**

**AADD**

**ALASKA ASSOCIATION ON DEVELOPMENTAL DISABILITIES**

**EXECUTIVE DIRECTOR REPORT**

**May 2021**

**NOTEWORTHY NEWS**

* CMS Guidance on the 10% FMAP increase for HCBS services has been released. See update below.
* The federal government has extended the Public Health Emergency to September 21, 2021. With our Appendix K extension, the latest end of flexibilities could be March 21, 2022.

**ATTACHMENTS:**

* AADD recommendations on the 10% FMAP increase
* Care Coordination recommendations to SDS
* Residential Habilitation Home Recommendations to SDS

**SDS UPDATE**

10% FMAP Increase - The American Rescue Plan Act (ARPA) included a 10% FMAP increase for HCBS services above the state’s budget for those services last year. The legislative intention was for those funds to go to providers. Guidance was released from CMS on April 13th and they hosted a webinar on April 17th. States have 30 days from the Guidance release to submit a plan to CMS on how to spend the funds. States can request a 30 extension, giving them 60 days to put the plan together. SDS quickly organized listening sessions with major HCBS stakeholders with May 20 focusing on the senior population and May 21st focused on IDD. AADD was able to attend and speak at both sessions. Our recommendations are listed in the newsletter and in the attached letter sent to SDS. They include:

* Workforce stabilization: 50% of funds should go toward DSP’s recruitment and retention support
* Transition support from institutions to the community
* Companion Services pilot project
* Add hours to the ISW waiver

AADD also supports multiple Care coordination issues. Meghan Heim (your AADD board member representing care coordination) initiated a letter that AADD submitted to SDS on May 14th concerning a number of issues. (See letter attached). Both Meghan Heim and Kimberly Adkinson were able to present their recommendations on the May 21st SDS listening session. Those recommendations include:

* Grants for CC to recoup pandemic expenses
* Adopt on-going flexibilities of Appendix K, particularly remote visits and the extended support plan
* Greater flexibility within Harmony – particularly goals
* Develop a contact/liaison at SDS for care coordinators with supervisory authority over n IDD and NFLOC units to improve communication
* Grants are needed to hire and train new care coordinators
* Care coordination rates need to match increased responsibilities

Appendix K –With the federal Public Health Emergency extended to September 21, 2021, combined with Alaska’s approved 6 month extension of Appendix K, means the earliest date the flexibilities expire is March 21, 2022. With the Presidents preference for an extension to the end of the calendar year, it is possible that Alaska’s Appendix K will extend to June 21, 2022.

Family Habilitation—SDS is awaiting a summary from Steve Lutsky (HCBS Strategies) of the input from the three webinars SDS hosted to solicit stakeholder input on their Potential Changes to Residential Habilitation. These changes will differentiate between Group Homes and Family Habilitation Homes. SDS assured the membership that there will be another round of input once the feedback has been incorporated, prior to any final plan. AADD made significant recommendations including: 1) Grandfathering in group home providers that own their homes, 2) Allow providers to be become the Organized Health Care oversight Entity, 3) Increase the Family Habilitation Home rate, and 4) Define “live-in” staff in group homes. See attached letter (again this month).

Companion Services —SDS agrees that Companion Services would be of value but they are currently on the backburner with the pandemic and difficulties with the service being cost neutral. AADD has recommended that some of the 10% FMAP increase be dedicated to professional service contracts to pilot Companion Services.

Harmony – All Care Coordinators will be required to enter plans into harmony exclusively beginning July 1, 2021. Care Coordinators are going through the training now and it is time intensive and not set up well to allow person directed services. Goals are from a drop down menu for example and have limited character space for inputting

EVV for IDD providers not on SDS’s radar for the foreseeable future.

**MENTAL HEALTH TRUST AUTHORITY**

Mental Health Trust Grant 8464.03 for FY21 is for $65,000. The grant has received approval to extend for 3 months to September 31, 2021 for activities in the summer/fall. The three primary goals are:

1. Advocate for a strong system and best practices through involvement with national trends and organizations.  *Supported HCBS Conference attendance (2 individuals), ANCOR Conference (4 individuals), V.J. Smith to keynote, Ben Drew to keynote*
2. Change management support for leadership in provider organizations. *Hosted University of Delaware Leadership Institute attended by 32 individuals statewide.*
3. Support for Agency Sustainability and Work Force Development – *Funding to support AADSP (Alaska Association on Developmental Disabilities) to meet in person for workforce planning. Note: Received an amendment, extending the grant to September 31, 2021 to support AADSP meeting in September.*

**COMPLIANCE GROUP**

The Compliance Group met May 20th. Discussion topics included current vaccination rates and policies, Meyers and Stauffer audits and DSP wages. Highest DSP wage mentioned (of providers on line) was $19.95/hour and lowest $14.75/hour. Cost of care remains a huge issue.

