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

INCLUSIVE COMMUNITY CHOICES COUNCIL

Meeting Minutes
Thursday, July 21, 2016

Voting Members:
- Art Delaune - telephonic
- Banarsi Lal
- Alavini Lata, not present
- Karli Lopez
- Sara Kveum
- Bruce van Dusen, not present
- Rusty Best, not present
- Ken Helander - telephonic
- Patricia Branson
- Cindy Shults - telephonic
- Mary Schaeffer, not present

Advisors:
- Theresa Brisky, not present
- Allison Lee
- Kim Champney
- Tom Chard - telephonic
- Dave Branding
- Marianne Mills - telephonic
- Connie Beemer
- Mellisa Heflin, not present
- Sandra Heffern
- Denise Shelton

Facilitators:
- Duane Mayes, SDS
- Shane Spotts, HMA
- Steve Lutzky, HCBS Strategies
- Stephanie Denning, HMA - telephonic

Guests:
- Amanda Lofgren, AMHTA
- Deb Etheridge, SDS
- Ulf Petersen, SDS
- Jetta Whittaker, SDS
- Lisa McGuire, SDS
- Shaun Wilhelm, DBH
- Patrick Reinhart, GCDSE - telephonic
- Liz Donnelly, ABIN
- Denise Daniello, ACoA - telephonic
- Paul Cornils, AYFN
- Andrew Cieslinski, HCBS Strategies

Minutes prepared by: Paula DiPaolo, Peninsula Reporting

CALL TO ORDER – 9:00 a.m.
WELCOME AND ROLL CALL

Roll call of voting members and advisory members was taken.

MEETING OVERVIEW

Duane Mayes stated that Health Management Associates' contract ends July 31st, and there will be no more work from HMA going forward. The deliverables of the contract will be completed by July 31st. HCBS Strategies is on contract with the Trust to provide technical assistance in a variety of ways, and they will be of support when SDS/DHSS needs guidance specific to the implementation of 1915(i) and (k).

REVIEW AND APPROVAL OF MEETING MINUTES

Duane Mayes asked for a motion to approve the minutes from the June 2016 teleconference.

MOTION:
Pat Branson **MOVED** to approve the minutes, **SECONDED** by Banarsi Lal. Hearing no opposition to accepting the minutes as presented, the minutes were **APPROVED**.

ELIGIBILITY CRITERIA AND SERVICE PACKAGE / COST IMPACT ANALYSIS

Shane Spotts led council members and guests through the presentation related to the I/DD, ADRD, TBI, and SMI programs under the 1915(i) as well as the 1915(k) Community First Choice Option. He reviewed the estimates on the number of individuals, the eligibility criteria, service packages, utilization factors, and the costs they estimate associated with these programs as follows:

Individuals with Intellectual and Developmental Disabilities (I/DD)

Population Estimate:

Number of Medicaid recipients*	164,783
*According to Alaska Medicaid 2015 Annual Report	
Number of Alaskans*	738,432
*According to 2015 US Census data	
Rate of I/DD of Alaskans*	2%
*Based on estimate in Alaska scorecard	
Estimated I/DD rate of Medicaid recipients	2966

Estimated adults with I/DD in other programs	1051
CDDG	966
Registry	693
Duplication of CDDG and Registry	227
Estimated # of current registry and grantees participating in Medicaid*	796
Number of I/DD waiver recipients*	2002
*2015 I/DD waiver claims	
Estimated number of Alaskans eligible for I/DD 1915(i) program	964
Estimated IDD 1915(i) participation rate	90%
Estimated number of Alaskans participating in I/DD 1915(i) program	868

Eligibility Criteria:

A severe, chronic disability that:

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the individual attains age 22;
- is likely to continue indefinitely;
- results in substantial functional limitations in three of the following areas of major life activities:
  - – self care;
  - – receptive and expressive language;
  - – learning;
  - – mobility;
  - – self direction;
  - – capacity for independent living;
  - – economic self sufficiency;
- and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic assistance, supports or other services that are of lifelong or extended duration and are individually planned and coordinated.

Service Package and Rates:

Case Management	$	240.77	Monthly
Screening	$	90.33	One Initial
Plan of Care Development	$	384.81	Annual
Supported Employment - Individual	$	12.12	15 minute
Supported Employment - Group	$	8.49	15 minute
Day Habilitation - Individual	$	10.71	15 minute
Day Habilitation - Group	$	7.50	15 minute
Respite	$	6.26	15 minute
Respite	$	299.78	Daily
Intensive Active Treatment - Local	$	22.38	15 minute
Intensive Active Treatment - Non Local	$	44.77	15 minute

Shane Spotts noted that there would be an enhanced rate based on geographic factors, and the rates above are the base rates. He also noted that they were unable to develop a feasible way to move forward with any residential component of this package.

Utilization Rate – Unduplicated Recipients

Service	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	868	894	921	948	977
Screening	868	26	27	28	28
Plan of Care Development	868	894	921	948	977
Supported Employment - Individual	130	134	138	142	146
Supported Employment - Group	87	89	92	95	98
Day Habilitation - Individual	685	706	727	749	772
Day Habilitation - Group	243	250	258	265	273
Respite	260	268	276	284	293
Respite	104	107	110	114	117
Intensive Active Treatment - Local	26	27	28	28	29
Intensive Active Treatment - Non Local	1	1	1	1	1

Allison Lee commented on the idea that perhaps the habilitation rate would go down if people in the I/DD population were employed.

