support initial and ongoing training and workforce development opportunities. Technology enhancements are an additional cost associated with the Hub and intervention arms of the Collaborative. Site development and other start-up costs will also be additional, although the extent of those costs will depend in part, on the availability of existing underutilized space. Additionally, when undertaking significant system changes and program development there may be costs associated with the transition. For example, there may be some current activities that need to continue until new activities are fully operational, which may result in some costs associated with the overlap period. While such costs are difficult to quantify, it is important to recognize this early on in the development phase as well as throughout implementation.

The overall costs of the current services model, by comparison, include the ongoing financial cost of serving Alaskan's out-of-State including providing long-distance administrative oversight, and the cost of transportation for these individuals served out-of-State. Additionally, the current services model includes emotional costs for families who are separated from one another and for individuals who are removed from their home communities. The removal of many of these individuals has a significant cultural impact, as many are Alaskan Natives with rich cultural traditions that are not maintained in out-of-State placements.

Benefits

The primary benefit of the proposed three models is the development of the capacity for Alaska to serve some of its most vulnerable beneficiaries without being transported for long, uncertain periods of time, to other states. It also makes the planning and oversight of the programs and services to these beneficiaries more efficient from a DHSS operational perspective. From a budgetary perspective, the Collaborative offers opportunities to have more strategic budgetary expenditures as well as opportunities to capture more federal Medicaid match for some services that are currently being provided solely through State General Funds. Additionally, the development of a better-trained, more robust, competent workforce and more comprehensive system of care will benefit all beneficiaries receiving services, not just those with complex behaviors. This will improve outcomes and the quality of life for individuals receiving services and will also benefit their families and local communities. The proposed models are an investment in the future of vulnerable Alaskan beneficiaries, which bring significant emotional and cultural benefits, that cannot be realized when services are provided out-of-State. Continuing the current model of sending individuals out-of-State will inhibit the will and capacity of the State and providers to meet the needs of this vulnerable population.

Risk Assessment of Taking No Action

The following list serves to highlight the risks associated with taking no action to enhance services within Alaska to better address the needs of individuals with cognitive disabilities and complex behavioral needs:

- ✓ Potential exists for Americans with Disabilities Act (ADA) violations; specifically regarding *Olmstead versus LC*. The Department of Justice expects states to demonstrate progress on their waiting lists to move individuals with disabilities to less restrictive, integrated community-based settings, to have a clearly defined method to manage movement on the waiting lists, and to demonstrate their methodology regarding how their lists are developed and tracked. It appears that while limitations in state budgets may affect states rate and scope of compliance with the ADA's integration mandate, budget limitations do not relieve the states of their obligation to take effective steps to end inappropriate institutionalization. Such lawsuits are quite costly to states due to imposed court mandates and while such lawsuits may result in the development of needed services, they are not the most effective or cost efficient way to develop them.
- ✓ Continued un-budgeted, non-Medicaid general fund expenses related to things such as the need to provide additional staff to 'manage and contain' some individuals, cover out-of-State travel and related expenses.
- ✓ Continued escalating costs associated with providing an inadequate continuum of care, which currently adds additional expenses by bringing in extra staff to 'manage and contain' complex behaviors, instead of investing up-front in the workforce and programs to provide appropriate interventions and services.
- ✓ Unsupported stays at API since placement of adults ages 22-64 in API for which Medicaid funds cannot be used.
- ✓ Continued inappropriate use of jails, corrections and emergency rooms, which places an unnecessary burden on these systems and is generally not in the best interest of the individuals being served. This can result in the need to grow these resources unnecessarily and at significant expense to the State.
- ✓ Iatrogenic results with prolonged lengths of stay, such as creating, for some individuals, an over-reliance on restrictive institutional -based care; which can make successful transition back to integrated community based settings difficult.
- ✓ Increased numbers of individuals placed out-of-State for extended periods, often losing family bonds based on recent trends and future projections.
- ✓ Continued inappropriate use of jails, corrections and emergency rooms, which places an unnecessary burden on these systems and is generally not in the best interest of the individuals

being served. This can result in the need to grow these resources unnecessarily and at significant expense to the State.

- ✓ Development/reinforcement of 'institutional behaviors', especially when co-mingling individuals with cognitive disabilities with large numbers of other individuals, including those individuals with behavioral health disorders, from which they may learn additional undesirable behaviors.
- ✓ Perpetuates individuals with disabilities and complex behavioral needs languishing in existing placements for extended periods of time (often as they await an out-of-State placement) when they could otherwise be developing new skills and supports so that they could someday thrive in an integrated community-based setting.
- ✓ Taxing Alaska's current relationships with the out-of-State facilities that frequently receive the individuals who cannot be appropriately served in Alaska.
- ✓ Continuing lack of incentives for the current care system in Alaska to serve the target population.
- ✓ When an individual meets the criteria for an Intermediate Care Facility for the Mentally Retarded (ICF/MR - See Appendix 3 for more information) level of care and requests this level, Alaska's only option at this time is to find an out-of-State placement since this level of care does not currently exist in-State. Compounding this is Alaska is experiencing an increase in these requests coupled with an increasing difficulty accessing these services in other states since many states prioritize their services for their in-state residents.
- ✓ Safety risks are associated with inadequately managing complex behaviors. These risks are to the personal safety of the individual with complex behaviors as well as to other residents, providers and may impact the safety of the public.

Cost Comparison of the Current Services and the Proposed Model

Problem Statement: Alaska's current system of care does not include appropriate services for individuals with cognitive disabilities and complex behaviors. Because of this, many of these individuals are served by API, where they languish in an unnecessarily restrictive environment for extended periods of time, or they are inappropriately held in places such as jails and emergency rooms. Many are ultimately sent out-of-State for care, where in many cases they remain indefinitely. The result of the lack of appropriate services in Alaska is significant financial cost to the State and personal cost to the individuals and their families. This Cost Comparison section of this report will compare the fiscal costs of the current services model, including the current costs of out-of-State placements and in-State treatment placements, with the costs of the proposed Collaborative services. Although frequently utilized in the current model, the costs of non-treatment placements, such as jails and emergency rooms, are not included in this comparison. A detailed Cost Benefit Analysis will follow.

Summary of Background and Population: When considering expansion of the continuum of services within Alaska instead of relying on out-of-State placements for adults with cognitive disabilities and complex behavioral needs, it is important to not only consider the costs of providing the new services, but to also consider the costs of the current services.

While it is not realistic to develop definitive numbers for at-risk individuals, the table in Appendix 1 illustrates the broad scope of individuals at a point-in-time with significant complex behavioral needs, some of whom are currently in out-of-State placements. Because behaviors are not static over time, it is important to understand from a planning perspective that the specific individuals needing the services proposed by the Collaborative will change. However, the need for more coordinated, intensive consultation and services persists and will likely grow over time as the identified population continues to expand.

Adults: For the adult population there are typically 10-14 individuals with cognitive disabilities in long-term out-of-State placements due to complex behavioral needs who cannot be safely and effectively managed in Alaska. Additionally, there are typically an additional 10-12 adults receiving services at API, as a last in-State resort and not because it is the most appropriate placement for services for these individuals, many of whom have cognitive disabilities, such as intellectual disabilities and dementia. Therefore, there are anywhere from 20 to 26 adults with cognitive disabilities out-of State or at risk for out-of-State placement at any given time. This is in addition to the 36 individuals noted in the table in Appendix 1 at API with mental health and substance use disorders, who are also at-risk of out-of-State placements. These numbers do not account for the numerous individuals who end up in emergency rooms, jails and corrections, when appropriate services are not available. These individuals often face significant challenges when trying to re-integrate back to their home communities and have a high risk of recidivism.

Current efforts to develop disposition and transition plans for these individuals is very difficult because of the dearth of resources and the complexity of the services and supports that are often needed.

Additionally there is a growing population of older adults in Alaska, many of whom are served through Pioneer Homes, with Alzheimer's and other forms of dementia, who have significant behavioral needs. The table in Appendix 1 notes that 11 of the 72 API inpatients at one point met these criteria, some of which are also included (duplicated) in the adult count for API above. At the same time, there were an additional seven (7) individuals in Pioneer Homes with very complex behavioral needs, many of whom were receiving special resources, such as one-to-one staffing to promote the safety of these individuals as well as that of the other residents. This totals 18 older Alaskans with complex behaviors in need of specialized services and supports.

Therefore, a conservative estimate of the adults with cognitive disabilities and complex behavioral needs would include the 20-26 adults plus approximately seven (7) older adults for total of 27 to 33. **The comparison of the current service costs with the proposed Collaborative services will be based on estimated costs to serve 30 adult individuals.**

Youth: While this report targets the adult population at the direction of the Workgroup, it is also helpful to review out-of-State activities for adolescents, especially since many of those placed out-of-State are transitional-aged older adolescents - soon to be young adults in need of specialized services for complex behaviors. As of July 20, 2010, of the 128 youth in out-of-State placements, 15 had a Mentally Retarded/Developmentally Disabled waiver or the offer of the waiver and four (4) had an open Senior and Disabilities Service file and may or may not have been on the waitlist for a waiver. These are all youth with co-occurring diagnoses and complex behavioral needs. Of these 19 youth, approximately three-fourths were originally from the Anchorage area, which demonstrates at a minimum, a strong need for more intensive services for youth in Anchorage. However, given the importance of trying to keep families united, it will also be beneficial to develop more intensive services for youth in Juneau, Fairbanks and other parts of the State over time.

Fiscal Implications

The following sections identify the current costs and proposed costs of services for beneficiaries with cognitive disabilities and complex behavioral needs. This discussion is followed by short- and long-term cost / benefit analyses. Below is a listing of the flow of the upcoming sections that provide the framework, assumptions and fiscal implications of the proposed Collaborative.

Current Service Cost Estimates

- Out-of-State Costs

- In-State Costs
- Combined Out-of-State and In-State Costs

Proposed In-State Collaborative Services Costs

- Costs Not Included in Estimates
- Assumptions
- Hub Costs
- Brief Stabilization Services Costs
- Intensive Intermediate Intervention Services Costs
- Full Collaborative Costs
- New Collaborative Costs- Adjusting for the Costs of Services Already Being Provided
- New Collaborative Costs - Adjusting for State General Fund and Federal Medicaid Mix

Cost / Benefit Analysis

- Comparison of Alaska Group Home Costs with 2 Other States
- Comparison of Alaska Group Home Costs with the Proposed Collaborative Services
- Short-Term Cost / Benefit Analysis
- Long-Term Cost / Benefit Analysis
- Cost / Benefit Analysis Summary

Current Service Cost Estimates

The current service cost estimates will be used to compare current costs with two other states and with the proposed Collaborative costs later in the Cost Benefit Analysis section of this document. It is important to note that the current costs estimates are based primarily on Group Home costs (one variation includes a brief stay at API) and do not include the additional costs incurred when many of these individuals are also served in private hospitals, jails, corrections, etc. when they are not able to be served safely in a Group Home. Therefore, using the Group Homes costs is conservative and under-represents the true costs to Alaska at this time.

The proposed Collaborative supports the bed capacity to serve 30 individuals in addition to the services that will be provided by the Hub. The 30 is based on three five-bed sites for Brief Stabilization Services and three five-bed sites for Intensive Intermediate Intervention Services. Therefore, for purposes of calculating the current service costs estimate to serve the identified population, the estimates below are based on half (15) of the individuals receiving out-of-State services and the other half (15) in-State services, in order to be comparable to the proposed Collaborative, which will have a bed capacity to serve 30 individuals.

Out-of-State Placements

Alaska's current Medicaid daily rates for out-of-State Intermediate Care Facility for the Mentally Retarded (ICF/MR - a level of service designation from the Centers for Medicare and Medicaid Services) services range from \$501.37 - \$555.09 (mean is \$524.76). [These rates are for facilities with a much larger bed capacity than is proposed for development in Alaska, which does reduce the daily rates and Alaska may need higher rate to provide this level of service with the fewer beds.]

It is estimated that it would cost Alaska approximately \$2,874,375 annually for 15 out-of-State placements, based on an average daily rate of \$525 (\$524.76) per individual. While this cost includes Medicaid match in addition to State funds, this is likely to be an ongoing and increasing cost. ($\$525 \times 365 \text{ days} = \$191,625$ annually per individual)

Estimated Out-of-State Costs = \$2,874,375 / 15 individuals = \$191,625 annually per individual

Currently there is no licensed or enrolled ICF/MRs in Alaska. Developing the necessary types and level of service within Alaska, either with or without the Center for Medicare and Medicaid's designation as an identified intensive facility ; will help contain costs over time, build Alaska's workforce and develop intensive programs and supports for vulnerable beneficiaries while keeping Alaska's financial resources within the State.

[Note: Alaska's longest out-of-State ICF/MR placement has been three years and three months, the shortest, one month. Of 11 individuals who have left the State, one has returned and five have been out-of-State over two years. Only one of the active 10 is working to transition back to a home in Alaska. - This information was provided in the Spring of 2010; there are now 13 individuals placed out-of State in ICF/MR (two adolescents and 11 adults) and one adolescent funded with general funds in a residential program not licensed as an ICF/MR or Residential Psychiatric Treatment Center (RPTC). There are an additional two adolescents and 11 adults that have requested ICF/MR placement who are either in the referral process or have not been able to locate an enrolled program able to accept the referral.]

In-State Placements

Alaska's daily rates for Group Homes range from \$167 - \$1,794 (mean is \$360.32) for individuals less than 22 years of age, while the current daily rates is \$86 - \$809 (mean is \$351.94) for individuals 22 years and older. (Data from 2007-2010.) Since Alaska currently does not provide the level of services proposed with the Collaborative, cost estimates above are being used as a proxy for comparison purposes.

Given that the primary population to receive the proposed services significantly exceeds the resources needed for the average population, the \$351.94 rounded to \$350 is adjusted by a factor of 1.80, resulting in an average daily cost of \$630 per individual served or \$229,950 annually per individual, which is \$3,449,250 for 15 individuals. (The 1.80 factor is based on the assumption that the individuals targeted for these intensive services are within the upper 20% of the Group Home costs.) While this cost includes Medicaid match in addition to State funds, this is likely to be an ongoing and increasing cost. The 15 individuals for this calculation are based on the proposed Intensive Intermediate Intervention Services with five (5) beds in each of three (3) locations. ($\$630 \times 365 = \$229,950$ annually per individual)

**In-State Estimated Placement Costs = \$3,449,250 / 15 individuals =
\$229,950 annually per individual**

Out-of-State and in-State Placement Costs Combined

It is estimated that approximately **\$6,323,625 (\$2,874,375 for out-of-State services+ \$3,449,250 for in-State services) is spent annually** to provide services to the identified population. As stated previously, this includes a mix of both State General Funds and Federal Medicaid Funds. These costs are based on the services being provided to a total of 30 individuals (15 out-of-State placements plus 15 in-State placements - 30 is being used to compare the current services with the proposed services, which would develop the capacity for 30 individuals). Using this methodology, the average annual cost per individual is currently **\$210,788**. ($\$577.50 \times 365 = \$210,788$ annually per individual)

**Estimated Out-of-State + In-State Placement Combined Costs = \$6,323,625/ 30 individuals =
\$210,788 annually per individual**

Proposed In-State Collaborative Services Estimates

Costs not included in estimates:

The estimates below are based on one Hub in Anchorage, three Brief Stabilization Services programs and three Intensive Intermediate Intervention Services programs; one of each in Anchorage, Juneau and Fairbanks. Estimates do not include initial facility or facility-related operational costs. It is anticipated that these programs will occupy underutilized space in existing facilities or current programs will be converted to provide the new identified services, therefore facility costs are not included at this time. If this is not feasible, additional costs will be incurred. Additionally, these estimates include plans only for adult programs, as this is the target population identified by the Workgroup, therefore does not include programs specifically for adolescents at this time.

