STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SENIOR AND DISABILITIES SERVICES

INCLUSIVE COMMUNITY CHOICES COUNCIL

Meeting Minutes

Tuesday, January 5, 2016

Voting Members:

Art Delaune
Banarsi Lal
Alavini Lata
Karli Lopez
Sara Kveum
Bruce van Dusen
Rusty Best
Ken Helander
Patricia Branson
Cindy Shults – telephonic
Mary Schaeffer

Advisors:

Theresa Brisky
Allison Lee
Kim Champney
Tom Chard - telephonic
Dave Branding
Marianne Mills - telephonic
Connie Beemer
Mellisa Heflin
Sandra Heffern
Denise Shelton

Facilitators:

Duane Mayes, SDS
Shane Spotts, HMA

Guests:

Amanda Lofgren AMHTA
Ulf Petersen, SDS
Jetta Whittaker, SDS
Shaun Wilhelm, DBH
Teri Keklak, DBH

WELCOME, BRIEF INTRODUCTION AND ROLL CALL

Roll call of voting members and advisory members was taken, and guests were introduced.

UPDATE ON PROJECT STATUS

Shane Spotts reviewed the current project status with the council members as follows:

1. Project planning – 100% complete
2. Stakeholder input – 70% complete
3. Review of regulations – 57% complete
4. Review of current operations – 60% complete
5. Identify eligibility/resource allocation criteria – in process, incomplete
6. Environmental scan of functional assessment tools – 50% complete
7. Determine service package – 0% complete
8. Establish quality assurance and improvement plan – 0% complete
9. Develop a provider manual/conditions of participation – 0% complete
10. Cost impact analysis – 0% complete
11. Develop implementation plan – 0% complete

Shane Spotts explained that HMA has multiple staff working on various aspects of this project simultaneously, and many of the tasks are co-dependent upon the completion of various aspects of other tasks.

Shane Spotts provided some background information by reviewing with the council members the difference in eligibility between the two options with 1915(k) requiring an institutional level of care, and the eligibility of 1915 (i) being below the threshold of institutional level of care. He stated that in order to meet institutional level of care, a person must meet three of six activities of daily living to be eligible as well as meet other criteria.

Based on a question from Ken Helander, Shane Spotts explained that as a part of the process, they will have to evaluate the (c) options, because it is likely that not all (c) services will move into the (k) option. HMA will then recommend what the structure of (c) should look like for Alaska. Duane Mayes stated that based on conversations they have had with Montana, he predicts they will begin moving services over one at a time through a slow and methodical process.

Mary Schaeffer asked if the Council can review the implementation plan and get community feedback prior to its implementation. Shane Spotts explained that the plan will be delivered to the State on July 31, 2016. He anticipates presenting all the recommendations to the Council during a potential July face-to-face Council meeting. Duane Mayes added that when HMA gives the implementation plan to the State, the State would like to flip the switch on the plan July 1, 2017. As a part of the work during that 12-month period, they will need to do a regulatory package, which will go out to the public in a very formalized way. Mary Schaeffer and Pat Branson shared their concerns that rural Alaskans need more education on these plans to get everyone on the same page and keep communities up to date on the progress of this project.

Shane Spotts stated that he believes it's the role of this Council to educate and be the voice of communities as this work is in process. Pat Branson and Vini Lata agreed that they believe the role of the voting members is to get the pulse of the communities and bring it back to these conversations. Karli Lopez also noted that everything that is happening with this project is also available on the website.

Bruce van Dusen commented that he feels the public should be informed about the parameters they are working within, such as CMS rules on eligibility and eligible services.

Pat Branson asked about what the process will be to educate the legislature. Duane Mayes stated that the Department and divisions plan to ensure they have a consistent message to share with House Finance. He stated that he and Jon Sherwood and possibly Shane Spotts will present to Senate HSS. He stated that he also sees all the Council members doing their part by meeting with their legislators and sending a consistent message.