Cost Estimate

	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	$2,506,949.05	$2,582,157.53	$2,659,622.25	$2,739,410.92	$2,821,593.25
Screening	$94,053.54	$2,821.61	$2,906.25	$2,993.44	$3,083.25
Plan of Care Development	$333,893.71	$343,910.52	$354,227.84	$364,854.67	$375,800.31
Supported Employment - Individual	$1,892,940.72	$1,949,728.95	$2,008,220.81	$2,068,467.44	$2,130,521.46
Supported Employment - Group	$883,997.07	$910,516.98	$937,832.49	$965,967.47	$994,946.49
Day Habilitation - Individual	$5,873,114.11	$6,049,307.53	$6,230,786.75	$6,417,710.36	$6,610,241.67
Day Habilitation - Group	$1,093,282.60	$1,126,081.07	$1,159,863.51	$1,194,659.41	$1,230,499.19
Respite	$102,659.24	$105,739.01	$108,911.18	$112,178.52	$115,543.87
Respite	$280,923.65	$289,351.36	$298,031.90	$306,972.86	$316,182.04
Intensive Active Treatment - Local	$34,371.24	$ 35,402.38	$36,464.45	$37,558.39	$38,685.14
Intensive Active Treatment - Non Local	$44.77	$46.11	$ 47.50	$ 48.92	$50.39
	$13,096,229.70	$ 13,395,063.05	$ 13,796,914.94	$ 14,210,822.39	$14,637,147.06

Shane Spotts stated that speaking personally, he believes the figures above are the State's best-

case scenario, and he considers these to be very conservative estimates. He stated that they are conservatively looking at a $13,000,000 I/DD 1915(i) program in year one.

Cost Savings:

Total CDDG grant awards	$	11,555,795.00
Total CDDG grant recipients		966
Average CDDG cost per recipient	$	11,962.52
Estimated number of grant recipients participating in 1915(i)		560
Estimated grant funds shifted to Medicaid	$	6,700,949.52
Estimated number of individuals with no GF offset participating in 1915(i)		308
Medicaid funds matching grant funds	$	13,401,899.05
I/DD 1915(i) spend estimate	$	13,096,229.70
State matching funds	$	6,548,114.85
Total State savings	$	152,834.67

Shane Spotts stated that the State fiscal note estimated that basically half of the $11,555,795 CDDG grant award funding would be saved, and based on the analysis, this goal would not be reached. Sandra Heffern reminded the group that SB 74 had the caveat that they would only move forward with this change if there was going to be a significant cost savings to the State, and it appears that this would be an awfully large system change for very little return. Shane also noted that this very conservative cost estimate could potentially end up to be a large cost to the State with no savings at all.

Kim Champney commented that she hopes they continue to make the case for a billable service called case management because there is a large group of people being served under the grants that only need that minimal level of support versus actual services. Duane Mayes stated that there have been conversations about case management for the past couple weeks, so it's not off the table.

Shane Spotts stated that HMA's report is going to recommend, based on the information they've learned from a year's worth of work and analysis on the 1915(i) for the I/DD population, is to move forward with a 1915(c) waiver at a lower capped tier. The initial recipients of that waiver service would be shifting individuals who meet the level of care criteria in Medicaid eligibility from the grant program. The recommendation would be to then develop a registry for that waiver and then move people onto the program as the State can afford it. This would result in achieving the general fund savings that Alaska is committed to saving all the while not exposing the State to the financial risk of the entitlement program of the 1915(i). The 1915(c) would be a good vehicle for what the State is trying to accomplish, and would be easy for the State to move forward because the infrastructure is already in place.

Art Delaune also commented on looking to employ more people with intellectual and developmental disabilities realizing that there are many areas of State government that will

benefit, so there will be greater cost savings other than just to SDS. This is a message that needs to be demonstrated to the legislature.

Alzheimer's Disease and Related Dementia (ADRD)

Population Estimate:

Estimated # not living w/caregiver*		8,500
*Alaska Roadmap estimates 60% of individuals with ADRD reside with caregiver		3,400
Number of Medicaid recipients age 21-59*		54,269
Number of Medicaid recipients age 60+*		15,164
*according to Alaska Medicaid 2015 Annual Report		
Number of Alaskans age 18-64*		186,085
Number of Alaskans age 65+*		73,843
*According to 2015 US Census data		
Estimated % of Alaskans age 18-59 Medicaid recipients		29.2%
Estimated % of Alaskans age 60+ Medicaid recipients		20.5%
Rate of Dementia of Alaskans age 22-59		1.2%
Rate of Dementia of Alaskans age 60+		8.5%
Estimated ADRD rate of Medicaid recipients age 18-59		642
Estimated ADRD rate of Medicaid recipients age 60+		1,294
Estimated ADRD rate of Medicaid recipients not living with caregiver age 18-59		160
Estimated ADRD rate of Medicaid recipients not living with caregiver age 60+		970
Estimated # of Alaskans not on Medicaid with ADRD age 18-59		1,558
Estimated # of Alaskans not on Medicaid with ADRD age 60+		5,006
Estimated grant funded individuals with ADRD		315
Adult Day grants	114	
Senior In-home grants	123	
General Relief	78	
Current grantees not on Medicaid*		63
*Assuming 80% are currently on Medicaid		
Number of Alaskans not currently on Medicaid accessing Medicaid benefit (5% take-up rate)		328
Estimated number of Alaskans accessing ADRD 1915(i) program		1,459

Ken Helander noted that the 18 – 59 age category would be the inclusive category for early-onset Alzheimer's, which typically would never happen to somebody in the 18 to 45, 50-year-old range. He believes the estimate of 642 individuals is way too large, and he doesn't believe that Alaska has near that many young onset people relative to the number of people that are aged 60 plus. Shane Spotts noted that he will take that under advisement.

