Evaluation of Intellectual and Developmental Disability Provider Organizations

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Trust
Alaska Mental Health Trust Authority

TABLE OF CONTENTS

ACKNOWLEDGEMENTS 1
EXECUTIVE SUMMARY 2
INTRODUCTION 5
EVOLUTION OF ALASKA'S HCBS FRAMEWORK 6
NATIONAL SCAN 9
ALASKA PROVIDER PROFILE 12
SYSTEM READINESS FOR CONCURRENT REFORMS 15
STRATEGIC RECOMMENDATIONS 17
GENERAL OBSERVATIONS 24
CONCLUSION 31
REFERENCES 33
APPENDIX A 38

ACKNOWLEDGMENTS

This project would not have been possible without the support and foresight of the Alaska Mental Health Trust Authority (Trust) and the cooperation and openness of the ten provider organizations that participated in this assessment. Their leadership and staff shared their operational experiences candidly and provided valuable insight into the realities of delivering services across Alaska's Home and Community Based Services (HCBS) system. I am deeply appreciative of their willingness to contribute their time and perspectives, and I recognize the dedication of the many staff members who work each day to support Alaskans with intellectual and developmental disabilities in pursuing meaningful lives within their communities.

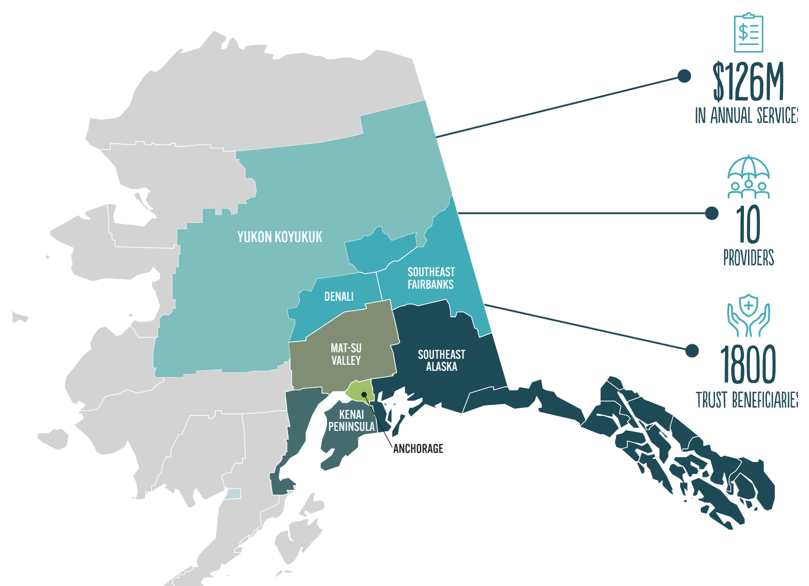
The observations, interpretations, and recommendations presented in this report are my own and reflect more than four decades of experience in Alaska's health and human services system, including work across both nonprofit and for-profit service environments. This perspective is informed by practical operational experience as well as academic training inclusive of a PhD in health care administration.

EXECUTIVE SUMMARY

Project Purpose

The Alaska Mental Health Trust Authority (Trust) commissioned this assessment to evaluate the sustainability of Alaska's long-standing Home and Community-Based Services (HCBS) providers serving individuals with intellectual and developmental disabilities (IDD). These legacy providers form the backbone of the state's community-based service delivery system and play a central role in ensuring access for Trust beneficiaries across multiple regions.

Collectively, the ten providers reviewed operate approximately $126 million in annual services and serve roughly 1,800 Trust beneficiaries across Anchorage, the Mat-Su Valley, Fairbanks, the Kenai Peninsula, Southeast Alaska, and rural communities. They employ a substantial share of the statewide direct support workforce and maintain infrastructure developed over decades of system transition from institutional-based models to predominantly community-based services supported through Medicaid waiver authority.



For the purposes of this report, legacy providers refer to established organizations with sustained histories of service delivery in their communities. Many have operated for decades and have navigated transitions from grant-funded models to Medicaid fee-for-service systems, implementation of conflict-free care coordination, evolving federal HCBS requirements, and ongoing shifts toward individualized and community-based supports. Their scale, geographic reach, and experience make them essential components of the statewide service continuum.

Intellectual and developmental disabilities (IDD) refers to "a group of developmental conditions" characterized by significant impairment of cognitive functions, which are associated with limitations of learning, adaptive behavior and skills. An intellectual disability manifests before the age of 22, with an IQ below 70 and with significant limitations in two or more adaptive areas (such as communication or self-care).

The providers reviewed remain mission-driven, community-based, and operational. However, the system in which they operate is stable but capacity-constrained.

Workforce shortages are the defining limitation. Persistent vacancies, turnover, wage pressure, and cross-sector competition restrict deliverable capacity even where demand remains strong. Authorized services do not consistently translate into delivered services because staffing levels do not support full utilization. Financial margins are narrow. Some organizations have historically generated modest surpluses through conservative budgeting and diversified revenue streams. Others are projecting deficit conditions as wage compression, administrative expansion, and underutilization converge. Reserve capacity varies across organizations and is generally limited.

Administrative requirements have expanded steadily over time. Documentation expectations, audit activity, electronic systems, licensing standards, and coordination demands consume leadership and supervisory bandwidth. At the same time, leadership transitions are occurring across multiple organizations during a period of accelerating reform and workforce instability, increasing governance and succession planning demands.

This assessment examined organizational structure, governance, financial condition, workforce composition, service array, utilization patterns, and administrative systems across the ten providers. The central finding is structural rather than organizational: sustainability risk is driven by system-wide conditions, not isolated management weakness. The provider network remains resilient and functional, but it operates with limited elasticity.

Alaska's IDD system continues to evolve toward individualized, community-based, and data-informed service models. Simultaneously, the state is advancing significant reforms, including interRAI-based eligibility and resource allocation tool, expansion of self-directed services, complex care initiatives, rate methodology recalibration, and alignment with Rural Health Transformation Program efforts. Each reform independently advances legitimate policy objectives. Collectively, they increase operational strain.

Trust Role

Reform success depends on the continued viability of the existing delivery infrastructure. Within this environment, the Trust has a distinct and strategic role. While it does not regulate providers or set Medicaid rates, it is uniquely positioned to convene system partners, elevate shared data, and align stakeholders around realistic implementation expectations.

Specifically, the Trust can:

- Convene cross-agency leadership to align reform sequencing with operational capacity
- Support development of a statewide sustainability monitoring framework using shared workforce and utilization metrics
- Fund targeted technical assistance to strengthen financial modeling, succession planning, and governance capacity
- Encourage exploration of shared infrastructure models, including Community Care Hub or back-office collaborations
- Promote administrative simplification discussions across departments where cumulative burden constrains capacity
- Ensure reform evaluation incorporates deliverability indicators, not solely authorization or policy benchmarks

Conclusion

The ten providers reviewed are not failing but they are struggling. They are absorbing cumulative system pressure in order to maintain continuity of service for individuals and families across Alaska.

Sustaining access will require aligning policy ambition with operational capacity and addressing sustainability alongside reform implementation. Workforce sufficiency, administrative clarity, financial planning, governance strength, and reform sequencing are interconnected components of system resilience.

Sustainability is not a secondary issue. It is the foundation upon which access, quality, and reform depend.

Alaska's IDD system continues to evolve toward individualized, community-based, and data-informed service models. Simultaneously, the state is advancing significant reforms, including the interRAI-based eligibility and resource allocation tool, expansion of participant-directed services, complex care initiatives, rate methodology recalibration, and alignment with Rural Health Transformation efforts. Each reform independently advances legitimate policy objectives. Collectively, they increase operational strain.

INTRODUCTION

The Alaska Mental Health Trust Authority initiated this review to better understand the sustainability of ten legacy Home and Community-Based Services (HCBS) provider organizations that play a central role in Alaska's intellectual and developmental disabilities (IDD) service delivery system. These organizations collectively represent a substantial portion of the state's community-based service infrastructure and workforce capacity. As Alaska advances significant policy and system reforms, the Trust sought to assess whether current operating conditions support long-term provider viability and overall system stability.

This review was not a compliance audit, performance evaluation, or financial examination. It was not designed to assign responsibility for workforce shortages, fiscal pressures, or policy constraints. Rather, the objective was to examine the structural conditions affecting provider sustainability and to identify shared risk factors that may influence system performance over time.

For the purposes of this project, sustainability refers to an organization's ability to recruit and retain a stable workforce; consistently deliver authorized services; maintain leadership and administrative capacity; manage financial variability; and adapt to evolving policy and regulatory requirements. This definition reflects the understanding that access and quality are directly dependent on provider stability. Without reliable delivery infrastructure, authorization, and rate adequacy, policy reform cannot translate into consistent services for individuals and families.

The scope of the review focused on organizational operations and system-facing pressures. Ten long established providers located in Anchorage, the Matanuska-Susitna Valley, Fairbanks, the Copper River Valley, the Kenai Peninsula, and Southeast Alaska participated in structured, in-person assessments. These organizations vary in size, service mix, and geographic reach, but collectively represent a significant share of Alaska's IDD service capacity. Their diversity in structure and geography provided a meaningful cross-section of the statewide delivery environment. It should be noted that tribally operated IDD providers were not included in this study due to a lack of comparable organizational structures.

The review examined workforce conditions, utilization patterns, administrative burden, financial operating dynamics, leadership continuity, and exposure to upcoming system changes. It did not include compliance audits, corrective action reviews, or provider rankings. The emphasis was on identifying recurring themes and structural pressures across organizations rather than comparing individual performance.

Information was gathered through in-person meetings with executive leadership, review of organizational summaries and available operational data, and discussion of workforce and service trends. Because data systems and reporting practices vary across providers, findings were synthesized at a system level. The consistency of themes across organizations of different size, service mix, and geography was treated as evidence of broader structural conditions rather than isolated organizational challenges.

As with any assessment of this nature, limitations exist. The review reflects operating conditions at a specific point in time and does not represent a comprehensive evaluation of all HCBS providers statewide. However, the convergence of findings across diverse organizations provides a clear and consistent picture of shared sustainability pressures.

This introduction clarifies the intent and boundaries of the project. The analysis that follows should be understood as system-level observations designed to inform policy alignment, strategic stewardship, and reform implementation planning, not as critiques of individual providers.

EVOLUTION OF ALASKA'S HCBS FRAMEWORK

Alaska's home and community-based services (HCBS) system for individuals with intellectual and developmental disabilities (IDD) has developed over several decades through steady policy evolution and community partnership. The current framework reflects long-term shifts in federal requirements, state priorities, and the expectations of individuals and families seeking community-based supports.

Early service delivery models relied more heavily on grant funding, congregate settings, and program-driven structures. Over time, Alaska transitioned to a Medicaid fee-for-service environment and embraced national policy direction favoring community integration, person-centered planning, and individualized supports. Legacy provider organizations were central to this transition. They expanded services, built infrastructure, and supported individuals through major changes in financing and regulation, including the closure of Harborview and the implementation of federal HCBS settings requirements.

As the system matured, several structural shifts occurred. Service delivery moved away from predictable, congregate models toward individualized supports delivered in homes and community settings. This change aligned with participant choice and integration goals but altered staffing patterns, supervision needs, and service coordination requirements. Individualized services require more flexible scheduling and greater workforce coordination than earlier models.

Administrative expectations also evolved. Conflict-free care coordination, enhanced documentation standards, increased audit activity, and expanded reporting requirements became embedded within the operating environment. These changes strengthened oversight and accountability but increased operational complexity for providers.

Over time, eligibility determination, referral management, and service authorization processes became more centralized. This structure improved consistency across regions, but also shifted certain operational controls away from providers. Providers remain responsible for delivering services and maintaining staffing, while key drivers of service volume are managed through system-level processes.

Regulatory changes also allowed for the development of smaller, individualized residential models. These changes expanded participant choice and supported community-based living arrangements tailored to individual needs. At the same time, they diversified the provider market and redistributed workforce demand across a broader range of organizations.

Alaska is now entering another phase of system evolution. Implementation of an interRAI-based assessment tool framework, expansion of self-directed services, increased attention to individuals with complex needs, and alignment with broader health transformation initiatives represent the next stage of modernization. These reforms are grounded in goals of equity, transparency, and improved outcomes.

Understanding the historical progression of Alaska's HCBS system is important in interpreting the current landscape. The framework in place today reflects cumulative policy decisions made over decades. Each phase of reform advanced legitimate objectives and reshaped how services are organized, financed, and delivered.

Today's operating environment reflects cumulative policy layering across four decades of system development.