Group clarified that a provider cannot be required to do a self-audit the same year they are being audited by Meyers and Stauffer. Regulation 7AAC 169.115 states that “An enrolled provider who bills the department for services rendered during a calendar year shall conduct, once every two years, a review or audit of a statistically valid random sample of claims…..unless the provider is being audited under AS 47.05.200 (a).” And that citation refers back to the Meyers and Stauffer audits.

**CFO GROUP**

The CFO Group met May 20th. The group clarified that only one organization has received a Meyers and Stauffer audit request at this time. Certification is now requiring that Board members have a Background check. Several organizations have received questions about their cost studies from the Office of Rate Review. The next self-audit will be due June 30, 2022. Anchorage municipality is requiring sprinkler systems for all homes caring for 3 or more individuals in the coming years. There was a discussion about organizations supporting cell phones for employees.

**HOT TOPICS**

The Hot Topics call May 27th focused on the DSP Hire website. There were 37 participants. Jake Carpender, the developer walked the group through the current web site and responded to suggestions and answered questions. The App (for a mobile device) will be available for review at the end of June but will take time to implement.

**ADVOCACY A**laskans Standing For Medicaid is a broad coalition of organizations that rely on Medicaid (including health, homelessness, food insecurity, Native Health, Mental Health Trust, Mat Su Health Foundation, ABHA, AADD and others). The group met with 3 staff from Region X on May 18th to share priorities and concerns. Michael Bailey (for AADD) spoke to workforce concerns.

Shared Vision Advocacy Coalition included the Key Coalition of Alaska, the Alaska Association of Developmental Disabilities, Peer Power, the Governor's Council on Disabilities and Special Education and the Statewide Independent Living Council. AADD had 18 members who contributed $16,350 dollars to Key Coalition, to support the lobbyist, David Parish. These organizations receive an invitation to an hour long meeting with David Parish each month of the session. The group met May 20th. His update included Josephson’s bill for 1.2 million to support an additional draw of 20 folks from the waitlist to add to the 50 currently being drawn. The House has approved this, the Senate did not include it in their budget. The legislature has moved into special session.

**ANCOR**  Briefings: ANCOR continues a 15 to 30 minute briefing of what is happening on the “hill” (federal congress) and the Administration each Friday morning at 8:30. I attended four in April.

* Key Finding: Vaccination rates among people with I/DD are higher than that of the general population, but remain inconsistent. ANCOR survey, which was fielded between April 14-27, 2021, 73.2% of respondents reported that at least 60% of the people with I/DD they supported were at least partially vaccinated. By comparison, the U.S. Centers for Disease Control & Prevention (CDC) reported that only 44.4% of Americans were at least partially vaccinated as of May 3, 2021
* DOL withdrew the contractor Final Rule introduced in the last administration that would have undermined the financial rule. It is no long moving forward.
* SOC (Standard Occupation Code) for DSP’s that is under the Dept. of Labor, has been re-introduced in the Senate sponsored by Senator’s Hassin and Collins.
* A new bill is being prepared for the Congress to make Home and Community Based Services a required service under Medicaid instead of optional

**CALENDAR**

June 1, 2021 AADD Board meeting 9 to 10

June 1, 2021 Care Coordination Group 10:30 – 11:30

June 9, 2021 Shared Vision Meeting 1:00 to 4:00

June 10, 2021 AADD Monthly Meeting 11:00 – 12:00

June 14 – 16, 2021 ANCOR Conference

June 20, 2021 Compliance Group 8:30 – 9:30

June 20, 2021 CFO Group meeting 10- 11

June 20, 2021 Advocacy meeting with David Parish – 11:00

June 27, 2021 Hot Topics – To be announced

October 19 & 20, 2021 Fall Face2Face meeting – hybrid at BP Center and zoom

**SUMMARY OF SDS ALERTS**

May 18, 2021 E-Alert: Web SharePoint Outage Affecting DHSS Website and Mandatory and Critical Incident Reporting

