

## Themes from Community/Provider Forums Related to Home and Community-Based Services Medicaid State Plan Options 1915(k) and 1915 (i)

Health Management Associates and the State of Alaska's Department of Health and Social Services' Division of Senior and Disability Services, along with the Division of Behavioral Health, conducted forums in nine communities throughout the State to provide information on the opportunity of the Home and Community-Based Services (HCBS) Medicaid State Plan options and to obtain input from community members and service providers in the design and implementation of these programs should the State choose to pursue them. Below is a list of the communities in which forums were held and the dates of these activities. We also conducted a State-wide webinar for individuals who were unable to participate in the in-person forums. The forums were held in:

Anchorage:	October 29 and 30, 2015
Barrow:	November 12, 2015
Bethel:	December 18, 2015
Fairbanks:	November 10 and 11, 2015
Juneau:	January 7, 2016
Kenai:	December 15, 2015
Ketchikan:	January 6, 2016
Nome:	December 16 and 17, 2015
Wasilla:	January 8, 2016
Statewide Webinar:	January 13, 2016

At each location, we held one community forum, and depending on the number of providers in the area, between one and four provider forums as well as individual meetings with selected provider organizations. While the provider forums were open to all providers, particular emphasis in recruitment was placed on providers of service for seniors, individuals with developmental disabilities, individuals with Serious Mental Illness, and individuals with Traumatic Brain Injury. All sessions were open to the public.

The forums were typically two hours in length, and began with a presentation<sup>1</sup> on the HCBS State Plan Options followed by testimony and open discussion. Kenai Reporter transcribed each of the forums word for word. Health Management Associates reviewed the transcripts, and identified themes and issues for each forum in each community and the State-wide webinar. Once all forums and the webinar were completed, we reviewed themes and issues documented from across the State, coded and categorized them into several topic areas. We described the most salient themes from across the State and presented them in the following.

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<sup>1</sup> The presentation can be accessed on the Senior and Disability Services website at <http://dhss.alaska.gov/dsds/Pages/MRICC/MRICC.aspx>

## **Person-Centered Planning and Coordinating Care**

Person-Centered Assessment. The State Plan Options require “person-centered planning”, which is a process where the needs, goals and preferences of the participant, as described by the participant along with family, friends and care team members, are foremost in the planning. Several providers indicated the need to assure the use of a person-centered assessment tool that primarily serves to determine individual needs and desires, “not just right-sizes services.”

Providers indicated that some of the current survey tool response options are “black and white” and that this needs to be changed to be able to capture a better understanding of the individual. For example, for a person with a behavioral health issue, the answer to an assessment question may be “yes” one day and “no” the next. An additional point was made by providers and community members that the assessment tools are only as good as the person administering them, and that we need to assure person-centered training for assessment staff.

Coordinating Care. Another theme that emerged from providers was the need to coordinate services for individuals that have a complexity of issues that don’t neatly fit into one category, such as individuals with Intellectual and Developmental Disabilities as well as Serious Mental Illness (SMI). Providers raised concerns about how the assessment will accommodate individuals with co-occurring diagnoses and the need to minimize the assessment burden for such individuals. Providers also requested to continue the requirement of face-to-face assessments in the home; “assessments done in a clinical setting do not reveal the needs that become apparent when the assessor observes the home environment and the caregiver situations.” Providers indicated that there is “enormous energy and capacity in the existing provider network, if silos are pulled down and regulatory restrictions changed, we can innovate.”

Individualized Budget for Services. Providers also advocated for individuals to be able to control an “individualized budget” and purchase services in line with their own goals. Consumers advocated for local control and its importance in identifying problems and solutions to those problems.

Service Hours Based on Individual Need. Community members gave testimony about the need to provide hours of Personal Attendant Care based on the individual in the context of their existing support network. One example provided by a participant included the State cutting back on overnight support hours even though it has become too difficult for the aging caregiver to provide this support. The participant indicated that she strongly preferred to remain at home but “this action may ultimately lead me to having to be supported by the State at a much greater cost in an institutional setting.”