HISTORIC PROGRESSION TIMELINE

1984-1992 Deinstitutionalization & Community Expansion

- 1984: Closure of Harborview Developmental Center (state run residential institution)
- 1992: Final closure of Harborview completed
- Expansion of community-based residential and day habilitation services statewide
- Growth of Alaska's 1915(c) Medicaid waiver authority for IDD services

1996 Medicaid Waiver Formalization

- Expansion and stabilization of Alaska's 1915(c) Intellectual and Developmental Disabilities Waiver
- Transition from grant-supported models to Medicaid fee-for-service financing
- Formalization of provider enrollment and billing structures

Early 2000's (2000- 2011) System Growth & Professionalization

- Expansion of service array (supported living, employment, in-home supports)
- Increased Medicaid dependency across provider network
- Growth of multi-service nonprofit provider organizations
- Strengthening of licensing, certification, and compliance standards under Alaska Administrative Code

2012 (Federal) - 2017 (State Compliance Period) CMS HCBS Settings Rule

- 2012: CMS issues HCBS Settings Final Rule (42 CFR §441.301(c))
- 2014-2017: Alaska transition plan development and provider compliance implementation
- Residential and day services restructured to meet community integration standards
- Increased documentation and person-centered planning requirements

2014-2018 Conflict-Free Care Coordination Implementation

- CMS requirement separating case management from direct service provision
- Alaska transitions to independent care coordination structure
- Referral and authorization processes centralized
- Increased administrative documentation and oversight responsibilities

2015-2019 Expansion of Individualized Residential Models

- Regulatory flexibility supporting small-home and single-site residential models
- Growth of independent and small provider participation
- Increased participant choice
- Diversification of provider market structure

2020-2022 COVID-19 Public Health Emergency (PHE)

- March 2020: Federal Public Health Emergency declared
- Temporary Appendix K flexibilities implemented in Alaska
- Emergency rate enhancements and workforce stabilization measures
- Delayed assessments and service planning activities
- Significant workforce turnover acceleration

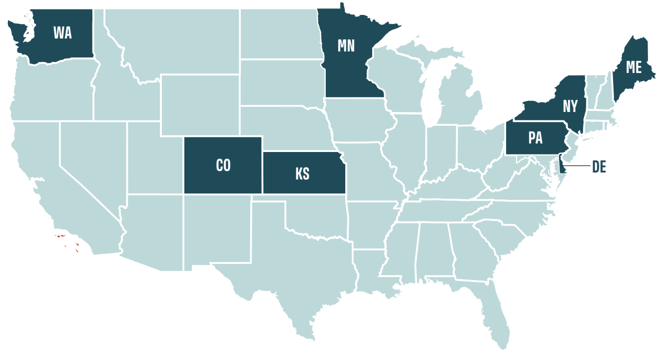
2023 Guidehouse HCBS Rate Study

- Alaska Department of Health engages Guidehouse to conduct comprehensive HCBS rate review
- Cost modeling and provider wage data collection
- Increased transparency regarding structural cost pressures
- Ongoing rate methodology recalibration discussions

2024-2026 (Planned Implementation Period) Reform Acceleration Phase - continued planning

- interRAI-based eligibility and resource allocation tool framework
- Self-directed services
- Increased focus on individuals with complex care needs
- Continued rate methodology adjustment discussions
- Alignment of HCBS with broader Medicaid transformation initiatives

NATIONAL SCAN



To better understand how Alaska's sustainability challenges align with national trends, selected states were reviewed for their approaches to workforce stabilization, rate methodology, service design, documentation requirements, self-direction infrastructure, and reform sequencing. States examined included Minnesota, Colorado, Washington, Pennsylvania, New York, Delaware, Maine, and Kansas.

Rather than replicate full state profiles in this section, the analysis below highlights strategic themes and structural contrasts relevant to Alaska.

Across states, three patterns are evident. First, rate reform alone has not resolved workforce shortages. Second, administrative simplification is increasingly treated as a sustainability lever equal in importance to reimbursement adjustments. Third, reform sequencing and buffering are used intentionally to prevent destabilization of provider networks.

MINNESOTA

Minnesota has pursued broad system simplification through its Waiver Reimagine initiative. Rather than layering new services onto an already complex structure, the state consolidated service definitions, reduced administrative variation, and aligned expectations across counties and providers. Rate recalibration was paired with simplification to reduce indirect cost pressure. Technology and self-direction are not treated as add-ons, with standardized service definitions that explicitly allow for technology-enabled supports such as assistive technology, remote monitoring, and flexible staffing models, while preserving person-centered planning principles.

COLORADO

Colorado has implemented community-first choice strategies to expand access to attendant and personal care services outside traditional waiver caps. and invested significantly in self-direction infrastructure. As a result, personal care and attendant services now represent the largest service category in Colorado's IDD system. Expansion of self-directed services was accompanied by documentation streamlining and clearer service definitions in order to maintain provider participation and workforce stability.

WASHINGTON

Washington maintains strong centralized oversight while supporting a large, integrated provider base. The state emphasizes documentation that is sufficient to demonstrate service delivery and outcomes, rather than exhaustive narrative requirements. This approach reduces administrative burden without weakening accountability. Washington explicitly tracks individuals who are eligible for services but receive no paid supports. The state treats this population as a structural indicator of unmet need and workforce limitation. This transparency allows policymakers to connect access challenges directly to provider capacity, labor availability, and service design, grounding reform discussions in operational reality rather than theoretical adequacy.

PENNSYLVANIA

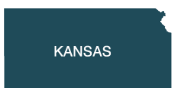
Rather than relying solely on volume-driven reimbursement, the state has explored performance-based contracting, particularly within residential services, and expanded access to assistive technology and remote supports. By expanding technology and self-direction options within a residential-dominant system, Pennsylvania seeks to make existing capacity more effective and sustainable. Self-direction is well established in Pennsylvania and functions as a central component of its workforce and sustainability strategy.

NEW YORK

New York operates within a highly structured reporting environment, using standardized documentation fields and centralized data alignment to reduce ambiguity in compliance expectations. Administrative clarity is treated as a system strength. New York has invested heavily in a centralized, standardized reporting and billing infrastructure for HCBS that intentionally reduces provider ambiguity around what constitutes compliant documentation. The state supports multiple self-directed models through large-scale fiscal intermediary infrastructures and sophisticated digital tools for budgeting, payroll, and compliance.

DELAWARE AND MAINE

Delaware and Maine, both smaller states, benefit from more centralized oversight structures and limited geographic dispersion. Their experiences demonstrate how administrative coherence can simplify reform implementation, though their scale differs significantly from Alaska's. Their IDD systems are organized around a life-span waiver framework that emphasizes continuity of supports across an individual's lifetime rather than segmentation by age or program. This life-span design supports long-term planning stability in a rural state with limited workforce capacity.



KANSAS

Kansas utilizes regionally coordinated access through Community Developmental Disability Organizations (CDDOs), which serve as local administrative entities responsible for eligibility coordination and provider network oversight. A centralized Program Eligibility Determination process establishes consistent functional eligibility before individuals enter the waiver waiting list. While the state continues to manage a significant waiting list, the combination of centralized eligibility and regional coordination provides clearer system entry pathways and consistent interpretation of eligibility criteria.

TABLE 1: STATE COMPARISON

STATE	RATE REFORM	WORKFORCE	DOCUMENTATION	SELF-DIRECTION	REFORM
MINNESOTA	Guidehouse-supported recalibration + service simplification	Statewide workforce engagement	"Sufficient to demonstrate service"	Structured expansion	Phased implementation
COLORADO	Rate updates tied to service clarity	Strong community-first workforce focus	Streamlined documentation	Robust infrastructure	Buffered rollouts
WASHINGTON	Centralized oversight	Large integrated workforce base	Outcome-focused documentation	Moderate expansion	Controlled sequencing
PENNSYLVANIA	Quality-linked payment models	Workforce tied to quality metrics	Standardized reporting	Structured	Incentive-aligned reform
NEW YORK	Rate reform within managed environment	Regional workforce investment	Highly structured documentation fields	Limited relative to others	Strong centralized alignment
DELAWARE	Stable rates	Small labor market	Simplified reporting	Limited scale	High administrative coherence
MAINE	Incremental rate adjustments	Rural-focused workforce policy	Standard HCBS reporting	Moderate	Gradual reform pace
KANSAS	Incremental rate updates within existing waiver structure	Regional coordination through CDDOs	Standard waiver documentation	Moderate availability	Administrative stabilization
ALASKA	Guidehouse study completed	Workforce shortage across sectors	High documentation burden	Limited	Multiple reforms concurrent

Several implications for Alaska emerge from this comparison. Administrative simplification is increasingly paired with rate reform in other states. Workforce stabilization strategies are embedded within broader system design rather than treated as separate initiatives. States that expanded self-direction typically invested in infrastructure before accelerating implementation. Reform sequencing is used deliberately to reduce destabilization risk. No state reviewed resolved workforce instability through rate adjustments alone.

Alaska's geographic scale, limited labor pool, rural fragility, and concurrent reform activity distinguish its operating environment from most peer states. These factors elevate the importance of pacing, alignment, and sustainability planning as reforms move forward.

Full state profiles and supporting analysis are provided in Appendix A.

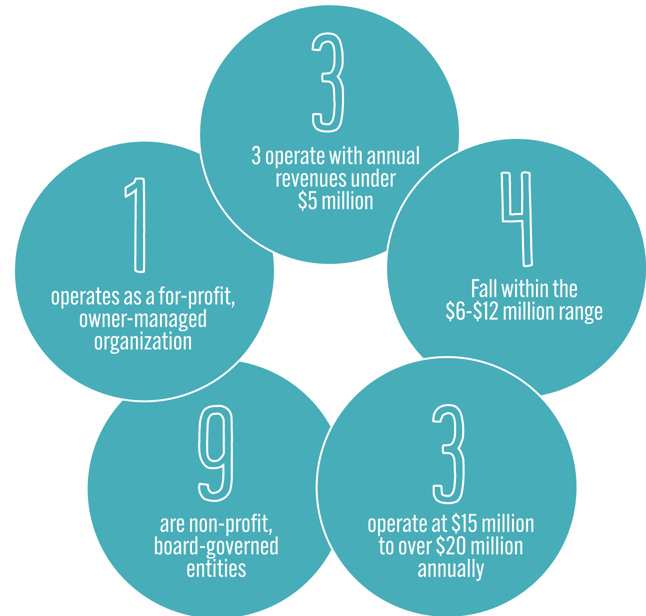
ALASKA PROVIDER PROFILE

CATEGORY	DISTRIBUTION ACROSS 10 PROVIDERS	INTERPRETATION
ORGANIZATIONAL SIZE (REVENUE)		PROVIDER NETWORK INCLUDES A MIX OF SMALL, MID-SIZED, AND LARGE LEGACY ORGANIZATIONS.
GOVERNANCE STRUCTURE		SYSTEM IS OVERWHELMINGLY NONPROFIT-BASED WITH TRADITIONAL COMMUNITY GOVERNANCE.
BUDGET TREND		INDICATES SYSTEM- WIDE CONTRACTION RATHER THAN ISOLATED ORGANIZATIONAL DECLINE
CURRENT FINANCIAL POSITION		FINANCIAL CONDITIONS VARY, THOUGH OVERALL PRESSURE REMAINS WIDESPREAD.
INVESTMENT ACCOUNTS		RESERVES ARE GENERALLY USED TO BUFFER VOLATILITY RATHER THAN SUPPORT EXPANSION.
LEADERSHIP STABILITY		LEADERSHIP TURNOVER REFLECTS GENERATIONAL TRANSITION AND SECTOR STRESS

Ten long-established HCBS provider organizations were reviewed as part of this assessment. Together, they represent a substantial share of Alaska's IDD service delivery capacity, operating across Anchorage, the Mat-Su Valley, Fairbanks, the Kenai Peninsula, Southeast Alaska, and rural communities. Collectively, they serve approximately 1,800 Trust beneficiaries annually and operate with a combined footprint of roughly $126 million.

The organizations vary in scale and structure.

- **Three operate with annual revenues under $5 million.**
- **Four fall within the $6–12 million range.**
- **Three operate at $15 million to over $20 million annually.**
- **Nine are nonprofit, board-governed entities;**
- **One operates as a for-profit, owner managed organization.**



Despite these structural differences, the sustainability pressures they face are strikingly consistent. The provider system remains operational and mission-driven, but it is operating with limited elasticity. Workforce instability is the defining constraint. All providers report persistent vacancies, elevated turnover, and reliance on overtime or supervisory backfill. Competition for direct support professionals extends beyond the IDD system to behavioral health, hospitals, retail, public employment, and self-directed models. Even modest wage or scheduling differences shift workforce across sectors. As a result, staffing levels often overstate deliverable capacity.

Underutilization of authorized services is primarily workforce-driven. Individuals may be approved for services that cannot be fully delivered due to unfilled positions. Smaller providers operate with minimal staffing redundancy, where one or two departures can disrupt entire programs. Larger organizations have broader infrastructure but carry higher fixed costs and greater exposure to vacancy-related margin erosion.

Service demand has shifted toward individualized, in-home, and supported living models. These approaches align with community integration and participant choice but are more labor-intensive, less predictable, and less scalable than earlier congregate models. Travel time, scheduling variability, and higher coordination demands increase operational intensity and compress efficiency margins. Providers are responsible for staffing and service continuity but do not control referral timing, authorization issuance, or reassessment schedules. Variability in these processes creates utilization instability and financial unpredictability that providers must absorb. This imbalance between operational responsibility and demand control increases planning uncertainty across the network.

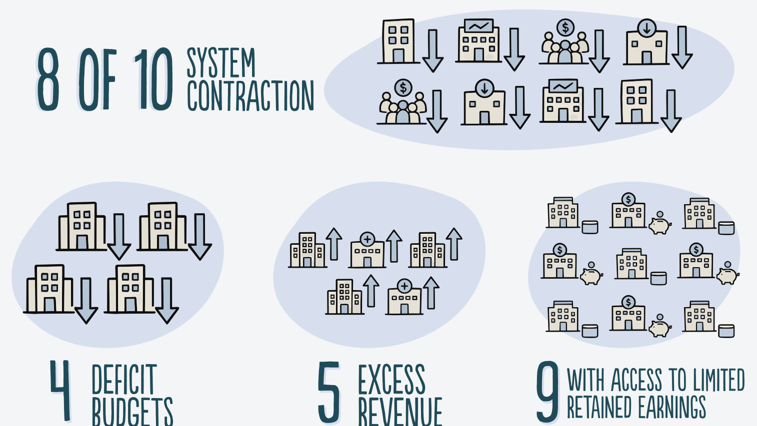
Administrative and compliance expectations have expanded steadily. Documentation standards, audit activity, reporting obligations, and coordination requirements require increasing supervisory oversight. While oversight is necessary, cumulative administrative growth reduces leadership capacity available for workforce stabilization, innovation, and long-term planning. Administrative expansion has not been matched by simplification.

Market structure has also evolved. The growth of smaller, individualized residential models has expanded choice and diversified the provider landscape. However, the available labor pool has not expanded proportionally. Workforce demand is now distributed across more organizations, intensifying competition and reducing buffering capacity within the legacy network.

Geography compounds these pressures. Rural and regional providers operate within narrower labor markets and have limited replacement capacity if destabilization occurs. Urban providers face broader competition and higher wage expectations. Across regions, redundancy is limited.

Financial conditions reflect these structural dynamics:

- Eight of the ten organizations have experienced reductions in annual operating budgets, numbers of individuals served, and employee counts.
- Four are operating with deficit budgets, Five are operating with excess revenue, and one is operating at budget.
- Nine maintain investment accounts in varying amounts, generally used to stabilize operations rather than expand services.



Organizations running modest surpluses tend to share certain characteristics: revenue diversification, conservative fiscal modeling, stable leadership, gradual wage adjustments, and strong utilization monitoring. Organizations trending toward deficit more frequently report rapid wage schedule adjustments, workforce-driven underutilization, billing or electronic system transition challenges, leadership turnover, and limited reserve depth.