May 18, 2021 E-Alert: UPDATE: Centralized Reporting Down with SharePoint Outage

May 19, 2021 E-Alert: Vaccinations for People with Disabilities

May 19, 2021 E-Alert: Update: Centralized Reporting Link is Active

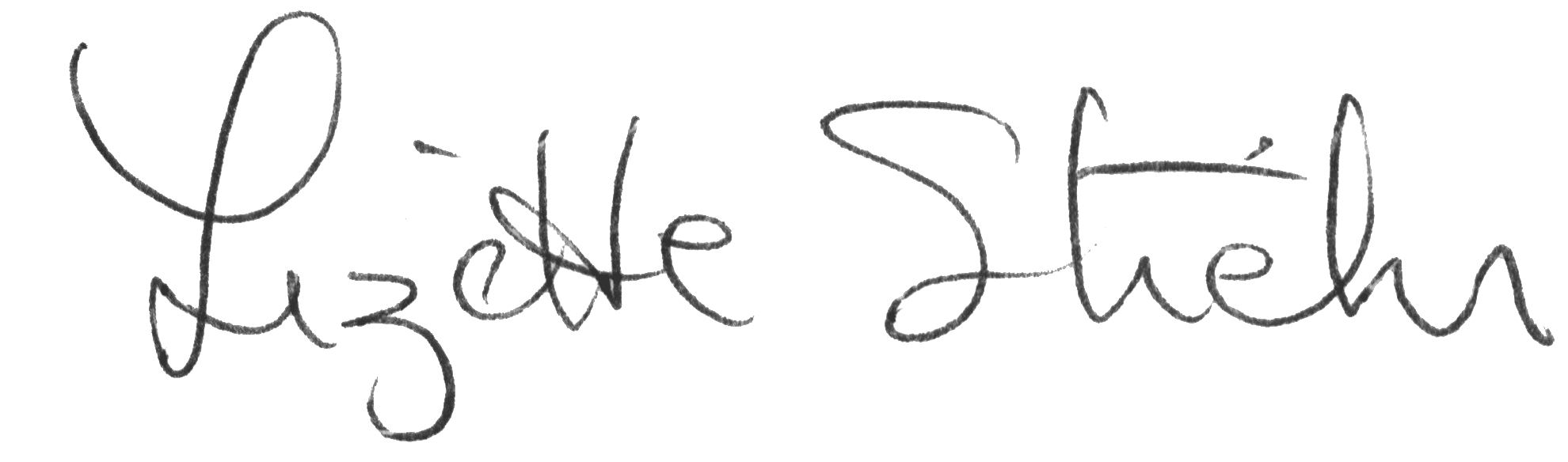
May 24, 2021 E-Alert: Planned Maintenance message regarding MyAlaska

May 24, 2021 E-Alert: SDS Announces DSP Hire, a web-based tool to recruit and hire direct support professionals

May 25, 2021 E-Alert: UAA CHD Training Announcement: Supporting Relationship and Sexuality for People with Intellectual and Developmental Disabilities

May 26, 2021 E-Alert: SDS and UAA/CHD Announce the upcoming summer schedule for Basics of Care Coordination

Respectfully submitted,



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***To facilitate a united provider voice for best practices, advocacy, partnerships and networking.***

Thanks Lizette for getting things started for us. I’d like to continue with what we’ve identified is our Top Priority…the DSP Current workforce and the DSP workforce crisis. What we know is that our DSP’s have been in the trenches for the past 14 months. And while we are seeing a glimmer of light on the other side of the Covid -19 tunnel, our DSP’s are still in the midst it. Some have been on lockdown in Covid positive homes, staying for the long haul to support the people they serve and to stop the spread of COVID -19 by not putting their colleagues as well as their own families at risk. Other DSP’s who are themselves immunocompromised jumped into the deep end of online service delivery and have been daily delivering day habilitation services through the Zoomiverse. Through it all our DSP’s have not asked for more pay and have not asked for more time off. They have unselfishly continued to Give and Give and Give of their hearts and their time because they are Dedicated and Committed to their profession. And…after 14 months they are beginning to get weary. We are asking the State to consider using half of the of the 10% increase to support DSP’s. This can be used to support those who have stayed with Agencies with fiscal rewards, to provide agencies who are in a current state of staffing crisis with incentives for new hires, to enhance training and supports and to increase staff retention. The state can fiscally “see” the amount of money that was billed over the course of 2020 – billing means DSP’s were providing those services. Based on that concrete information, we are asking that lump sum amounts go to individual agencies based on a portion of their billing, which then can in turn be utilized by Service providers to reward current DSP’s, to offer incentives for new hires and to increase training opportunities. We are then asking Providers for a promise as well as proof that indeed that money was spent on increased pay, benefits, recruitment, retention and training activities. We need more feet on the ground right now, and we need to retain the current set of boots that we do have. When Burger King is offering $1500 signing bonuses, we need something to be able to compete…. and we need to do it now.

The next topic we’d like to address is that of Companion Services. We all know that companion services have been put on the back burner since the cap of Day Habilitation. Budget constraints and the fact that introducing a new waiver service is not cost neutral continue to quell this much needed service. We offer the idea of Piloting Companion Services through professional service contracts so that both nonprofit and for-profit Providers could utilize Companion Services. As a State, we passed into Statute the DD Shared Vision in 2018. The Vision states: ***Alaskans share a Vision of a flexible system in which each person directs their own supports, based on their strengths and abilities, toward a meaningful life in their home, their job and their community.*** What it doesn’t say is “as long as those supports are habilitative”. There are many people currently receiving habilitative service that do not want nor do they need the level of hab services they are currently receiving. Don’t misunderstand me. They absolutely NEED the amount of service (the physical hours) they are getting. What they don’t need is to be “habilitated every 15 minutes”. They need opportunities to access their communities, to attend social engagements with friends, and to volunteer where they are in the driver seat assisting someone else to learn a skill. Companion services are critically needed for Seniors as well as people with I/DD. With the introduction of a Pilot program, we can finally discern not only the cost, but the need.

In closing I will restate what the ACL said, “this funding is a lifeline for people with disabilities, older adults and their families. It will help service providers use lessons learned from the challenges of COVID-19 to strengthen access to, and quality of, Home and Community Bases Services, for everyone who relies on these vital & important services.