While the start-up costs include some funding for training, funding for ongoing staff training and back-fill expenses related to providing coverage during training for direct care providers and the transition costs associated with service development are not included. It is recommended that Medicaid rates be adjusted to include an increment that will cover ongoing training and workforce development expenses.

Additionally, the costs for technology development and enhancements that may be necessary to provide telemedicine consultation and other services are also not included in the estimates, primarily because these costs will vary significantly depending on the sites selected to house the various components of the Collaborative. It is recommended that programs interested in applying to be part of the Collaborative clearly discuss their current technology capacity and the resources they would need to successfully provide the identified services.

Proposed In-State Collaborative Services: Assumptions

The proposed in-State Collaborative services are based on the following assumptions:

- 1) Rates will need to be adjusted.
- 2) Depending on the beneficiary population served, their ages and level of care needs; regulation and certification issues will need to be addressed.
- 3) The proposed services will be provided to existing beneficiaries, therefore, there are already costs associated with treating these individuals. Therefore, the estimates for the Brief Stabilization Services and the Intensive Intermediate Intervention Services assume that 70% of the costs are already being incurred by State, including through Medicaid funds. Therefore the analysis uses a factor of .30 to estimate the additional new costs.
- 4) When the calculations refer to the number of individuals to be served (e.g. 15 for Brief Stabilization Services), this does not imply that only 15 will be served annually, just at a point-in-time. Given the short-term intent of this program many more unique individuals will be served, however the cost is relatively the same for one person to be served for a month as for two individuals to each be served for two weeks.
- 5) Start-up costs are estimated at \$50,000 per program/site for the first year of operation for a total of \$350,000 for the Collaborative. These costs are intended to cover necessary infrastructure and initial staff training and development activities.

Budget Estimate for the Hub

The Hub will offer comprehensive assessment, diagnostic and consultation services by drawing on a pool of identified experts. Individualized triage services will be available, in order to direct each individual to the appropriate level of care within the Collaborative or outside of it. Therefore, the associated costs are primarily for clinical staff, travel, assessment tools and training materials, as identified below.

Budget Estimate

Personnel-

- 1 Collaborative Administrator - \$130,000
- 1 Doctoral Level Behavioral Specialist - \$130,000
- 2 Master Level Specialists - \$200,000
- 1 Administrative Assistant (Billing, logistics, etc.) - \$60,000

Travel: \$40,000 (\$2,000 / trip @ 20 trips)

Collaborative assessment tools, manuals and training materials: \$15,000

Contractual consultants in and out-of-State: \$75,000

Total: \$650,000

Total Budget Estimate for the Hub = \$650,000
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Budget Estimate for Brief Stabilization Services

The Brief Stabilization Services component of the Collaborative is one of two intervention arms included in the proposed model. The Brief Stabilization Services will consist of three small units of approximately 5 beds each that may be used for brief crisis stabilization of generally less than a week, if deemed clinically appropriate following consultation. These units will be located in Anchorage, Juneau, Fairbanks, and potentially other regions with existing bed space that may be dedicated for this purpose.

Given that comparable services are not currently available in Alaska; this estimate is based on costs for 16-bed Acute Treatment Units in Colorado. These costs include management, administration, direct care, contractual costs and operating costs, without facility costs of approximately \$3 million, adjusted for the loss in economy of scale by operating fewer beds. Staffing includes at least one licensed professional in addition to other direct care staff, who will be a mix of highly trained and experienced high school graduates along with degreed staff. A breakdown of the costs is provided below.

Staffing to provide personal care and community living support services

2 FTEs - Program and Assistant Program Managers

19 - Direct Care Staff FTEs [5 days, 5 Evenings, 3 Nights]

Average Cost per FTE = \$50,000

Total Staff Costs = \$1,050,000

Operating costs to provide personal care and community living support services

Staff Liability Insurance \$2,000

Activities, Transportation, and Consumables \$35,000

Medications and Medical/Lab Expenses \$60,000

General Supplies (Office equipment supplies, linen, etc.) \$11,000

Staff Training and Development \$20,000

Total \$128,000

Total Staff plus Operating Costs (\$1,050,000 + 128,000) = \$1,178,000

Allowable Administrative Costs \$117,800

Maximum Payor Obligation for the Year \$1,295,800 - rounded to \$1,300,000

Days per Covered Year - 365

$\$1,300,000 / 365 \text{ days} = \$3,562 / 5 \text{ residents} = \712 based on similar program

The calculation for this request is based on \$1,300,000 resulting in an Average Daily Rate per Resident: **\$712/ day, \$259,880/year (based on 5 residents)**

<p>Brief Stabilization Services Total Estimated Costs (sans facility costs) = \$1,300,000 per 5-bed program, \$712/day per individual, \$259,880 per bed annually</p>
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Budget Estimate for Intensive Intermediate Intervention Services

The Intensive Intermediate Intervention Services component of the Collaborative will provide a residential option to individuals who require longer-term services prior to returning to previous or lower-acuity placements. This Service will be community-based and will provide a high level of structure and active behavioral intervention. The Intensive Intermediate Intervention Services will consist of three small units of approximately 5 beds each, staffed by highly-trained direct care staff, who will be a mix of highly trained and experienced high school graduates along with degreed staff capable of providing intensive behavioral interventions. These units will be located in Anchorage, Juneau, Fairbanks, and potentially other regions with existing bed space that may be dedicated for this purpose.

Given that comparable services are not currently available in Alaska; this estimate is based on a similar program in another state with an average daily rate of approximately \$540/day.

Staffing to provide personal care and community living support services

2 FTEs - Home and Assistant Home Managers

19.08 - Direct Care Staff FTEs [5 days, 5 Evenings, 2-3 Nights]

Average Cost per FTE = \$42,120

Total Staff Costs = \$884,520

Operating costs to provide personal care and community living support services

Staff Liability Insurance \$1,728

Activities, Transportations and Consumables \$11,000

Total Staff plus Operating Costs \$897,248

Allowable Administrative Costs \$89,200

Maximum Payor Obligation for the Year \$986,448

Days per Covered Year - 365

$\$986,448 / 365 \text{ days} = \$2,703 / 5 \text{ residents} = \$540 \text{ daily per individual based on similar program}$

The calculation for this request is based on rounding the \$986,448 above to \$1,000,000 resulting in an Average Daily Rate per Resident: **\$548/ day, \$200,000/year** ($\$548 \times 5 \text{ residents} \times 365 \text{ days} = \$1,000,000$).

Intensive Intermediate Services Total Estimated Costs (sans facility costs) \$ 1,000,000 per 5 bed program, \$548/day per individual, \$200,000 per bed annually

Collaborative - Full Costs, not adjusting for the cost of services currently provided

The **full cost** of providing all of the proposed Collaborative services in Alaska would be \$7,550,000 (not adjusting for the current costs to serve these individuals or potential federal Medicaid match). This does not include the transition costs related to transforming the services system.

<p>\$650,000 (The Hub) + \$3,900,000 (Brief Stabilization Services: 3 facilities at \$1,300,000 each) + \$3,000,000 (Intensive Intermediate Intervention Services: 3 facilities at \$1,000,000 each) = \$7,550,000</p>

When accounting for the additional services made available through the full Collaborative, which will divert individuals from emergency departments, jails, corrections, API etc., keep individuals closer to their home communities, and increase workforce competence; numerous vulnerable beneficiaries will benefit from these additional resources annually. While services such as those provided at API are necessary for some individuals, it is important to only serve those needing the most restrictive, intensive and expensive service as provided in this institution. Otherwise, Alaska is at risk of an ADA violation such as with *Olmstead versus LC*. Additionally, because of federal restrictions, API is not able to bill Medicaid for adults ages 22-64 for care provided, therefore requiring this care to be provided without the benefit of federal dollars, whereas the proposed community-based programs will be eligible for federal Medicaid matching funds. For this reason, diverting individuals from API when it is not the most appropriate placement will result in a significant cost savings for the State.

<p>Total Collaborative Cost: \$7,550,000 Sans adjustment for current services costs or federal Medicaid match</p>

New Collaborative Costs- Adjusting for the Costs of Services Already Being Provided

As noted previously in the *Proposed In-State Collaborative Services: Assumption 3*) The proposed services will be provided to existing beneficiaries, therefore, there are already costs associated with treating these individuals. Therefore, the estimates for the Brief Stabilization Services and the Intensive Intermediate Intervention Services assume that 70% of the costs are already being incurred by State, including through Medicaid funds. The .30 factor is not applied to the Hub services, as these are not services currently available, nor does it apply to the start-up and training costs. Therefore this analysis uses a factor of .30 to estimate the additional new costs for the Brief Stabilization and Intensive Intermediate Intervention Services.

Total estimated **new** costs (sans facility costs) to provide Brief Stabilization Services based on Assumption 3 above:

**Brief Stabilization Services per site = \$1,300,000 x .30 = \$390,000 per site in new funding,
\$214/day per individual, \$78,000 per bed annually
x 3 sites = \$1,170,000**

Total estimated **new** costs (sans facility costs) to provide Intensive Intermediate Intervention Services based on Assumption 3 above:

**Intensive Intermediate Intervention Services per site = \$1,000,000 x .30 = \$300,000 per
site in new funding, \$164/day per individual, \$60,000 per bed annually
x 3 sites = \$900,000**

Summary of new funding needed for the full Collaborative:

\$3,070,000 (\$2,720,000 programs + \$350,000 start-up and training)

\$650,000 (The Hub)

\$1,170,000 (3 Brief Stabilization Services programs)

\$900,000 (3 Intensive Intermediate Services programs)

Subtotal = \$272,000 for the services above

+ \$350,000 for start-up and training

Total = \$3,070,000

Total = \$3,070,000 in new costs for the Collaborative

New Collaborative Costs - Adjusting for State General Fund and Federal Medicaid Mix

Of the \$3,070,000 needed to support the new (additional) costs of providing the Collaborative services, it is important to estimate the mix of State General Funds and Federal Medicaid Funds. While it is recognized that some of these new costs are not Medicaid reimbursable, most of them will be. Conservatively assuming only 50% of the services are Medicaid reimbursable, the necessary State funds would be \$767,500 for State Medicaid match (50% State match) plus \$1,535,000 for the State General Fund services for a total of \$2,302,500 for the first year and a total of \$2,040,000 for continued funding (sans start-up costs) in subsequent years.

New Collaborative Costs - Adjusting for State General Fund and Federal Medicaid Mix					
	Total Funds Needed (Federal & State GF)	Estimated Federal Medicaid Reimbursable Amount (50% of half of the total costs)	State General Funds for Medicaid Match (50%)	Estimated State GF Needed for Non-Medicaid	Total Estimated New State General Funds Needed
Year 1 (With start-up costs)	\$3,070,000	\$767,500	\$767,500	\$1,535,000	\$1,535,000 + \$767,500 = \$2,302,500
Year 2++ (Sans start-up costs)	\$3,070,000 - start-up = \$2,720,000	\$680,000	\$680,000	\$1,360,000	\$1,360,000 + \$680,000 = \$2,040,000

New Collaborative General Fund Costs: Year 1 with start-up costs = \$2,302,500
Continued General Fund Costs without start-up costs = \$2,040,000

Summary Comparison of Costs and Services

Summary - Cost Comparison - Based on Annual Estimates				
Current Services	The Hub	Brief Stabilization Services	Intensive Intermediate Services	Cost of Proposed New Service Models
\$2,874,375 (in-State estimate)+ \$3,449,250 (out-of State estimate) = \$6,323,625	Total Cost: \$650,000	Total Cost for 3 Sites: \$3,900,000	Total Cost for 3 Sites: \$3,000,000	Total Cost: \$7,550,000
	\$650,000	Estimated NEW Cost to Alaska for 3 Sites: \$1,170,000 [\$1,300,000 x .30* = \$390,000 per site x 3 sites = \$1,170,000]	Estimated NEW Cost to Alaska for 3 Sites: \$ 900,000 [\$1,000,000 x .30* = \$300,000 per site x 3 sites = \$900,000]	Estimated Total NEW Cost to Alaska: \$3,070,000 ** (\$2,720,000 programs + \$350,000 start-up and training: \$50,000/program/site)
Total Estimated New State General Funds (GFMH) with start-up costs (year 1)				\$2,302,500
Total Estimated Continued State General Funds minus start-up costs (out-years)				\$2,040,000
<i>See notes above for detailed explanation of costs and assumptions</i>				
Current Array of Services for the Targeted Population				
The Hub	Brief Stabilization Services	Intensive Intermediate Services		
Periodic consultation services may be sought, however no structured consultation or technical assistance is available.	Emergency departments, jails, corrections, API, medical and surgical units of private hospitals, and other resources are generally used.	API, private hospitals, in-State residential services with increased staff (2:1), and out-of-State placements such as Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and Residential Psychiatric Treatment Centers (RPTCs).		

Notes:

* The proposed services will be provided to existing beneficiaries, therefore, there are already costs associated with treating these individuals. Therefore, the estimates for the Brief Stabilization Services and the Intensive Intermediate Services assume that 70% of the costs are already being incurred by State, including through Medicaid funds. Therefore the analysis uses a factor of .30 to estimate the additional new costs.

** Of the \$3,070,000 needed, some of these costs are not Medicaid reimbursable - such as some of the technical assistance and distance consultation as well as the start-up costs, however, most of them will be. Conservatively assuming only 50% of the services are Medicaid reimbursable, the necessary State funds would be \$767,500 for State Medicaid match (50% State match) plus \$1,535,000 for the State General funded services for a total of \$2,302,500 for the first year and \$2,040,000 for subsequent years (sans start-up costs).

Cost Benefit Analysis

The table below shows Alaska's Group Home costs compared with those of Colorado and Michigan, both of which have five-bed group homes. It also provides four different Alaska Group Home costs, three for in-State costs (one including a stay at API since many individuals are placed at API prior to transfer to an out-of-State placement) and one for out-of-State costs, to adjust for some of the existing cost options.