Leadership continuity is an additional system consideration. Six of the ten providers have new executive leadership within the past two years. Leadership transition during a period of workforce instability and reform acceleration increases operational vulnerability, particularly in organizations with expanding administrative complexity.

Across the network, a consistent structural profile emerges: thin margins, chronic workforce instability, increasing administrative load, limited control over service flow, higher operational intensity due to individualized demand, and minimal geographic redundancy. No segment operates in a low-risk environment.

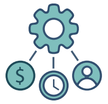
Despite these conditions, providers continue to deliver services and maintain regulatory compliance. Stability is sustained through leadership commitment, workforce dedication, cross-subsidization across service lines, and adaptive management. These are stabilizing behaviors, not structural solutions.

The sustainability of Alaska's HCBS system depends on the continued viability of this provider network. The organizations reviewed are not experiencing isolated management failures; they are operating within structural conditions that constrain elasticity and heighten exposure to reform acceleration. Preserving access for individuals with IDD requires acknowledging these operating realities and aligning policy expectations with deliverable capacity.

SYSTEM READINESS FOR CONCURRENT REFORMS

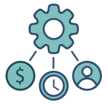
Alaska's HCBS system is entering a period of overlapping reform, with several major changes moving forward at the same time. The interRAI-based eligibility and resource allocation tool, expansion of self-directed services, complex care initiatives, Guidehouse-informed rate recalibration, and alignment with the Rural Health Transformation Program are all advancing within a compressed timeframe. Each reflects sound policy direction. Taken together, however, they place added pressure on a provider system that is already operating with limited capacity.

The ten legacy providers in this assessment form the core delivery infrastructure through which these changes will be implemented. This places system readiness at the center of the discussion. The question is not whether reform is warranted, but whether the system has the capacity to absorb multiple changes at once without disrupting access. The system is currently functioning, but with limited buffer. While each reform is manageable on its own, their combined effect intensifies existing pressures across the provider network.



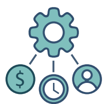
Implementation of interRAI-based eligibility and resource allocation framework

Implementation of InterRAI-based eligibility and resource allocation tool will increase assessment precision and may shift service authorization levels. Even without rate changes, adjustments in authorized hours can alter staffing configurations and financial projections. Preparatory steps should include phased implementation timelines, provider education on assessment interpretation, and transitional monitoring of authorization shifts to prevent abrupt service disruption.



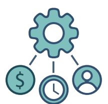
Expansion of participant-directed services

Expansion of participant-directed services potentially redistributes workforce supply and may intensify competition for direct support professionals in an already constrained labor market. Preparatory planning should include monitoring of workforce movement across service models, clarification of roles between provider agencies and participant-directed models, and safeguards to maintain service continuity for individuals with higher support needs.



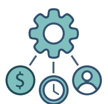
Complex care initiatives

Complex care initiatives raise expectations regarding acuity, training, supervision, and coordination. Providers may require additional workforce training pathways, clinical consultation resources, and clear service definitions before expansion occurs. Early alignment on staffing expectations and reimbursement structures can reduce uncertainty during implementation.



Guidehouse-informed rate recalibration

Guidehouse-informed rate recalibration introduces financial modeling uncertainty as providers prepare for potential changes in reimbursement structure or methodology. Advance communication regarding implementation timelines, transition provisions, and modeling assumptions will be essential to support provider planning and financial stability.



Alignment with the Rural Health Transformation Program (RHTP)

Alignment with the Rural Health Transformation Program (RHTP) could introduce additional cross-sector coordination and reporting expectations. Preparatory steps should include clarification of HCBS provider roles within regional health structures, development of coordination pathways with healthcare entities, and alignment of reporting expectations with existing provider administrative capacity.

Taken together, these reform dynamics do not operate independently. Their interaction places added pressure on a system that is already operating with limited excess capacity.

In summary, the system's ability to absorb concurrent reforms is limited. Workforce capacity remains constrained, administrative demands continue to grow, and financial reserves vary across organizations, while leadership transitions and minimal geographic redundancy—particularly in rural regions—further reduce flexibility. Under these conditions, layering multiple reforms without sequencing or

operational guardrails is likely to create cumulative strain rather than isolated impact. Services may remain authorized while delivery declines due to staffing limitations, workforce turnover may accelerate, individualized service models may contract, and regional access gaps may emerge, with reduced provider participation in innovation efforts.

This analysis does not argue for delaying reform. Rather, it highlights the importance of sequencing, buffering, and operational alignment. Phased implementation, transitional monitoring, administrative simplification, and integration of workforce strategy into reform planning can reduce destabilization risk. While current policy direction appropriately emphasizes precision, accountability, participant choice, and oversight, successful implementation ultimately depends on whether the system has the operational capacity and stability to absorb these changes without disrupting access.

The providers reviewed remain mission-driven and operationally capable. However, the system platform on which reform depends has limited elasticity. Aligning reform implementation with operational readiness will be essential to sustaining access for individuals with intellectual and developmental disabilities across Alaska.

STRATEGIC RECOMMENDATIONS

The strategic recommendations presented in this section focus on actions that can strengthen the stability and adaptability of Alaska's Home and Community-Based Services (HCBS) system as policy changes move forward. The findings of this assessment highlight the importance of maintaining a stable provider platform capable of supporting consistent service delivery across regions and populations.

These recommendations emphasize practical steps that support operational readiness, system coordination, and long-term sustainability. The intent is not to introduce new programmatic structures, but to identify areas where targeted alignment, sequencing, and system support can help ensure that reforms translate effectively into day-to-day service delivery.

To reflect the different timeframes in which system improvements typically occur, the recommendations are organized across short-, mid-, and long-term horizons. Short-term strategies focus on near-term operational readiness and system stabilization. Mid-term strategies emphasize alignment of workforce, financing, and service delivery structures as reforms mature. Long-term strategies address the broader conditions needed to sustain provider capacity and maintain access to services across Alaska.

Within each timeframe, the recommendations distinguish between system-level strategies and the specific roles the Alaska Mental Health Trust Authority can play in advancing them. The Trust's contribution centers on convening stakeholders, supporting shared interpretation of system data, funding targeted technical assistance, and promoting coordination across agencies and service sectors.

The charts that follow summarize these strategic priorities and corresponding Trust roles across the three implementation horizons.

Short-Term (0–24 Months)
System Stabilization and Reform Readiness

SYSTEM STRATEGY

- Stabilize workforce capacity and monitor vacancy and turnover trends
- Support provider readiness for interRAI assessment tool implementation and other emerging policy changes.
- Monitor service utilization and early indicators of underdelivery or disruption
- Clarify implementation timelines and expectations across concurrent initiatives
- Strengthen coordination pathways with emerging Rural Health Transformation Program structures
- Support leadership skills development and management capacity within provider organizations

TRUST ROLE

- Convene cross-agency leadership to align reform sequencing
- Support development of system sustainability and workforce monitoring metrics
- Fund targeted provider technical assistance and implementation support service disruption
- Elevate workforce and access indicators to inform policy decision-making reform initiatives
- Facilitate shared interpretation of system data across agencies and
- Fund leadership development initiatives, peer learning opportunities, within provider organizations

Mid-Term (2–5 Years)
System Alignment and Operational Adaptation

SYSTEM STRATEGY

- Align workforce development strategies with evolving service models
- Refine rate structures and financial forecasting
- Improve predictability of authorization and service flow processes
- Monitor workforce movement across self-direction and provider models
- Expand workforce training pathways for complex care supports

TRUST ROLE

- Sustain cross-agency collaboration and coordination
- Support pilot initiatives exploring shared infrastructure
- Provide financial planning and governance technical assistance
- Support leadership development and succession planning
- Elevate statewide workforce strategies

Long-Term (5+ Years)
System Sustainability and Structural Resilience

SYSTEM STRATEGY

- Maintain sustainable HCBS workforce pipeline
- Strengthen provider infrastructure in rural regions
- Integrate HCBS with broader health system transformation
- Ensure administrative systems remain proportionate to operational capacity
- Maintain consistent access across Alaska’s geographic regions

TRUST ROLE

- Support long-term workforce initiatives
- Encourage shared service infrastructure models
- Maintain sustainability monitoring across the system
- Support rural capacity development
- Sustain cross-sector coordination

Short-Term Strategies (0–18 Months): Stabilize the System and Establish a Shared Baseline

In the near term, system priorities must center on stabilizing the existing provider network and improving visibility into sustainability risk. Immediate actions should reduce administrative strain, strengthen workforce pipelines, and establish shared measures that anchor interpretation of ongoing reforms. The consistency of findings across the ten provider assessments underscores the need for a system-level sustainability and reform readiness assessment. While provider-specific reviews illuminate important operational patterns, a statewide assessment is necessary to understand deliverable capacity, labor pool constraints, utilization gaps, and how multiple reforms interact in practice. Initiating scope and governance for this assessment in the short term will help ensure that reforms are grounded in operating conditions rather than assumptions.

1

First, Alaska should formally recognize workforce stability and service utilization as core indicators of HCBS access and sustainability and establish baseline measures prior to full reform implementation. Core indicators should include vacancy and turnover rates, utilization levels, referral timelines, leadership transition risk, service mix, and administrative workload. A pre-interRAI assessment implementation tool baseline should document current utilization patterns and workforce capacity across providers. Establishing this shared baseline will enable policymakers to distinguish between pre-existing structural constraints and reform-related impacts, reducing the risk that longstanding system stress is misattributed to interRAI assessment tool implementation or other reforms.

2

Second, system expectations should be anchored to the Guidehouse rate study while explicitly acknowledging its limits. Rates alone cannot resolve workforce shortages or administrative burden. Short-term implementation should therefore pair rate adjustments with realistic assumptions regarding staffing feasibility, supervision requirements, and utilization variability, particularly for individualized services. Authorized services that cannot be staffed represent an access gap, not an efficiency issue. Treating deliverability as a system-level performance indicator strengthens accountability and centers access in reform evaluation.

3

Third, providers should be convened to assess the feasibility of shared infrastructure functions, including governance options, voluntary participation, cost modeling, and phased implementation pathways. The objective at this stage is structured exploration and alignment, not consolidation. Fragmentation continues to drive administrative burden and limits economies of scale in high-overhead operational functions; feasibility assessment creates the foundation for coordinated solutions.

4

Finally, targeted support for leadership stability is essential. Many legacy providers are navigating executive transitions during a period of heightened system complexity. Structured onboarding, peer support, and time-limited technical assistance can reduce organizational disruption and protect service continuity during a critical period of reform implementation.

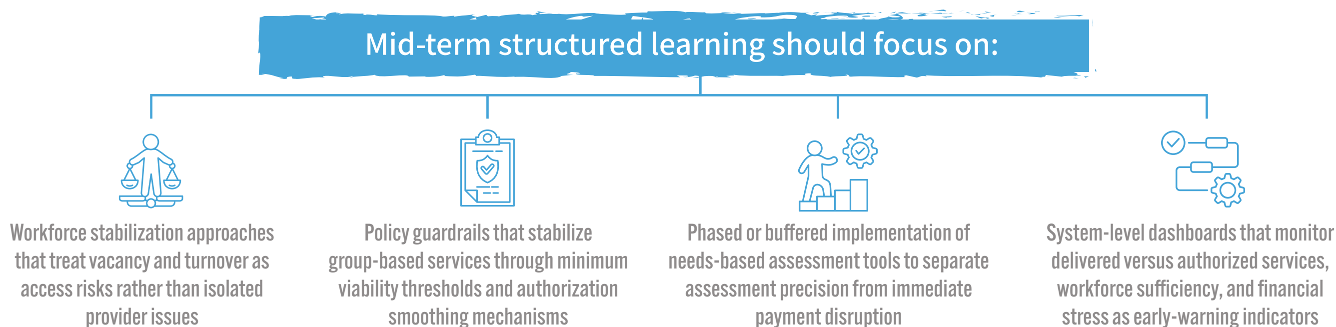
Mid-Term Strategies (18 Months–3 Years):

Align Policy Design With Service Delivery Reality

The mid-term focus should shift from stabilization to structural alignment, ensuring that policy design supports, rather than undermines, deliverable services. As reforms move from planning into implementation, Alaska must examine how individual policy choices interact at the operational level. The interRAI assessment tool implementation, rate recalibration, self-direction expansion, and complex care initiatives do not operate independently; they interact within a workforce-constrained system with limited redundancy, particularly in rural regions. Without deliberate alignment, well-intended reforms risk compounding volatility rather than strengthening access.

Mid-term strategy should emphasize coherence across policy design, workforce capacity, financial feasibility, and administrative infrastructure. This phase should incorporate structured learning from other states facing similar HCBS sustainability pressures. While Alaska's geography and labor dynamics are distinct, the challenges identified in this assessment (workforce instability, administrative burden, service underutilization, and reform interaction risk) are widely shared. The purpose of cross-state review is not replication, but disciplined learning. Alaska should identify implementation strategies in other states that reduce destabilization risk, preserve provider capacity, and support sustainability under real-world workforce conditions.

A central mid-term strategy is the formal development of a voluntary Community Care Hub (CCH) or shared services infrastructure to reduce fragmentation and increase operational resilience. Feasibility discussions initiated in the short term should transition into structured development during this phase. Core functions may include centralized billing and revenue cycle management;



shared HR infrastructure and coordinated recruitment; compliance monitoring and documentation standardization aligned with interRAI assessment tool; shared policy libraries and regulatory tracking; system-level analytics and dashboards; collective purchasing of technology platforms; and coordination mechanisms to support rural service continuity. The objective is not provider consolidation, but shared administrative capacity that allows leadership to focus on workforce retention and service delivery rather than absorbing expanding administrative complexity independently. Shared services are particularly important as interRAI assessment tool driven variability

and rate recalibration introduce financial fluctuation, increasing the need for buffers against volatility.

Oversight emphasis should shift from authorization to delivery. Monitoring systems should prioritize whether services are actually delivered as planned, where persistent gaps exist, and what structural factors contribute. Underutilization driven by workforce shortages or referral dynamics should trigger system-level problem-solving rather than provider-level compliance responses.