Thank you Director Lee, Commissioner Crum, and Deputy Commissioner Wahl for your time today.

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May 27, 2021

Re: 10% FMAP increase in the American Rescue Plan Act

Dear John Lee,

AADD is very appreciative of the fact that SDS set up stakeholder input for the 10% FMAP Increase so quickly following the release of the Guidance from CMS. We welcome the opportunity to have input prior to the plan being developed so that the relief funds have more direct positive impact in the field than previous Federal relief packages. It feels more like a partnership. Thank you.

AADD leadership has identified four major recommendations for utilization of the additional 10% FMAP funds within the Guidance released by CMS. In addition, AADD stands behind a number of recommendations to support the care coordination field that could also be served by these funds. You have already received that letter.

The original intent of the FMAP increase, strongly advocated for by ANCOR (American Network of Community Options and Resources), as listed in the original Bill from the House of Representatives was to get funds to providers of HCBS services who had suffered grave losses during the pandemic. Our recommendations for that funding include:

* Workforce
* Companion Services
* Transition Costs
* Add hours to the ISW waiver

Workforce. The first priority is stabilizing and rebuilding the workforce. The current workforce and particularly the DSP workforce is in crisis. Our DSP’s have been in the trenches for the past 14 months, playing an essential role in preventing our hospitals from becoming overwhelmed. We also lost DSP workforce during the pandemic, exacerbating the previous workforce shortage. While we are seeing a glimmer of light on the other side of the COVID -19 tunnel, our current DSPs are still in the midst it and despite unemployment levels the low rate of job applicants for DSP work is very disconcerting. Some have endured quarantine in COVID-19 positive homes, staying for the long haul to support the people they serve and to stop the spread of COVID -19 following the more restrictive DHSS guidance to avoid putting their colleagues, as well as their own families, at risk. Other DSP’s, who supported online service delivery through the Zoom platforms.

Through it all, our DSP’s have not demanded for more pay and have often sacrificed time off. They have unselfishly continued to give of their hearts and their time because they are dedicated and committed to their profession. After 14 months they are weary and fatigued. We need more feet on the ground right now and we need to retain the current workforce. Competition for labor is fierce with some companies offering $1,500 signing bonuses, so providers need to be able to compete with a high degree of urgency.

We believe that the State needs to dedicate half of the 10% FMAP increase to support DSP’s. Without DSP’s, services are not delivered, documented and billed. Any state receiving the increased FMAP is fully dependent on a healthy, sustainable workforce so any projected amount for planning purposes must include reinvestment in the revenue generator. The state can fiscally “see” the Medicaid billing for DSP-based services over the course of the authorized period April 1, 2021 – March 31, 2022. Based on this fiscal information, we are asking that lump sum amounts go to individual agencies on a quarterly basis as a percentage of their billing for direct care services. This will be utilized by service providers to retain current DSP’s, to offer incentives for new hires, to offer benefits and to increase training opportunities and tuition assistance for credentialed positions. Providers would then be required to offer proof that that the funds were spent on pay enhancements, benefits, recruitment, retention and training activities.

**Recommendation: Use 50% of the increased FMAP funds to stabilize the workforce through enhanced pay, benefits, recruitment, retention and training opportunities.**

Companion Services are sorely needed. We recognize that companion services have been put on the back burner since Day Habilitation services were significantly capped. Budget constraints and the difficulty in making a new waiver service cost neutral continue to quell this much needed service. We recommend that funds be allocated to Pilot Companion Services through professional service contracts so that both nonprofit and for-profit providers could utilize this service.

As a State, we passed the DD Shared Vision into Statute in 2018. The Vision states: *Alaskans share a Vision of a flexible system in which each person directs their own supports, based on their strengths and abilities, toward a meaningful life in their home, their job and their community****.*** What it doesn’t say is “as long as those supports are habilitative”. There are many people currently receiving habilitative service that do not want nor need the habilitative services they’re currently receiving. Don’t misunderstand this. They absolutely NEED the amount of service (the physical hours) they’re getting. What they don’t need is to be “habilitated every 15 minutes”. They need safety and monitoring support opportunities to access their communities, to attend social engagements with friends, and to volunteer where they are in the driver seat assisting someone else to learn a skill. Companion services are critically needed for seniors as well as people with I/DD. With the introduction of a Pilot program, we can objectify the feasibility of cost and qualitative benefits.

**Recommendation: Pilot Companion Services through professional service contracts to help determine the need and cost of the service.**

Transition services for bringing folks from institutional care in API or from out of state, back into the community, is long a goal of both the AADD and SDS. Much work has been done in this area to understand the barriers. AADD recommends that some of the FMAP increase be utilized in two unfunded categories. Bringing individuals successfully back into the community from institutional care is a complicated and lengthy process. Visitation to understand the behaviors and how they are being addressed is necessary. Overlap of staff from the sending institution to the community setting is needed. Homes must be modified. Staff must be hired and trained. A medical provider must be found to continue the extensive medications prescribed for those institutionalized. These are currently all non-billable expenses. Providers no longer have the capacity or flexible funding to pay these costs. We recommend the increased funding be utilized to help cover these costs for services providers to make transition possible. An AADD task force developed a grid of these needed services, both those currently reimbursed and those not billable that could be utilized to clarify the needed services.