Comparison of Alaska's Group Homes Costs with Two Other States - Colorado and Michigan

Current Alaska Group Home Costs for Adults Compared with 2 Other States			
Alaska's Group Home In-State Costs	Group Home daily rate based on a population adjusted mean of \$630/ day	Current Annual Cost per Individual \$630 x 365	\$229,950*
Alaska's Group Home In-State Costs	Group Home daily rate based on the high-end of costs for this population \$809/ day	Current Annual Cost per high-acuity Individual \$809 x 365	\$295,285
Alaska's Out-of-State Group Home Costs	Group Home daily rate \$525	Current Annual Cost per Individual \$525 x 365	\$191,625**
Alaska Out-of-State Costs Adjusted for 3 months at API	Daily rate \$1,143 (API) for 1 Quarter and \$525 for 3 Quarters Combined daily rate of \$680	Estimated Annual Cost per Individual at API for 3 months prior to out-of State placement \$680 x 365	\$248,200***
Alaska's Group Home (w/ API) Average Costs	Average of the 4 daily rates noted above \$661	Annual Cost per Individual (\$661 x 365)	\$241,265
Michigan Group Home Costs	\$542 daily rate	Annual Cost per Individual \$542 x 365	\$197,830
Colorado Group Home Costs	\$620 daily rate	Annual Cost per Individual \$620 x 365	\$226,300
Michigan & Colorado Group Home Costs	Average of the 2 daily rates noted above (CO & MI) \$581 daily rate	Annual Cost per Individual (\$581 x 365)	\$212,065

Notes for table above:

* The \$229,950 is close to the proposed new Medicaid rate with the acuity add-on, which totals \$224,136 annually per person, \$614 per day per individual.

** This cost is only for the out-of-State placement and not costs incurred by the State for the individuals who are placed at API for 3-12 months (all State funds) prior to being transferred out-of-State, which is shown in the next calculation.

*** 1 Quarter of a year = API rate of \$1,143 + 3 Quarters at the out-of-State rate = \$525 equals an average daily rate of \$680 and an annual cost of \$248,200.

Comments:

When assessing the costs and benefits of group home services in Alaska with other states it is important to recognize that the comparison states have a more robust continuum of options, which can lead to program and cost efficiencies. That being said, Colorado and Michigan were selected because they do have five-bed group homes, some of which operate in rural parts of the states. Even though Idaho was visited, they were not used for the comparison because that is where Alaska currently sends adults needing intensive services, so their costs are the same as those that appear in the table as Alaska's out-of-State Group Home costs, which would not have been a useful comparison. Comparing the costs in Alaska with the two other states in the table above, if Alaska's four typical daily rates are combined, the mean is \$661, which is \$80 more than Michigan and Colorado's combined average daily costs. The \$80 per individual per day is 12% more than the comparison states, which is significant without any other considerations. However, it is important to note that the comparison states are providing more robust intensive services than are currently being provided to this population in Alaska, therefore they are also providing more intensive services at lower costs.

Comparison of Alaska's Group Homes Costs with the Proposed Collaborative Services

The following table illustrates the relative cost neutrality from a daily rate perspective of implementing the Collaborative services when compared with the current Alaska Group Home Average Annual Costs per Individual of \$241,265 (below in row 2). When the Hub is included, the total cost of the proposed services is approximately \$10,000 more than current costs and when omitted the costs are approximately \$10,000 less. The Collaborative significantly expands the continuum of care within Alaska for this population and offers consultation and technical assistance services through the Hub, across a much broader portion of Alaska's vulnerable beneficiaries than the target population identified by the Workgroup. When considering only the current out-of-State costs, (\$191,625 in row 1) the costs of the full Collaborative services (\$251,666 in row 3) are 24% more than what is currently being spent. However, this does not account for the numerous other beneficiaries who will directly and indirectly benefit from the services provided by the Hub, such as the consultation and technical assistance, which will allow many more individuals to receive specialized services without having to relocate to another facility.

Comparison of Alaska Group Home Costs Compared with the Proposed Collaborative			
Alaska's Out-of-State Group Home Costs	Group Home daily rate \$525 daily	Current Annual Cost per Individual \$525 x 365	\$191,625
Alaska's Group Home Average Costs	Average of the 4 daily rates noted in table above \$661 daily	Annual Cost per Individual (\$661 x 365)	\$241,265
Proposed Collaborative - Total Costs	Full Collaborative Costs of \$7,550,000 / 30 individuals / 365 days \$690 daily	Annual Cost per Individual (\$690 x 365) [actual is \$251,850 the difference from \$251,666 is due to rounding]	\$251,666
Proposed Collaborative- BSS & IIS Costs Only (Sans Hub services)	Average of the BSS & IIS daily rates \$630 daily	Annual Cost per Individual (\$630 x 365)	\$229,950

The Collaborative also allows for significantly more beneficiaries to benefit from this investment in services than is feasible when dollars are sent to another state, which offers Alaska's providers no experiential opportunities or incentive to enhance their ability to provide services to individuals with complex behaviors. Ultimately, the Collaborative offers Alaska greater control of the costs over time by eliminating or at least reducing out-of-State costs.

Short-term cost/benefit analysis for Alaska

Development of the proposed services has the potential to result in cost savings for the State while expanding the availability and quality of care to the identified population.

The proposed Brief Stabilization Services are estimated at \$712 per day (\$259,880 per individual annually - however this is a brief service of no more than 30 days) and the Intensive Intermediate Intervention Services are estimated at \$548 per day (\$200,000 per individual annually) for a more extended stay of up to approximately 18 months.

Therefore, assuming an individual uses the Brief Stabilization Services for 30 days for a cost of \$21,360 (\$712 x 30 days) and the Intermediate Intensive services for the remaining 11 months in the year for a cost of \$183,580(\$548 x 335 days), the total annual cost to serve that individual would be \$204,940.

Adjusting this to also include the average cost per person who receives services from the Hub at \$18,056 (\$650,000 annually /36 individuals estimate provided by the Governor's Council on Disabilities & Special Education) the total is \$222,996, which is \$18,269 less than the current average annual cost per person (\$241,265 - \$222,996 = \$18,269), as illustrated in the table below.

Short-term Cost/Benefit Comparison of Current Costs with the Proposed Collaborative					
Alaska's Group Home Average Annual Costs per Person	30 Days of Brief Stabilization Services	11 Months of Intermediate Intensive Intervention Services	Hub Consultation Services	Total Annual Collaborative Service Costs	Difference between Alaska's current and the proposed Collaborative Costs
\$241,265	\$21,360	\$183,580	\$18,056	\$222,996	-\$18,269
Conclusion: The average annual cost of providing services through the proposed Collaborative is \$18,269 less per person than the average annual cost of providing current services.					

These costs do not include the proposed start-up and training costs of \$50,000 per site, however this is a relatively small investment in the development of a more robust continuum of services within Alaska for some of its most vulnerable beneficiaries. Additionally, the implementation of the proposed Collaborative is an investment in Alaska's workforce, the benefits of which will span across the State for many years to come, an advantage that is priceless. Additional costs and benefits are noted in the *Comparative positive and negative characteristics of the proposed models and the current services model* section of this document, Appendix 4.

Long-term cost/benefit analysis

As noted in the Short-term cost/benefit analysis, the estimated average cost savings per person is \$18,269 annually, which if calculated on serving 30 people per year (based on the 30 beds that would be available within the Collaborative), there would be a savings of \$548,070 annually, which is enough to serve approximately two additional beneficiaries with cognitive disabilities and complex behavioral needs. While this represents considerable cost savings, it also provides Alaska with an opportunity to provide significantly more effective services to vulnerable beneficiaries.

The table below illustrates that within six years, the cost of the new services will be less than the cumulative savings over time. The demand for services evidenced by the ongoing waitlist supports serving additional individuals rather than actually saving or diverting these funds. Funding the Collaborative this does present a significant opportunity for Alaska to invest in more appropriate and effective services for vulnerable beneficiaries within the State.

The schedule of costs and benefits for the project are as follows:

Time (year)	Total Estimated Collaborative Annual Costs	Benefits (cumulative costs saved)
1	\$3,070,000	N/A due to start-up
2	\$2,720,000	\$548,070
3	\$2,720,000	\$1,096,140
4	\$2,720,000	\$1,644,210
5	\$2,720,000	\$2,192,280
6	\$2,720,000	\$2,740,350

Note: The benefits and costs are in constant value dollars- there was no inflation factor included in the analysis. Also, Year 1 includes \$350,000 in start-up funding, which is not included in the subsequent years. ($\$3,070,000 - \$350,000 = \$2,720,000$) Lastly, the estimated costs do not include initial facility costs that may be necessary depending on the site(s).

Additional savings exist when the improved continuum of care reduces admissions of vulnerable Alaskan beneficiaries to a more restrictive level of care than clinically necessary. This not only saves these limited resources for individuals who need them, but also better positions Alaska to avoid an *Olmstead* lawsuit because of potential Americans with Disabilities Act - related case. Such lawsuits are quite costly to states and while they may result in the development of needed services, are not the ideal way to develop them. However, it is important to note that while the Collaborative supports more effective and efficient use of resources, diverting some individuals from services such as those provided by the API will not directly result in a cost savings, as the demand for this level of care prohibits cost saving from downsizing that would be necessary for true cost savings. The proposed Brief Stabilization Services is a valuable program to divert individuals from emergency departments, jails and potentially corrections, by offering avoiding potential crises through clinically sound interventions, however projecting the potential cost savings is difficult up-front, but would be an important metric to track over time.

Cost/benefit analysis summary

Developing the Collaborative requires an investment in services for vulnerable Alaska beneficiaries with cognitive disabilities and complex behavioral needs. However, providing intensive services to individuals within the State allows for more control of the costs over time. Currently Alaska has some reasonable rates established with Idaho and a few other states, however this can change at any time and if these other states do not have capacity to serve Alaskans, it is unclear what could be negotiated with other states. However, what is clear based on trends in recent years is the need for more intensive services with behavioral supports for individuals with cognitive disabilities. Alaska can choose to develop capacity in-State to appropriately serve such individuals, investing locally in the infrastructure and workforce necessary or it can choose to continue separating individuals from their families and communities for indefinite periods of time.

Additionally, the proposed Collaborative model offer opportunities to better leverage Medicaid funds by keeping adults ages 22-64 years with cognitive disabilities out of the Alaska Psychiatric Institute and through the development of enhanced telemedicine capacity that not only extends consultation and technical assistance across the State allowing for timely engagement with less travel, but that can also be Medicaid reimbursable, if Alaska chooses to pursue this.

The diversion opportunities provided by the Collaborative have the potential to avert individuals in crises from emergency departments, jails and potentially corrections, which opens capacity for these services to individuals more appropriate for such services. At the same time, diverting these individuals with cognitive disabilities to the services provided through the Collaborative provides clinically sound interventions to vulnerable beneficiaries, which is more likely to lead to improved behavioral outcomes as well as less of a burden on other less appropriate systems, thereby reducing the likelihood of the need for these systems to increase their capacity over time; a significant potential savings for the State.

While the long-term savings for DHSS and the State may not be immediate or substantial, the long-term benefits are significant. Investing in services and the workforce within Alaska through the proposed Collaborative will have far-reaching benefits beyond individuals with cognitive disabilities. Developing a more competent workforce and the necessary infrastructure to support collaborative interventions and continuity of care is an important and overdue investment for vulnerable Alaskans, their families and their communities.

Recommendations

General Recommendation

It is recommended that a comprehensive continuum of care be developed for the identified population. To this end, the three components of the Alaska Complex Behavior Collaborative may be adopted and developed. The Collaborative supports Alaska's *Olmstead* plans as it broadens the continuum of services through the development and enhancement of integrated community-based services. A decision will need to be made regarding the implementation timeline, and whether the development should occur in phases. A commitment to providing the requisite support to ensure this development will need to be made at the State level and it is suggested that the Workgroup continue to meet to prioritize and track progress on the accepted recommendations from both Phase I and Phase II of this project; and to identify opportunities to implement and evaluate elements of the Collaborative for high-risk individuals, while the components are being developed and made fully operational.

Mentally Retarded / Developmentally Disabled (MRDD) Waiver Recommendation

The Department should track the number of Health and Safety Requests received by the Program Managers and the percent approved, along with denial information to assist the providers with understanding the request criteria and process and to promote uniformity of approvals across the State.

Rate Setting and Acuity Recommendation

Consider using cost-based rate setting methodology combined with an acuity-based tier or level system when setting individual budgets or levels of care rates for persons receiving services from the Alaska's 1915(c) MRDD and possibly other waivers.

Licensing Fees Recommendation

Alaska should evaluate their licensing fee structure and the intent of these fees, and if so determined, increase these fees to support program oversight and development.

Telemedicine Recommendations

Take necessary steps to allow for identified telemedicine claims to be reimbursable through Medicaid and State funds. Appendix 6 includes an example of this from Colorado.

Seek federal or other grant funding to support the expansion of telemedicine capacity across providers in Alaska, including having sufficient capacity at the DHSS.

Staff Competence Recommendations

Specific staff competence requirements should be developed and adopted. Requirements may include minimum educational achievement levels, specialized training, and continuing education. Detailed recommendations for staff competence can be found in Appendix 7.

Workforce Training and Development Recommendation

Consider having rates adjusted to include a portion specifically for staff training (such as ten cents per billing code) and that the Department, potentially through the Hub, ensures providers are aware of training opportunities and monitors training participation.

Assisted Living Home Program Expectations / Licensing Recommendation

Consider either adding more population-specific minimum intervention program expectations to the Assisted Living Home regulations or create more population-based regulations for individuals able to benefit from structured services and active interventions, such as individuals with developmental disabilities or Alzheimer's.

Facility Security Recommendation

Make a policy decision about which approach to facility security will be chosen for use within the Brief Stabilization Services and the Intensive Intermediate Intervention Services. If a decision is made to use building security, an official opinion of the current regulations is needed and depending on the findings, any necessary changes should be incorporated. However, if the preference is to use the staff secure option, an investment in adequate staffing and staff training will be necessary. Additionally, depending on the physical plant of each facility, there may be some building modifications that can be made to improve the line-of-sight and other safety and security matters.