Rate adequacy discussions should move beyond aggregate averages to test service-type feasibility. Individualized services, group-based services, and residential supports operate under distinct staffing ratios, scheduling realities, and cost structures. Mid-term strategy should explicitly assess whether rates and authorization patterns support sustainable delivery under workforce scarcity and interRAI-assessment tool variability, using scenario testing supported by system-level data infrastructure developed through shared services or CCH mechanisms.

Group-based services such as day habilitation and adult day are particularly sensitive to small fluctuations in attendance or authorization. Mid-term policy should establish guardrails, including minimum viable enrollment thresholds, temporary stabilization buffers, authorization smoothing mechanisms, and transition protections during assessment changes. Without such guardrails, incremental policy shifts can destabilize entire programs, particularly in rural regions with limited participant density. Shared infrastructure can further support group viability through coordinated scheduling, workforce pooling, and shared recruitment.

Because HCBS, self-direction, behavioral health, and complex care draw from the same labor pool, planning assumptions must reflect shared workforce realities. Mid-term strategy should incorporate cross-sector workforce modeling, shared recruitment initiatives, monitoring of workforce migration patterns, and coordinated training investments.

Finally, the system-level assessment initiated in the short term should be completed and used for structured scenario modeling. Alaska should test how interRAI assessment tool implementation, rate changes, self-direction expansion, shared services development, and complex care initiatives interact under varying workforce supply conditions. Scenario testing supports mid-course correction before instability becomes embedded. Mid-term alignment is ultimately about coherence: policy design, workforce capacity, shared infrastructure, and technology platform coordination.

Long-Term Strategies (3–7 Years): Build a Durable and Adaptive HCBS System

Long-term strategies should redesign system expectations to reflect enduring realities rather than temporary conditions. Workforce scarcity, individualized service demand, and administrative

complexity are structural features of Alaska's HCBS environment. Sustainability therefore depends on building resilience into system design.

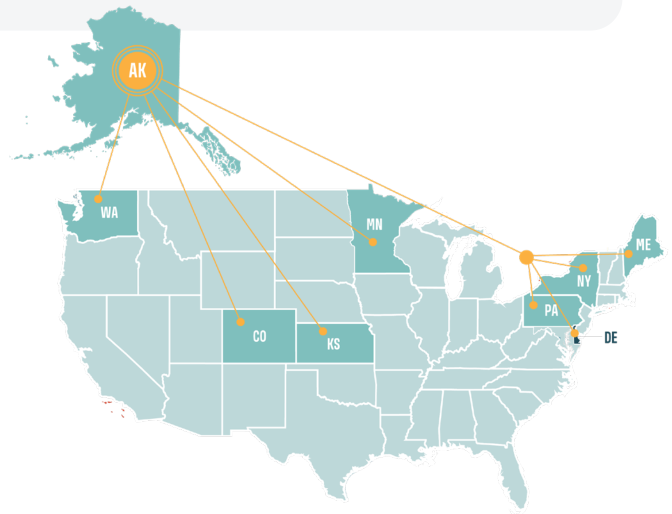
At the system level, Alaska should expand its HCBS access framework to explicitly incorporate provider sustainability. Access assurance must extend beyond authorization and enrollment metrics to include workforce sufficiency, financial viability, leadership continuity, and service stability over time. This reframing aligns access, quality, and sustainability as mutually reinforcing objectives.

Long-term capacity planning should also anticipate future demand. Children and youth represent a growing share of service demand, with implications for adult residential, employment, and community supports over time. Proactive planning is needed to ensure service models evolve in parallel with demographic shifts.

Finally, Alaska should institutionalize a standing system-integration function that evaluates how policy changes interact prior to implementation. Rather than managing reforms as discrete initiatives, ongoing system stewardship should assess cumulative impact on provider sustainability, workforce capacity, and service delivery. Embedding this function reduces the risk of unintended access failures and supports continuous course correction.

Over time, cross-state learning should be institutionalized as part of routine system stewardship. Sustained monitoring of national trends in needs-based assessment, workforce scarcity, self-direction growth, and service complexity will help Alaska remain adaptive as HCBS policy evolves, while ensuring strategies are stress-tested against Alaska's rural delivery realities, limited labor pool, and reliance on legacy provider infrastructure.

A central function of the Trust is its ability to convene stakeholders who may meet regularly but do not routinely operate within a shared planning or governance framework.



This includes legacy providers, state agencies, care coordinators, workforce partners, policymakers, and reform implementers. Structured convening enables

the system to move from siloed initiatives toward a unified understanding of reform interaction risk and delivery constraints. In the short term, convening provides a neutral space to normalize discussion of sustainability risk without attributing blame. Over time, it supports alignment between policy intent and operational reality and creates continuity across reform cycles rather than episodic, initiative-specific problem solving. The Trust's convening role carries credibility because it is grounded in beneficiary outcomes and system stewardship, not program administration, allowing difficult system questions, such as workforce feasibility, utilization volatility, and provider capacity, to be surfaced without undermining trust among stakeholders

Equally central to the Trust's role is elevating data as a shared system asset rather than a compliance or performance tool. The Trust is positioned to support data collection, synthesis, and interpretation that crosses organizational and programmatic boundaries, strengthening the system's capacity to identify emerging risk before access failures occur. In the short term, this role centers on establishing a shared, pre-reform baseline of workforce capacity, utilization, service mix, administrative load, and leadership stability prior to full implementation of the interRAI assessment tool, self-direction expansion, complex care initiatives, and related reforms. This baseline is essential to accurate interpretation of future change and to preventing misattribution of system stress to individual reforms or providers.

In the mid-term, the Trust can support the use of data to identify patterns and leading indicators of risk, including persistent underutilization, vacancy-driven service gaps, and administrative overload. Framing these indicators as system signals rather than provider shortcomings reinforces a culture of early intervention and continuous improvement.

Over the long term, the Trust can help embed data-driven system monitoring into routine stewardship by promoting consistent definitions, longitudinal trend analysis, and scenario modeling to evaluate how policy changes interact over time. This approach strengthens the system's ability to adapt deliberately rather than reactively.

GENERAL OBSERVATIONS

The current environment demands more than maintenance of legacy structures. It requires providers to actively re-engage with innovation, adaptability, and strategic urgency. Communities do not need institutions that rely solely on past success; they need partners that are responsive, flexible, and willing to evolve alongside changing needs. Innovation is no longer optional, it is a responsibility. Reclaiming the energy that once defined the system's formative years requires organizations to ask difficult questions, challenge established norms, and lead change rather than react to it.

At the same time, demand for services continues to shift. Families increasingly seek individualized supports within home environments rather than group settings, while the workforce places greater value on flexibility, autonomy, and work-life balance. These dynamics are unfolding within a system that remains highly structured and compliance-driven, creating tension between regulatory expectations and the realities of individualized service delivery.

Looking ahead, several key factors will shape the trajectory of Alaska's IDD service system:

1 Self-Direction Expansion

The Centers for Independent Living are actively pursuing an option for participant directed services to be a component of the service array offered under the home and community-based waiver system. This would allow individuals and families to direct their own services and corresponding budgets. The number of individuals who choose this option is unknown as is the potential impact on existing service providers. Families who have been navigating the Medicaid waiver and special education system on behalf of their children are more educated and adept at advocacy and managing multiple services and providers. This may be a cohort that embraces the flexibility and potential freedoms associated with a self-directed model.

2 Philosophical Drift

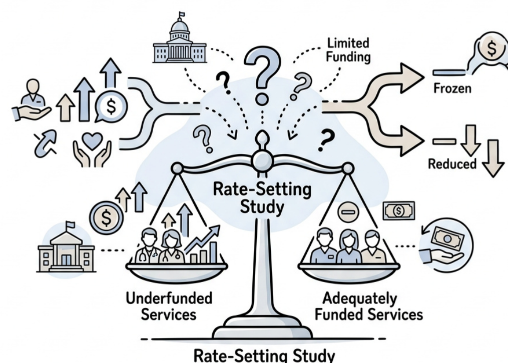
Although person-centered planning remains a foundational principle, implementation has in some cases shifted toward documentation and billing rather than outcomes and independence. This creates a risk that community-based services become institutional in function, if not in form. Meaningful planning must extend beyond immediate needs. As individuals and families age, and as service systems evolve, there is a growing need for structured, forward-looking planning. Personal futures planning, once a core element of service philosophy, has diminished in practice and warrants renewed emphasis as a tool for long-term stability and continuity.

3 interRAI Assessment Tool Implementation Uncertainty

The long-anticipated implementation of the interRAI assessment eligibility determination and resource allocation tool is expected within the next three to five years. While Senior and Disabilities Services (SDS) has publicly indicated that it does not anticipate disruption to current service levels, the actual impact will remain uncertain until implementation occurs. It is widely anticipated that some individuals who currently receive higher levels of categorical support may experience adjustments as service authorizations more closely align with assessed need. As the system recalibrates, the full implications for provider finances, workforce requirements, and service mix remain unclear. Providers may face shifts in revenue, staffing models, and program design as authorization patterns evolve, underscoring the need for careful planning and adaptability during the transition period.

4 Rate Study and Fiscal Constraints

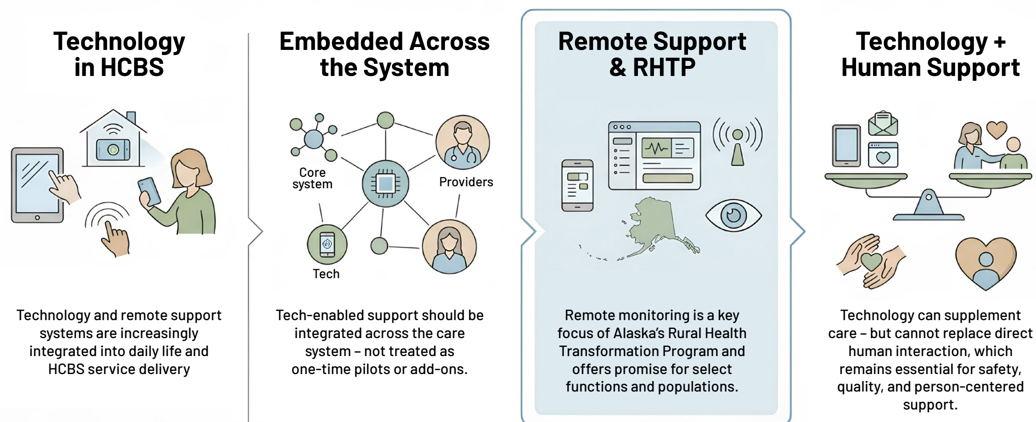
The outcome of the Department of Health's rate-setting study, conducted in partnership with Guidehouse, remains uncertain. While the study has identified services for which current reimbursement levels are insufficient, it is unclear whether the State of Alaska has the fiscal capacity to implement corresponding rate adjustments given ongoing budget constraints. Of equal concern, for services the study has determined to be adequately reimbursed, there is a risk that rates may be frozen or potentially reduced.



Compounding this uncertainty, all Alaska state departments are currently operating under a regulatory freeze, alongside an administrative directive to reduce the overall volume of state

regulations. These conditions are likely to create a backlog for new or revised regulatory packages requiring Department of Law review, further delaying any potential implementation timeline for rate changes resulting from the updated study.

The Guidehouse study is further complicated by variability in the quality and consistency of data reported by providers. Many organizations have experienced significant turnover in executive leadership, including CEOs and chief financial officers, contributing to inconsistencies in financial reporting and institutional knowledge gaps. In addition, the absence of standardized accounting systems and uniform methodologies for allocating program support and administrative costs limits comparability across providers. To mitigate these limitations, Guidehouse supplemented provider-reported cost data with additional data sources and analytic adjustments to strengthen findings.



5 Technology as a Complement, Not a Substitute

Technology devices and remote support systems are increasingly integrated into daily life and service delivery, but they require a sustainable, ongoing funding stream to be viable within HCBS. Evaluating where and how tech-enabled supports can be appropriately used should be embedded across the care delivery system, not treated as a one-off pilot or add-on. Remote monitoring is a major focus of Alaska's RHTP and offers promise for certain functions and populations. However, for individuals with IDD, technology can supplement, but not replace, direct human interaction and hands-on support, which will remain essential to quality, safety, and person-centered care.

6 Need for Cross-System Collaboration

As financial and workforce constraints intensify, collaboration across providers and sectors becomes increasingly important. Models such as Community Care Hubs offer a potential pathway to reduce duplication, centralize administrative functions, and support shared workforce strategies while preserving local service delivery.

7 Workforce and Market Dynamics

In a Medicaid HCBS fee-for-service environment, traditional market dynamics do not operate in the same way they do in commercial markets. While competition typically reduces costs in private markets, within the HCBS system, too much competition can potentially increase costs and strain both providers and the state.

A high number of providers competing for a limited pool of qualified DSP's can drive up wages, a positive outcome for the workforce but a serious financial challenge when state reimbursement rates remain fixed. Without corresponding rate adjustments, providers may be forced to reduce administrative or quality investments, operate at a loss, or exit the market altogether. To remain competitive, agencies often raise compensation or benefits to attract the most skilled staff, further inflating their cost structures. These higher provider costs are ultimately reflected in the cost reports used for rate rebasing, driving future state expenditures upward.

In addition to workforce competition, greater numbers of providers increase the state's administrative burden. Each agency requires separate oversight, contracting, and compliance monitoring, leading to higher administrative costs or increased burden on existing personnel resources at the state level.

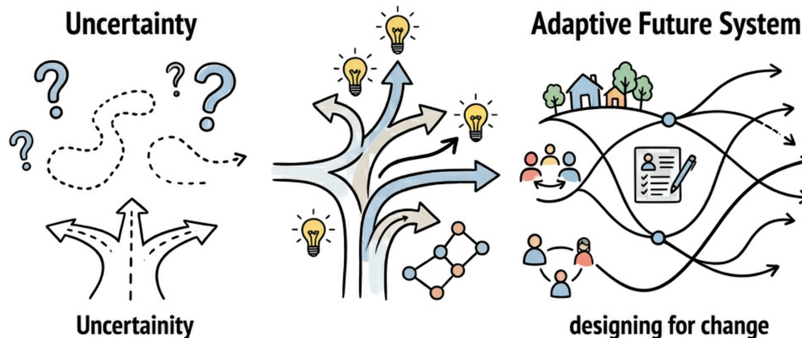
Moreover, competition in HCBS is not about price since the state sets fixed reimbursement rates but rather about access to talent, referrals, and limited system capacity. When the state caps new entries into the IDD waiver system, larger providers cannot operate at full capacity. Group homes may have vacant beds, day programs run below enrollment, and administrative overhead is spread across fewer individuals being served. Ironically, these underutilized structures form the basis of cost reports used in rate setting, perpetuating a cycle where inefficiency becomes embedded in the reimbursement model.