The second major key to successful transitions and the reason many providers no longer feel they can take on such individuals, is assurance of an adjustable acuity rate. This is the additional rate, based on the difficulty of care that is paid to allow expanded staffing for an individual with intense behaviors. Providers have experienced that the initial acuity rate is reduced before the individual is stabilized. The limitations of current “all or nothing” regulations can be overcome through allocation of some FMAP funds on a case-by-case basis. The need to go to hearing to fight for those funds is a key factor in many organizations no longer willing to take such individuals.

**Recommendation: Fiscally support non-billable services for those transitioning from institutional care into the community and provide adequate acuity rates until true stabilization.**

AADD strongly supports adding up to 5 hours a week, to the existing ISW waiver plans. The ISW currently supports approximately just 7 hours a week of services. For many families, awaiting a full waiver this is woefully short of what is needed.

As we know all too well the pandemic has had a huge impact on all of us. But for individuals with IDD the isolation of being home with extremely limited service or without services resulting in limited contact with their friends has led to two major outcomes. One is that provider’s report regression of social skills as small group services reconvene. Individuals have lost skills they have not used in group settings or with other individuals during the isolation of the last year. Additionally, many exhibit anxiety or even behavioral health issues. An additional five hour a week would give providers the ability to address both the regression of social skills as well as behavioral support. Of course, this would be providing more services for those on the DDRR or our waitlist within the CMS guidelines.

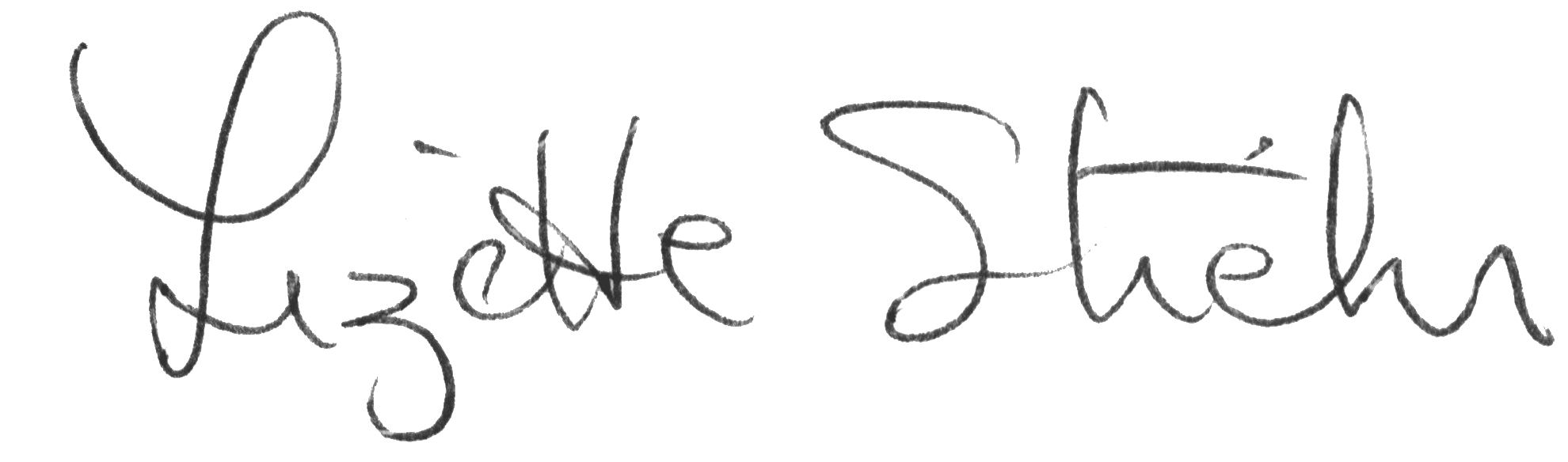
**Recommendation: Support up to 5 additional hours for those receiving ISW waiver services to address pandemic outcomes.**

In closing we will restate what the Administration on Community Living said, “This funding is a lifeline for people with disabilities, older adults and their families. It will help service providers use lessons learned from the challenges of COVID-19 to strengthen access to, and quality of, Home and Community Based Services, for everyone who relies on these vital and important services.“

We understand that there is a requirement for additional state matching funds for the FMAP increase, and that clarification on the specifics are pending from CMS and subsequent legislative approval is necessary. We firmly believe that this unique increased FMAP opportunity needs to be invested in the sustainability of service providers and we stand ready to participate in legislative advocacy to access these federal monies to maintain home and community services in our state.

Thank you again for the opportunity to provide stakeholder input into the planning process.