Council members shared their thoughts on educating the legislature as follows:

- In the face of the current budget challenges, this plan is something that would be very sustainable moving into the future.
- The legislature needs to understand the hardship in the rural areas, and they need to understand that the regulations need to be less stringent in rural Alaska in order to deliver services.

Advisors were then asked for their comments about the project overview as follows:

- The three Medicaid reform bills currently in the legislature have some mention of exploring 1915(i) and (k), so there are many opportunities to discuss these and educate.
- Put something together to present to the legislature now that shows what has already happened with this project and show how it will realize cost savings.
- Create an FAQ for provider associations and advisory groups to get out to people.
- Ensure they address the "woodwork effect" in the final report.

APPROVAL OF THE DECEMBER 2015 MEETING MINUTES

VOTE:
Mary Schaeffer **MOVED** to approve the minutes from December 2015, **SECONDED** by Pat Branson. Hearing no objection, the motion **PASSED.**

REVIEW STAKEHOLDER FORUMS

Shane Spotts stated that an issue that was not included on the slides but was an issue that came up frequently is the issue of FASD in Alaska. He stated that HMA will take a look at some numbers and try to understand the issue for Alaska. He stated that he believes that when they delve deeper into the issue, a lot of people with FASD will have a developmental disability or will qualify for developmental disability services, SMI, or other services under more broad populations. They would like to see how many individuals with FASD are being served under

these various population areas as a secondary diagnosis. He believes there may be a misconception that this population is outright being ignored, but rather they are currently receiving services under another population area. He believes there will be a subset of that population that will meet institutional level of care for the (k) option. There also may be a subset of the FASD population that would meet the threshold for the (i) option under a subset of the I/DD and SMI (i) options.

He stated that they need to make sure they do a better job of communicating that this population isn't being ignored through this process.

Council member comments were as follows:

- Concern about the four targeted (i) populations being focused on for their diagnosis and not the functionality of the spectrums. The focus should be on a person's functionality through the assessment rather than just the diagnosis itself.
- DHSS should partner with Department of Corrections and other departments that deal with FASD issues to set up programs that are relevant to the environment of children and young adults with FASD.
- They should try to focus on behavioral and functional analysis, but they should also continue with their target-population focus.
- If there was a better evaluation for the FASD population, they would know how to serve them better.
- Also important to look at functionality when looking at the ADRD population.
- How will assessing functionality relate to the current CMS guidelines? It was noted that DJJ and DOC have focused on their assessment tools and helping identify those people with FASD.

Advisory member comments were as follows:

- Understanding that people with FASD may be a subset of a particular group informs the service package, but sometimes it is difficult in the developmental disability field to serve someone who needs more case management rather than direct care, so that should be considered when developing the service package.
- During Meyers & Stauffer rate acuity discussions with Behavioral Health, there was a big question of a person experiencing a behavioral health disability, or were they just exhibiting difficult behaviors, and it had a big impact on the discussion of how much people were being paid and how the services were being delivered.

Shane Spotts then reviewed that they had visited the communities of Anchorage, Fairbanks, Barrow, Nome, Kenai, and Bethel. The visits consist of a provider meeting during the day, and a community forum in the evening. Depending on their time in the rural communities, they would also try to do site visits to see the facilities and learn about them.

Shane Spotts reviewed the common themes from the provider forums held to date:

<u>**Consumer Forums:**</u>

- Workforce challenges.
- Transportation to and companion for appointments.

- Inadequate training of in-home workers.
- Unnecessary burden of Medicaid application/re-certification process.
- Individuals being released from the correctional system/juvenile justice system (many with SMI, TBI, I/DD) lack supports and wind up back in prison.
- Need more robust system of behavioral health support; many individuals are falling through the cracks.