8 Diversification and Organizational Complexity

Many legacy provider organizations have diversified their service offerings and the populations they serve in response to evolving community needs and as a strategy to sustain revenue

While several organizations initially began as IDD providers focused on a limited set of services, they have since expanded to include behavioral health, senior services, early childhood and infant learning programs, and now function as large-scale employers with complex contractual obligations. This diversification increases organizational complexity and requires compliance with multiple, program-specific regulatory frameworks, specialized workforce training, and additional administrative and operational costs.

In combination, these dynamics suggest that while diversification can enhance organizational resilience and revenue stability, it also introduces significant operational and regulatory complexity that may dilute focus and strain leadership and administrative capacity. For provider organizations, careful evaluation of service mix, margin performance, and mission alignment is essential to ensure that diversification remains a strategic asset rather than a driver of unsustainable cost or organizational drift.



9 System Uncertainty as Opportunity

The future of IDD services will continue to evolve in response to changing expectations, demographics, and innovations. While uncertainty presents challenges, it also creates space for redesign. Building a system that is flexible, responsive, and capable of adapting to emerging needs will be critical to long-term sustainability. Acknowledging that we don't know what we don't know allows organizations to stay open, flexible, and responsive. Building systems that can adapt to new priorities, models of care, or partnerships with individuals and providers will be critical to the success of the service system.

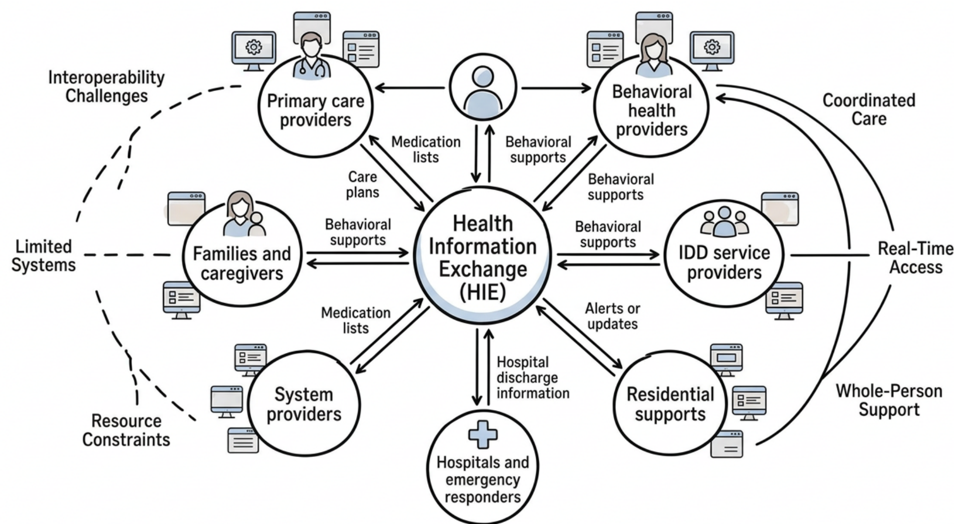
10 Regulatory Compliance

The relationship between state administrators who regulate IDD services and the providers who deliver them is often complex and can be fraught with tension. Both groups share the overarching goal of improving the lives of individuals with developmental disabilities, yet they approach this mission from fundamentally different perspectives.

State regulators carry the responsibility of fiscal stewardship, compliance with federal Medicaid requirements, and ensuring that services meet standards of accountability, equity, and safety. Their focus on oversight frequently translates into extensive documentation, strict audits, and uniform processes. While these measures are intended to protect public resources and safeguard individuals, providers often experience them as burdensome requirements that divert staff time and energy away from direct service delivery.

For providers, the central challenge is sustainability. They operate in environments defined by workforce shortages, escalating service demands, and reimbursement rates that often fail to keep pace with the true cost of care. From their vantage point, regulatory frameworks can feel rigid and disconnected from on-the-ground realities.

At its core, the relationship reflects a balancing act. Oversight is necessary to ensure accountability, but innovation requires space and flexibility. Uniform rules promote equity, but person-centered services demand adaptability. Fiscal limits constrain what states can fund, yet sustainability requires adequate reimbursement and investment in the workforce. Bridging these tensions requires trust, transparency, and a commitment to collaborative policymaking that centers on the shared mission of ensuring individuals with IDD have access to quality supports that enable meaningful, inclusive lives.



11 Health Information Exchange

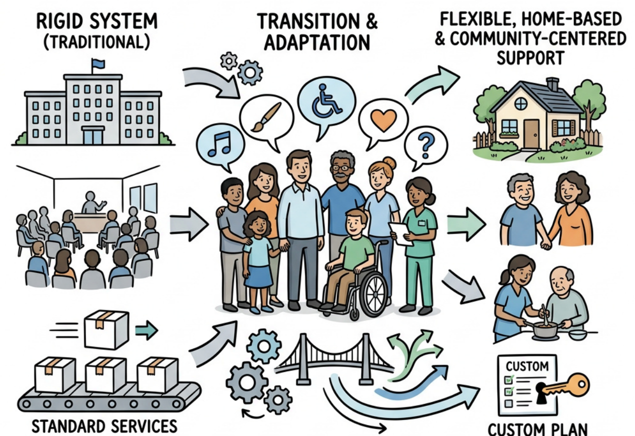
Health Information Exchange's (HIE) have transformed how medical, behavioral, and social service providers share critical information to improve coordination of care. For individuals with intellectual and developmental disabilities (IDD), who often require complex, lifelong support spanning multiple providers, the potential impact of connecting to the HIE is especially significant.

Individuals with IDD frequently navigate fragmented systems of primary care, specialty medical providers, behavioral health services, residential supports, and long-term care. Without effective data sharing, critical information such as medication changes, behavioral intervention plans, hospital discharges, or crisis events can be lost between systems, creating risks for poor outcomes. By integrating IDD providers into an HIE infrastructure, information can flow more seamlessly, ensuring that care teams have timely access to accurate records.

The HIE can also support person-centered planning by centralizing data that reflects not only medical histories but also functional assessments, waiver services, and social determinants of health. For example, including individualized service plans, assistive technology usage, and crisis stabilization protocols within an exchange can help hospitals, emergency responders, and community providers respond appropriately when individuals with IDD enter their systems. Despite these benefits, challenges exist. Many IDD service providers are small, community-based organizations that lack sophisticated electronic health record (EHR) systems or are using multiple software platforms (Therap, Sandata, AlayaCare, Care Logic, Care Smarts 360), creating challenges to interoperability. Funding constraints, workforce capacity, and privacy concerns also complicate implementation. States that have advanced HIE integration often provide technical assistance, subsidies, or shared platforms to ensure that smaller IDD agencies can participate fully. The Alaska HIE, housed at healtheConnect Alaska, has funding available to assist behavioral health providers to connect which is also available to providers serving individuals with IDD.

Ultimately, expanding the HIE to meaningfully include IDD services represents a critical step toward a whole-person care model, reducing duplication, improving safety, and ensuring that individuals with IDD receive coordinated and equitable care across the lifespan. Organizations could utilize medical information in the HIE to confirm medication lists and to ensure primary care or specialist physicians have access to the current condition and care of their patient panel.

CONCLUSION



The assessment of ten legacy Alaska HCBS provider organizations indicates that provider sustainability in Alaska is shaped primarily by the broader system conditions in which organizations operate. While individual providers demonstrate varying strengths in areas such as administrative infrastructure, service expertise, and community relationships, all operate within the same workforce, financial, and policy environment. As a result, sustainability cannot be understood solely through organizational performance.

Within the context of this assessment, sustainability refers to the ability of providers to maintain reliable service delivery capacity over time while adapting to changing operational demands. This includes maintaining workforce stability, managing financial variability, sustaining administrative capacity, and responding to evolving policy requirements. Across the organizations reviewed, similar operational pressures were observed regardless of size, geography, or tenure. Workforce constraints, utilization instability, narrow operating margins, and increasing administrative complexity affect providers throughout the system.

The consistency of these findings suggests that sustainability challenges facing Alaska's HCBS provider network are largely structural rather than organization-specific. For this reason, identifying a single "most sustainable" organization would not accurately reflect the results of the assessment. The central issue is not comparative provider performance, but the resilience of the provider network as a whole and its ability to continue functioning as the operational platform for service delivery.

This distinction is particularly important as Alaska's HCBS system enters a period of significant policy change. Multiple reforms are advancing simultaneously, including new assessment tools, changes in service models, rate recalibration, and broader health system alignment initiatives. Each effort individually reflects legitimate policy objectives. However, the effectiveness of these reforms ultimately depends on the capacity of the provider network responsible for implementing them.

The findings of this review therefore raise an important system-level consideration: whether sustainability challenges should be viewed primarily as organizational issues or as indicators of broader system capacity constraints. While provider turnover can occur in many service sectors without major disruption, the structure of Alaska's HCBS system creates conditions in which provider contraction can have wider consequences.

The organizations reviewed represent a significant portion of the operational infrastructure supporting services for individuals with intellectual and developmental disabilities across multiple regions of the state. Many operate at considerable scale, maintain specialized workforce capacity, and have long-standing relationships with beneficiaries, families, and community partners. In several regions, particularly outside major population centers, alternative service providers are limited.

If one or more of these organizations were to significantly reduce services or cease operations, the system would likely experience a range of impacts. Individuals receiving services could face disruptions in continuity of care, particularly in regions where replacement providers are not readily available. Workforce displacement could further destabilize an already constrained labor pool, as trained direct support professionals may leave the field rather than transition between providers. In rural areas, rebuilding service capacity could prove difficult due to workforce availability and geographic barriers. Provider contraction could also affect the implementation of ongoing system reforms. Many policy initiatives rely on established providers to pilot new approaches, participate in implementation efforts, and provide operational feedback necessary to refine system changes. A reduction in provider capacity could therefore slow reform implementation and limit opportunities for system learning.

These considerations do not suggest that individual organizations should be preserved regardless of performance or operational viability. Rather, they highlight that provider sustainability in Alaska functions as a system capacity issue rather than solely an organizational one. Maintaining a stable provider platform helps ensure continuity of services, protects workforce investment, and supports the effective implementation of policy reforms.

Ultimately, protecting beneficiary access over the long term depends on recognizing provider sustainability as a shared system responsibility. When workforce policy, rate structures, assessment tools, and service delivery expectations are aligned with the operational realities of providers, the system is better positioned to maintain stable access to services while advancing policy goals. Conversely, when these elements evolve without coordination, even well-managed providers may struggle to absorb cumulative pressures.

The findings of this assessment suggest that the long-term success of Alaska's HCBS system will depend not only on the design of individual policy reforms, but on the stability of the provider infrastructure responsible for implementing them. When provider capacity is strong, reforms can be introduced thoughtfully, tested operationally, and refined over time. When provider capacity becomes strained, even well-intentioned reforms may produce unintended service disruptions or implementation delays.

Ensuring that workforce policy, rate structures, assessment tools, and service delivery expectations evolve in coordination will therefore be critical to maintaining reliable access to services. Strengthening the resilience of Alaska's HCBS provider network is not simply an organizational concern; it is a foundational requirement for sustaining community-based services for Trust beneficiaries across the state.

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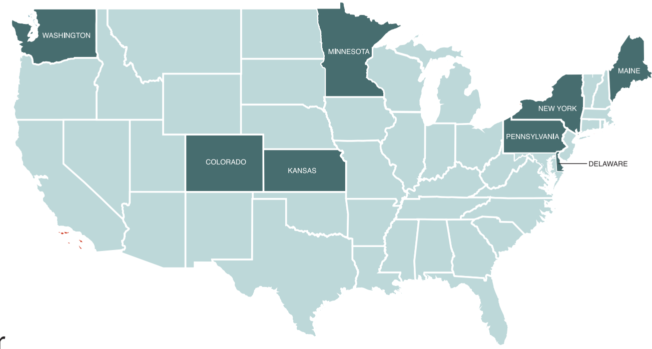

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APPENDIX A

Minnesota

Minnesota's IDD innovation is best understood as a comprehensive system reset grounded in sustainability through simplification. Through its multi-year Waiver Reimagine initiative, the state has deliberately shifted away from incremental program expansion and instead confronted the administrative complexity that has historically undermined provider stability, workforce retention, and effective service delivery. Rather than layering new services or add-ons onto an already fragmented system, Minnesota has focused on simplifying waiver structures, standardizing service definitions, and clarifying expectations across counties, providers, and managed care entities.

This approach reflects a core policy insight that administrative burden functions as a cost driver equivalent to inadequate rates. Fragmented service menus, inconsistent interpretations, and duplicative requirements increase overhead, drain supervisory capacity, and accelerate workforce burnout, regardless of nominal reimbursement levels. By reducing service sprawl and aligning expectations statewide, Minnesota seeks to ensure that funding is directed toward actual service delivery rather than absorbed by compliance inefficiencies. Extensive convening of counties, providers, advocates, and state agencies underscores the state's recognition that sustainable reform requires shared ownership and system-wide alignment.

Minnesota's Guidehouse-supported rate and cost evaluation has functioned less as an immediate rate-reset mechanism and more as foundational infrastructure for long-term system reform. The state used the Guidehouse process to collect detailed provider cost and wage data across HCBS services, explicitly acknowledging that prior rate methodologies lacked sufficient transparency and consistency. While the work is still in progress and has not yet resulted in broad, enacted rate increases, it has already reshaped policy discussions by grounding them in provider-reported cost realities rather than historical utilization or incremental adjustments. A next phase consideration for Minnesota is performance-based reimbursement.

The most significant outcome to date has been visibility rather than resolution. The study has reinforced Minnesota's conclusion, already embedded in Waiver Reimagine, that administrative complexity and fragmented service definitions are cost drivers alongside wages. Rather than treating the rate study as a one-time correction, Minnesota has positioned it as an ongoing input into methodology reform, service simplification, and future legislative decision-making. For providers, this has created cautious optimism paired with frustration as the data validates sustainability concerns, but relief has not yet fully materialized. For policymakers, the study has shifted the debate from "are rates adequate" to "what system design can be sustained given real costs."