Sincerely,



Lizette Stiehr

Executive Director, AADD

Cc: Al Wall, Deputy Commission, DHSS

Adam Crum, Commissioner, DHSS

Tony Newman, Deputy Director, SDS

Maureen Harwood, Manager, SDS



**AADD**

**ALASKA ASSOCIATION ON**

**DEVELOPMENTAL DISABILITIES**

**P.O. Box 241742**

**Anchorage, Alaska 99524**

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***To facilitate a united provider voice for best practices, advocacy, partnerships and networking.***

May 14, 2021

To: Senior and Disabilities Services

From: AADD

Re: Care Coordination services in Alaska

Dear John Lee,

On behalf of AADD, we would like to thank SDS for assisting Care Coordinators (CC), provider agencies and individuals/families receiving waiver services through an unprecedented year. The pandemic has been tough but also a learning experience for all of us.

As the dust settles from the pandemic, AADD has been gathering feedback from providers discussing what worked, what didn’t work, and what could possibly be continued. During this process, AADD created a Care Coordination group with representatives around the state to allow care coordinators an opportunity to have their voices heard collaboratively.

On behalf of AADD, the Care Coordination group would like to offer SDS feedback and suggestions regarding the impact of the COVID-19 pandemic on the recipients we serve and how care coordinators provided support during a rapidly evolving service environment. Our comments are outlined below and include the following categories: Appendix K, Harmony, Communication and Workforce.

**COVID-19:** In mid-March 2020, when the pandemic began, Care Coordinators quickly responded to meet the challenges generated by the unrelenting pandemic and adjust to working remotely. The burden of remote working, as many of us know, was not an easy lift. Setting up home offices for employees has been expensive and the added costs have taken their toll, especially on our smaller agencies. Several Care Coordination organizations applied for available COVID-19 assistance but were unsuccessful in receiving reimbursement for these added costs. Care coordinators are asking SDS to explore possible grant funding opportunities to allow care coordinators to recoup some of the expenditures required during this transition.

**Appendix K:** The Appendix K amendment was the silver lining of the pandemic, offering flexibilities that insured that care coordinators were able to continue supporting waiver recipients. We recommend that SDS consider adapting and continuing some of these flexibilities to improve care coordination services in Alaska. Working remotely, without monthly face to face contacts, gave care coordinators, individuals and their families’ opportunities to be creative. Meeting via platforms such as Zoom, phone, and FaceTime, supported recipients in maintaining the continuity of care they received prior to the pandemic whenever possible. Care coordinators agree there are numerous waiver recipients that don't require face to face monthly visits to maintain the level of supports and care needed to live the life they chose with the support they direct. By adjusting the monthly face to face requirement, care coordinators would have increased capacity and could serve rural areas more easily. Care Coordinator’s would like SDS to consider face to face meeting flexibilities as a permanent change.

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Another flexibility that has been extremely beneficial is the extended support plan. The option to extend support plans when recipients feel their needs are being met with the services outlined in their current support plan enable recipients and their teams to focus on service quality and goal achievement. Continuing this flexibility would benefit recipients and their families by reducing the burden of paperwork required to receive waiver services, and enable care coordinators, providing agencies, and SDS to increase capacity and quality of services.

**Harmony:** The Harmony trainings in order to work in the database have been very time consuming for care coordinators. They have discovered that the system does not embrace person-centered services. Care coordinators have had to set aside an enormous amount of time during an unrelenting pandemic and time of increased needs for support by those we serve, to learn and become proficient in a complex database that is rigid and inhibits our ability to be person-centered in our work. Care coordinators fully support Alaska’s

Shared Vision and feel that Harmony is a barrier to person- centered planning and does not align with Alaska’s Shared Vision statute (SB174). Specifically, the habilitative goal sections force habilitative services into restricted categories and limits individual choice on how to develop their skills to obtain their goals. Care coordinators would like greater flexibility within the Harmony System. Supporting individual choice in structuring goals and objectives would support person-centered planning and align with the values enshrined in Alaska’s Shared Vision. Despite the lengthy and time-consuming training involved in gaining proficiency in Harmony, the Training Unit at SDS has been a valuable part of the process. It has been enjoyable working with such supportive individuals at SDS.

**Communication:** Clear, effective communication is the foundation to developing and maintaining successful working relationships. Effective communication between SDS units has been an ongoing challenge. Care coordinators are concerned about the disconnect between how the IDD and NFLOC units approach their work and the policies and procedures each unit employs. Care coordinators experience a more collaborative work environment with the IDD unit. The experience with the NFLOC unit is more contentious, with significant deviations from how the IDD unit approaches the work. These deviations in policies and procedures lead to substantial incomplete plan submissions due to superfluous requirements and exceedingly long processing times, resulting in delays for recipients to receive the supports they need. In addition, care coordinators experience significant variation in requirements and answers to questions from individuals in the NFLOC unit. It would be beneficial for care coordinators to have one contact (a liaison) with supervisory authority within the IDD and NFLOC units to improve communication with care coordinators and to bridge the gap between the two units. It is our hope to receive consistent, clear answers from the division to enable us to better support the individuals we serve.