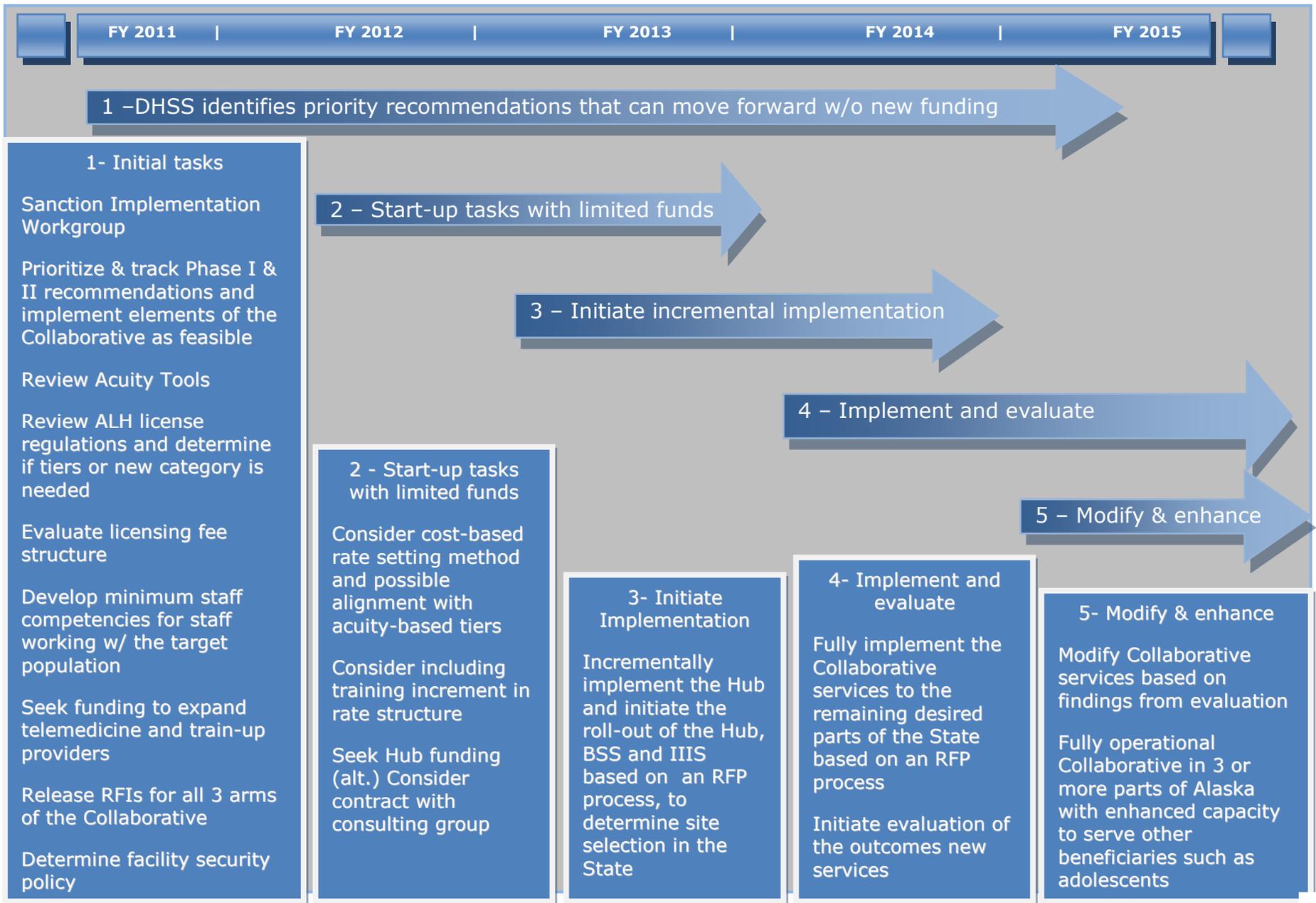
Licensing Recommendation

Designate at least some of the facilities that serve individuals with complex behaviors and complex management needs as more intensive and comprehensive; using the Centers for Medicare and Medicaid Services (CMS) regulations as guidelines, focusing specifically on facilities that become Intensive Intermediate Intervention Services.

Request for Interest Recommendation

Submit a solicitation of interest to determine the current desire and capacity of providers and potential providers to manage all of parts of the Collaborative. This effort will help inform next steps, including the roll-out of services to various parts of Alaska.

Alaska Complex Behavior Collaborative - Development Timeline



Appendix 1

Project Background Information

The following General Population Clusters are based on information from Phase I as well as additional information provided by the Phase II Workgroup. Many of the specific individuals identified in the Phase I sample had multiple co-occurring disorders identified while the tables below focus on the most frequently identified disorder clusters. For example, many individuals across the identified population clusters had substance use disorders and the individuals with a Traumatic Brain Injury (TBI) also were noted as having a mental health or developmental disorder.

While the Phase II Workgroup identified the population focus as *Individuals (adults) with cognitive disabilities and challenging behaviors, who often present safety issues for themselves and, or others*; it was noted that with the development of new service models, the broader treatment needs of the population cluster(s) will be addressed, either directly or indirectly. This information gleaned from the Project Workgroup helped in the identification of the needed service components as the Collaborative model for Phase II was developed. The table below summarizes the broad treatment needs of all population clusters considered prior to narrowing the Phase II focus to the identified population.

Service Gaps/ Needs by Cluster Identified by Phase I Data and the Phase II Project Workgroup

<u>DD/MI</u>	<u>DD</u>	<u>MH (SA)</u>	<u>ADRD</u>	<u>TBI/Neuro</u>
Crisis Stabilization and Supports	Crisis Stabilization and Supports	Crisis Stabilization and Supports	Crisis Stabilization and Supports	Crisis Stabilization and Supports
Longer term residential (structured behavioral intervention)	Longer term residential (structured behavioral intervention)	Supported Housing? Other “step down” options?	Long- term residential (behavioral intervention)	NeuroRehab Program 3-24 months Neurobehavioral program
If Serious Medical Needs: Medical Staff/Facility				Supportive living (2-5 years) Long-term residential

Estimated Number of Out of State or 'At-Risk' Individuals and Approximate Costs for Alaska

Population Clusters	Statutory Priority	# At-Risk of OOS Est. (PIT)	Average Cost/Day	Average LOS	Annual Cost/Person
Youth					
DD/MH	YES	FY09 = 42 placed OOS	Estimated \$450	18 months	\$164,250
DD	YES	19 (11/2/09)	Group Home \$360*	Long-term	\$131,400
Adult					
DD/MH	YES	13 (duped w/ DD)	API \$1,143	3-12 mo	\$417,195
DD	YES	14 11: OOS	ICFMR (ID) \$525 Group Home \$352**	22.4 months+ Long-term	\$191,625 \$128,480
MH (SA)	YES	36	API / \$1,143 (Not all)	1-6 months	\$417,195
ADRD	YES	11/72 7+	API \$1,143 PH \$206+ 1:1 staff	1-3 months Long-term	\$417,195 \$75,190 +
TBI	YES for DHSS	Data not available, however many of the individuals noted above also have a traumatic brain injury (TBI). This is a growing population.			

(OOS = Out of state)

* Range for daily rates for Group Homes is \$167 - \$1,794 (less than 22 years of age)

** Range for daily rates for Group Homes is \$86 - \$809 (22 years and older)

+ The longest placement has been 3 years and 3 months, the shortest, 1 month. Of 11 individuals who have left the State in Spring of 2010, one has returned, 5 have been out-of-State over 2 years. Only 1 of the 10 is actively working to transition back to a home in Alaska.

While it is not realistic to develop definitive numbers for at-risk individuals, the table above illustrates the broad scope of individuals at a point in time with significant complex behavioral needs, some of whom are currently in out-of-State placements. Because behaviors are not static over time, it is important to understand from a planning perspective that the specific individuals needing the services proposed by the Collaborative will change. However, the need for more coordinated, intensive consultation and services persists and will likely grow over time as the identified population continues to expand.

Youth: As of 7-20-10, of the 128 youth in out-of-State placements, 15 had a Mentally Retarded/Developmentally Disabled waiver or the offer of the waiver and four (4) had an open Senior and Disabilities Service file and may or may not have been on the waitlist for a waiver. These are all youth with co-occurring diagnoses and complex behavioral needs. Of these 19 youth, approximately three-fourths were originally from the Anchorage area, which demonstrates at a minimum, a strong need for more intensive services for youth in Anchorage. However, given the importance of trying to keep families united, it will also be beneficial to

develop more intensive services for youth in Juneau, Fairbanks and other parts of the State over time.

Adults: For the adult population there are typically 10-14 individuals with cognitive disabilities in long-term out-of-State placements due to complex behavioral needs that cannot be safely and effectively managed in Alaska. Additionally, there are typically an additional 10-12 adults receiving services at API, as a last in-State resort and not because it is the most appropriate placement for services for these individuals, many of whom have cognitive disabilities, such as intellectual disabilities and dementia. This is in addition to the 36 individuals noted in the table above at API with mental health and substance use disorders, who are also at-risk of out-of-State placements. These numbers do not account for the numerous individuals who end up in jail and corrections, when appropriate services are not available. These individuals often face significant challenges when trying to re-integrate back to their home communities and have a high risk of recidivism. Current efforts to develop disposition and transition plans for these individuals is very difficult because of the dearth of resources and the complexity of the services and supports that are often needed.

Additionally there is a growing population of older adults in Alaska, many of whom are served through Pioneer Homes, with Alzheimer's and other forms of dementia, who have significant behavioral needs. The table notes that 11 of the 72 API inpatients at one point met these criteria. At the same time, there were an additional seven (7) individuals in Pioneer Homes with very serious behavioral needs, many of whom were receiving special resources, such as one-to-one staffing to promote the safety of these individuals as well as that of the other residents.

Key Informant Interviews - Alaska

Once the identified population for the Phase II focus was determined, several key informants were interviewed in order to clearly detail the service gaps existing in the State. The information gleaned from these interviews centered on the recurrent themes of issues related to workforce, the need for crisis stabilization and mid-level acuity placements, the lack of active treatment in residential facilities, and the need for changes in the Medicaid reimbursement rates.

In terms of workforce issues, key informants frequently cited the need for a more highly trained workforce to manage the complex behavioral needs of the identified population. Currently, the majority of care providers have high school diplomas and no specific training in care provision or intervention for the identified population. For this reason, the majority of group homes in the State do not provide active intervention, although many focus on skill teaching and activities of daily living. Staff, reportedly, frequently do not have access to technical assistance or consultation when they are unsure how to best intervene with an individual who is experiencing challenging behaviors, or to obtain their own support related to the high-stress nature of the occupation. High turnover rates are frequently a problem, likely due to staff burnout from the ongoing stress of attempting to provide care for a challenging population without adequate support or training. The need for training, including on-the-job training, as well as technical assistance, recruitment and retention processes, and respite for providers were clearly prioritized by key informants.

The need for appropriate crisis stabilization and mid-level acuity placements for the identified population was also noted by multiple key informants. Currently, individuals must be admitted to API in order to receive crisis services. While API provides crisis services, there is not a designated intervention program for persons with intellectual disabilities which often means that it is not an optimally beneficial facility for the identified population. Additionally, individuals in crisis often get “stuck” in other systems such as corrections or medical hospitals where they are unlikely to receive intervention services for long periods of time. One informant stated that the Crisis Recovery Center through Providence Hospital will occasionally accept a member of the identified population; however, this is not seen as a reliable placement that can be consistently utilized. Therefore, the need for appropriate crisis stabilization services, adequately staffed by professionals trained to work competently with the unique needs of individuals with intellectual disabilities and complex behaviors, is a high priority. Informants also noted the need for partnerships between the professionals who care for the identified population and the medical systems, corrections, and API in order to enhance communication across systems about the needs of the population.

The mid-level acuity placements were conceptualized by several key informants as needed “step up” and “step down” facilities that could serve as intermediate placements between low-acuity community facilities and high-acuity crisis stabilization facilities. Following stabilization after a crisis, an individual is oftentimes not ready to return to a low-acuity community facility, as they require a higher level of ongoing structure and active intervention than what can be reasonably provided in their previous community setting. Without this ongoing structure and intervention, an individual may have a difficult time returning to their baseline level of functioning. Conversely, if an individual has not recently had a behavioral crisis but has demonstrated recurrent complex or unsafe behaviors, that individual is likely in need of a higher level of structure and active intervention in order to prevent a crisis.

According to key informants, many of the individuals within the identified population in Alaska require the option for long term placements within mid-level acuity placements with highly trained staff, active intervention, and a high level of structure. Several informants stated that these placements would need to be lockable, in order to ensure safety. Informants noted that these facilities should be small and not “institutional” and should make use of existing bed space in the State rather than new construction. One interviewee specified that these facilities should be conceptualized as transitional, with the goal of returning to the previous community-based residence. The need for a multi-disciplinary team approach was emphasized, as well as the need for contractual services from professionals who may be out-of-State. It was noted that contracting services typically means limited availability of services, thus the contracted services should be auxiliary and not the core component of high-level service.

The lack of active intervention within the current care system for individuals with intellectual disabilities and complex behavioral needs recurred as a theme in the key informant interviews. The identified population requires access to active intervention on an ongoing basis. The current care system in Alaska is comprised largely of group homes and Assisted Living Facilities staffed by personnel who have not been adequately trained and are not expected to provide this type of intervention. While all key informants interviewed shared the core value of preferring community-centered care, it was agreed that access to the necessary level of active intervention is not currently available in the community care system. Therefore, in addition to the need for facilities that are developed to provide care specifically for members of the identified population who require mid-level acuity services, there is a need to promote a culture of active intervention within the current care system in order to minimize the need for mid-level acuity and crisis stabilization placements.

Issues with the current Medicaid rate system in Alaska were noted frequently by interviewees. Most individuals within the identified population are Medicaid eligible, although obtaining reimbursement at an appropriate level based on the care that the individuals require is

challenging. Acuity levels are currently not used in the rate setting system, and the rates are determined instead on a provider cost basis. While reimbursement rates in Alaska were historically set on an individual basis, they are now aggregated within provider systems and each provider has a rate agreement. Rates have been frozen at the current level since 2004, although new rates are being set at this time and will be phased in over three years. Multiple key informants stated that the rate at their facility is insufficient to cover the costs of care provision, and one informant noted that her facility conducts fundraising events in order to compensate for the rate differential. Providers may apply to receive an augmented rate for individuals who require an exceptionally high level of services; however, there are no formal standards that govern how that rate is determined. Some informants stated that they seldom request to receive the augmented rate to better serve individuals with cognitive disabilities and complex behavioral needs. The request process is cumbersome and typically not successful. Instead, when appropriate they often try to get additional funding for mental health services. Informants reported that some individuals require the augmented rate indefinitely. The rate setting process is currently being modified and it was reported that more standardized processes were being developed.

Key Informant Interviews and Findings - Other States: Michigan, Idaho and New Hampshire

Michigan began moving from institutional to community based care in the 1980/1990s for individuals with disabilities. This began their movement from large institutions to alternative intermediate services. Recently, in the past year or so, the State has moved away from ICF/MR classified facilities in order to increase their programmatic flexibility and reduce their regulatory burden.