Pat Branson commented that one population this does not address are the numbers of seniors living with ADRD that do not qualify for Medicaid, which is a large number and is a major gap in service. Shane Spotts stated that this 1915(i) would not solve this problem if they don't qualify for Medicaid because they're financially ineligible. Pat Branson noted that it's not the financial ineligibility, it's that they don't qualify because of the assessment.

Eligibility Criteria:

Dementia is a loss of cognitive abilities in two or more areas such as memory, language, visual and spatial abilities, or judgment, severe enough to interfere with daily life. There are different types of dementia because the root causes of the symptoms are different. Alzheimer's disease is the most common form of dementia.

Individuals meeting the criteria of this 1915(i) target group have a severe, chronic disability that:

- is attributable to ADRD; and
- is manifested after the individual attains age 22; and
- results in the individual, who lives alone or is at risk of living alone or becoming homeless, having significant difficulty with memory, using information, daily decision making, or exercising judgment that requires intervention to maintain health and ensure the individual does not put themselves or their surroundings in danger; and
- is determined, based upon an approved functional assessment, to require assistance in activities of daily living and instrumental activities of daily living to live in the least restrictive living situation.

Shane Spotts commented on the discussion from the last meeting regarding the language "lives alone or is at risk of living alone or becoming homeless," and stated that the language was left as a program parameter to try to capture those who are in most need right now. Ken Helander asked for clarification if the program would not cover someone with ADRD who lives with family who otherwise would meet the eligibility criteria. Shane noted that there is some subjective language in there, so there is wiggle room for the State's interpretation of "at risk of living alone," through the assessment process. Ken also pointed out the importance of the assessment tool including the ability to assess the needs of the family caregiver, and he asked if that complicates the ability of having that element in the assessment and then plan of care. Steve Lutzky responded that it couldn't be part of the needs assessment of the individual; however, it could be addressed in how services are defined.

Kim Champney added that the services could be defined similar to the I/DD waiver in that the number of units for an individual will fluctuate depending on the availability of natural supports.

Service Package and Rates:

Case Management	$	240.77	Monthly
Screening	$	90.33	One Initial
Plan of Care Development	$	384.81	Annual
Chore	$	6.70	15 minute

Respite	$	6.26	15 minute
Adult Day Service	$	84.11	Half Day
Adult Day Service	$	5.25	15 minute

Sandra Heffern asked if the respite portion could be called "companion," which is a concept that has been discussed in many different venues over the years. Pat Branson agreed. Duane Mayes stated that it is being discussed in an external workgroup. The external workgroup is a vehicle for the Division to work with in realizing efficiencies and cost savings going forward.

Denise Shelton recommended calling it "homemaker services," which provides a multitude of flexible services depending on the person's needs each day. This is also a service category allowable with CMS. Ken Helander and Pat Branson agreed. Sandra Heffern noted that it is also referred to as a "universal worker." Duane Mayes stated that they are working on the universal worker concept with the tribes, and using some of that design is maybe something the State will want to consider.

Kim Champney commented on reducing the hidden costs of services by simplifying things to a universal worker. Duane noted that they have to use caution when simplifying to become efficient so as not to reduce the quality control and quality assurances. Allison Lee noted that it would reduce institutional fraud by not having to constantly switch billing units depending on types of services provided.

Utilization – Unduplicated Recipients:

	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	1,459	1,503	1,548	1,594	1,642
Screening	1,459	44	45	46	48
Plan of Care Development	1,459	1,503	1,548	1,594	1,642
Chore	875	902	929	957	985
Respite	379	391	402	414	427
Adult Day Service - ½ day	1,021	1,052	1,083	1,116	1,149
Adult Day Service - 15 min	365	376	387	399	411

Utilization – Average Units per Recipient:

	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	12	12	12	12	12
Screening	1	1	1	1	1
Plan of Care Development	1	1	1	1	1
Chore	1,232	1,232	1,232	1,232	1,232
Respite	1,406	1,406	1,406	1,406	1,406
Adult Day Service – ½ day	107	107	107	107	107
Adult Day Service – 15 min	587	587	587	587	587

Shane Spotts noted that there was not good data to estimate these figures, so he will need to do more work on it. He stated that the figures were derived from information from the ALI waiver utilization rates, and he tried to apply a sensible factor to them. He noted that he will need to

make a few adjustments to some of the figures in Adult Day Service.