**Workforce:** Lastly, we recognize that care coordination services in Alaska are nearing a crisis point. The state is experiencing a significant decrease in care coordination capacity and agencies are facing substantial recruitment challenges. Care coordination capacity has declined sharply in the past eight years. In 2013 there were 330 certified care coordinators in Alaska and there are just 185 care coordinators in 2021. In addition, SDS has added the ISW wavier to its menu of support options for recipients, and expanded care coordination responsibilities without providing higher reimbursement rates to compensate for the increased time commitment care coordination services require. Another significant barrier to attracting qualified care coordinators is the lengthy and arduous process of becoming certified and being issued a billing number. Care coordinators fear that individuals needing services will be faced with additional delays in accessing needed supports while waiting for an available care coordinator. The AADD Care Coordination Group has discussed a possible Care Coordination Accreditation Program. This would assist in recruiting and retaining qualified care coordinators in the state. Additionally, we feel that offering grants for care coordination organizations to hire and train new care coordinators. Training new care coordinators can take up to a full year before they can carry a full caseload and support their costs. If grants were available for administrative positions, it would allow organizations the capacity to hire and train new care coordinators in the field. We are hopeful that SDS will take action now to stabilize and improve Care Coordination Services which are an essential part of Alaska’s HCB Waiver supports.

Care Coordinators statewide are thankful to have the opportunity to provide feedback and suggestions on a collaborative level. It is our hope that SDS will engage collaboratively with care coordinators and AADD to address deficiencies and find solutions to sustain care coordination services in Alaska. The Care Coordination Group, on behalf of the AADD, sends tremendous thanks to SDS for all their hard work during this unprecedented year. Your dedication and commitment to helping Alaskans with disabilities remain healthy and safe through a global pandemic does not go unnoticed.

Please feel free to contact us with questions. Thank you!

# Sincerely,

|  |
| --- |
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***To facilitate a united provider voice for best practices, advocacy, partnerships and networking.***

April 27, 2021

John Lee

Division of Senior and Disability Services

1835 Bragaw, 501 Business Park Blvd., Suite 350

Anchorage, AK 99508

Re: Residential Habilitation Reform Proposal

Dear John,

AADD is grateful for the opportunity to submit written comments on the Potential Changes to Residential Habilitation Services put out for stakeholder input to resolve the issue of provider payments to subcontractors (family habilitation homes) not being allowed under 42 CFR 447.10. This lack of compliance has been looming for several years resulting in multiple sources encouraging family habilitation home providers to certify their services in order to bill directly, allowing them to shift to group home services. The Potential Changes to Residential Habilitation Services would have significant impact on those providers.

AADD hosted a Hot Topics call on this issue. The comments, questions and concerns raised by the thirty six providers in attendance are reflected in this letter. The consensus of the group was a wish that there had been engagement with stakeholders at some level prior to the release of a formal looking Potential Changes to Residential Habilitation Services with scheduled webinars addressing the content, potential regulations and oversight agency options. Providers were concerned that the request for stakeholder input was perfunctory and were grateful to hear that a great deal had been learned in the first webinar and that the state might be re-thinking portions of the proposal.

Several providers commented on the fact that group home staffing processes have nothing to do with the primary issue of family habilitation payments to subcontractor, family habilitation homes, not being allowed under 42 CFR 447.10.

The webinars hosted by SDS and the Hot Topics call made clear that licensure and certification requirements for family habilitation homes has been very burdensome. Concerned with the lack of compliance with CMS, family habilitation homes have been encouraged over multiple years to become their own billing agents through certification in addition to their licensure requirements. This allowed them to become group homes and access a billing rate three times the family habilitation rate. Now those group home providers are very concerned. Some of their direct comments include:

"We were encouraged some time ago, to become our own entity; so we went through the long complicated process of becoming our own biller and we were given the option to do group home or family habilitation. We went with group home. Now, you are telling us that we might have to go backwards. Why was there a choice when we went through the process originally? That just doesn't seem right."

"Being able to hire my own staff to occasionally work in the home is a must. If that option was taken away, it would significantly impact our day-to-day routine. Respite is not a reliable option. I need to be able to hire my own employees."

“I liked contracting with an agency to help with all the paperwork stuff, but we were encouraged to move away from this. When my home received approval to bill, it took me some time to get used to all the paperwork stuff. It sounds like this would change that. This news was a gut punch."

**Recommendation**: Allow a waiver to grandfather those group home service providers that live in their own home and changed to the group home service under the recommendation of SDS.

SDS is well aware that many family habilitation homes have been providing this service with the same individuals over a long period of time, sometimes up to 20 years. These homes have made it clear they are deeply dedicated to the service and do not want to operate or bill independently. They do need the respite care and some need to be able to hire staff to allow for their dedicated inclusion of the recipients they serve.

Organizations currently provide support to family habilitation providers through training, quality assurance of progress notes, insurance support, HIPAA compliance, behavioral challenges, consistent payment for services, assistance with paperwork, licensing compliance, support with out of services dates, providing daily respite or alternative family habilitation placement and more. How can this range of support be available through a remote oversight agency? There are concerns that an oversight agency might provide billing support but could not provide the level of regional and individualized support current family habilitation homes receive.