Michigan has 46 full-management Community Mental Health (CMH) Boards with responsibility for the needs of individuals with mental illnesses, substance use disorders and developmental disabilities. The CMHs are responsible for all State Hospital placements and pay the State Hospital for their services. They contract with the State as regional Prepaid Health Insurance Plans (PIHP) for Medicaid funds in low populated areas. To become a PIHP the federal government requires a capitation model and actuarial soundness. Structuring these regionally helps with the costs of services - given the improved 'economy of scale'. Their Medicaid match rate is currently about 55%.

Pathways is a CMH in the upper peninsula of MI, with responsibility for a four (4) county region. Pathways has not operated an ICF/MR in the past 18 years. Since the 1990s they have been operating about two dozen group homes, several with six or fewer beds. Pathways had growing concerns about the management and care of several individuals with cognitive disabilities and complex behaviors and decided to seek a provider willing to provide specialized services to this population. After a competitive bid resulting in the award of a contract, Life Options began operations in April of 2009 in Marquette, which is a six-bed facility (only 5 individuals so far) specifically targeted for individuals with significant challenging behaviors. Typically they see that 'gaps or flaws' in the service system expose individuals with significant challenging behaviors.

Life Options is a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited facility that currently has five residents ages 24 to 56; currently four males and one female. Common diagnoses include mild to moderate developmental disabilities, autism and co-occurring developmental and mental health disabilities. All of the current residents were previously served in state facilities. The behavioral history of the individuals served includes extreme aggression toward others - sometimes resulting in significant injuries to staff, property destruction and elopement. Life Options is staffed with five direct care staff on days and evenings and three on nights. In addition, there is an administrator on the day and evening shifts most days and on-call other days.

Prior to the opening of Life Options and serving individuals with the most challenging behaviors within the same facility, one resident caused approximately 12 serious staff injuries, many

which included lost work time. Since Life Options has been open, staff have only had some minor injuries and none of these resulted in lost work time. This change is associated with increased staff training and support, a highly structured program, behavioral plans and hiring the right staff. Their staffing composition is an equal mix of males and females. Staff need to be agile enough to physically manage residents when necessary, however they do not need to be 'body builders'. A local occupational therapist developed an endurance test that potential staff have to pass before being hired to work at Life Options to ensure they have the agility and strength to reduce the risk of injury while working at Life Options. It was noted that staff who are warm, positive, engaging and disarming tend to work the most effectively with the residents. Recruitment activities focus on hiring individuals with college degrees and staff at Life Options earn 25% more than other group home staff because of their higher level of training and competence and because of the higher risk of working with the identified population.

Prior to the opening of Life Options, staff received four weeks of eight-hour per day trainings. While the residents for Life Options had been identified, staff had no contact with these individuals until after they completed their training. Some of the training was client-specific and included role plays, in addition to trainings that covered areas such as biopsychosocial assessment information and Professional Crisis Management through the Professional Crisis Management Association, Inc. based in Sunrise Florida. In addition, opportunities for team development and socialization were part of the training. This initial training for about 22 staff cost approximately \$60,000. While Life Options believes that this was well-spent time and money, they have since had to reduce the duration and content of the training. They continue to provide the 'resistance training' role plays but have had to reduce the team building exercises. They have also adapted the training for smaller groups of new hires, since the program is now operational, which it was not for the first staff who received the training. In addition they use the Toolbox Kit developed in Brighton Michigan for basic direct care staff training. The cost to use this training is \$200 for the provider for the first year and \$50 for subsequent years.

Life Options has mandatory weekly staff meetings to broaden staff skills in areas such as low level interventions and to trouble-shoot behavior plans. This is also a time for staff to support one another and to allow for de-briefing of incidents. Staff are strongly discouraged from working overtime or covering extra shifts in order to reduce the risk of burnout. Life Options continues to work on developing and enhancing community relations with the neighborhood, law enforcement, local hospitals and other community agencies.

Since Life Options opened, none of the residents have returned to state facilities (although a couple went to local hospitals for one-to-two days) and there have been no serious resident or

staff injuries. The staff that have chosen to resign have been positive in their reports about their work experience. Some did not feel that the work suited them well, while others had to resign because they left the area.

Idaho

Westcare Management, Inc. - Belmont operates two care options for individuals living with developmental disabilities including an Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/ID - previously called ICF/MR) and a Residential Habilitation Program. The ICF/IDs are community-based and have a high level of structure a vigorous active treatment with services provided by a comprehensive team of professionals. Their Residential Habilitation program is apartment-based, less structured, with varying levels of supervision based on the needs of each individual. These programs are 100% Medicaid funded and their Department of Health and Welfare determine Medicaid eligibility.

Three ICF/ID programs were visited during Phase II that are operated by Belmont; one in Pocatello and two in Idaho Falls, one six bed ICF/ID facility and a new twelve bed facility, which began operations July of 2010. Idaho continues to be an approved Alaska Medicaid provider successfully serving several adult Alaskans with developmental disabilities and complex behavioral needs, which is why it was re-visited during Phase II.

Their services include but are not limited to self-help, medical, behavioral, vocational, academic, and social. In addition, they have a specialized program for individuals with inappropriate or illegal sexual boundaries. Participants are involved in a caring and safe environment with group and individual treatment settings. Belmont also provides Waiver services to individuals residing in their own homes or apartments, providing up to 24 hours of supervision and treatment in a community setting. These participants can receive assistance with daily life in the areas of self-help, medical, behavioral, vocational, and social.

The staff at Belmont are well trained to meet the complex needs of the individuals served. The Idaho programs visited provide direct care staff with 90 hours of training during their first 30 days of hire, with subsequent periodic training and in-services. They attribute the much of their success to their training program. There is also a strong emphasis on hiring people well-suited for the jobs and then providing them with the knowledge and support they need to be successful in their work.

One of the ICF/IDs visited has 15 beds and the one opening soon has 12 beds, while most of their other facilities are smaller six to eight bed group homes. These facilities provide highly structured, active treatment seven days per week to individuals ages 18 and older, with most ages 20-30 years, although the ages generally range from 18 to 50 years. Their direct care staffing for a six bed program is usually three on days and evenings and two on nights. The

individuals observed during the facility visit were actively engaged in the program and appeared to function well in these structured, supportive environments.

Admissions from Alaska continue to have a difficult time transitioning to programs in Idaho. One reason involves cultural, geographic and seasonal differences between the two states; such as missing their previous home and families (visits are infrequent if they occur at all, because of the cost), and experiencing day and night transition issues. Another reason is that most individuals coming from Alaska appear unaccustomed to 'active treatment or interventions', - the structure and expectations that are part of a more robust individualized program.

Idaho's waiver services for individuals with developmental disabilities specifically allow for behavior consultation and crisis management services. A description of these services is located in Appendix 8.

Idaho regulations allow for these services to include the provision of training and staff development to providers related to the needs of an individual. This service requires the provider to meet directly with the individual. This information provides an example of a role that the proposed Hub can fulfill in Alaska, and would be enhanced if telemedicine services are allowable.

New Hampshire

While New Hampshire's programs were not reviewed for this project, they are one of the few states without ICF-MR facilities, thus information about their capacity to serve individuals with complex behaviors was obtained through a report. This report, A Governor's Commission to Study Area Agencies and Their Role in Providing Services to New Hampshire, November 18, 2005, has a section specific to services for individuals with complex needs, which follows. These paragraphs are excerpted directly from the report. A full copy of the report with footnotes can be viewed at: www.drcnh.org/AAGovCommrept.pdf

"Services for Persons with More Intense or Complex Needs"

The consequences from funding constraints are heightened for individuals with more complex needs, i.e. children or adults with developmental disabilities:

- with very challenging behaviors
- who may pose a danger to others and the community and have so-called forensic issues
- with complex medical needs, including aging adults with significant medical needs
- with multiple other disabilities, e.g. communication, deafness, motor, (coupled especially with significant cognitive impairments) and particularly in more rural parts of the state where services are more difficult to obtain

In a highly constraining budget situation, several concerns emerge. One is that individuals in these groups will receive services, and high cost services, at the expense of others. This is because they have greater service needs and/or public safety issues are of concern, in the case of the “forensic group.” A second, is that their needs will not be met well or they will be placed in an inappropriate or overly, and generally more costly, restrictive environment. All of these phenomena have occurred.

- With regard to individuals with so-called **forensic needs**, the issue and costs associated with this group have been well and publicly chronicled. There have been only 11-12 individuals committed under RSA 171-B, the Involuntary Admission For Persons Found Not Competent To Stand Trial law passed in 1995, with only a one dollar appropriation. There are significantly more than 11-12 individuals who are reported to have forensic type issues being served by the AAs who have never been committed under RSA 171-B and/or may not be committable. There is concern amongst family members of persons on the wait list or receiving services that persons with forensic needs are taking away resources from their family members. There are overgeneralizations here to be sure. There has not been clear agreement on the nature, scope or solution to the issue. The need for more expertise in treating this population has been recognized. A recommendation is proposed below (Section VI(C)(5)(e)) which is cost effective and addresses the critical treatment and safety needs.
- As to “adult family members with complex medical needs or extremely challenging behavior,” who require total care and supervision” or “cannot be left alone for fear of harming themselves,” as found in Renewing, families are under great “stress and at risk of physical and emotional exhaustion,” while the individuals are on the wait list. These persons are of high priority to be taken off the wait list. Generally services are in-home, which does relieve the stress. However, an overriding concern remains “when living at home is no longer an option [and] these individuals will require intensive community-base residential services.” As was stated in Renewing in addressing this population: Currently, New Hampshire’s developmental services system lacks the capacity to provide adequately for the needs of its most challenging citizens.
- Individuals with a **primary** diagnosis of developmental disabilities are increasingly finding themselves at the state psychiatric facility, where the cost of care is between 10-15 times the cost of DD community services. This despite the fact that positive, humane and effective approaches to address serious behavior problems have been in existence and enjoyed fairly widespread use for 20-25 years. However, from 1998 to 2004, there was a 450% increase in the number of individuals with a primary diagnosis of a developmental disability when discharged from NHH, from 7 individuals to 32. "

Appendix 2

Current Array of Services and Service Gaps in Alaska

Alaska's service system for individuals with cognitive disabilities is adequately developed over most of the State, which includes an array of group homes, assisted living facilities, and other home and community-based services. However, often the existing programs and services lack the intensiveness and the structure that some individuals need. This gap is especially apparent for individuals with complex behavioral needs. Whether the individual is a young adult with a co-occurring cognitive and mental health disorder or a senior with Alzheimer's, programs lack the capacity to adequately and appropriately serve these individuals. Even with Alaska's Waivers (Section 1915(c) of the Social Security Act, which are generally for individuals who need higher levels of care than those typically funded through other programs, the needs of many vulnerable beneficiaries are not being met within the State.

During Phase I of the project, a survey was developed to capture client-level data about individuals who represent, as a sample, the target population to assist with efforts to identify the program and service needs for individuals at-risk of out-of-state placement. Findings from this survey are summarized below and include the demographic and clinical presentations of the individuals who were placed out-of-State and those who were determined to be at-risk of out-of-State placement. Information from the survey assisted with determining the placement barriers and resources needed for successful treatment of these and other similar individuals in Alaska. Survey respondents were asked to select the usual or typical place of residence and services for the individuals surveyed. Approximately half identified their usual place of residence as either private home/apartment (38%) or group boarding home (11%). Twenty percent identified assisted living facilities, while 10% identified nursing homes or other long-term care facilities. Another 19% identified residential treatment facilities (youth - 7%) and foster home/family habilitation (12%), while the remaining two percent identified a hospital as the usual place of residence.

The survey indicated the Regions identified below as the permanent home or residence for the identified individuals. Region IV, the Anchorage Municipality was the most frequently noted Region across all age groups in Alaska. This information is helpful in determining the regions for developing more intensive services while allowing as many individuals as possible to be served close to their home communities.

<u>Region</u>	<u>Description</u>	<u>Number</u>	<u>Percent</u>
Region I	Bethel Census Area, Wade Hampton	1	2%
Region II	Denali Borough, Fairbanks North Star Borough Southeast Fairbanks, Yukon-Kuskokwim	2	3%
Region III	North Slope Borough,	2	3%
Region IV	Anchorage Municipality	33	55%
Region V	Kenai Peninsula, Matanuska-Susitna, Valdez-Cordova	14	24%
Region IX	Haines Borough, Ketchikan Gateway Borough Juneau Borough, Prince of Wales - Outer Ketchikan, Sitka Borough, Skagway-Hoonah-Angoon, Wrangell-Petersburg, Yakutat Borough	6	10%
X	Other (Out-of-State and Country)	2	3%
Total		60	100%

Intensity of Treatment/Placement Needed

This survey item addressed the type of intervention/placement needed along with the level of independence and supervision that would be needed to safely address the treatment needs of the individuals surveyed. The following table summarizes the data from this survey item.

Intensity of Treatment/Placement Needed (one answer only)		
Answer Options	Response Percent	Response Count
Independent; may need home/community-based/outpatient services/therapy.	0.0%	0
Independent; needs home/community-based/outpatient therapy and limited case management.	3.3%	2
Semi-Independent; needs support/supervision and/or moderate case management, home/community-based/outpatient program.	3.3%	2
Semi-Independent; needs moderate to extensive case management and home/community-based/outpatient program.	5.0%	3
Needs moderate supervision, extensive case management and home/community-based/outpatient program.	10.0%	6
Needs 24 hour MH/DD supervision, home/community-based/outpatient day program and some behavior management (unlocked).	33.3%	20
Requires 24 hour care with possible locked capacity; total case management, behavior management and extensive therapeutic interventions.	35.0%	21
Needs lockable hospital-type setting in facility with seclusion/restraint capacity, diagnostic services and behavior management.	10.0%	6
answered question		60

78 percent
47 individuals

Seventy-eight (78) percent of the individuals (47) sampled require 24-hour supervision with levels of intensity varying from home, community-based or outpatient services to a lockable hospital-type facility, all with the availability of behavior management programming. The remaining 22%, 13 individuals, can be managed in an independent or semi-independent community-based setting with some supervision, case management and possibly therapy or other services. Therefore, a significant majority of the identified individuals required 24-hour intensive, structured active treatment services.

Survey respondents were also asked if residential services were needed and responses indicated that approximately 72% were in need of a residential facility.

For the individuals needing a residential facility, the identified facility security indicated that approximately half of the facilities could be open, while the other half should be locked or at least lockable as noted in the following table.

Facility Type - Security			
Open	Locked	Lockable	Response Count
22	5	16	43

With regard to the staffing needs for residential facilities, only three (3) indicated needing nurses available 24-hours per day, one needing a physician available during the day, while 39 would need non-medical direct care staff around the clock. Clearly the individual staffing needs vary, however as noted in the table below, most of the individuals either do not need nurses or physicians, or having these staff available on-call would be adequate. Some of these medical needs may be addressable through the development of telemedicine capacity.