Technology and self-direction are not treated as add-ons, but as integral components of Minnesota's system redesign. Standardized service definitions explicitly allow for technology-enabled supports such as assistive technology, remote monitoring, and flexible staffing models, while preserving person-centered planning principles. Self-direction is supported through structured budget authority and technology-enabled financial management services that reduce friction for both participants and providers. By clarifying allowable uses of technology and simplifying administrative requirements, Minnesota reduces indirect costs that otherwise erode provider margins and workforce stability. Importantly, the state's convening processes consistently frame technology as a legitimate and expected service modality, reinforcing that modern HCBS delivery depends as much on digital infrastructure as on human labor.

Minnesota applies electronic visit verification (EVV) in a targeted manner that aligns closely with federal requirements under the personal care program. Rather than extending EVV broadly across all IDD services, EVV is required for IDD-related services when they function as personal care or in-home supports delivered through time- and visit-based models, but it is not required for residential services, day habilitation, or employment supports. Minnesota does not mandate use of a specific electronic medical record (EMR) or documentation platform; providers may use systems such as Therap or other HCBS management tools, provided they meet state and federal documentation and EVV integration requirements. The state's EVV infrastructure supports multiple vendor interfaces through a centralized aggregator, allowing providers to integrate EVV functionality with existing documentation systems rather than duplicating data entry. More broadly, Minnesota's documentation expectations emphasize records that are sufficient to demonstrate that authorized services were delivered and aligned with person-centered outcomes, rather than requiring exhaustive narrative detail. By clearly distinguishing between documentation needed for billing, oversight, and quality assurance, Minnesota reduces administrative burden while maintaining accountability, a balance often cited by providers as supporting service deliverability and workforce sustainability.

Minnesota emphasizes documentation that is sufficient to demonstrate service delivery and outcomes, without requiring narrative notes for each 15-minute increment or explicit linkage of every unit to a discrete service plan objective. Time verification for in-home services is handled through EVV where required, allowing narrative documentation to focus on overall supports and person-centered outcomes. Non-EVV services require documentation that describes supports provided and outcomes while referencing the service plan at a high level.

Workforce sustainability is addressed through system design rather than wage adjustments alone. Waiver Reimagine explicitly acknowledges workforce strain as both a cost driver and a long-term sustainability threat. Simplifying waiver structures, standardizing services, and clarifying roles reduces indirect workforce costs, improves operational efficiency, and alleviates supervisory burden. Expanded use of assistive technology and remote supports further reduces reliance on one-to-one staffing

models, allowing providers to deploy limited workforce resources more effectively. Workforce retention is thus treated as a function of clarity, manageable workloads, and predictable expectations, not solely compensation.

Minnesota has taken a long-standing approach to treating family caregivers as essential components of its HCBS infrastructure. Through family and/or consumer support grants, Minnesota allows public funding to be used for caregiver training, education, and skill development. Importantly, these supports are structured so that individuals continue to receive services while caregivers participate in training, either through authorized backfill staff or concurrent respite services. Minnesota's model reflects a policy understanding that caregiver training is a preventative investment that stabilizes home-based care, delays higher-cost services, and reduces long-term system demand.

Residential services including community residential settings and supported living, remain the largest service category in Minnesota's IDD system and represent the primary driver of both costs and workforce demand. Recognizing this reality, Minnesota's reforms prioritize administrative clarity, technology-enabled supports, and service standardization to make a residential-dominant system deliverable and sustainable. Rather than expanding the service array, the state has streamlined and aligned services to improve real-world access and reduce hidden costs that undermine provider viability.

Waiting lists and access challenges are addressed indirectly but intentionally through this design. By reducing fragmentation and aligning expectations across counties, Minnesota improves providers' ability to deliver authorized supports consistently, narrowing the gap between services on paper and services in practice. Self-direction, supported by technology-enabled financial management services, expands flexibility for participants while maintaining accountability and system oversight.

Minnesota maintains a robust and independent IDD oversight structure through the Office of the Ombudsman for Mental Health and Developmental Disabilities. This statutorily independent office serves individuals with developmental disabilities across service settings and investigates complaints related to access, quality, rights, and systemic failures. The ombudsman is empowered not only to resolve individual concerns but also to identify and publicly report recurring system issues to policymakers. In the context of Minnesota's Waiver Reimagine initiative, the ombudsman function reinforces the state's emphasis on transparency and accountability, providing an external check that complements administrative reform. Minnesota's model treats independent IDD oversight as essential infrastructure in a complex, county-administered system.

Taken together, Minnesota's Waiver Reimagine initiative reflects a clear overarching priority of reducing system complexity to protect long-term sustainability. Administrative burden, fragmented service definitions, and inconsistent expectations are treated as threats equal to underfunding. The system prioritizes clarity, standardization, and deliverability, even when that means fewer distinct service

options, based on the conviction that a simpler, more predictable system is ultimately more sustainable for providers, workforce, and the individuals served.

interRAI Assessment Tool Implications

Minnesota's move to a comprehensive, standardized assessment system, implemented through MnCHOICES and often compared nationally to interRAI-based models, fundamentally reshaped how access, service planning, and sustainability are understood in the state's IDD system. The shift was not simply a change in assessment tools, it represented a system redesign that linked eligibility, service authorization, and long-term budget policy to a single, structured understanding of functional need.

For participants and families, MnCHOICES created a more unified "front door" to long-term services and supports. Instead of navigating multiple, program-specific assessments, individuals now experience a single, person-centered interview process designed to identify strengths, needs, risks, and preferences across life domains. This consistency improved perceived fairness and transparency, particularly for people moving between programs or counties. At the same time, the process raised the stakes of assessment accuracy, as results directly inform service planning, and increasingly budget methodologies, participants became more sensitive to how needs were interpreted and coded. When the assessment aligns well with lived experience, it can improve clarity and access, when it does not, it can feel rigid or difficult to challenge.

For providers, the implementation reduced variability but also narrowed flexibility. Standardized assessments replaced the informal negotiation that had historically occurred between providers, counties, and care coordinators about what services were "reasonable" or "necessary." This increased predictability and consistency across counties, which many providers welcomed, particularly those operating in multiple regions. However, it also meant that provider revenue and service volume became more tightly tied to assessed need categories rather than historical utilization or local practice norms. Documentation discipline moved upstream with what could be delivered and billed increasingly dependent on how needs were captured during the assessment rather than how providers later described service intensity.

The workforce implications were significant. MnCHOICES required counties and lead agencies to invest in assessor training and certification, creating new workforce demands and capacity pressures on local governments. At the same time, the standardized assessment highlighted workforce strain more clearly by exposing gaps between assessed need and deliverable services. Rather than masking shortages through inconsistent planning, the system made visible where staffing limitations, not lack of eligibility, were driving unmet need.

At the system level, Minnesota used MnCHOICES data as foundational infrastructure for broader reform, most notably Waiver Reimagine. The state explicitly treated assessment outputs as a bridge between individual need and system financing, using standardized data to inform service definitions, individual

budgets, and policy evaluation. This reinforced a core Minnesota policy position that administrative complexity and inconsistency are themselves cost drivers. By standardizing assessments, the state could pursue simplification elsewhere across service arrays, definitions, and expectations, while grounding reform in a common data framework.

Importantly, Minnesota's experience illustrates that comprehensive assessment tools do not solve access or workforce challenges on their own. Instead, they change the conversation. By tightening the link between assessed need, authorized services, and system financing, MnCHOICES made workforce shortages, service gaps, and administrative burden more visible and harder to ignore. This visibility supported Minnesota's broader shift toward sustainability through simplification, rather than expansion.

In effect, Minnesota's interRAI-like assessment implementation reframed the IDD system from one driven by historical practice and local variation to one driven by explicit choices about need, capacity, and deliverability. The state accepted that standardization would reduce flexibility in some areas in exchange for greater equity, predictability, and system accountability, laying the groundwork for reforms that treat clarity and sustainability as prerequisites for meaningful access.

Colorado

Colorado's IDD innovation is best understood as a deliberate shift toward structural access reform as a provider and workforce sustainability strategy. Rather than relying on waiver expansion alone, Colorado has leveraged Community First Choice (CFC) to expand access to attendant and personal care services outside traditional waiver caps. This approach directly reduces volatility caused by waiting lists and slot scarcity, stabilizing service demand for providers and creating a broader, more predictable entry point for the direct care workforce.

As a result, personal care and attendant services now represent the largest service category in Colorado's IDD system. By shifting the service array toward these supports through CFC, the state reduces dependence on waiver enrollment for basic assistance and mitigates access bottlenecks that traditionally destabilize provider operations. Waiting list pressure is addressed structurally rather than administratively, allowing access to expand without constant recalibration of waiver slots. This design reflects a clear policy choice that maintaining service flow and workforce continuity takes precedence over tight program boundaries.

Self-direction is deeply embedded within this access strategy and functions as a core workforce policy. Colorado's long-standing Consumer Directed Attendant Support Services (CDASS) program, now transitioning under CFC, positions participants as employers, supported by robust, technology-enabled financial management services. These systems handle payroll, scheduling, tax compliance, and reporting, significantly reducing administrative burden for providers while making direct care roles more accessible and predictable for workers. By simplifying onboarding and payment, self-direction

expands the labor pool and reduces workforce churn tied to provider staffing constraints.

Colorado's CFC does not impose a universal cap on service hours. Instead, services are authorized based on individual functional need, as determined through a standardized assessment process. The amount, frequency, and intensity of services reflect what the individual requires to live safely in the community, rather than a fixed hourly ceiling. This approach distinguishes CFC from many traditional HCBS waivers, where access may be constrained by slots or prescriptive service limits. In practice, CFC establishes enforceable access tied to assessed need rather than program availability.

Colorado's engagement with Guidehouse-informed rate analysis has played a supporting role rather than serving as the primary driver of reform. Unlike states that use rate studies to justify large, discrete increases, Colorado has treated rate evaluation as one tool within a broader access and workforce strategy, anchored by Community First Choice (CFC) and self-direction. Guidehouse analysis helped validate known pressures in personal care and attendant services, but Colorado's policy response focused on stabilizing service volume and workforce pipelines rather than waiting for full rate rebasing.

The practical outcome is that structural reform moved faster than rate reform. Colorado did not pause access expansion while debating adequacy; instead, it used State Plan authority to reduce waiver bottlenecks and smooth provider demand. Rate analysis reinforced the workforce narrative but did not by itself produce transformational funding changes. For providers, the benefit has come indirectly, more consistent service demand and reduced administrative volatility, rather than through immediate reimbursement increases. Colorado demonstrates how a Guidehouse-style study can inform policy without becoming the sole or decisive lever.

Technology is integral to Colorado's model. Electronic visit verification, digital payroll platforms, and service management tools support accountability while improving operational efficiency. These tools allow providers to manage higher volumes of services with less administrative overhead, reinforcing sustainability even in a constrained labor market. Importantly, technology-enabled self-direction is treated not as an exception, but as standard infrastructure, recognizing that modern HCBS delivery depends on digital systems as much as traditional staffing models.

Colorado's family support services program provides flexible funding that can be used for caregiver training, counseling, and consultation while ensuring service continuity through respite or provider backfill. The program intentionally separates caregiver development from direct service authorization, allowing families to strengthen their capacity without creating service gaps. Colorado's model is particularly notable for recognizing that caregiver burnout often stems from lack of training and support rather than lack of time off alone.

Workforce strategy is explicitly aligned with access reform. By expanding attendant services through CFC without requiring waiver enrollment, Colorado creates more consistent demand for direct care workers and reduces workforce volatility tied to waiting lists. Employment First initiatives further reinforce this approach by connecting individuals with disabilities to competitive integrated employment, embedding labor participation as a system-wide goal rather than a discrete service outcome.

From a sustainability lens, Colorado demonstrates how access authorities can function as a rate-adjacent tool. By stabilizing service volume, simplifying administration, and broadening workforce participation, the state improves provider viability even in the absence of immediate across-the-board rate increases. The system prioritizes continuity, flexibility, and workforce participation over rigid service silos.

Taken together, Colorado's IDD system reflects a clear overarching priority of keeping services flowing despite workforce shortages. Through structural access reform, a personal-care-dominant service array, embedded self-direction, and technology-enabled administration, Colorado aligns access, workforce stability, and provider sustainability into a single, coherent system strategy.

Pennsylvania

Pennsylvania's IDD innovation is best understood as a deliberate shift toward modernization and incentive alignment, with an explicit focus on linking funding to performance, quality, and long-term sustainability. Rather than relying solely on volume-driven reimbursement, the state has explored performance-based contracting, particularly within residential services, and expanded access to assistive technology and remote supports by removing lifetime caps that historically limited innovation. Together, these reforms signal a clear policy move away from staffing volume as the primary driver of funding and toward outcome-oriented accountability.

Residential services, including licensed community homes and supported living, remain the largest service category in Pennsylvania's IDD system and the primary driver of both cost and workforce demand. Persistent workforce strain in residential settings has shaped the state's reform trajectory, prompting Pennsylvania to emphasize flexibility, accountability, and technology substitution rather than assuming workforce expansion alone can resolve access pressures. By expanding technology and self-direction options within a residential-dominant system, Pennsylvania seeks to make existing capacity more effective and sustainable.

Pennsylvania's Guidehouse HCBS rate and wage study has had the most direct and visible impact among the reviewed states. The completed study identified substantial gaps between existing reimbursement rates and market-based benchmarks, particularly in residential and employment-related services. These findings gave the state and provider community a shared factual baseline, replacing anecdotal workforce complaints with quantified evidence of under-reimbursement.

The immediate outcome has been policy leverage. Provider associations, advocates, and state agencies now reference the Guidehouse findings directly in budget deliberations, legislative testimony, and rate-setting discussions. While not all recommended increases have been fully implemented, the study has already influenced funding proposals and shifted the tone of debate. Sustainability is no longer framed as a provider management issue, but as a documented structural mismatch between rates and costs. For participants, the impact is indirect but meaningful as the study strengthened the argument that workforce shortages and service gaps are predictable consequences of payment policy, not isolated failures.