## **Target Populations**

Individuals in the Justice/Correctional System. Consumers and providers both emphasized a need to select target populations for the 1915(i) option with an eye to cost savings in other State Departments such as the correctional system. They advocated for a formal system to identify individuals being released from the correctional system who might qualify for assistance. “Assisting these individuals will

reduce recidivism and ultimately save the State dollars.” Another theme related to this population is the difficulty of finding stable housing for the offender population with behavioral health issues.

Individuals with Alzheimer’s Disease and Related Dementias (ADRD.) Providers discussed the great need for services for the large population of individuals with ADRD that do not meet nursing facility level of care. Services for these individuals, such as cuing and other supports, are in great demand. They also described a sizable group of seniors with behavioral issues admitted to the Alaska Psychiatric Institute that don’t meet nursing facility level of care; these individuals are not accepted to senior homes because these homes are not prepared to address the behavioral issues.

Individuals with Behavioral Health Diagnoses. Providers and consumers gave testimony to the importance of assisting individuals with SMI and/or Substance Use Disorder (SUD); indicating concern about individuals that fall through the cracks of services offered by Senior and Disability Services, and the Division of Behavioral Health.

Both community members and providers expressed a great need for expanding or making more robust the system for behavioral health services. Consumers noted increases in suicides in the State and the need to prevent these. Providers discussed lack of behavior supports available, and also emphasized unmet needs of the “General Relief Population” and the need for more services for this population and that a majority had SMI.

Individuals with Traumatic Brain Injury. Individuals with TBI and their advocates indicated that this population is under-diagnosed and under-treated [further described in the “Workforce” section on Page 4.]

Individuals with Fetal Alcohol Spectrum Disorder. Another population that both providers and community members indicated as being underserved are individuals with FASD, as many do not qualify under the Developmental Disabilities waiver but still have significant support needs related to activities of daily living.

### **Service Needs**

Supportive Housing and Supported Employment. One of the strongest themes related to service needs that emerged is the need to “focus on things that stabilize individuals such as supportive housing and supported employment.” Community members and providers discussed the difficulty that individuals with SMI, SUD and/or criminal backgrounds have in being able to find housing, treatment options, and supported employment if needed.

Low-Level Supports. Providers advocated for more “low-level supports” (personal care attendant-like) for individuals with SMI appropriate to their needs, and agreed that “even low-level supports can prevent emergency department visits.”

Transportation. Many community members and providers emphasized the need for transportation as well as a medical escort to ensure individuals get to their medical and behavioral health appointments and have an advocate with them. “[These enabling services] will prevent more costly emergency

department visits and hospitalizations.” Participants indicated that transportation is also “needed for other activities required for individuals to stay at home such as grocery shopping.”

Technology Supports. Providers and community members advocated for coverage of Personal Emergency Response Systems and other technologies that can support individuals in living at home and/or living more safely at home.

### **Workforce Issues**

State Workforce. Providers expressed concern about the efficiency of the existing state infrastructure to manage the new State Plan optional benefits; “currently it takes months or years to access benefits.” Community members also expressed the concern the impact of new programs would have on an already limited workforce at the state level, citing lack of staff to return phone calls and address questions related to current State and Federal programs.

Capacity of Provider Workforce. Pediatric providers talked about children being sent out of State because services do not exist in Alaska to keep them home. Consumers and providers alike gave examples where individuals living in rural areas need to travel great distances to receive care, and where Medicaid beneficiaries were denied coverage for a personal care attendant (PCA) to travel with them to obtain medical services, which creates a barrier to getting needed care.

Community members indicated that current workforce challenges result in long waits for service, and expressed concern that this would become worse as they anticipate a greater demand for services under the State Plan Options.

Individuals with Traumatic Brain Injury (TBI) and their providers advocated for workforce development specific to this population. They identified a need for provider education on TBI and case management particular to brain injury to address unique needs, as well as an array of services for which there are current workforce shortages, such as: cognitive rehabilitation, physical therapy, occupational therapy, vision therapy, speech and language therapy.

Community members, as well as some providers, indicated that providers do not always have the appropriate training to manage behaviors of individuals with SMI and will admit them to the Alaska Psychiatric Institute instead of treating in the community.