On site staffing needs for residential facilities:						
Staffing Needs - Nurses						
	None	On call	Day	24-Hour	Response Count	
	12	18	8	3	41	
Staffing Needs - Physicians						
	None	On call	Day	24-Hour	Response Count	
	12	28	1	0	41	
Non-medical Direct Care Staff						
	None	On call	Day	24-Hour	Response Count	
	0	1	3	39	43	
					<i>answered question</i>	43

Appendix 3

CMS Regulations for Intermediate Care Facility for the Mentally Retarded Compared with Practices in Alaska

While Alaska is not currently interested in or prepared to seek CMS Intermediate Care Facility for the Mentally Retarded (ICF/MR) certification for some of its facilities, designating at least some of the facilities that serve individuals with complex behaviors and complex management needs as intensive supportive environments and using the CMS regulations as guidelines will help to develop staffing and program structure that would better serve these individuals and reduce the likelihood of out-of-State placements.

Staffing

Alaska's group homes are licensed as Assisted Living Homes and typically have one to four individuals receiving services at each site. For a four-bed facility, day and evening shifts usually have two to three staff, with two awake staff at night. Occasionally individuals receive one-to-one supervision in an effort to contain behaviors for the safety of the individual as well as other residents and staff. Facility staff are typically high school graduates with variable levels of training, and many facilities experience high staff turnover. Some agencies also have behavioral health associates, psychologists and other staff available to provide technical assistance and training for direct care staff.

Alaska's staffing patterns are similar to those of other states such as Colorado and Michigan however, a notable difference is the higher level of training that is generally supported by other states. This is especially true in states that have ICF/MRs, as the corresponding CMS regulations require specified staff qualifications. For example, with regard to staffing, Title 42 Page 473 states:

"Sec. 483.430 Condition of participation: Facility staffing.

(a) Standard: Qualified mental retardation professional. Each

client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who--

- (1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and
- (2) Is one of the following:
 - (i) A doctor of medicine or osteopathy.
 - (ii) A registered nurse.

(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)5)of this section.

(b) Standard: Professional program services.

(1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.

Professional program staff must work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members."

(http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr483_00.html, 8/2/2010)

Additionally, CMS mandates that direct care staff be Qualified Mental Retardation Professionals with specific training requirements:

"(e) Standard: Staff training program.

(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. [42CFR483.15 Page 475]

Service and staffing needs in Alaska

The current staffing patterns for most programs in Alaska appear to work well for many individuals with cognitive disabilities; however, it is clear from discussions with key informants

that for the sub-set of these individuals with complex behavioral needs, more staff are needed. Equally important however, is the training and support that staff need to successfully work with individuals with complex behavioral needs.

Program infrastructure and services/activities

Direct care staff in other states, such as Colorado, Idaho and Michigan, accompany residents to day programs as well as various appointments and meetings such as with medical staff, therapists, psycho-social rehabilitation and employment counselors as well as to a variety of recreational and social activities. While the amount of structured activities provided to individuals varies across sites, in general there are more structured client-specific interventions in these states than what is typically available to individuals in Alaska. This appears to be related to the fact that most of other states serve individuals in ICF/MRs or, when no longer certified by CMS as such, the states still follow the CMS requirements within their treatment facilities, which have specific program, activity and staffing requirements. For example, these regulations with regard to activities, state:

"f) Activities

- (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.
- (2) The activities program must be directed by a qualified professional who--
 - (i) Is a qualified therapeutic recreation specialist or an activities professional who--
 - (A) Is licensed or registered, if applicable, by the State in which practicing; and
 - (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
 - (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in patient activities program in a health care setting; or
 - (iii) Is a qualified occupational therapist or occupational therapy assistant; or
 - (iv) Has completed a training course approved by the State."

(Code of Federal Regulations)[Title 42, Volume 3, Parts 430 to end] [Revised as of October 1, 2000] From the U.S. Government Printing Office via GPO Access [CITE: 42CFR483.15] [Page 434-435 http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr483_00.html, 8/2/2010.

Appendix 4

Summary highlights of the comparative positive and negative characteristics of the proposed models and the current services model

Positive and Negative Characteristics	The Hub	Brief Stabilization Services	Intensive Intermediate Services	Current Services
Fiscal Environment Positive Characteristics	Need to examine Medicaid regulations to determine and leverage billable opportunities Workforce investment	Cost control within Alaska Workforce Investment Requires new resources	Cost control within Alaska Workforce Investment	
Fiscal Environment Negative Characteristics	Requires new resources Need flexible funds Adequate service rates and resources are needed for staffing, workforce training and development and technology enhancements	Adequate service rates and resources are needed for staffing, workforce training and development and technology enhancements	Adequate service rates and resources are needed for staffing, workforce training and development and technology enhancements Requires new resources	Ongoing indefinite and likely increasing investment Risk of expenses related to ADA lawsuit, dollars that could otherwise be used to develop and support intensive services
Workforce Positive Characteristics	Development of trained experts Improved staff retention & recruitment	Development of professional and para-professional staff Improved staff retention and recruitment		
Workforce Negative Characteristics	Requires new resources	Need for higher level of salary compensation	Start-up and ongoing staff training costs essential for quality services Need for higher level of salary compensation	No current incentive to train - up Alaska's workforce

Positive and Negative Characteristics	The Hub	Brief Stabilization Services	Intensive Intermediate Services	Current Services
Geographic Positive Characteristics	Base in Anchorage with televideo connectivity across the State and with other states	Initially in Anchorage, may be expanded to other parts of the State	Initially in Anchorage, Fairbanks and Juneau Expand resource opportunities with underutilized capacity in 2-3 other parts of the State	
Geographic Negative Characteristics				Frequently a burden on existing community providers and API Transportation - Individuals are sent to other states for indefinite periods of time
Environmental Positive Characteristics	Many good technology resources currently exist	Culture change to provide a greater degree of active interventions with less reliance on jails, emergency departments, API and medical/ surgical units	Culture change to provide a greater degree of active interventions and responsibility to serve individuals with complex behavioral needs instead of turning them away	
Environmental Negative Characteristics	Requires some technology investment			Limited options when other states do not have capacity Relieves AK of responsibility for program development

Positive and Negative (and Neutral) Characteristics	The Hub	Brief Stabilization Services	Intensive Intermediate Services	Current Services
Policy Implications Negative Characteristics	Requires an ongoing commitment to dedicate resources to build and sustain a strong workforce and adequate continuum of care	Requires an ongoing commitment to dedicate resources to build and sustain a strong workforce and adequate continuum of care May require statute/regulatory change for a lockable facility	Requires an ongoing commitment to dedicate resources to build and sustain a strong workforce and adequate continuum of care May require statute/regulatory change for a lockable facility	Out-of-State administrative and quality of care responsibilities for DHSS
Policy Implications Neutral Characteristics	Depending on the beneficiary population served, age and level of care; regulation and certification issues will need to be addressed	Depending on the beneficiary population served, age and level of care; regulation and certification issues will need to be addressed	Depending on the beneficiary population served, age and level of care; regulation and certification issues will need to be addressed	
Costs Positive Characteristics	Keeps Alaska's dollars in-State	Keeps Alaska's dollars in-State	Keeps Alaska's dollars in-State	
Costs Negative Characteristics	Staffing and transitional costs Staff development: start-up and ongoing including both direct training costs as well as costs incurred when direct care provider positions need to be back-filled Technology enhancements	Start-up and transitional costs Staffing Staff development: start-up and ongoing including both direct training costs as well as costs incurred when direct care provider positions need to be back-filled	Start-up and transitional costs Staffing Staff development: start-up and ongoing including both direct training costs as well as costs incurred when direct care provider positions need to be back-filled	Takes Alaska's dollars out-of-State Emotional costs Cultural costs Distance administrative oversight Transportation

Characteristics	The Hub	Brief Stabilization Services	Intensive Intermediate Services	Current Services
<p>Benefits Positive Characteristics</p>	<p>Improved program and outcomes</p> <p>Development of system of care for the future</p>	<p>Improved program resources and outcomes</p> <p>Investment in a continuum of care</p> <p>Emotional and cultural benefits for individuals and their families</p>	<p>Improved program resources and outcomes</p> <p>Investment in a continuum of care</p> <p>Emotional and cultural benefits for individuals and their families</p>	<p>Status quo - no greater expectations to treat individuals with serious disabilities and complex needs and behaviors</p>

Appendix 5

Medicaid Rate Structure

The use of acuity assessment instruments for accessing levels of care and support needs and assigning client budgets and provider reimbursement rates ensures that similarly situated individuals have access to comparable Medicaid waiver services and providers are reimbursed accordingly. States use a variety of strategies and instruments in assigning persons to waiver services and levels of care within waiver programs. Many states use their own state-development assessment tools (i.e. Massachusetts Comprehensive Assessment Process MASSCAP) yet other states use nationally normed or recognized tools such as the Inventory for Client and Agency Planning (ICAP), Scales of Independent Behavior – Revised (SIB), Developmental Disabilities Support Needs Assessment Profile (DD-SNAP), and the Support Intensity Scale (SIS).

Reimbursement rate and acuity assessment tool information from Oregon and Colorado was obtained to compare Alaska's rate structure for providers who care for individuals with developmental disabilities. Of particular interest to Alaska is the rate structure for the most complex behavior management individuals residing in group homes using the procedure code T2016.

Oregon – Restructuring Budgets, Assessment, and Rates (ReBAR)

Oregon has two Medicaid waivers for persons with developmental disabilities: a community supports waiver and a comprehensive waiver which includes residential services. Similar to Alaska, Oregon does not use an ICFMR level of care.

Oregon is in the second year of a two-year project that, which when completed, will result in all individuals living in "DD 50 Sites" (group homes and apartments) under the comprehensive waiver having completed assessments, assigned budgets and service rates developed based upon their level of need. There are a total of 2,500 individuals living in DD 50 sites and as of July 7, 2010, and 1,629 assessments were completed. The ReBAR is designed to ensure that (i) support needs assessments for consumers are conducted; (ii) assessment results are used to determine a service budget amount for the consumer; and (iii) fair and equitable rates are established for providers. The service rate for an individual living in a 24-hour group home or apartment is equivalent to the Individual Budget Amount (IBA). The rate meets the CMS requirement and is prospectively-determined for the provision of 1915(c) waiver services. It is based on the individuals ReBAR assessed level of support (Tier) and the licensed size of the residential setting in which they live.

Oregon's Department of Health Services Developmental Disabilities Program Assessment Unit is responsible for administering the Supports Intensity Scale (SIS) where the SIS is the primary assessment tool used for assessment and reassessment of persons living in group homes or apartments. The SIS was developed by the American Association of Intellectual and Developmental Disabilities (AAIDD) in 2004 and measures support requirements in 57 life activities and 28 behavioral and medical areas. The assessment is done through an interview with the consumer, and those who

know the person well. There are at least 9 other states using the SIS including Colorado, Georgia, Louisiana, Pennsylvania, Rhode Island, Utah, Virginia, Washington and North Carolina.

The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing). Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale.¹

Once the SIS is completed, the information is uploaded to AAIDD and a numerical report is generated based on the frequency, amount and type of support needed. Oregon takes the process a step further and the results are downloaded to Human Services Research Institute (HSRI) which populates an algorithm with the SIS data. From this data, an individual’s IBA is determined according to a 6-tier acuity level within 4 settings. The tiers and settings values were determined by a separate cost study. Table 1 below illustrates the Oregon’s DD50 IBA by assessment tier and setting and includes Alaska’s proposed rate for Group Home Habilitation T2016 and T2016 TG (modifier for acuity add-on). Chart 1 depicts Oregon’s 3-person or less setting compared to Alaska’s standard and acuity add-on rates. For comparison purposes, Alaska’s rates have been converted to a monthly rate.

Table 1: Oregon’s DD50 IBA Rate Structure by Tier and Setting with Comparison to Alaska’s Group Home Habilitation Rate Structure – T2016 (Monthly)

Oregon IBA Tier	T1	T2	T3	T4	T5	T6	Oregon Exceptional Support Review (T7)
9 or more people	2,777	2,780	2,781	3,236	3,999	4,529	
6-8 people	3,641	3,973	4,294	5,195	6,420	7,271	
4-5 people	4,995	5,758	6,222	7,528	9,377	10,996	
3 or fewer people	4,995	5,758	6,222	11,238	12,805	15,011	
Alaska – 3 ² or less people	8,865 ³	8,865	8,865	8,865	8,865	8,865	
Alaska – 3 or less people with acuity add on	18,678 ⁴	18,678	18,678	18,678	18,678	18,678	

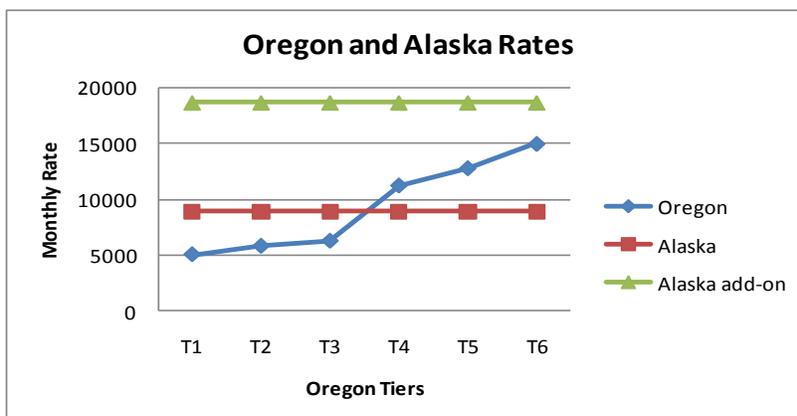
¹ See http://www.siswebsite.org/cs/product_info

² Discussions with Alaska revealed that with the exception of one group home, all group homes care for three or less people

³ Alaska’s daily rate of \$289.03 x 30.67 days equivalent to a monthly rate of \$ 8,865.

⁴ Alaska’s daily rate of \$289.03 + \$320 acuity add-on x 30.67 days equivalent to a monthly rate of \$18,682.

Chart 1: Oregon’s DD50 IBA Rate Structure by Tier and 3-Person Setting with Comparison to Alaska’s Group Home Habilitation Rate Structure – T2016 (Monthly)



Through July 7, 2010, Oregon completed 1,622 conversion assessments. Persons were placed in the following tiers per individual level of need:

Table 2: Oregon’s DD 50 Rate Conversion Assessments Completed by Tier as of July 7, 2010

Tier	Number of Assessments by Tier	Percentage of Assessments with Assigned Tiers ⁵
T1	391	24.0%
T2	295	18.1%
T3	412	25.3%
T4	262	16.1%
T5	191	12.2%
T6	51	3.1%
T7	20	1.2%
Total	1,622	100.0%

According to the data in Table 2, a majority of assessments fall within tiers 1-4. Further research is needed to understand how the first 1,622 conversion assessments were chosen (were clients chosen for the conversion reassessment based on an existing assessment score? Did those previous scores produce a need for more intensive group home settings or less than the average for all 2,500 individuals?) Regardless, a quick comparison of a possible range of costs based on Oregon’s new tiers and Alaska’s existing payment structure using 3 or fewer people as the setting capacity can be calculated and is found in Table 3:

⁵ See <http://www.oregon.gov/DHS/dd/rebar/2009.shtml>.