Cost Estimate:

	Year One	Year Two	Year Three	Year Four	Year Five
Case Management	$ 4,215,208.86	$ 4,341,665.12	$ 4,471,915.07	$ 4,606,072.53	$ 4,744,254.70
Screening	$ 158,142.55	$ 4,744.28	$ 4,886.60	$ 5,033.20	$ 5,184.20
Plan of Care Development	$ 561,412.18	$ 578,254.54	$ 595,602.18	$ 613,470.24	$ 631,874.35
Chore	$ 7,225,572.12	$ 7,442,339.28	$ 7,665,609.46	$ 7,895,577.74	$ 8,132,445.08
Respite	$ 3,338,631.46	$ 3,438,790.40	$ 3,541,954.11	$ 3,648,212.74	$ 3,757,659.12
Adult Day Service – ½ day	$ 9,191,045.79	$ 9,466,777.16	$ 9,750,780.48	$ 10,043,303.89	$ 10,344,603.01
Adult Day Service –15 min	$ 1,124,017.03	$ 1,157,737.54	$ 1,192,469.67	$ 1,228,243.76	$ 1,265,091.07
	$ 25,814,029.98	$ 26,430,308.33	$ 27,223,217.58	$ 28,039,914.11	$ 28,881,111.53

Cost Savings:

Total SIH grant awards	$2,823,643.68
Total SIH grant recipients	1327
Average SIH cost per recipient	$2,127.84
Estimated number of grant recipients participating in 1915(i)	123
Estimated grant funds shifted to Medicaid	$ 261,724.32
Total Adult Day grant awards	$1,757,010.87
Total Adult Day recipients	423
Average Adult Day cost per recipient	$4,153.69
Estimated number of grant recipients participating in 1915(i)	114
Estimated grant funds shifted to Medicaid	$473,520.66
Medicaid funds matching grant funds	$1,470,489.96

Shane Spotts stated that he didn't even bother to put a savings figure in because based on the data, it has been exceeded by $23,000,000. He stated that he can do some reconfiguration of some of the figures based on today's conversation, but it won't reduce the end result by much.

Duane Mayes stated that there has been discussion among the workgroup of the idea of a mini (c) waiver. Steve Lutzky noted that it's not going to be cost neutral to implement the (i) entitlement program, and the challenge with shifting to the mini (c) is going to be nursing facility level of care for people who have dementia but have not crossed the ADL threshold. The State could try exploring an (i) that has an extremely limited range of services or a very tight budgetary control. His concern with that is that Alaska doesn't have very tight mechanisms for resource allocation control for assigning budgets. It's something that could be considered if the State develops something more sophisticated with the interRAI tools and then gains tight control over the budgets, but it still might be fairly challenging.

Shane Spotts stated that the problem for Alaska is that there are two problems they are trying to solve: lack of funding and a population with a very clear need. It's difficult to come up with a

Medicaid vehicle to solve both of these problems.

Pat Branson stated that the legislature needs a reality check, and the language to educate them needs to be that Alaska has the fastest growing senior population in the nation, and their needs aren't being met through either Medicaid services or grant services, especially for people with ADRD, and that population is going to be increasing.

Ken Helander added that what will happen if the population is growing and there are not enough supports is that people will die, become vulnerable, will become injured, and will get sicker, and it will become a matter of public conscience that we would treat our elders this way. The alternative to that is if the family unit is strengthened to provide care so people don't become vulnerable, it takes the burden from the State to the families, but there has to be some sort of collective support to provide that care to the families to endure that kind of care. Duane Mayes stated that the Family Caregiver Program would be a logical, low-cost solution to that, and that program has been flat for quite some time. He noted that a follow up to that is showing the more global savings results that could be achieved by implementing these low-cost solutions.

Sandra Heffern asked if there was a 1115 waiver they could explore for ADRD.

Traumatic Brain Injury (TBI)

Population Estimate:

Estimated # of Alaskans with TBI diagnosis	10,000
Estimated number of TBI diagnosed individuals requiring ongoing care*	1,000
*ABIN study from 2004-2008 estimated 10%	
Number of Medicaid recipients age 21-59*	54,269
Number of Medicaid recipients age 60+*	15,164
*According to Alaska Medicaid 2015 Annual Report	
Number of Alaskans age 18-64*	186,085
Number of Alaskans age 65+*	73,843
*According to 2015 US Census data	
Estimated % of Alaskans age 18-59 Medicaid recipients	29.2%
Estimated % of Alaskans age 60+ Medicaid recipients	20.5%
Rate of TBI of Alaskans	3.8%
Estimated TBI rate of Medicaid recipients over age 18	2,671
Estimated TBI rate of Medicaid recipients requiring ongoing care	267
Estimated # of Alaskans not on Medicaid with TBI	7,329
Estimated # of Alaskans not on Medicaid with TBI requiring ongoing care	733
Estimated grant funded individuals with TBI	105

TBI mini grants	43
General Relief	62
Current grantees not on Medicaid*	21
*Assuming 80% are currently on Medicaid	
Number of Alaskans not currently on Medicaid accessing Medicaid benefit (10% take-up rate)	73
Estimated number of Alaskans accessing TBI 1915(i) program	340

Shane Spotts explained that he lacks confidence in these numbers, and both Liz Donnelly and Paul Cornils agreed that the numbers are inaccurate based on what they have seen, but this is a place to start.

Eligibility Criteria:

The State of Alaska targets Medicaid eligible individuals with a traumatic brain injury (TBI) who may not have sufficient deficits to qualify for an institutional level of care but meet the following criteria:

- is between the age of 19-64;
- shows the capacity to make progress in rehabilitation and independent living skills;
- is determined, based upon an approved functional assessment, to require assistance in activities of daily living and instrumental activities of daily living to live in the least restrictive living situation;
- for purposes of the 1915(i) target group, a traumatic brain injury is a trauma that has occurred as a closed or open head injury by an external event that resulted in damage to brain tissue, with or without injury to other body organs. The extent of the injury must be certified by a physician. The insult or damage caused a decrease in cognitive, behavioral, emotional, or physical functioning resulting in a substantial need for assistance.