Provider Forums

- Streamline certification requirements for providers for different waivers and state plan options.
- Streamline certification requirements for independent care coordinators for different waivers, state plan options.
- Regulations from different state divisions, licensing, auditing is overwhelmingly burdensome.
- Improve coordination and comprehensiveness of services for those with a complexity of issues (I/DD and mental health).
- Streamline application process for General Relief. This is taking up to 30 days resulting in inappropriate, lengthy hospital stays.
- Dissatisfaction with current functional assessment tools. Need new one that's less black and white. Need to involve providers in selection of new tool(s).
- Assessment tool is only as good as the person administering. Need better assessment staff.
- Focus on things that stabilize individuals such as supported employment and supported housing.
- Consider family caregiver payment.
- Individuals with Alzheimer's disease and related dementias are falling through the cracks. Need for cueing and supports at home.
- Seniors want to stay at home/in community; few options in rural areas.
- Many people don't have financial means to leave an assisted living home if they wanted to; need sufficient financial support to enable this transition.
- Recommended phased-in migration of services similar to the state DD grant services in the 1915(c) waiver. This approach has worked well for states migrating services to the state plan options.

Shane Spotts opened the floor to Council members and advisors to share their thoughts about the provider and community themes asking if there was anything they felt was missing or was information they expected to hear.

Council member comments were as follows:

- Same-day access to see a provider to get help quickly.
- Education, an explanation of Medicaid itself and the (i) and (k) in laymen's terms. *Shane Spotts suggested the creation of a "Waiver Journey" document for people to use as a roadmap of the system. It could also be used to educate the legislators as well. This would also be helpful for providers because the turnover is so great.*
- A clarification was made that behavioral health includes alcohol and substance abuse.

- Transitional services from structured home environment or foster care to higher education, independent living, and employment. This would also include transition out of DOC.
- How would a person transition from assisted living into nursing home care because they now require that level of service? *This could happen by transferring from the (i) to the (k) option because they meet that level of care.*
- Providers are trying to figure out financially how to meet the needs of people returning to their communities from drug and alcohol rehabilitation services outside of the community.
- How are the community and provider comments going to be considered in moving forward with this process? *These comments will be used as consideration for the recommendations made to the State to improve the system.*
- It was reiterated that people need to be made aware that there are many restrictions that come straight from CMS that providers have no control over.
- Streamlining needs to be considered for efficiencies in provider audits and quality reviews with the understanding that the state has options under the CMS regulations. Need to come back more to the "middle of the road."
- Are there national groups advocating for the issues regarding CMS? *National Council for Behavioral Health has federal advocacy partners, ANCOR, International Association of Peer Supporters, and Appalachian Consulting Group are some examples.*

Advisory member comments were as follows:

- The state's Medicaid recertification of providers should occur on the same timeline as SDS's waiver recertification with CMS. *It was explained that CMS requires providers to be recertified at a minimum of every three years.*
- Surprised that the waitlist for services wasn't a theme in the community forums. *The waitlist was discussed in community forums in terms of there not being a waitlist anymore under these entitlement options. It was also explained that in order to accomplish this, they will need to carefully design the service package to remain budget neutral.*
- Need to address the Alaska background check regulations to address the workforce challenges and getting people to provide peer support. *The State is currently talking about this issue.*
- People were encouraged to look at the reports from the Medicaid Redesign Group, in particular the Business Process Improvement Initiative.

Shane Spotts then led the Council through a review of the FAQ document that is currently up on the website and asked Council members and advisory members to provide feedback as follows:

- FAQ 3 – Clarify the word "expand" in the answer.
- If 1915(i) and (k) are going to extend Medicaid benefits to additional populations, how can they do that without higher expenses unless they are cutting services? *The enhanced 6% match of (k) was explained, as was the refinancing of current general fund dollars to Medicaid for the (i) where there will be a 50/50 state and federal match. The cost analysis will further clarify this and should be budget neutral or realize cost savings.*
- FAQ 8 – Include under the eligibility that both options will include a functional eligibility

as well as the financial eligibility that's listed there.

