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

INCLUSIVE COMMUNITY CHOICES COUNCIL

Meeting Minutes
November 20, 2019

Attendees: Rebecca Marinelli, Deb Etheridge, Cheri Herman, Ulf Petersen, Caroline Hogan, Travis Noah, Amanda Faulkner, Melissa Castaneda, Kristin Vandagriff, Denise Shelton, Maureen Harwood, Ric Nelson, Kelda Barstad, Moli Atanoa, Jetta Whittaker, Corina Castillo-Shepard, Rodney George, Kara Thrasher-Livingstone, Renee Gayhart, Kim Champney, Lisa Morley

I. Overview

1. Deb Etheridge introduced herself and provided an overview of the agenda, found at: https://drive.google.com/file/d/1lErblHcGbQ4ffQ9YNfuJNloF577wrSKx/view?usp=sharing

II. Update on the Transition of Chore Services to CFC

1. Deb Etheridge explained that SDS plans to transition chore from a home and community based (HCBS) waiver service to Community First Choice (CFC), which would allow SDS to draw down an additional 6% federal match for chore services.
2. Deb said that a new regulatory package will need to be developed to authorize this transition. She added that as part of the regulatory package development there will be a public comment period.
3. Deb said that SDS is planning on passively enrolling individuals who currently receive chore through an HCBS waiver into CFC to prevent service disruptions.
    i. Deb said that SDS learned from the initial rollout of CFC that care coordinators should also be notified of this change for their participants.
    ii. Rodney George said that similar to the initial CFC transition, SDS will send an opt-out letter so individuals can select not to enroll in CFC.
        a. If individuals not already on CFC do not opt out of CFC, they will automatically transition to CFC.
4. Denise Shelton asked how quickly the shift of chore to CFC would occur.
    i. Caroline Hogan said that the regulations package will not be finalized for approximately six months.
    ii. Rebecca Marinelli said that it will be important for SDS to update care coordinators on the timeline throughout the process to make sure they provide accurate communication to the participants and associations.
        a. Caroline Hogan said that she would like to work with Denise Shelton and Rebecca Marinelli to develop the steps necessary for effective messaging of this transition.
5. Cheri Herman said that SDS does not anticipate certification changes for chore providers as a result of this transition.

III. Other Services that Could Transition to CFC in the Future

1. Deb Etheridge reminded the group that a major benefit of including services under CFC rather than the waiver is the 6% federal match.
2. Deb explained that there are two new eligibility groups in addition to nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF-IID) who would be entitled to CFC services. These new groups are individuals over 65 who require institutionalization for mental disease (IMD) and individuals under 21 who require residential psychiatric treatment facility (RPTF).
3. Deb said that services under CFC become State Plan services, which means they are an entitlement. Because of this entitlement, one major concern is the unknown number of individuals in these new groups who will enroll in CFC.
    i. Steve Lutzky said that SDS will need to consider whether the additional 6% match will result in a cost savings after deducting the additional costs associated with making these services available to a broader group of individuals under CFC.
    ii. Jetta Whittaker said that there are no data available for the IMD and RPTF populations to model the impact of these populations.
4. Denise Shelton said that she has a concern around the capacity for care coordinators to manage a complex transition if similar challenges from the initial rollout arise.
    i. Deb said that SDS has actively sought feedback on the initial rollout and will use it to mitigate challenges during future changes to CFC.
5. Deb Etheridge clarified that there cannot be a waiting list for CFC.
6. Ric Nelson asked what would happen to individuals who are on a waiver and do not meet eligibility for CFC.
    i. Deb Etheridge explained that everyone enrolled in a waiver has met a level of care (LOC) and would be eligible for CFC.
7. Deb Etheridge said that SDS is considering adding a new service, transition services, under CFC. The intent of this service is to support individuals transitioning to the community.
    i. Denise Shelton said that there is a grant that provides this function.
        a. Deb said that SDS is aware of the grant, however there may be even more flexibility under CFC because federal requirements allow transition services to be in place even approximately 60 days prior to the transition.
        b. Rebecca Marinelli said that this would be a major benefit because the grant does not offer the option to receive case management while still in the institution.
    ii. Deb said that SDS has flexibility in the type of services offered within the transition package.