Service Package:

	Rate	Unit
Targeted Case Management	$ 240.77	Monthly

Other Service Options:

- Behavior management
- Tenancy supports
- Transition living skills
- Rehabilitation therapies.

Utilization:

	Year One	Year Two	Year Three	Year Four	Year Five
Targeted Case Management	340	350	361	372	383

Cost Estimate:

	Year One	Year Two	Year Three	Year Four	Year Five
Targeted Case Management	$ 982,341.60	$ 1,011,811.85	$ 1,042,166.20	$ 1,073,431.19	$ 1,105,634.13

Cost Savings:

- None calculated at this time.
- HCBS Strategies looking at Medicaid claims to determine if there are Medicaid cost savings opportunities such as emergency room utilization, PCA services, and mental health services.

Shane Spotts stated that he is going to look at New Hampshire and Kansas to look at other valuable TBI services that could be considered. He will put together an approximation of the utilizations and costs, knowing that Alaska doesn't have good data currently, so that they will have a good starting point even though a 1915(i) program will not be developed for TBI.

Shane Spotts stated that HMA's recommendation is going to be to first move forward with targeted case management as its own State Plan Medicaid service, and then consider other options in the future.

Duane Mayes stated that the workgroup has determined the following priorities in the area of TBI:

- Collect data through ABIN's new software system from the Brain Injury Association of Minnesota.
- Explore Kansas's transition living specialist concept model and New Hampshire's Crotched Mountain rehabilitation facility.
- Creation of a TBI registry, possibly in conjunction with Dr. Butler and the Division of Public Health.

Sandra Heffern suggested that another place to gather data would be emergency room data, and Connie Beemer stated that she is the point of contact for the ER project, and she would be happy to discuss it further. Connie further recommended being in contact with the Alaska E-Health Network and look at how a registry could be facilitated through there rather than the State creating a new one.

Serious Mental Illness (SMI)

Shane Spotts stated that HMA will be recommending that the contractor addressing the 1115 waiver redesign and the Division of Behavioral Health (DBH) take on the SMI population and factor in the General Relief Program, so they will be excluding that population from their final report

Shaun Wilhelm stated that as DBH looked at the options of the 1915(i), it didn't feel like it was a

good fit for their population. The 1115 waiver is a process where they are still going to engage their stakeholders and incorporate some of the work that has been done by this group into the process of discussion. The contractor is assisting them with the design right now, and they will be having workgroups go through a similar process as this group is.

Dave Branding stated that although he understands and supports the rationale behind this shift, he wanted to voice, from the perspective of a provider that serves both the I/DD and SMI populations as well as that population of people eligible for both sets of services, the reality is that this will maintain a bifurcated funding system for that population. It will maintain two sets of distinct regulatory requirements and double the compliance risk around that population for the eight or nine organizations statewide that are similar to his. His wish is that they could take advantage of the opportunity to serve that co-occurring population more distinctly. Duane Mayes stated that the Complex Behavior Solutions Group is looking specifically at this population, and they are looking for providers willing to help address those populations. They are also talking about a model waiver approach for people with challenging issues. Shaun Wilhelm added that in their 1115 waiver design, they are also looking into augmented services for those subsets. They will be very cautious and collaborative with SDS in their progress of moving forward for the services being delivered through the 1915(k).

Shane Spotts summarized the recommendations on the 1915(i) State Plan Options as follows:

- I/DD – recommend utilizing a (c) waiver option versus the (i) option
- ADRD – will require continued discussion on options
- TBI – moving forward with targeted case management services and exploring what an (i) option could look like for TBI moving forward after further analysis by HCBS Strategies and ABIN.

Duane Mayes suggested that a small workgroup could be formed regarding ADRD, possibly as part of the external workgroup, to discuss some of the brainstorming that took place today and determine a direction for the ADRD population.

Community First Choice – 1915(k)

Shane Spotts led the council through a review of the analysis regarding the 1915(k) option as follows:

Population Estimate:

- 1,603 individuals currently on a waiver receiving PCA services.
- There are likely other PCA recipients that meet level of care criteria, but that information is not available at this time.

Shane Spotts stated that the 1915(k) option has a maintenance of effort (MOE) requirement. The MOE requires that the State maintain the same level of State expenditures for the service recipients of attendant services and supports for the previous full year. The reason this is a problem for Alaska is that there are other HCBS cuts happening that are going to affect the MOE

level moving forward. If Alaska makes cuts after implementing the 1915(k), they will have to somehow maintain the same level of State expenditures they had before the cuts. Shane stated that he doesn't currently know what the penalty would be from the federal government.

Another consideration is that in addition to shifting PCA services over to the (k), they will also have to add another service called the back-up system in order for Alaska to be compliant with the program.

Steve Lutzky added that the MOE doesn't count just what is in the (k) option, they look at all of the home and community-based services across the whole Medicaid program. He noted that by the State implementing another (c) waiver for I/DD, it could be used as a pressure valve that could be adjusted to make up for the maintenance of effort.