- Make sure the answers to the questions are clear so that people don't have to draw their own conclusions. Draw the conclusions for them so these answers aren't left open for interpretation.
- People are getting confused by the two options when answers about each are given in one paragraph.
- It needs to be emphasized in a clear manner that these services are not going away and that services are not going to be reduced, but rather it is an effort to increase the amount of money available.
- Need to state that there is a functional eligibility to each of these options.
- Clarify severe mental illness versus serious mental illness, because the federal government has separate definitions for each.
- Need to take into account that there will be a cost to providers for training if there will be new assessment tools put in place for behavioral health providers.

Once the community forums are complete and beyond, they will continue to update the FAQ document on the website, and Shane Spotts encouraged Council members to provide feedback. It was asked that the information be updated immediately on the website once it has been finalized.

Council members found the comparison chart very helpful to distinguish between the (c), (i) and (k).

REVIEW STATUTORY AND REGULATORY FINDINGS

Shane Spotts provided an overview of the regulatory review as follows:

- Reviewed federal regulations/guidance on 1915(i) and (k).
- Focus on specific requirements
  - Person-centered planning
  - Conflict-free case management/care coordination
  - HCBS settings rule.
- Outreach to four states with both 1915(i) and (k) – CA, MD, MT, OR.
- Authority to proceed with state plan amendments was researched, and it was determined that HMA does not believe that Alaska needs any specific additional legislative authority beyond what already exists in order to implement these options.

Regulatory Review – Senior and Disabilities Services

- Catalogued relevant sections of the Alaska Administrative Code (AAC) Conditions of Participation.
- Completed analysis of HCBS settings rule and identified recommended revisions to AAC.
- Currently reviewing AAC regarding conflict-free case management and person-centered care planning.
- Conducted outreach to four states with both 1915(i) and (k).

Regulatory Review – Behavioral Health

- Catalogued relevant sections of the Alaska Administrative Code.
- Recently learned that DBH has already undergone a series of revisions to 7 AAC 135 that are still in draft form.
- HMA has submitted a request to review the draft version of 7 AAC 135.

Council member and advisory member comments were as follows:

- Karli Lopez stated that although it is still in a draft form, she would like to see the entire regulatory review document.
- Were the draft personal care attendant regulations included in the review? *Yes.*
- Should they anticipate the legislature being involved in any budget considerations for this program? *No. DHSS does not need any additional legislative authority.*
- With the 6 percent drawdown, has the Department indicated where those revenues are going to be allocated? *Not specifically, but it has been discussed that that money will go to some of the new populations being served through the options.*

REVIEW OPERATIONAL ANALYSIS

Shane Spotts led the Council members through an update of Task 4, Operational Review.

- Task 4a – Review of current Medicaid service delivery systems, including but not limited to Home and Community Based Service. Complete.
- Task 4b – Review of related state-funded programs. Complete.
- Task 4c – Review of rate structures in place. Complete.

The full document is roughly 150 pages and will be shared with DBH and SDS shortly for a final review. Once that review has been completed, they will share the document with the Council.

Mary Schaeffer asked if they have looked at Tanana Chiefs Conference community home-based program as a resource in setting up part of this program. Duane Mayes stated that they have been working with the Office of Rate Review on a rate specific to rural service delivery with PCA, chore, and respite calling it the Universal Worker Project. The Office of Rate Review wants to pilot it in the TCC region and then roll it out statewide.

Vini Lata stated that over the last several years, providers have requested a rate review consistently. Is this rate review in conjunction with the rate review that the Department is supposedly doing for providers? Duane Mayes stated that the current rate review is specific to their current structure, and this is a little bit different from that.

Shane Spotts then reviewed a chart contrasting the four 1915(c) waivers. Because there are so many services that are exactly the same across all the waivers, it will make it easier for them to look at how to shift the services from the waivers under one umbrella option, the (k) option.