Table 3: Comparison of Homes with 3 or Few Persons by Tier – Simulated Oregon and Alaska Costs⁶ (Monthly)

Oregon Tier	Oregon	Alaska w/o add-on	Alaska w/add-on
T1	\$ 1,953,045	\$ 3,466,215	\$ 7,303,098
T2	\$ 1,698,610	\$ 2,615,175	\$ 5,510,010
T3	\$ 2,563,464	\$ 3,652,380	\$ 7,695,336
T4	\$ 2,944,356	\$ 2,322,630	\$ 4,893,636
T5	\$ 2,445,755	\$ 1,693,215	\$ 3,567,498
T6	\$ 765,561	\$ 452,115	\$ 952,578
T7	n/a	n/a	n/a
Total Simulated Costs	\$ 12,370,791	\$ 14,201,730	\$ 29,922,156

The simulation depicted in Table 3 illustrates that with or without the acuity add-on to Alaska’s base rate for T2016, the amount of spending is significantly higher (14.8% -141.9%) for Alaska based on their current fee structure combined with the same distribution of persons among the tiers when compared to Oregon, *if* all persons in Oregon were placed in a home of 3 or fewer people. The amount of spending in Oregon could actually be *lower* than what is depicted in Table 3 if persons were placed in larger group home settings.

Colorado – Rate Development for Colorado’s Comprehensive Waiver

In late 2007, Colorado completed a rate review and developed new rates based on a cost-based mathematical model and the use of the Supports Intensity Scale (SIS) to establish levels for its comprehensive waiver services. The mathematical model included variables for each type of service under review. Sources of data included a provider cost and wage survey, Bureau of Labor Statistics Statewide hourly wage data, SIS based participant levels, home health data from the Medicare Economic Scale, and information from the State office.

The process to associate consumer needs with proposed rate levels included a study of 10 assessment tools by the Human Services Research Institute (HSRI). The SIS was selected for its ability to measure general and specific support needs that are significant predictors of cost. In developing habilitation levels, HSRI identified people with similar characteristics then grouped these individuals based on

⁶ The monthly costs for Oregon’s T7 placements are not available.

resource consumption patterns. Seven levels of funding were identified to match individual support needs with funding.⁷

For Procedure Code T2016 with various modifiers (U3, HQ, 22, TF, TG, and SC), Group Home, Colorado has established six unit rates, with the ability to set unique rates for level 7 (similar to Oregon’s Tier 7 – exceptional support review. For the purposes of Table 4, daily rates have been converted to a monthly rate for both Colorado and Alaska using a multiplier of 30.67 days per month. Table 4 compares Colorado’s rates⁸ to Alaska’s rates on a monthly basis:

Table 4: Comparison of Monthly Rates - T2016 Group Homes⁹, Colorado and Alaska

Colorado’s Levels	L1	L2	L3	L4	L5	L6
Colorado’s Rate	\$2,548	\$3,354	\$3,951	\$4,667	\$5,156	\$6,101
Alaska’s Rate	\$8,865	\$8,865	\$8,865	\$8,865	\$8,865	\$8,865
Alaska’s Rate with acuity add-on	\$18,682	\$18,682	\$18,682	\$18,682	\$18,682	\$18,682

Again, it is clear that Alaska’s rates for group homes (with or without the acuity add-on) are significantly higher than Colorado, although the size of the group home settings in Colorado is not known and could skew this type of comparison. However, Colorado has developed Personal Care Alternatives and Host Homes services that also use T2016 and use a different set of modifiers. The monthly rates for these types of settings fall into the range of \$1,737 to \$6,503, resulting in a further departure from Alaska’s group home rate.

Recommendations

Based on the rate data from two states who use different rates to pay for services based on an individual’s support needs and acuity level, Alaska should consider using cost-based rate setting methodology combined with an acuity-based tier or level system when setting individual budgets or levels of care rates for persons receiving service from the Alaska’s 1915(c) waiver for individuals with developmental disabilities.

⁷ Overview of Rate Development for Colorado’s Comprehensive Waiver, Colorado’s Division for Developmental Disabilities, Navigant Consulting, December, 2007.

⁸ Colorado Division of Developmental Disabilities, HCBS-DD Service Rates Effective October 1, 2009 (revised 10-01-09)

⁹ Colorado Group Home size is not available.

In both Colorado and Alaska, a significant amount of consultant time (HSRI, Navigant, Burns Health Policy), resources and training went into the development of the rates and the approach to the rates. Likewise, financial and population characteristics were studied and grouped into similar yet numerous groupings in order to maintain enough difference between the fully developed rates. Budget goals (i.e. neutrality), stakeholder involvement, and provider solvency/provider stability were articulated throughout the rate setting process.

Appendix 6

Telemedicine and Related Issues

Colorado Medicaid Reimbursement for Telemedicine

On October 1, 2007, the Colorado Medical Assistance Program began accepting telemedicine claims. This enables providers to be reimbursed for selected *services provided via telecommunications equipment*.

To receive Medicaid reimbursement, telemedicine services must be provided “live”. The patient and the distant provider interact with one another in real time through an **audio-video** communications circuit. Peripherals may be included, such as transmission of a live ultrasound exam.

Exclusions

“Telemedicine” **does not** include:

- Consultations provided by telephone (interactive audio)
- Facsimile machines

Does Telemedicine Add New Services?

- Providers may only bill procedure codes which they are already eligible to bill.
- Services appropriately billed to managed care should continue to be billed to managed care. All managed care requirements must be met for services billed to managed care. Managed care may or may not reimburse telemedicine costs.
- Colorado Medicaid does not pay for provider or patient education when education is the only service provided via telemedicine.
- Services not otherwise covered by Colorado Medicaid are not covered when delivered via telemedicine.
- The use of telecommunications equipment for delivery of services does not change prior authorization requirements established for the services being provided.

Telemedicine and Managed Care

No enrolled managed care organization may require face-to-face contact between a provider and a client for services appropriately provided through telemedicine if:

The client resides in a county with a population of 150,000 or fewer residents **and** the county has the technology necessary to provide telemedicine services.

The use of telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance. Please refer to 10 CCR 2505-10, Section 8.200.4.B. for more information.

When Should A Provider Choose Telemedicine?

The Colorado General Assembly considers a primary purpose of telemedicine is to bring providers to people living in rural areas. Providers should weigh this advantage against quality of care and client safety considerations. They should also consider the provider's liability. Clients may choose which is more convenient for them when providers make telemedicine available.

However, telemedicine should not be selected when face-to-face services are medically necessary. Clients should establish relationships with primary care providers who are available on a face-to-face basis.

Telemedicine Confidentiality Requirements

All Medicaid providers using telemedicine to deliver Medicaid services must employ existing quality-of-care protocols and client confidentiality guidelines when providing telemedicine services. Health benefits provided through telemedicine must meet the same standard of care as in-person care. Record-keeping should comply with Medicaid requirements in 10 CCR 2505-10, Section 8.130.

Transmissions must be performed on dedicated secure lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telemedicine services must implement confidentiality procedures that include, but are not limited to:

- Specifying the individuals who have access to electronic records.
- Using unique passwords or identifiers for each employee or other person with access to the client records.
- Ensuring a system to routinely track and permanently record such electronic medical information.

Waiving the Face-to-Face Requirement

The Medicaid requirement for face-to-face contact between provider and client may be waived prior to treating the client through telemedicine for the first time. The rendering provider must furnish each client with all of the following written statements which must be signed by the client or the client's legal representative:

- The client retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the client's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled.
- All applicable confidentiality protections shall apply to the services.
- The client shall have access to all medical information resulting from the telemedicine services as provided by applicable law for client access to his or her medical records.

These requirements do not apply in an emergency. [C. R. S. 2006, 25.5-5-320 (4) & (5)].

General Billing Instructions

Billing Providers

Telemedicine services will only be reimbursed for providers who are enrolled in the Colorado Medical Assistance Program at the time service. The availability of services through telemedicine in no way alters the scope of practice of any health care provider; or authorizes the delivery of health care services in a setting or manner not otherwise authorized by law. [C. R. S. 2006, 25.5-5-414 (7)(a) & (b)].

Originating Site Billing

All telemedicine services are billed on the Colorado 1500 paper claim form or as an 837P transaction regardless of provider type.

The originating provider may bill for an office, outpatient or inpatient Evaluation & Management (E&M) service that precedes a telemedicine consultation and for other Medicaid-covered services. In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment.

Originating providers bill as follows:

- If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014, the procedure code for the telemedicine originating site facility fee.
- If the originating provider also provides clinical services to the client, the provider bills the rendering provider's appropriate procedure code and bills Q3014.
- The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating site claim is made. The originating provider must submit two separate claims for the client's two separate services.

The following provider types may bill procedure code Q3014 (telemedicine originating site facility fee):

Physician	05
Clinic	16
Osteopath	26
Federally Qualified Health Center	32
Psychologist	37
MA Psychologist	38
Physician Assistant	39
Nurse Practitioner	41
Rural Health Clinic	45

If practitioners at both the originating site and the distant site provide the same service to the client, both providers submit claims using the same procedure code with modifier 77. (Repeat procedure by another physician.)

The originating site may not bill for assisting the distant site provider with an examination.

Distant Provider Billing

All distant site rendering providers bill the appropriate procedure code using modifier GT (interactive communication) on the Colorado 1500 paper claim form or as an 837P transaction. The previously listed provider types may bill using modifier GT. The procedure codes for billing telemedicine are listed below. Using modifier GT adds \$5.00 to the fee for the procedure code billed.

Rendering Providers

If a rendering provider's number is required on the claim for a face-to-face visit, it is required on the claim for a telemedicine visit.

Rural Health Clinics should leave field 19D on the Colorado 1500 paper claim form blank. Federally Qualified Health Centers, Clinics and the other provider types are required to enter the rendering provider's Colorado Medical Assistance Program provider number in field 19D.

When an originating site bills Q3014 (originating site facility fee), there is generally no rendering provider actually involved in the service at the originating site.

However, a rendering provider number is still required and must be affiliated with the billing provider. The facility may enter either the patient's usual provider's number; or another provider number affiliated with that site as the rendering provider.

When the patient sees a rendering provider at the originating site and also uses the site as the telemedicine originating site, the facility bills the rendered service procedure code and Q3014

for the use of the telemedicine facility. The same rendering provider number is entered in field 19D.

Procedure/HCPCS Codes Overview

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program clients and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services Bulletins section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by completing and submitting a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

Telemedicine Procedure Coding

The following procedure codes, when billed with modifier GT by appropriate providers, pay the telemedicine transmission fee. Any other procedure codes billed with modifier GT will not pay the telemedicine transmission fee.

Procedure Codes	Description	Comments
Outpatient Mental Health		
90801	Psychiatric diagnostic interview examination	
90804	Individual psychotherapy 20 - 30 min	
90805	Individual psychotherapy 20 -30 min with medical evaluation and management services	
90806	Individual psychotherapy 45 - 50 min	
90807	Individual psychotherapy 45 – 50 min with medical evaluation and management services	
90808	Individual psychotherapy 75 - 80 min	Medicare crossover only
90809	Individual psychotherapy 75 - 80 min with medical evaluation and management services	Medicare crossover only
90862	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy	
90846	Family therapy – patient not present	
90847	Family therapy – patient present	
Evaluation & Management		
99201	Office or other outpatient visit, new patient, 10 minutes	
99202	Office or other outpatient visit, new patient, 20 minutes	
99203	Office or other outpatient visit, new patient, 30 minutes	
99204	Office or other outpatient visit, new patient, 45 minutes	
99205	Office or other outpatient visit, new patient, 60 minutes	
99211	Office or other outpatient visit, established patient, 5 minutes	
99212	Office or other outpatient visit, established patient, 10 minutes	
99213	Office or other outpatient visit, established patient, 15 minutes	
99214	Office or other outpatient visit, established patient, 25 minutes	
99215	Office or other outpatient visit, established patient, 40 minutes	
99241	Office consultation, new or established patient, 15 minutes	
99242	Office consultation, new or established patient, 30 minutes	
Procedure Codes	Description	Comments
99243	Office consultation, new or established patient, 40 minutes	
99244	Office consultation, new or established patient, 60 minutes	
99245	Office consultation, new or established patient, 80 minutes	
99251	Inpatient consultation, new or established patient, 20 min	
99252	Inpatient consultation, new or established patient, 40 min	
99253	Inpatient consultation, new or established patient, 55 min	
99254	Inpatient consultation, new or established patient, 80 min	
99255	Inpatient consultation, new or established patient, 110 min	

Procedure Codes	Description	Comments
Obstetrical Ultrasounds		
76801	Ultrasound, pregnant uterus, real time first trimester	
76802	Each additional gestation	
76805	Ultrasound, pregnant uterus, real time after first trimester	
76810	Each additional gestation	
76811	Ultrasound, pregnant uterus, real time plus detailed fetal anatomical exam, single or first gestation	
76812	Each additional gestation	
76813	Ultrasound, pregnant uterus real time first trimester fetal nuchal translucency measurement	
76814	Each additional gestation	
76815	Ultrasound, pregnant uterus, real time, limited, one or more fetuses	
76816	Ultrasound, pregnant uterus, real time, follow-up	
76817	Ultrasound, pregnant uterus, real time, transvaginal	
Other		
96116	Neurobehavior status exam	

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542320888> Pages: S128-132

Appendix 7

Regulatory Recommendations

Staff Competence

Alaska's current regulations for Assisted Living Homes do not include very specific expectations regarding staff competence, which is important for the implementation of successful interventions for vulnerable Alaskans. This impacts the ability of staff to provide interventions that promote skill development, community integration, psychosocial rehabilitation and improved quality of life for the individuals served. Below are some excerpts from Alaska's regulatory documents followed by comments and recommendations.

"Before caring for a resident without direct supervision, a care provider shall receive the orientation required in this subsection and, unless the [UNLESS A] care provider has sufficient documented experience working with the population of residents to be served, [THE CARE PROVIDER] shall work under the direct supervision of the administrator or an experienced care provider who is at least 21 years of age for not less than three complete work days [BEFORE CARING FOR A RESIDENT WITHOUT DIRECT SUPERVISION]." [7 AAC 75. ASSISTED LIVING HOMES. REPORTING REQUIREMENTS AND TRAINING; Effective March 7, 2009]

"Alaska's Assisted Living Home staff preparedness requirements:

- *Cardiopulmonary resuscitation (CPR);*
- *First aid training; and*
- *The ability to carry out the disaster preparedness plan."*

Additionally, new staff expected to receive orientation, which includes a review of policies and procedures.