Eligibility Criteria:

- Individuals who meet financial eligibility requirements for medical assistance are eligible for CFC if they meet the institutional level of care requirement as determined on an annual basis.
  - The level of care criteria is established by the State.

- The standard for functional eligibility for this group is: "in the absence of the home and community-based attendant services and supports…the individual would otherwise require the level of care furnished in a/an:
  - hospital,
  - nursing facility,
  - intermediate care facility [for the developmentally disabled],
  - institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan."

Cost Estimate:

Total PCA Spend (FY 2015)	$ 85,200,043.36
% PCA Spend to Move into (k)	49.0%
PCA Spend - Currently on a Waiver	$ 41,786,777.39
State Spend Currently	$ 20,893,388.69
State Spend CFC	$ 18,386,182.05
Current PCA State share	$ 42,600,021.68
Non-(k) PCA spend after implement	$ 21,706,632.99
PCA Total State share with (k)	$ 40,092,815.04
PCA Savings	$ 2,507,206.64

Shane Spotts stated that HMA's recommendation will be to proceed cautiously on the implementation of the 1915(k) and be aware of other program reductions on the maintenance of

effort.

Shane Spotts and Duane Mayes stated that the intent is to use the interRAI as the assessment tool moving forward with the (k). Duane stated that the rollout of the (k) option is to occur in July 2017, and if all goes as planned specific to the new assessment tool, they would want that to align at the same time. They are hopeful they can make that happen.

Council Recommendations on 1915(i) State Plan Options

I/DD

Roll Call Vote Results: **(Y) – 7** **(N) – 0** **Motion Passed**	**MOTION:** Kim Champney **MOVED** the following: In light of information and analysis of the impact of (i) related to cost of services, this council has decided not to pursue (i) for I/DD and instead to achieve the same outcomes and look at a mini (c), **SECONDED** by Pat Branson.

Discussion:

Art Delaune would like more information about the mini (c) and how it would work. Duane Mayes stated that they will put forth more information through AADD, GCDSE, et cetera.

Karli Lopez offered an **AMENDMENT** to the motion to not specify mini (c) but to say "through other available options or programs," **SECONDED** by Pat Branson.

The vote on the amendment carried the motion.

ADRD

Roll Call Vote Results: **(Y) – 7** **(N) – 0** **Motion Passed**	**MOTION:** Pat Branson **MOVED** the following: In light of information and analysis of the impact of (i) related to cost of services, this council has decided not to pursue (i) for ADRD and instead to achieve the same outcomes through other available options or programs to include the possibility of a separate ADRD waiver, **SECONDED** by Banarsi Lal.

Discussion:

Amanda Lofgren stated that through the larger Medicaid Reform efforts, there was a dementia care initiative and a stakeholder group convened, and it was very clear that there needed to be more discussion to really understand what their purpose was and what their potentials are. There

might be an opportunity to pull this project together with that one.

TBI

Roll Call Vote Results: **(Y) – 7** **(N) – 0** **Motion Passed**	**MOTION:** Pat Branson **MOVED** the following: For the TBI population to have targeted case management, actively collecting needed data in order to assess future service delivery for Alaskans, and also be fiscally responsible, **SECONDED** by Cindy Shults.

Discussion:

Nothing further was discussed on this motion.

SMI

MOTION:
Dave Branding **MOVED** the following: I recommend not pursuing the 1915(i) as it pertains to SMI, acknowledging that there is significant opportunity for service coordination, improvement, and efficiency that should be fully pursued through the development of an 1115 waiver, **SECONDED** by Pat Branson.

Discussion:

Art Delaune asked if this includes the discussion they had earlier regarding dual diagnosis or if this just addresses the SMI diagnosis. Duane Mayes stated that it's the SMI diagnosis, but it is dually noted that there is this other co-occurring population.

Sandra Heffern added a caveat that it's not just a person with a developmental disability and a behavioral health issue, but other co-occurring populations to consider are people aging with SMI as well as TBI and it's just thinking holistically about behavioral health touching throughout people's lives.

Karli Lopez suggested not limiting the possibilities to just the 1115 waiver, but to keep their motion more open to allow other options and opportunities to be developed. Amanda Lofgren suggested switching it to the Behavioral Health Initiative and reference SB 74, because there are a couple different components in there. She stated that there is the 1115, but ensuring the comprehensive mental health integrated program is included.

The motion was amended to read:

Roll Call Vote Results: **(Y) – 7** **(N) – 0** **Motion Passed**	**MOTION:** Dave Branding **MOVED** the following: I recommend not pursuing the 1915(i) as it pertains to SMI, acknowledging that there is significant opportunity for service coordination, improvement, and efficiency that should be fully pursued through SB 74 and the comprehensive integrated behavioral health reform, **SECONDED** by Pat Branson.

Community First Choice – 1915(k)

Roll Call Vote Results: **Motion Postponed**	**MOTION:** Allison Lee **MOVED** the following: My understanding is that the recommendation of this group would be to move the existing PCA Personal Care Attendant Program, Personal Care Services Program for those individuals who meet current nursing facility level of care, to include personal care services with the addition of back-up systems, while recognizing some concern regarding the ongoing maintenance of effort, **SECONDED** by Pat Branson.