Ken Helander noted that the waiver columns list adult day, and the definitions under (i) and (k) are adult day health. He asked for Shane Spotts to differentiate them and to talk about the

possibilities of adult day health in Alaska. Jetta Whittaker stated that the adult day health has a nurse on staff. In Alaska, the social model doesn't require a nurse oversight. Shane Spotts stated that adding a nurse would be a more expensive service, so they would have to do the cost analysis of that to see if it's feasible. Ken Helander added that he hopes Alaska doesn't miss the opportunity to consider to have an adult day health option in the service package. This is a common service in the Lower 48, and most adult day programs are day health. They are very beneficial for helping people stay in the community.

Ken Helander further explained that the social model of adult day provides daytime supportive care for people living in their community and provides them with activity, structure, and safety. It oftentimes provides family support and other opportunities. An adult day health center is medical day services so that people who have physical conditions that would probably qualify them for nursing facility level of care could actually receive nursing and other rehabilitation services as well as even physician or pharmacy services within the structure of an adult day program where they get the same level of care that they would get within a social model.

Pat Branson also recommended that they have the service options of adult day and adult day health included in the plan. She believes that more of these kinds of programs are needed, especially in the rural areas.

Shane Spotts then pointed Council members to the list of the Medicaid state plan services that are being considered under the umbrella of the (k) and (i). The list is as follows:

- Personal care assistance
- Mental health rehabilitation
- Alcohol and substance abuse rehabilitation
- Behavioral rehabilitation for children and youth
- Tribal targeted case management
- Case management for children in-home and residential care settings
- Case management for infants and toddlers at risk of developmental disabilities
- Case management for mentally ill children and adults
- Case management for substance abusing adults and children
- Clinic services in mental health clinics
- Home health services.

The state-funded programs and grant services they are looking to roll into the Medicaid state plan options include:

- Nursing Facility Transition Program (k)
- Senior Grant Program (i)
- Mini ADRD grants for persons with dementia (i)
- Short Term Assistance and Referral (STAR) for persons with I/DD (i)
- Community Developmental Disabilities Grants (i)

Bruce van Dusen pointed out that none of the Behavioral Health grants were listed on this

document. Shane Spotts stated that he's not sure why they weren't included in the presentation, but they are in the document. Allison Lee commented that she didn't see the General Relief Program on the document either. Shane Spotts noted that it was another oversight, but Duane Mayes stated that General Relief is a critical piece they are looking at refinancing with (i).

REVIEW DATA REQUEST

Shane Spotts stated that they have received a very large amount of data now. He received it just prior to the New Year, but he did not have time to summarize the data to present to the Council.

He summarized that they received three years of data for all the Medicaid programs as well as individual data so they can analyze all the different service utilizations. They will be using that data to extrapolate costs over to the different options as they look at the services that may or may not transition.

For the grant-funded programs, they are still in the process of receiving similar data. The way those funds are allocated is they are paid to a provider, a provider provides the services, but they don't necessarily claim back to the state on an individual service level. It's a little more of a challenge to work through the state grant programs as a result, but the State has worked out a solution.

They also want to get any eligibility or diagnosis information on the state-funded programs and current Medicaid programs.

Pat Branson asked if there was any data available on the number of waiver denials in the state. Duane Mayes stated that that information is available and they can pull that. Art Delaune expanded on that by saying he would be interested in also knowing any denials to other grant services. He also stated that unavailability of services in areas would also be important to know.

Shane Spotts stated that they will expand on the data at the next meeting.

NEXT STEPS

Shane Spotts reviewed the next steps as follows:

- HMA has conducted an environmental scan of assessment instruments. They will begin working with SDS and DBH on recommendations for an assessment instrument to be utilized for various populations.
- HMA to begin conducting eligibility and financial analysis.
- HMA to begin developing a service package for the 1915(k).
- HMA to begin developing 1915(i) eligible populations and associated service packages.