Technology is treated as a core lever for both quality and workforce sustainability. The removal of lifetime caps on assistive technology and remote supports integrates these tools into standard service planning rather than positioning them as exceptions. This shift recognizes technology as a means to extend workforce capacity, improve safety and oversight, and reduce reliance on highly staff-intensive service models. Technology also enables more consistent data collection and outcome measurement, which is essential to the state's broader move toward performance-based accountability.

Self-direction is well established in Pennsylvania and functions as a central component of its workforce and sustainability strategy. Participant-directed models are supported by sophisticated, technology-enabled financial management services that simplify employer-of-record responsibilities, payroll, and compliance. These systems expand workforce options beyond traditional providers, support worker recruitment and retention, and give participants greater control while maintaining accountability. Importantly, self-direction aligns closely with performance-based contracting by enabling clearer measurement of outcomes and service effectiveness.

From a workforce perspective, Pennsylvania's reforms reflect an understanding that sustainability depends on modernization, not just reimbursement. Workforce investment is tied to expectations for quality and outcomes, encouraging providers to deploy staff in ways that maximize effectiveness rather than volume. Performance-based contracting reinforces this alignment by linking funding to measurable results, particularly in residential settings where workforce pressures are most acute.

Pennsylvania embeds caregiver training and coaching directly into its waiver structure through Family Driven Supports Services. Caregivers may receive payment for training and consultation while individuals continue to receive services through agency staff or alternate caregivers. Pennsylvania's approach reflects a policy emphasis on family capability-building as a strategy to sustain home-based care, reduce crisis utilization, and prevent premature residential placement. Training is treated as part of service delivery rather than as an ancillary benefit.

Waiting lists and access pressures are addressed not through service expansion alone, but through diversification of delivery models. By combining residential services with self-direction, assistive

technology, and remote supports, Pennsylvania reduces dependence on one-to-one staffing and creates multiple pathways to meet needs within constrained labor markets. This approach allows the state to manage access challenges more flexibly while avoiding authorization of services that cannot be delivered consistently.

Taken together, Pennsylvania's IDD system reflects a clear overarching priority of aligning dollars with performance and outcomes in a residential-dominant system under workforce strain. By integrating technology, self-direction, and accountability into the core service array, the state treats workforce sustainability as a function of system design and incentive alignment, not merely staffing levels. Pennsylvania's innovation lies in its willingness to confront sustainability through modernization, recognizing that long-term provider stability depends on coherent alignment between rates, expectations, outcomes, and deliverable capacity.

New York

New York's IDD system is best understood as a deliberate strategy of stability through formalization and scale. In one of the nation's largest and most complex IDD service systems, the state has prioritized predictability, infrastructure, and clear "rules of the road" over rapid structural transformation. This approach reflects an explicit recognition that system instability with frequent policy shifts, ambiguous guidance, and inconsistent expectations, can be as damaging to provider sustainability and workforce retention as inadequate rates.

Residential habilitation remains the largest service category in New York's IDD system and anchors both the cost structure and workforce demand. Given the dominance of residential services, New York has invested in mechanisms that stabilize delivery rather than radically redesign it. A structured and standardized "front door" to services aligns eligibility determination, person-centered planning, and prioritization, reducing uncertainty in access decisions and waiting list management. This formalized access pathway provides predictability for individuals, providers, and care coordinators alike.

Self-direction is a core feature of New York's system and one of its most mature innovations. The state supports multiple self-directed models through large-scale fiscal intermediary infrastructure and sophisticated digital tools for budgeting, payroll, and compliance. These systems allow individuals to recruit and manage workers while reducing pressure on traditional provider staffing models. For providers and workforce, self-direction functions as a stabilizing force by expanding labor options and creating more reliable employment relationships supported by consistent administrative processes.

Technology underpins nearly every aspect of New York's approach. Electronic budgeting tools, standardized service documentation platforms, billing systems, and reporting infrastructure reduce ambiguity in compliance and reimbursement. Technology also plays a central role in employment-focused reforms, supporting data tracking, provider reporting, and performance monitoring across

employment pathways. By embedding technology into standard operations rather than treating it as an add-on, New York reinforces predictability and reduces administrative friction at scale.

New York has invested heavily in a centralized, standardized reporting and billing infrastructure for HCBS that intentionally reduces provider ambiguity around what constitutes compliant documentation. Rather than relying primarily on narrative interpretation at the provider or auditor level, New York embeds compliance expectations directly into its systems, definitions, and workflows. Providers are required to document what service was delivered, for whom, and when, but are not expected to generate expansive narrative justification beyond what is necessary to demonstrate that the authorized service occurred consistent with the plan of care but it is not required to restate or re-justify discrete objectives in each service note. This shifts compliance away from subjective narrative quality and toward objective alignment between authorization, service delivery, and claim submission. Workforce stability is pursued primarily through policy clarity and consistency, rather than continual redesign or episodic interventions. Structured employment pathways, standardized guidance, and regular state-led convening clarify expectations for providers and staff, improving workforce planning and retention even when rates are constrained. Ongoing convening functions as a sustainability tool in its own right, ensuring that policy changes are communicated clearly and implemented consistently across a large and diverse provider network.

New York supports caregiver training and education across several IDD and behavioral health waivers, with explicit mechanisms to maintain service continuity during training periods. Individuals may continue receiving services through paid staff, respite, or shared staffing arrangements while caregivers participate in approved training. New York's model is notable for addressing caregiver needs across the lifespan, including aging caregivers supporting adult children with disabilities, and for avoiding "training versus care" tradeoffs.

From a sustainability perspective, New York's strength lies less in any single rate adjustment and more in reducing uncertainty across the system. Clear pathways, formalized access processes, mature self-direction infrastructure, and consistent guidance allow providers to plan staffing, billing, and program design with confidence. While fiscal pressures persist, the state mitigates instability by ensuring providers operate within a predictable and well-defined system environment.

New York does not maintain a fully independent statewide IDD ombudsman office, but the Office for People With Developmental Disabilities (OPWDD) operates a formal Ombudsman Program within the agency. This function assists individuals and families in resolving complaints, navigating services, and addressing access or quality concerns within the OPWDD system. While not structurally independent, the program is embedded in New York's highly formalized and process-driven IDD system. The emphasis is on internal resolution, consistency, and system stability rather than external oversight. New York's approach reflects a preference for managing accountability through standardized procedures, regular convening, and internal escalation rather than an independent ombudsman model.

Taken together, New York's IDD system reflects a clear overarching priority focused on maintaining stability and continuity in a large, residential-dominant service system. By investing in formalized pathways, robust infrastructure, technology, and convening, New York demonstrates how clarity and predictability can function as powerful sustainability tools, supporting providers and workforce not through constant change, but through dependable systems that allow them to operate at scale even under fiscal constraint.

interRAI Assessment Tool Implications

New York's adoption of a comprehensive interRAI assessment framework marked a structural shift in how the state defines need, plans services, and governs sustainability within its IDD and broader LTSS system. Implemented through OPWDD, the interRAI assessment tool IDD assessment was not merely a clinical or data upgrade, it fundamentally altered the balance between standardization, provider discretion, and participant experience in one of the nation's largest and most complex service systems.

For participants and families, the interRAI assessment tool introduced a more uniform and predictable assessment experience across regions and provider types. The tool's structured, domain-based approach which covers functional ability, health conditions, behavioral supports, risks, and informal supports, reduced the variability that had historically characterized New York's county and provider-driven planning practices. This improved perceived equity and consistency, particularly for individuals transitioning between settings or providers. At the same time, the assessment became a higher-stakes gateway as the interRAI assessment tool outputs increasingly inform service planning, levels of supervision, and downstream resource allocation, participants experienced greater consequences when the assessment did not fully capture nuanced or episodic needs. Appeals and reassessment requests became more consequential, as assessment results now anchor long-term service expectations rather than serving as a starting point for negotiation.

For providers, the interRAI assessment tool implementation significantly narrowed the informal flexibility that had long existed in service planning and authorization. Historically, providers and care coordinators in New York operated within a system where professional judgment and historical service patterns played a substantial role in determining intensity and scope of supports, especially in residential settings. The interRAI assessment tool shifted this dynamic by anchoring service planning more firmly to standardized need profiles. This increased predictability and consistency across the system, which benefited multi-site providers and those seeking clearer planning rules. However, it also constrained providers' ability to respond flexibly to workforce realities, environmental factors, or individual complexities that are difficult to quantify within standardized assessment logic.

The effects were particularly pronounced in residential services, the largest service category in New York's IDD system and the primary driver of workforce demand and cost. The interRAI assessment tool reinforced a more explicit linkage between assessed need and staffing expectations, making

discrepancies between authorized services and workforce availability more visible. Providers experienced increased documentation and alignment pressure as staffing models, supervision ratios, and service justifications increasingly had to map back to assessment domains rather than historical practice. While this improved transparency and accountability, it also exposed the tension between standardized need determinations and the realities of workforce shortages in a residential-dominant system.

At the system level, the interRAI assessment tool functioned as foundational infrastructure for New York's broader strategy of stability through formalization. The state paired assessment standardization with structured service pathways, robust self-direction infrastructure, and regular state-led convening to mitigate disruption. interRAI assessment tool data enabled more consistent statewide oversight, performance monitoring, and long-term planning, supporting New York's emphasis on predictability rather than rapid transformation. Importantly, the assessment system strengthened the state's ability to defend access and adequacy claims by grounding them in uniform data rather than localized practice variation.

The workforce implications were indirect but significant. By standardizing how need is defined, the interRAI assessment tool reduced ambiguity in service expectations, which supported workforce planning and compliance but also limited providers' ability to compensate for staffing shortages through informal adjustments. Workforce strain became more visible as a system issue rather than a provider-specific failure, especially when assessed needs exceeded what providers could realistically staff. In this way, the interRAI assessment tool exposed, while not solving, the underlying labor constraints in New York's IDD system.

Overall, New York's implementation of the interRAI assessment tool reinforced a system philosophy centered on clarity, consistency, and scale. The state accepted reduced flexibility in exchange for greater equity, predictability, and accountability in a very large, residential-heavy service environment. The interRAI assessment tool did not eliminate access challenges or workforce shortages, but it reshaped how they are understood and governed, moving the system away from negotiated practice and toward explicit, data-driven policy choices.

In effect, the interRAI assessment tool became a cornerstone of New York's long-term strategy to stabilize a complex IDD system, not by expanding services indiscriminately, but by making the relationship between need, authorization, workforce capacity, and sustainability visible and defensible.

Washington

Washington's IDD system innovation is best understood as a deliberate shift toward transparency and realism about system capacity. Rather than relying on utilization data, waiver enrollment, or authorized services as proxies for access, Washington explicitly tracks individuals who are eligible for services but receive no paid supports. The state treats this population as a structural indicator of unmet need and

workforce limitation, not as a reflection of individual choice or provider performance. This reframing fundamentally changes how access, waiting lists, and adequacy are defined within the system.
By elevating "no paid services" data, Washington makes visible the gap between services that exist on paper and services that can actually be delivered. Waiting lists and underutilization are understood as symptoms of system and workforce failure, not administrative delay. This transparency allows policymakers to connect access challenges directly to provider capacity, labor availability, and service design, grounding reform discussions in operational reality rather than theoretical adequacy.

Washington's system remains residential-dominant, with supported living and residential habilitation representing the largest service category and the primary drivers of both expenditures and workforce demand. Workforce shortages in residential services therefore disproportionately shape access decisions and waiting list dynamics. In response, Washington has pursued waiver restructuring and service array alignment efforts aimed at simplifying pathways and ensuring that authorized services reflect what can realistically be staffed and delivered. The goal is not to expand the service menu, but to improve deliverability and credibility.

Technology plays a central role in this approach. Washington uses technology-enabled planning, utilization tracking, and data analysis tools to identify regional gaps in service access, workforce availability, and capacity. These tools improve visibility into where the system is breaking down and reduce reliance on blunt utilization metrics that mask unmet need. Technology also supports remote planning, documentation, and monitoring, helping providers operate more efficiently with limited supervisory resources.

Self-direction functions as a key stabilizing mechanism within Washington's constrained labor environment. Participant-directed services, supported by fiscal intermediaries and digital payroll systems, allow individuals to recruit and retain workers outside traditional provider staffing models. These options expand access even when provider capacity is limited and offer flexibility in a system where residential staffing shortages are acute. Importantly, self-direction is not framed as an alternative track, but as a core tool for maintaining access under real-world workforce constraints.

Washington explicitly recognizes that caregiver training without service continuity creates access risk. Under multiple HCBS waivers, caregivers may be compensated for training time while individuals continue to receive authorized services through respite or alternative staffing arrangements. Washington's approach is grounded in a systems perspective recognizing that caregiver competency, confidence, and retention are directly tied to service stability, particularly for individuals with complex behavioral or medical needs. The state's policy design avoids forcing families to choose between skill development and uninterrupted care.

Washington's workforce strategy emphasizes flexibility and system adaptation, not rapid expansion alone. Workforce capacity is treated as a fixed planning constraint that must be embedded into

access decisions, rate discussions, and service design. By doing so, Washington positions provider sustainability as a prerequisite for access, rather than an afterthought. Underutilization is explicitly recognized as a signal of provider instability, strengthening the policy argument that rates, workforce, and service array design must be evaluated together.

Washington operates a dedicated and independent Office of the Developmental Disabilities Ombuds, which plays a central role in the state's transparency-driven approach to IDD system management. The office focuses exclusively on individuals with developmental disabilities and addresses complaints related to access, provider capacity, service quality, and rights. Importantly, the ombudsman's work aligns closely with Washington's practice of tracking individuals who are eligible for services but receive no paid supports. By surfacing patterns of unmet need and workforce-related access failures, the ombudsman strengthens the credibility of Washington's access and adequacy discussions. The state's model demonstrates how an independent IDD ombudsman can function as an early-warning system for structural capacity issues.