Recruitment is a significant issue as well. One provider reported just three homes family habilitation homes are left from a pool of fifteen five years ago. Each of the three remaining was developed by an individual that began their work as a DSP for the agency. How could a governmental oversight agency recruit families to provide that service, particularly across the vast state including rural areas?

**Recommendation**: Allow providers to become Organized Health Care Oversight Entity with responsibility for recruiting, supporting, training and billing for family habilitation homes. Allow the entire stipend to be paid to the family habilitation homes while the agency providers, as oversight entities, receive a stipend from the state. The costs to develop a new oversight entity would significantly exceed the stipend costs.

Recruitment is compounded by the low reimbursement rate for family habilitation service that has remained the same for over a decade, while regulatory requirements keep increasing. Those stringent licensing rules, which are regulated by municipalities and boroughs have different requirements for different areas of the state. Anchorage is requiring sprinkler systems (at a cost of up to $30,000) for all Assisted Living Homes, including those licensed as family habilitation homes serving more than two recipients, over the next two years. This is not fiscally viable at the current family habilitation rates.

**Recommendation:** Increase the family habilitation service rate to be more commiserate with the group home reimbursement rate in order to keep this service viable.

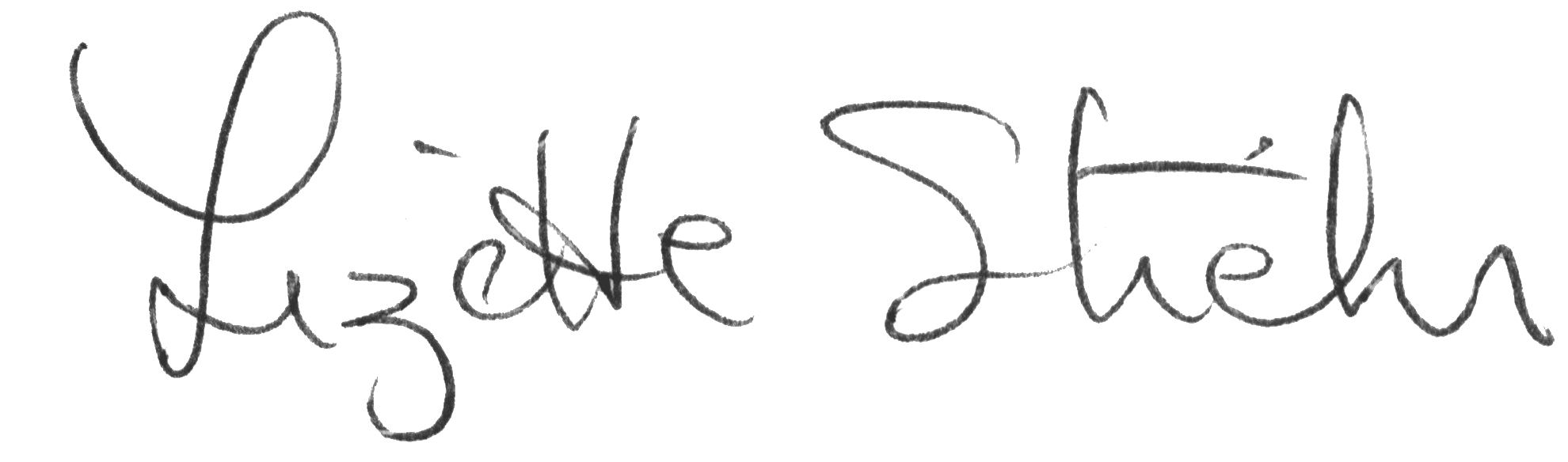
AADD was grateful to learn it was not the intention of the Potential Changes to Residential Habilitation Services to deny live-in options for group homes. There are many benefits to having live-in staff. Families and guardians advocate strongly for security and stability for those they love and the live-in models have given many people the opportunity to develop long term meaningful relationships. There are numerous benefits of stable staff including historical knowledge for health care and personal histories and relationships with guardians and family members to name a few. The ability to keep people safe and secure during the pandemic was enhanced greatly with live-in models.

**Recommendation**: Define “live-in” staff and ensure different staffing models are available for the group home service including: 24 hour shift model for staff who have a residence outside the group home, staff who live on the premises, or other models that providers currently implement.

Providers are hopeful that the changes to family habilitation can be approached and implemented in as simple and fair a manner as possible. And at the heart of any decision is alignment with the DD Shared Vision- does this decision support flexible outcomes? Does it enhance self-determination? Does it enhance and retain work force? Does it support families? Service language continues to devalue people with disabilities. While we may not be able to change the language overnight, our practices can certainly align better with value driven outcomes- honoring choice, rights and preference while enhancing stability.

Again, we thank you for bringing this issue to stakeholders for conversation and we hope that these comments help guide the process.

Sincerely



Lizette Stiehr

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