DISCUSSION ON SHAPING (i) AND (k) IN ALASKA

Duane Mayes opened up the discussion by telling Council members that they have heard some support from provider and community forums for implementing the Supports Intensity Scale

(SIS) as an assessment tool. Shane Spotts stated that the ICAP that is currently used in Alaska looks for individual deficiencies, whereas the SIS tries to take the approach of what can the individual do, and what supports are needed to support those activities. He stated that at least 20 to 25 states have adopted the SIS, and many of them use it for resource allocation.

Shaun Wilhelm stated that the tool being looked at on the Behavioral Health side is the DLA-20. Similar to the SIS, this tool looks at the functional assessment of an individual and what services would be needed. Duane Mayes stated that they have received funding from the Trust to use the DLA-20 to assess the approximately 600 recipients in the General Relief Program, approximately 60 to 70 percent of whom have a severe mental illness.

Mary Schaeffer asked what they are looking for in the long run with the assessments. Are they looking at doing the assessments faster, because in some areas they are waiting up to six months to get an assessment done? It would be a lot faster if the local nurses or care coordinators could complete the assessments instead of waiting for a state assessor to come in to do it. Duane Mayes commented on the telehealth project in conjunction with three tribal partners. Through this project they will be able to use videoconferencing equipment in the village health clinics to do reassessments. Duane noted that they currently have no backlog on assessments, but weather is a contributing factor to the length of time to complete an assessment.

Ken Helander stated that one of the objectives in helping people to remain independent at home is the ability of the home environment and the family or caregivers there to be able to support the individual. He would hope that the assessment process would include the ability to assess the caregiver's needs and build that into the plans of care.

Art Delaune suggested a method whereby they could collect previous assessments for individuals such as school assessments, medical assessments, and neurological assessments to make the process go a little easier and take advantage of work that has already been done. Shane Spotts mentioned that there are a couple of different approaches states take. Some states have state staff administer their assessments face to face, other states take a variety of assessments that have been performed on an individual previously and use that to inform their state-developed eligibility tool, and other states have contractors to perform the assessments. He stated that as they make recommendations on assessment tools, they will take all of that into consideration. Pat Branson stated that given the current fiscal crisis, it would be important for the state to consider some of these other options as a cost savings to the state.

Duane Mayes stated that there will be changes in the I/DD world specifically around assessments, and they will be coming out with that. They are also looking at doing a mini Consumer Assessment Tool (CAT) for that subset of the population that will always meet eligibility. The state has been having ongoing and regular communications with CMS about all of this, and they seem on board with it.

Shane Spotts stated that there is a correlation between the task of looking at functional assessments and looking at resource allocation methodologies. He stated that the functional assessments not only look at an individual's functioning, but they also set service levels. They will then use those service levels to allocate funds to an individual to then go through a person-

centered planning process with their team based on the allocation of those funds. This algorithm then produces soft caps that a person should fall within a certain range of service. This process should take the subjectivity out and create equity among the system to produce an objective view of how the resources should be allocated, but it would still allow for the human touch of reviewing the plan and adjusting if necessary.

Advisory member comments on the assessment tools:

- The eligibility determination and the functional assessment provide two separate functions. The eligibility determination determines eligibility for services, and the functional assessment determines the service package. It appears as if the two concepts have been blended into one within the state, and they should be kept separate.
- There has been some provider dialogue going on around the SIS and some possible legal challenges to using it for rate setting purposes.
- The state of Montana has a pre-assessment and a high-risk assessment where the assessor can telephonically do a full assessment authorized for a certain time period before they have the face-to-face assessment. Alaska should consider this option. The Personal Care Attendant program used to have that ability

Shane Spotts posed this question to the Council:

Relative to how the current service delivery system is, what is your opinion about having some objective methodology of helping inform that service planning process by saying, "Here is the resources we suggest you work within"?