Discussion:

Sandra Heffern respectfully disagreed with the motion. One issue is that SDS is pursuing a new assessment tool to determine waiver eligibility, so they don't know yet if all the current PCA recipients will be eligible for the waiver with the new tool. She suggested that they begin with the new assessment tool and fully vet what that is going to look like and then move towards the 1915(k). Another issue Sandra has is it's a huge lift to shift to this State Plan Option, and although 2.5 million dollars is a lot of money, it may not be a lot of money for the potential impact that it could have on the system. If they do the new assessment tool in July of 2017, then by July of 2018 they would have some data to be able to understand what the impact would be of implementing (k). Sara Kveum agreed.

Allison Lee suggested that her recommendation would be to more deeply explore the 1915(k) to include person-centered planning and the components that she thinks exist within the 1915(k) that they didn't really explore. She also agreed that if they had a year with the new assessment tool, they would have a greater understanding of the impact of moving PCA.

Banarsi Lal suggest that Pat Branson withdraw her second so the motion would die and a new motion could be brought forth with all of the suggested changes. Steve Lutzky proposed postponing this motion because they will be discussing resource allocation and the timelines of the implementing the assessment processes, and that will provide the council with more information they may want to factor in to their decision.

RESOURCE ALLOCATION DISCUSSION

Shane Spotts stated that resource allocation is an important component for moving all this forward, and it is putting program controls around not only the 1915(k) but the various (c) waivers and having an objective way of allocating those resources.

The way resource allocation will look is that the individual will be assessed with the interRAI for eligibility for the waiver program. From that assessment there are algorithms that can then tie function as defined by the assessment tool to the resources and the services that are available to the individuals on those programs. That takes some of the subjectivity out of how services in dollars are distributed to people on the waivers.

Steve Lutzky talked about their 2008 report, and one of the recommendations they had was for the State to be developing some mechanisms so they can set greater parameters on an individual's budget; give the person flexibility on how they can spend their budget; and then let the individual, with guidance from their care coordinator, make decisions how to spend those funds in order to move the State staff out of the role of setting plans while allowing greater flexibility. To be able to do this, the State will need a stronger resource allocation approach.

Steve Lutzky stated that the State also needs to develop an exceptions process. He gave the example of Hennepin County in Minnesota that has a five-tiered budget system for people with I/DD. Care coordinators work with the individuals to develop a plan that falls within one of the tiered levels. If it doesn't fall below the tier level, then they do a more thorough review of the plan to determine if any exceptions need to be made.

A third area the State needs to consider in resource allocation is a risk pooling mechanism, some ability to share the money across participants to make the money go further.

Steve Lutzky stated that because of the State's current fiscal situation, the State will need to look at limiting waiver slots, number of hours, and access to services. If they were to have one of the above-mentioned approaches, it allows the individuals along with their care coordinators make more of the difficult choices and figure out how to make their money go the furthest.

IMPLEMENTATION PLAN

Shane Spotts announced that the end of this contract is his last day with HMA, and Stephanie Denning will be picking up where he leaves off to answer any follow-up questions. She has been working on the implementation plan component of the contract, which is still under development.

Stephanie Denning introduced herself and provided some background information and then led the council through the report as follows:

Implementation Plan Purpose

The purpose of the Implementation Plan Deliverable is to synthesize the various project tasks and to help the Department of Health and Social Services (DHSS) and Senior and Disabilities Services (SDS) Division leadership:

- Identify major implementation requirements such as project governance, oversight, and infrastructure
- Understand the key milestones they must meet and when they must meet them to successfully transition clients into the new programs with the least interruption possible to their supports and services
- Determine core resources needed to support the Implementation Plan – from within DHSS, among other key stakeholders, from contractors or vendors
- Recognize potential risks and create mitigation strategies
- Establish plans for how it will work with stakeholders to support a successful implementation over the next several years.

Implementation Plan Deliverable

The Implementation Plan Deliverable has several required components, besides the Table of Contents and Executive Summary:

- A description of the planning efforts, including:
  - Creating policies, procedures, and tool development
  - Community outreach
  - Recommendations of rate setting
- Approvals and rules – a review of federal 1915 (i) and (k) requirements and where Alaska will need to make statutory or rules changes to meet those requirements
- Operations infrastructure – recommended changes to support new programs
- Plan and timeline for communications to participants and providers
- Plan and timeline for transitioning waiver and PCA services to the HCBS and CFC programs
- Plan and timeline for transitioning grant program services to the HCBS program.
- Cost impact analysis based on the target populations and services SDS chooses
- Recommended information systems and technology systems changes
- A training plan for internal staff (provider training is addressed above)
- Lessons learned in other states – how they implemented 1915(i) and (k)
- Best practices in other states – what worked best and can be replicated by Alaska
- Questions posed to CMS and their responses
- A summary of input from focus groups and community forums conducted over the past summer and fall
- A preliminary version of the Intake Protocol – a high-level recommendation for adjusting the intake process to better support the new programs.

Implementation Plan Status

- Some of the sections of the Implementation Plan document are essentially complete, such as those related to research or work completed as part of other project task deliverables (summaries of other states' experiences, community forum recaps, regulatory reviews, etc.)
- The Cost Impact Analysis is the most critical component, as it must reflect the Department's decisions about target populations, services and other important program design factors
    - HMA is working closely with SDS to finalize the cost impact analysis based on these factors
- Sections that are more explicitly related to operational changes and implementation planning need to reflect the program design factors SDS chooses, so are not as fully developed yet
    - As SDS and HMA finalize on program design elements, review the fiscal impacts and overall operational impacts, these sections can be further refined to reflect the key milestones and critical path to implementation.