Taken together, Washington's IDD system reflects a clear overarching priority focused on accurately representing what the system can and cannot deliver. The state is willing to bring forward data about unmet need and workforce limits in order to ground reform in reality. By making access, workforce capacity, residential service dominance, technology, and self-direction inseparable policy considerations, Washington strengthens the credibility of its access and adequacy narrative and reframes sustainability as the foundation of meaningful access.

interRAI Assessment Tool Implications

Washington's implementation of the interRAI assessment tool marked a decisive shift toward system realism, using standardized assessment not to expand access on paper, but to make capacity constraints visible and unavoidable. Unlike systems that adopt comprehensive assessments primarily to improve equity or clinical consistency, Washington used the interRAI assessment tool to surface the structural limits of its IDD system, particularly workforce availability and service deliverability.

For participants and families, interRAI assessment tool introduced a more consistent and structured assessment experience across regions and service types. Functional needs, health risks, behavioral supports, and informal supports were captured using standardized domains rather than variable local practices. This improved transparency and comparability, especially for individuals moving between counties or service settings. At the same time, the assessment became a higher-stakes gateway as the interRAI assessment tool outputs were increasingly used to identify individuals who were eligible but receiving no paid services, participants experienced the assessment not only as a planning tool, but as a mirror of system capacity. Eligibility no longer guaranteed access, and the interRAI assessment tool made that distinction explicit rather than implicit.

For providers, the interRAI assessment tool reduced the space for informal adjustment that had

historically allowed services to be shaped around workforce realities. Service expectations became more tightly anchored to assessed need profiles, which increased consistency but constrained flexibility. Providers, particularly residential and supported-living operators, found that the interRAI assessment tool tool clarified what services were justified, while simultaneously exposing when those services could not realistically be staffed. This shifted the narrative away from provider performance and toward system constraints, but it also intensified documentation and alignment pressure in a workforce-constrained environment.

The effects were most pronounced in residential habilitation and supported living, the largest service category in Washington's IDD system and the primary driver of workforce demand. The interRAI assessment tool reinforced a direct connection between assessed need and expected staffing intensity, making gaps between authorized services and workforce availability more visible. Rather than masking shortages through inconsistent planning or underutilization, the assessment data highlighted where residential models were structurally misaligned with labor supply, especially in rural and high-cost regions.

At the system level, Washington leveraged the interRAI assessment tool as foundational infrastructure for reframing access itself. The state explicitly tracked individuals who were eligible based on the interRAI assessment tool but received no paid services, treating this population as a system-level indicator of unmet need and capacity failure. This represented a major philosophical shift as underutilization was no longer interpreted as choice, efficiency, or adequacy, but as evidence that rates, workforce, service array design, and authorization logic were misaligned. The interRAI assessment tool thus became central to Washington's credibility-driven access narrative.

The workforce implications were intentional. By standardizing assessment and linking it to visibility around non-delivery, Washington made workforce scarcity impossible to ignore. The interRAI assessment tool did not resolve staffing shortages, but it reframed them as structural planning constraints rather than provider-specific shortcomings. This supported the state's broader emphasis on flexibility, including the use of self-direction and technology-enabled supports to maintain access when traditional provider capacity was insufficient.

Importantly, Washington paired the interRAI assessment tool with policy restraint rather than expansion. The state did not treat standardized assessment as justification for broader authorizations alone, but as a tool to align service expectations with what could realistically be delivered. Waiver restructuring, service-array simplification, and technology-enabled planning were used to respond to what the interRAI assessment tool revealed, rather than to override it.

Overall, Washington's interRAI assessment tool implementation reinforced a system philosophy centered on honesty, deliverability, and sustainability. The state accepted that standardized assessments would expose uncomfortable truths about access gaps and workforce limits, and chose

to use that visibility to ground reform discussions. The interRAI assessment tool did not expand access by itself, but it reshaped the system's understanding of access, making clear that meaningful access depends on provider stability, workforce capacity, and service models that can be staffed.

In effect, the interRAI assessment toolI became a cornerstone of Washington's approach to IDD governance, not a tool to promise more, but a tool to align expectations with reality, strengthening the credibility of access and adequacy claims in a constrained system.

Delaware

Delaware's IDD system innovation is best understood as a strategy of coherence and deliverability shaped by small-state scale. With a limited labor pool and a tightly interconnected provider network, Delaware does not pursue sustainability through market expansion or service proliferation. Instead, the state emphasizes centralized governance, close coordination, and deliberate convening among Medicaid, managed care entities, and providers to align expectations, rates, and service models within realistic operational limits.

Delaware's IDD system is organized around a life-span waiver framework that emphasizes continuity of supports across an individual's lifetime within a single, tightly coordinated service structure. Rather than segmenting services by age or requiring transitions between multiple waivers, Delaware allows supports to adjust in intensity and configuration over time while maintaining consistent eligibility, policy expectations, and oversight. This structure provides the foundation for Delaware's broader emphasis on predictability and operational discipline. In a small, centralized state, this life-span design supports predictability and deliverability. By minimizing program transitions and maintaining a stable service framework, Delaware reduces administrative churn for individuals, families, and providers, and aligns long-term service planning with workforce availability and provider capacity. The life-span waiver reflects Delaware's core system value focused on sustaining access through coherence and continuity rather than expanding service categories beyond what the system can reliably deliver.

Residential services are the largest service category in Delaware's IDD system and dominate both expenditures and workforce demand. Recognizing this reality, Delaware has intentionally maintained a streamlined service array rather than an expansive or highly fragmented menu. This design choice reduces administrative burden, improves clarity for providers, and allows the state to more accurately assess whether authorized services can be staffed and delivered. Service breadth is intentionally subordinated to deliverability.

Waiting list management is tightly integrated with service capacity and workforce availability. Rather than functioning as a passive backlog or blunt rationing tool, Delaware's waiting lists operate as an active planning and prioritization mechanism. Demand, acuity, and provider readiness are monitored closely, enabling the state to match individuals to services that can be sustainably delivered. This approach avoids authorizing services that exist on paper but cannot realistically be staffed in a constrained labor market.

Self-direction plays a critical role in expanding effective access without expanding provider infrastructure. Self-directed services, supported by financial management services and digital payroll systems, allow individuals to recruit workers outside traditional provider models which is an essential strategy in a small labor pool. By broadening who can provide care, self-direction eases pressure on residential providers and mitigates waiting list growth while maintaining accountability.

Technology supports this model by reducing the disproportionate administrative burden small providers face. Digital tools for compliance, billing, payroll, and workforce management improve operational efficiency and help providers function within thin margins. Technology is not treated as a supplemental enhancement, but as core infrastructure that enables centralized oversight and consistent implementation.

From a sustainability perspective, Delaware explicitly recognizes that provider stability in small states depends on predictability, simplicity, and coordination rather than scale. Rate discussions are framed within this broader context: nominal reimbursement levels matter, but so do administrative simplicity, workforce flexibility, and clear guidance. Regular convening and centralized policy direction reduce uncertainty and allow providers to plan and operate with confidence despite constrained capacity.

Taken together, Delaware's IDD system reflects a clear overarching priority based on ensuring that authorized services can actually be delivered in a small, tightly managed system. By aligning service array design, waiting list management, workforce strategy, self-direction, and technology within a centralized governance structure, Delaware demonstrates how coherence and coordination function as the primary sustainability tools in small-state IDD systems.

Maine

Maine's IDD system reform reflects the realities of a rural, geographically dispersed state with chronic workforce shortages. Innovation in Maine centers on stabilizing providers through workforce investments, technology-enabled supports, and expanded self-direction, while gradually modernizing system expectations.

Maine's IDD system is organized around a life-span waiver framework that prioritizes continuity of supports across an individual's lifetime rather than segmentation by age or program. Instead of requiring individuals to transition between separate waivers as they age, Maine allows services to adjust in intensity and focus within a consistent eligibility and policy structure, reducing disruption for individuals, families, and providers.

This life-span design supports long-term planning stability in a rural state with limited workforce capacity. By minimizing program transitions and reauthorization cycles, the waiver reduces administrative churn, preserves service relationships over time, and enables providers to plan staffing and service delivery with a longer horizon. The approach reflects Maine's recognition that

continuity, rather than program expansion, is essential to maintaining access and provider viability in a geographically dispersed system.

Workforce initiatives in Maine include targeted wage investments, retention efforts, and explicit acknowledgment of direct support professionals as the backbone of the system. These efforts are reinforced by expanding self-directed services that allow individuals to hire workers locally, often family members or community residents, supported by financial management services and electronic payroll systems. This approach is particularly critical in remote areas where traditional provider staffing models are not viable.

Technology plays an increasing role in Maine's sustainability strategy. The state has expanded the use of assistive technology, remote supports, and telehealth-adjacent tools to reduce reliance on one-to-one staffing and extend limited workforce capacity. These technology-enabled supports are treated as legitimate service options rather than exceptions, signaling a shift toward modernization. Maine's innovation lies in treating workforce scarcity as a permanent design condition, using technology and self-direction to adapt the system rather than waiting for labor markets to recover.

Maine's IDD system reflects the realities of a rural, geographically dispersed state where both the service array and waiting list dynamics are inseparable from workforce scarcity. The service array increasingly emphasizes flexibility, allowing assistive technology, remote supports, and self-directed services to substitute for or supplement traditional staff-intensive models. This evolution reflects an understanding that a broad but rigid service menu does not equate to meaningful access when providers cannot recruit staff.

Waiting lists in Maine have historically been significant and are explicitly acknowledged as a symptom of workforce and funding constraints rather than a lack of individual eligibility. As a result, Maine's access strategy focuses on phased entry, prioritization, and the use of lower-intensity or technology-enabled services to reach individuals sooner while higher-intensity supports remain constrained. This approach allows the state to partially mitigate the harms of long waits without promising services that cannot be delivered.

Self-direction is a central mechanism for expanding practical access within Maine's service array. By allowing individuals to recruit local workers, including family and community members, supported by financial management services and electronic payroll systems, Maine reduces reliance on traditional provider staffing models. Technology-enabled supports further extend limited workforce capacity. Maine's innovation lies in treating the waiting list as a system design challenge, adapting the service array and delivery models to rural labor realities rather than preserving urban-centric assumptions. Residential services remain the largest service category in Maine's IDD system and drive both cost and waiting list pressures. Because traditional residential staffing models are often infeasible in remote areas, Maine relies on self-direction, local hiring, and technology-enabled supports to extend limited

capacity. Waiting lists are managed through prioritization and phased entry, reflecting the state's emphasis on deliverability rather than authorization alone.

Maine operates the Ombudsman Program for Aging and Disability Services, which serves individuals with disabilities across the lifespan, including those with IDD. Rather than maintaining an IDD-exclusive office, Maine integrates IDD concerns within a broader aging and disability framework. The ombudsman addresses access barriers, service coordination challenges, and rights issues, particularly during transitions across age groups or service systems. This model emphasizes integration and continuity over specialization, reflecting both the state's scale and its cross-disability service philosophy.

Taken together, Maine's IDD system prioritizes designing for chronic labor shortages, especially in rural and remote areas. Rather than assuming workforce recovery, the system elevates self-direction, technology, phased access, and flexible service models as core infrastructure. The overarching priority is maintaining meaningful access statewide, even when traditional residential or staff-intensive models cannot be universally sustained.

Kansas

Kansas's IDD system innovation is best understood as a governance-driven modernization strategy that prioritizes political durability and legislative visibility over rapid structural overhaul. Rather than pursuing frequent administrative redesigns, Kansas has embedded IDD reform within KanCare governance, legislative committees, and public policy discourse, ensuring that workforce shortages, rate pressures, service gaps, and access challenges remain visible to decision-makers across budget cycles and leadership transitions. This approach reflects a deliberate choice where stability in governance is treated as a prerequisite for long-term system sustainability.

Residential and day services together represent the largest service categories in Kansas's IDD system and are the primary drivers of workforce demand and waiting list pressure. In a state with significant rural geography and limited provider capacity, Kansas recognizes that these service models cannot be sustained through traditional staffing approaches alone. As a result, the state has emphasized service array flexibility rather than expansion, allowing supports that can be realistically delivered in workforce-constrained environments.

The service array includes financial management services, wellness monitoring, and remote supports, reflecting a broad and pragmatic interpretation of what constitutes meaningful support. These services are particularly important in rural regions where workforce shortages make conventional service delivery infeasible. Rather than treating technology-enabled supports as supplemental or temporary measures, Kansas incorporates them into standard waiver design, signaling acceptance of modernized delivery models as essential infrastructure.

Waiting lists are managed within the broader KanCare framework, with access discussions explicitly tied to workforce availability and funding realities. Workforce shortages are openly acknowledged in legislative and policy forums, and waiting lists are framed as a structural challenge rather than an administrative failure. By situating access constraints within governance processes, Kansas reduces the risk of over-authorizing services that cannot be delivered and avoids abrupt policy shifts that destabilize providers.

Self-direction plays a central role in Kansas's workforce and access strategy. Participant-directed services allow individuals to recruit workers locally, often from their own communities, supported by technology-enabled payroll, scheduling, and compliance systems. These models reduce provider overhead, expand workforce options in rural areas, and allow smaller providers to remain viable. Self-direction is not positioned as an alternative track, but as a core mechanism for sustaining access within a constrained labor market.

Workforce initiatives are reinforced through Employment First principles, which are embedded in statewide policy discussions and legislative engagement. These principles emphasize workforce participation for individuals with disabilities while also acknowledging broader labor shortages across the system. By keeping workforce realities visible in public governance, Kansas frames sustainability as a long-term structural issue, not a temporary staffing crisis.

Kansas allows caregiver training expenses under its Family Support Waiver and preserves service continuity through authorized respite or alternative providers. While flexibility varies by region, the policy framework acknowledges that caregiver education and skill-building are necessary to sustain families over time. Kansas's approach reflects a recognition that early investment in caregiver capacity, particularly for families of children with IDD, can reduce future system strain.

From a provider sustainability perspective, Kansas's innovation lies in its emphasis on political durability. Rate pressures, workforce challenges, and service design tradeoffs are addressed incrementally through governance rather than through rapid programmatic change. While this approach may move more slowly, it provides predictability for providers and reduces the risk of disruptive policy swings that undermine long-term viability.

Taken together, Kansas's IDD system reflects a clear overarching priority focused on maintaining a stable, deliverable system through legislative anchoring and governance coherence. By aligning a residential and day service dominant system with flexible service definitions, technology, self-direction, and sustained legislative engagement, Kansas demonstrates how governance itself can function as a sustainability tool, particularly in rural and mixed-delivery states where workforce constraints are persistent and structural.