Comments included:

- It can sometimes be overly complicated for clients and individuals seeking service to come into one organization, be required to go through an assessment, then get referred to a secondary organization to go through a second assessment there. People often lose the will to want to be sober or go through a treatment program.

Shane Spotts recognized that HMA will need to do additional research into how provider assessments are being conducted at the behavioral health provider level in Alaska.

- The client satisfaction survey in behavioral health has been very difficult and the clients frequently randomly circle numbers, and it is used as a reflection of how effective and successful the provider is. One of the reasons clients are so flippant about completing the survey is because they are tired of all the assessments they've had to sit through.

Shaun Wilhelm stated that the division is currently looking at a systems change. They are looking at all of their instruments for assessments, the Alaska Screening Tool, the Client Status Review, and others to see what data they're gathering and how they evaluate a client's performance. She stated that assessing an individual's functionality is something she is keenly aware of that needs to be improved.

- When the assessment is made, a lot of places in the state don't have the resources to provide services. What happens then? *Shane Spotts stated that as they come across those gaps in the system, they will recommend potential solutions.*
- They have to go back to ground one to begin with. There has to be some trust between the state and the local communities in order for people to get the services that are really needed out there. If the state would be willing to accept the assessment that was done by a local nurse or social worker at the community level, that would really begin the assessment process. But that trust hasn't been there for a long, long time.
- People seem to want assessments when they are at the crisis stage, but is there a way to do assessments before people reach that crisis, perhaps at diagnosis to prepare for those critical life stages at which time they may want to take advantage of the services available to them?
- The same is true for aging. Aging is a predictable thing as is the eventuality of becoming dependent in some fashion on the state. Going back to this idea of being able to project, seniors have health records, and do they ever look at coordinating Medicaid and the state programs with the private sector?

GUEST PRESENTER

Shane Spotts introduced Kelly Reynolds from the State of Montana who participated in their Development and Implementation Council when they were doing Community First Choice, and she was heavily involved in Montana's development of their CFC program as an official advisory member.

Kelly Reynolds stated that they tried really hard not to change a lot of things at once, but rather to just integrate new services so it wasn't a cumbersome process for the consumers. One of the beneficial aspects Montana has is a contract with Mountain Pacific to do their level of care screening for Medicaid services. This has been beneficial to them in that Montana then has the ability to draw down data from that for all services, and it has streamlined the process.

Kelly stated that Montana has trust with their providers, so they can do a high-risk referral, and then Mountain Pacific can do a pre-screen over the phone to ensure something gets in place quickly. Mountain Pacific then follows up with that individual to do the full assessment in 30 days. Mountain Pacific also handles all of the amendments and reassessments, and their annual assessments are over the phone. People are only reassessed face to face every three years.

Kelly Reynolds stated that after the state received approval from CMS, it took them approximately a year-and-a-half to fully implement and get everybody onto services. Allison Lee noted that when they did the implementation, Montana matched people's transitions to when their services came up for renewal.

Kelly further explained that people who were on waiting lists for waivers were able to receive services through the (k) option, and they were able to access the enhanced services that Montana chose to offer. Duane Mayes asked Kelly Reynolds to further explain the enhanced services offered through the (k) option. She stated that with Community First Choice, they provide people with the flexibility to use up to ten hours over a two-week period to do something that is

meaningful to them. There are no constraints on what the person wanted to do for these community integration activities. Another one of the enhanced services that Montana selected to offer was the personal emergency response system.

Pat Branson asked if the State has considered having a private company do the assessments. Duane Mayes stated that if it's something they are going to consider, they will need to have tight controls on it. Allison Lee commented that a private company used to do it, but when the state put out an RFP again, no one answered it, so the State took over the responsibility.

Kelly Reynolds explained that Montana has an agency-based program as well as a consumer-directed program. She hopes that Alaska looks at bringing those two models back.