Implementation Plan Next Steps

- HMA will continue to work closely with SDS to finalize program design elements and to further build out the key milestones and core tasks that must be accomplished to implement both the 1915 (i) and (k) options
- This will include estimated timelines that are based on as realistic as possible expectations for all the critical pieces to come together across multiple parties that play important roles in making the work happen.

IMPLEMENTATION TIMELINE

Steve Lutzky provided the council an overview of HCBS Strategies and provided a report on the timeline as follows:

- Legislative mandates that must be met:
    - Converting PCA/CDPCA to 1915(k) by July 2017
    - Converting grant funds to Medicaid and realizing savings to State in 2018
- Major implementation challenges to meeting timeframes:
    - Finalizing design
    - Making necessary changes to operations
    - Approvals:
        - State regulations
        - CMS approval of new options
    - Preparing participants, providers, care coordinators and others for the changes.

Major Components of the Draft Plan

- First priority is to meet legislative mandates and address fiscal crisis
- Immediate effort to obtain more 90/10 match for building infrastructure
- Longer term effort to build infrastructure that will allow SDS, participants, and providers to do more with less:
  - Streamlining access processes
  - More comprehensive reforms to services that allow them to be more cost-effective
  - Draw down more federal dollars.

Changes to Access Processes

- Access processes vs. single tool:
  - Reexamine all processes from initial contact to service connection
- Major goals:
  - Incorporate valid and reliable items
  - Support major objectives, such as making system more person-centered
  - Comply with CMS HCBS rules requirements
  - Support data-driven policies and quality management
  - Efficient division of labor between ADRCs, SDS staff, care coordinators, and providers
- Participants as drivers in the process rather than passengers.

Duane Mayes stated that they are shooting for a target date of July of 2017 for the implementation of the interRAI. It is possible that they may not meet that target date.

NEXT STEPS AND FEEDBACK FROM THE COUNCIL

Communication Plan

Duane Mayes stated that he sees this council as one vehicle in the communication plan as well as the external workgroup.

The external workgroup is a group that is being convened to brainstorm solutions to the $26 million in reductions to home and community-based services. The workgroup has a contractor, Sandra Heffern with Effective Health Designs, and she has been working with the Division as they have formalized the external workgroup. There is representation on the workgroup from all the different associations and leadership from the Division as well as beneficiary boards.

Duane Mayes stated that some of the agreements that they made through the external workgroup was done in partnership with the different associations around cost saving ideas such as technology, soft caps, and the ADRC pre-screening pilot project.

Duane stated that this council will need to be connected to the external workgroup as they continue to work on 1915(i) and (k).

SDS will continue to maintain the Inclusive Community Choices Council portion of their website as a method of communication of the progress of this effort going forward. Duane will also reach out to communicate with various associations during their monthly teleconference calls to keep people abreast of the new system changes until they flip the switch.

Council members suggested being in contact with the following additional associations and providing the following formats for communication:

- Alaska State Hospital and Nursing Home Association's long-term care committee
- Down Syndrome Congress
- Autism community
- Quarterly town hall meetings – Duane Mayes will meet with Karli Lopez to discuss town hall meeting formats
- Webinar series
- Steering Committee
- SDS's e-alert system
- SDS newsletter

Duane Mayes stated that he sees this council continuing until the new system is actually implemented, but it will not be a permanent structure in government. He queried council members and advisors as to their interest in continuing on in their roles with the council. The time commitment would be approximately two-hours for monthly teleconferences. Responses were as follows:

- Karli Lopez – yes
- Sara Kveum – yes
- Pat Branson – yes
- Banarsi Lal – yes
- Ken Helander – yes
- Cindy Shultz – look to ABIN to appoint another person
- Art Delaune – yes
- Will check with Mary Schaeffer
- Connie Beemer – yes
- Denise Shelton – yes
- Sandra Heffern – yes
- Allison Lee – yes
- Kim Champney – yes for AADD
- Dave Branding – yes
- Will check with Mellissa Heflin

Community Follow Up

Duane Mayes stated that the Trust is providing funding for SDS to go back out to the communities and communicate the outcomes from this process. They may hit some of the same communities as last time, but they would also like to have an opportunity to present at some communities they were unable to visit last time.

Feedback from the Council

Art Delaune asked to see if it were possible to put more information on the website such as the

PowerPoints that are used during these meetings. Connie Beemer would like to see the presentations before the meeting.

Sandra Heffern asked what the status was of the larger dollar grant-funded consumers that could be potentially moved to the (c) waiver. Deb Etheridge stated that there is active communication between the managers of the CDDG component and the I/DD unit. Deb believes there are opportunities to make some improvements to that as they continue to actively monitor it. They do the same thing within their senior programs as well. Duane Mayes stated that they will make this a discussion point for the next ICCC meeting.

Pat Branson shared her concerns that provider grantees are communicated with regarding all of the layers of this process, because many of them are unaware. Deb Etheridge stated that the Commissioner's Office has developed a communication plan around the entire Medicaid reform.

Connie Beemer suggested developing a couple of talking points at the end of each of their meetings that would give all the members of this council something concrete to share with colleagues and to put into print through newsletters.

ADJOURN

Hearing no objections, the meeting adjourned at 4:09 p.m.