"Each administrator, each administrator designee who will serve in that capacity for 90 consecutive days or longer, and each care provider who is an employee of an assisted living home shall participate in continuing education that is relevant to that person's primary job responsibilities and the ongoing care of residents. If courses for continuing education are not available within 100 miles of where the home is located or through correspondence or distance learning, the administrator shall ensure that the continuing education is obtained not less than every 18 months. Training requirements are as follows:

(1) Each administrator shall complete 18 clock hours of continuing education annually;

(2) Each care provider shall complete 12 clock hours of continuing education annually;

(3) A home may count in-service training as continuing education if that training increases the knowledge, abilities, or skills of care providers and is approved by the licensing agency;

(4) Continuing education, whether in-service training or received from a state agency, a seminar, or a university, must be documented and placed in the employee's personnel file for review and approval by the licensing agency.

[Guide to Assisted Living Home Regulations and Statutes April 6, 2002, State of Alaska Department of Administration, Division of Senior Services, State of Alaska Department of Health and Social Services, Division of Mental Health and Developmental Disabilities]

Recommendation

Group Home staff should have sufficient population-specific knowledge and training prior to having direct resident contact in order to provide appropriate interventions and ensure the safety and security of the residents. The existing continuing education requirements should be monitored for compliance to the regulation and the degree to which such training improves staff competence and the quality of services provided.

Direct care staff such as Life (Skills) Coaches should have a minimum of a high school diploma with some experience and variable amounts of training. Providers across Alaska expressed that more training is needed for direct care staff. There is typically one Life Skills Coach for three individuals; however another can generally be available when needed. **Recommend** that rates include a portion specifically for staff training (such as ten cents per billing code) and that the Department, potentially through the Hub, ensures that providers are aware of training opportunities and monitors training participation.

Recommendation

Given the increasing Alzheimer's population at the Pioneer Homes, including many with complex behavioral needs, it is recommended that all direct care staff at a minimum receive the following training, or a reasonable equivalent, to support the safety and well-being of all residents:

Online Distance Certificate Program - Alzheimer's Disease and Related Disorders

Topics covered:

- Introduction and History of Alzheimer's Disease
- Stages of Alzheimer's Disease
- Communication in Alzheimer's Care

- Nutrition and Alzheimer’s Disease
- Therapies and Activities for Persons with Alzheimer’s Disease
- Ethical Issues in Alzheimer’s Care
- Cultural Issues in Alzheimer Care
- Caregivers in the Workplace and Home
- Improving Care through Knowledge and Skill

The cost of this continuing education course is \$289 per person. With funding from the Trust Training Cooperative / Alaska Mental Health Trust Authority, we are able to offer this course for \$55 per person. Limited scholarships are available. Please complete and fax scholarship application with registration. Visit <http://uas.alaska.edu/pub/adr/> to download the scholarship application. To meet the funding goals, priority will be given to caregivers working with ADRD elders. [<http://www.uas.alaska.edu/sitka/coed/certificates/ADRD-Training.html> 8/2/2010]

Assisted Living Home Program Expectations / Licensing

Alaska's Guide to Assisted Living Homes Regulations and Statutes, April 6, 2002, developed by the State of Alaska Department of Administration, Division of Senior Services and the State of Alaska Department of Health and Social Services Division of Mental Health and Developmental Disabilities and information from the *Department of Administration - Division of Senior Services 2 AAC 42, Assisted Living Homes As Amended Through June 28, 2002* do not include guidance or language about expected interventions or treatment for specific populations. The Assisted Living Home license is so broad in scope that it lacks the age and population specific requirements that some have. It does include information about residents having service coordinators; however there is not clear information about the expectations of these coordinators. Therefore, it is unclear what expectations and resources exist to fully implement regulations regarding helping adults with a physical or mental disability to become integrated into the community and to reach their highest level of functioning.

<http://www.cdphe.state.co.us/regulations/healthfacilities/index.html>

Recommendation

Consider either adding more population-specific minimum intervention program expectations to the Assisted Living Home regulations or create more population-based regulations for individuals able to benefit from structured services and active interventions, such as individuals with developmental disabilities.

Note: In Colorado:

1.102(6) "Assisted living residence" means any of the following:

102(6)(a) A residential facility that makes available to three or more adults not related to the owner of such facility, either directly or indirectly through a resident agreement with the resident, room and board and at least the following services: personal services; protective oversight; social care due to impaired capacity to live independently; and regular supervision that shall be available on a twenty-four-hour basis, but not to the extent that regular twenty-four hour medical or nursing care is required.

102(6)(b) A residential treatment facility for the mentally ill which is an assisted living residence similar to the definition under Section 1.102 (6)(a), except that the facility is operated and maintained for no more than sixteen (16) mentally ill individuals who are not related to the licensee and are provided treatment commensurate to the individuals' psychiatric needs which has received program approval from the Department of Human Services.

102(6)(c) The term "assisted living residence" does not include:

(i) Any facility licensed in this state by the Department of Human Services as a residential care facility for individuals with developmental disabilities pursuant to Section 27-10.5-101, C.R.S., et seq.; or

(ii) Any individual residential support services for individuals with developmental disabilities provided in accordance with Section 27-10.5-101, C.R.S., et seq., unless specifically authorized to be an assisted living residence by the Department of Human Services.

"Alternative care facility" means an assisted living residence certified by the Colorado Department of Health Care Policy and Financing to receive Medicaid reimbursement for the services provided by the facility.

However Colorado has a separate license category for: Community Residential Homes for Persons with Developmental Disabilities/Group Homes for the Developmentally Disabled

"Community residential homes for persons with developmental disabilities are homes that provide services and support for at least four and no more than eight persons with developmental disabilities. For purposes of this program, the definition of developmental disability means a disability that is manifested before a person is twenty-two years of age; and is a substantial disability attributable to mental retardation or related conditions including cerebral palsy, epilepsy, autism, or other neurological conditions which result in the impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

These facilities are operated by service agencies or community-centered boards. They are generally located in residential areas and are found throughout the state. Services may be paid for by Medicaid under its Home and Community-based Services program. Residents rights are clearly defined in the law. These facilities must provide a homelike environment, with use of common areas by all persons living there. Supportive services include meals, laundry, personal care, assistance with medications and protective oversight. Activities and transportation are also provided. Residents medical needs must be overseen by a primary care physician and the facility must furnish required medical services and keep residents' medical records.

The division conducts certification and licensing surveys for compliance with federal and state regulations and investigates any complaints filed against one of these providers. "
[<http://www.cdphe.state.co.us/hf/rcfdd/index.html>]

More details about their licensing can be found in Chapters II and VII Subchapter 5 at <http://www.cdphe.state.co.us/regulations/healthfacilities/index.html>

Facility Security

Facilities with secure capacity are sometimes needed for individuals with cognitive disabilities and complex behavioral needs. Phase I of this Project as well as key informants during Phase II, identified the periodic need for one or more community-based secure facilities, so that individuals did not have to be transported to an institution or jail when safety and security issues arise. One option for facility security is to physically secure the building with door locks or delayed egress. Another option used by states such as Idaho and Colorado is to have 'staff secure' buildings, in which staff are sufficient in numbers and training (such as recognizing the need for early intervention and de-escalation, building therapeutic relationships, etc.) to effectively monitor the safety and security of the residents.

State regulations appear to be silent on the use of delayed egress mechanisms (unless unobstructed escape is interpreted to prohibit this), which may allow for more facility security than is currently available, if this is the option preferred by the State. Alaska's Guide to Assisted Living Home Regulations and Statutes, April 6 2002, page 29 states:

"(6) have at least two means of emergency escape that are remote from each other and that provide unobstructed escape to the outside of the building, one of which must be an exterior door;

(7) have at least one fully-opening window in each resident's bedroom; the window

must be of sufficient size and free of obstructions to allow for emergency escape or rescue unless the room has a door leading directly to the outside; for purposes of this paragraph, “sufficient size” means that the window has a finished sill height that does not exceed 48 inches above the floor, has a net clear openable area that is at least 5.7 square feet, has a net clear openable height of at least 24 inches, and has a net clear openable width of at least 20 inches.”

Recommendation

The State should make a policy decision about which approach to facility security it chooses to use for the Brief Stabilization Services and the Intensive Intermediate Intervention Services. If a decision is made to use building security, an official opinion of the current regulations is needed and depending on the findings, any necessary changes should be incorporated. However, if the preference is to use the staff secure option, an investment in adequate staffing and staff training will be necessary. Additionally, depending on the physical plant of each facility, there may be some building modifications that can be made to improve the line-of-sight and other safety and security matters.

Other state's licensing definitions for services similar to the recommended Brief Stabilization Services for Alaska.

Rules of the Tennessee Department of Mental Health and Developmental Disabilities Office of Licensure

Chapter 0940-5-18 Minimum Program Requirements for Mental Health

Crisis Stabilization Unit Facilities

“Crisis Stabilization Unit” (CSU) means services specifically designed for service recipients eighteen (18) years and older in need of short-term stabilization, up to ninety-six (96) hours, who do not meet the criteria for other treatment resources, other less restrictive treatment resources are not available, or the service recipient is agreeable to receive services voluntarily at the CSU and meet admission criteria. If necessary, in order to assure that adequate arrangements are in place to allow for the safe discharge of the service recipient, the length of stay may be extended by up to twenty-four (24) hours.

Colorado DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT Health Facilities and Emergency Medical Services Division 6 CCR 1011-1

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES - CHAPTER VI ACUTE TREATMENT UNITS

“Acute treatment unit” means a facility or a distinct part of a facility for short-term psychiatric care, which may include substance abuse treatment, and which provides a total, twenty-four-

hour therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services."

Licensing Fees

Alaska's licensing fees are significantly lower than the comparison state of Colorado shown below. These fees can help to off-set the costs of providing program oversight, technical assistance and system improvement activities.

Alaska's licensing fees include:

"7 AAC 75.100. FEES. (a) An application for a license, or renewal of a license, must be accompanied by the appropriate fee, as follows:

(1) voluntary license... \$ 25

(2) probationary or standard license for homes with capacity to serve three to five residents.....\$75

(3) probationary or standard license for homes with capacity to serve six or more residents.....\$150.

(b) In addition to the base license application fee, set out in (a) of this section, an application under (a)(2) of this section must be accompanied by a fee of \$25 for each resident accommodation beyond three that the home seeks licensure to provide, and an application under (a)(3) of this section must be accompanied by a fee of \$25 for each resident accommodation beyond six that the home seeks licensure to provide." [Title 7. Health and Social Services, Chapter 75. Assisted Living Homes, Section 100. Fees]

Colorado's licensing fees include:

Initial License for an Assisted Living Facility in Colorado:

"(i) The appropriate fee, as set forth below, shall accompany a facility's application for initial license.

Three to eight licensed beds: \$5,000. Nine beds or more: \$6,000.

103(2)(d) License Renewal

(i) For licenses with a renewal date between January 1, 2009 and December 31, 2009, the appropriate fee, as set forth below, shall accompany the application:

(A) \$150 per facility plus \$43 per bed.

(B) for a high Medicaid utilization facility, \$150 per facility plus \$15 per bed.

(ii) For licenses with a renewal date after December 31, 2009, the appropriate fee, as set forth below, shall accompany the application:

(A) \$150 per facility plus \$56 per bed.

(B) for a high Medicaid utilization facility, \$150 per facility plus \$15 per bed.

In Colorado, privately owned and State operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are charged a service fee in order to maintain the quality and intensity of services provided. This fee shall not exceed five percent (5%) of the costs incurred by each Intermediate Care Facilities for the Mentally Retarded for the fiscal year in which the service fee is charged."

[[http://stateboard.cdhs.state.co.us:8008/CDHS/rule_display\\$.DisplayVolume?p_vol_num=168/2/2010](http://stateboard.cdhs.state.co.us:8008/CDHS/rule_display$.DisplayVolume?p_vol_num=168/2/2010)]

Recommendation

Evaluate facility licensing fee structure and the intent of these fees, and if so determined, increase these fees to support program oversight and development.

Appendix 8

Excerpt from the IDAHO MEDICAID PROVIDER HANDBOOK - DD GUIDELINES, January 2010, Pages 3-11 to 3-12]

3.5 Behavior Consultation/Crisis Management (BC/CM) Services

3.5.1 Service Description for DD Waiver

Behavior consultation and crisis management services are services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development to providers related to the needs of a participant. This service requires the provider to meet directly with the participant.

Note: BC/CM services are covered for Medicaid Enhanced Plan participants.

3.5.2 Provider Qualifications

3.5.2.1 Behavior Consultation and Crisis Management (BC/CM) Providers

DD waiver providers of this service must work in one of the following situations:

- In a provider agency capable of supervising the direct service.
- Under the direct supervision of a licensed psychologist or Ph.D. in special education with training and experience in treating severe behavioral problems, and training and experience in applied behavioral analysis.

DD waiver providers must have or be one of the following:

- Have a Master's degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study.
- Be a licensed pharmacist.
- Be a qualified mental retardation professional (QMRP).

3.5.2.2 Emergency Intervention Technicians

Emergency intervention technicians for the DD waiver must:

- Meet qualifications of a residential habilitation direct care provider as identified in *IDAPA 16.04.17 Rules Governing Residential Habilitation Agencies* and *IDAPA 16.03.10.705 DD Waiver Services – Provider Qualifications And Duties*.

- Have at least one year of experience working directly with adults with developmental disabilities who exhibit severe maladaptive behaviors that may cause harm to themselves or others.
- Be supervised by a QMRP or clinician.

3.5.3 Payment

Medicaid reimburses BC/CM services on a fee-for-service basis. All services must be authorized prior to payment and must be the most cost-effective way to meet the needs of the participant. The Department of Health and Welfare or its designee authorizes all services for the DD waiver. The PA number must be included on the claim or the claim will be denied.

3.5.4 Diagnosis Codes

Enter the ICD-9-CM code **V604** - No Other Household Member Able to Render Care for the primary diagnosis in field **21** on the CMS-1500 claim form or the appropriate field of the electronic claim form.

3.5.5 Place of Service (POS) Codes

BC/CM services can only be billed for the following POS:

- 11** Office
- 12** Home
- 99** Other (Community)

3.5.6 Procedure Codes

All BC/CM claims must use one of the following five-digit HCPCS procedure codes with the required modifier when billing. The units must be entered in field **24D** on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Service	HCPCS	Description
Behavioral Consultation/Crisis Management - Psychiatrist	H2019 U8 and AG Modifiers Required	<i>Therapeutic Behavioral Services</i> 1 Unit = 15 minutes
Behavior Consultation/Crisis Management - QMRP	H2019 U8 Modifier Required	<i>Therapeutic Behavioral Services</i> 1 Unit = 15 minutes
Emergency Intervention Technician	H2019 U8 and HM Modifiers Required	<i>Therapeutic Behavioral Services</i> Limited to 96 units per calendar month. 1 Unit = 15 minutes