Quality of the Provider Workforce. Community members discussed their experience with direct support providers and indicated that “maintaining stable, experienced staffing is a challenge.” Participants provided testimony on “unprofessional and unskilled workers” conducting assessments and providing in-home assistance. They emphasized the importance of background checks on personal service attendants to ensure client safety.

Proposed Solutions. Many community members and some providers advocated for payment for live-in/family caregivers; for many populations needing home and community-based services, it is the family members who are caring for them.

Providers discussed other types of workers to help address some of the workforce issues such as “village-based counselors” in rural communities, and “transitional living specialists” for individuals with Traumatic Brain Injury – individuals who have recovered from brain injury themselves and assist others with TBI in becoming more independent.

Providers expressed the need for training dollars for Direct Service Providers to “support skill-building of clients.”

Providers also discussed the need for health professions education to expand the workforce, and cited such efforts as a health academy in Anchorage and establishments of a registered apprenticeship training cooperative.

### **Alaska’s Unique Features and Implications**

Providers discussed the unique features of Alaska – lack of road systems, frontier regions, unique regional political/economic systems – and indicated that looking to the Lower 48 for implementation models may not be appropriate. Other providers addressed some of the same features of Alaska that make determining eligibility different than in many other states. For example, an individual may have the ability to mop their floor but they don’t have running water and they need wood for their wood stoves; these individuals may need assistance with hauling water and chopping wood to be able to stay at home.

Community members and providers expressed interest in ensuring that the great differences in the cost of living across the state are taken into account when determining financial eligibility for the State Plan Options.

Workforce capacity is limited, especially in rural and frontier areas in the State. Providers indicated that “streamlining processes will be important to maximize the limited provider time available for direct service.”

### **Opportunity to Improve Operational Efficiencies**

Eligibility/Enrollment. Community members provided testimony on the bureaucracy and burden of Medicaid recertification and appealed to the State to streamline this process.

Hospital providers discussed the lengthy process to obtain General Relief (GR); sometimes it will take up to a month for an individual to qualify for GR which is necessary for discharge to an Assisted Living Home. “For 30 days they sit in the hospital; hospitals in Alaska are full of people that don’t belong there.”

Providers expressed concern about young people with disabilities going from school straight into day habilitation instead of working so they don’t lose their SSI benefits. “This is done to avoid the possibility of parents having to reapply for their family member’s SSI because it is such an onerous process.”

Assessments and Assessment Tools. Providers advocated for streamlining annual re-assessment for individuals with lifelong disabilities where level of disability does not change from year to year. Providers expressed strong interest in participating in the selection or development of a functional assessment tool; and encouraged the State to consider tools that take into account the different types of functional impairments across populations.

Provider Burden. Providers expressed concern about the burden the introduction of the State Plan optional benefits might put on providers -- certification requirements, assessments, paperwork, regulations, reporting requirements, on-site licensing reviews, audits. Providers appealed to the State to streamline these processes as the system is currently burdensome.

Providers emphasized the need to ensure adequate care coordinator capacity prior to rolling out the State Plan Options. They expressed the need to clarify care coordinators' roles, and strongly advocated for certifying care coordinators across programs.

Technology. The use of technology in current programs is very limited, and some of the current information systems were described by some providers as "dysfunctional." Providers expressed the need to reduce paper and manual processes; "everything that can be done electronically should be considered." Providers appealed to reduce the volume of documentation required, and reduce the complexity of audits.

Providers identified opportunities to streamline processes using technology. For example, they suggested the development of a consistent care plan approach with integration where appropriate -- across 1915(c) and (k) programs -- and an investment in interfacing systems to enable care plan access across agencies. Another example is to have care coordinators conduct both face-to-face visits and virtual visits which would allow them to carry a larger caseload.

### **Conflict-Free Case Management**

Community First Choice -- 1915(k) -- requires "conflict-free case management" which is the provision of case management services by an independent entity, one that does not have a conflict of interest in either the assessment or care plan. Providers expressed concern about the ability to be "conflict-free" in rural and frontier areas where there may only be one organization -- the only game in town -- for direct service provision and case management.

### **Next Steps**

Community members and providers are interested in continuing to be kept informed about:

- how stakeholder input and feedback from initial forums will be incorporated into planning,
- other opportunities for the public to remain involved in implementation planning, and
- the timeline for decision-making and implementation.