Shane Spotts explained that there is a maintenance of effort requirement for the (k) option whereby the state can't spend less money in the first 12-month period of state dollars than they would spend without the (k) option. Allison Lee stated that the breakdown of money reinvested for Montana shows that about half of it was additional direct services to consumers, about a third of it was an increase to the number of consumers served, about an eighth of it was new services planning and quality assurance for community providers, about an eighth of it was emergency consumer backup systems, and the rest was used for the additional consumer assessment screening requirements and some administration and program oversight.

Pat Branson asked about transportation needs in the state of Montana and how they are able to integrate people into the community. Kelly Reynolds stated that there is no cap on a person's mileage, but it has to be justified, and they also allow for authorized medical escort, which is tied to the mileage. She noted that the consumer can also access Medicaid transportation without having a caregiver involved.

NEXT STEPS AND FEEDBACK FROM THE COUNCIL

Shane Spotts began his closing comments by stating that understanding Alaska's structure a little bit better now, he believes it is clear that the 1915(c) waiver populations can clearly move over to the (k) option. He also feels that there may be some people currently in grant-funded services that will qualify for the (k). ADRD is clearly a target population for the (i), and they will design a program around that population. They are looking at ADRD as a population that can also be possibly served under the (k).

Shane Spotts stated that the SMI population poses a challenge to them currently because of the way the service delivery system is set up for Behavioral Health to be able to meet a lot of the federal requirements of the (i) options. They are going to have to explore that further to understand the system and the state's and providers' willingness to adapt to the new world that would have to be created in order to move those services to the (i).

TBI appears to be a good candidate for the (i) option as well, although some may meet the level of care for the (k) option, and many of them would potentially qualify for services under the I/DD (i) option if the TBI manifested before age 22.

Duane Mayes stated that this is the last week of provider and community forums, and it will culminate with a statewide webinar on January 13th. He encouraged Council members to get the word out to the communities of Juneau, Ketchikan, and the Mat-Su Valley to ensure they have a good turnout for their final forums this week.

Shane Spotts asked for feedback from Council members on what they would like to have considered for the next meeting. Feedback was as follows:

- Need to consider people on the ground providing services and doing the work instead of being strapped to their computers doing assessments and an inordinate amount of paperwork.
- Need to address divisions and entities talking with each other and streamlining efficiencies.
- Never think that too much information is too much information. There are people that are willing to review all of the information related to this issue to be as informed as possible when making decisions.
- It might be nice to have a one-page paper that explains the purpose of this state option process for other groups going to the legislature so that they can use it to educate and support this process.
- If in-home services increase with people that meet nursing facility level of care and what remains in nursing facilities is only the people with the most acute needs, are the nursing home costs going to skyrocket? The way many of the rural hospitals survive is because of the nursing home beds, and there will be an impact on them as an unintended consequence.
- A lot of these conversations with the Council have seemed to focus on the I/DD population, and there is a need to reframe these conversations to focus on the opportunities to people with serious mental illness and providers.
- Because of the challenges with understanding the SMI population, do not put moving behavioral health grant services to the (i) option on the back burner. It is an important cost savings measure to the state.

Shane Spotts stated that there is some concern with the Division of Behavioral Health because HMA could end up doing hundreds of hours of work for the SMI population without support and backing from DBH to say that they are willing to make all the changes that are necessary. Duane Mayes stated that although DBH currently has no director, he is currently following up with the deputy commissioner to ensure this project will have consistent DBH representation, which will most likely be Shaun Wilhelm. He also noted that the Department is currently looking for an interim division director for DBH. Shaun Wilhelm stated that this is an extremely important component for them to address to serve the needs of individuals with SMI and SUD in the state.

Duane Mayes wanted to recognize ABIN's financial contribution to paying for the costs of Council members to travel in for this meeting.

ADJOURN

Hearing no objections, the meeting adjourned at 3:45 p.m.