8. Deb Etheridge asked what the group would like to see included within the transition service package and how it could be structured.
    i. Denise Shelton said that to avoid frustrations for participants and care coordinators SDS should set clear guidelines on what is allowable under the service.
        a. Deb Etheridge said that other states have structured their programs with a "no more than" budget constraint and SDS will look at developing the guidelines as the service progresses.
    ii. Rebecca Marinelli said that right now it takes months for people to transition to the community so the service would need to ensure the funds are available well in advance of the transition.
    iii. Amanda Faulkner said that the service needs to incentivize providers to accept individuals being discharged from an institution because it is a major barrier in the current system.
    iv. Steve Lutzky said that there are two current efforts that are building infrastructure that could be adapted or used as a model for this program:
        a. The SILC's enabling technology grant provides a model for tracking budgets.
            1. Steve explained that the SILC has received a grant through the Trust and Mat-Su Health Foundation to offer individuals enabling technology and home modification. He said that each participant may spend up to $10,000 for assessment, training, installation, and other fees.
        b. Dynamic budget and support tracking through Alzheimer's Resources Alaska's (ARA) caregiver grant.
    v. Kelda Barstad said that it makes sense for case management to be authorized during the transition period.
    vi. Deb Etheridge said that it sounds like there should be transition specialists who are knowledgeable about transition options.
    vii. Denise Shelton asked whether people enrolled in the waiver or CFC would be automatically able to receive transition services if they are admitted to a hospital and require additional supports to transition home rather than requiring an amended Support Plan.
        a. Deb Etheridge said that the draft idea would have services start before a participant transitions home. She said SDS will need to have additional discussions on the circumstances in which it would be authorized.

viii. Amanda Faulkner asked whether providers or care coordinators would bill for the transition support.
    a. Cheri Herman said that there is a lot of work to do to determine if a new provider type is needed, impacts on enrollment, certification, and billing, and how billing would be structured.
    b. Amanda said that it may be a challenge for providers and care coordinators to have capacity to handle all the coordination and responsibilities.
ix. Denise said that the transition function should exist within nursing facilities and hospitals rather than asked of care coordinators because it is such a specialized scope of work.
    a. Corina Castillo-Shepard said that asking this of care coordinators without providing additional funding may be a major barrier for this service.
x. **Next Steps:** SDS will provide a draft list of potential transition services to the next ICC meeting.

9. Deb Etheridge asked if other services should be considered for CFC in the future.
    i. Steve Lutzky suggested environmental modifications.
    ii. Steve also suggested that services from the State Plan could be transitioned into CFC.
        a. Deb said that this would be similar State Plan PCA and CFC-PCS.
    iii. Denise Shelton said that she thinks respite would make sense to add to CFC.
        a. Amanda Faulkner said that respite is billed at such a low rate that there may be challenges with getting providers to serve the RPTF population.
    iv. Ric Nelson asked whether there would still be a limit on the hours for respite if it were transitioned to CFC.
        a. Deb Etheridge said that the limit would remain.
        b. Deb said that one option is to offer basic respite under CFC and enhanced respite under the waiver. However, this would be administratively burdensome for SDS and they would lose out on the match for the non-CFC respite.
    v. Ric Nelson suggested looking at day habilitation under CFC.
        a. Maureen Harwood said that there may be a large number of children on the DD waiting list who would then have access to day habilitation, which may present issues with the budget.
    vi. Rebecca Marinelli suggested including adult day services.
        a. Deb Etheridge said that this could be an alternative for individuals using day habilitation.

b. Denise Shelton said that she supports this idea because there are many people who want to maintain their functioning and may not be appropriate for day habilitation. She said that adult day may be a less expensive but appropriate option.

vii. Ric Nelson said that a new service, companion, could be offered under CFC.

viii. Kara Thrasher-Livingston suggested having a family caregiving option.

ix. Kim Champney suggested remote monitoring and assistive technology.

a. Deb Etheridge said that SDS is actively monitoring lessons learned from the enabling technology grant to determine whether it would be a good fit.

10. Steve Lutzky said SDS would likely want to have CFC services count against the ISW cost cap. He said that if this did not occur, overall costs for those participants could increase substantially.
11. Amanda Faulkner asked if there is an annual cap for CFC fiscal or enrollment.
    i. Deb Etheridge said there is no enrollment cap for CFC. She added that SDS would need to look into what a service cap may look like to ensure all appropriate individuals would be able to access the services.
12. Amanda Faulkner said that she would like CFC to continue to encourage more settings to offer full community inclusion rather than target specific populations.

IV. Shared Services Proposal

1. Deb provided an overview of the discussion document, which can be found at: https://drive.google.com/file/d/14yjOF7w6K8mAHrJvcX6BFzMbWeiw07JW/view?usp=sharing
2. Deb explained that several advocacy groups and providers have requested that SDS explore allowing participants to share staff time for services.
    1. Deb Etheridge added that another catalyst for this change was providers who want to be able to more effectively use staff's time and participants who want to reduce the number of people in their homes.
2. Deb said that the SDS has been working with Health Care Services (HCS) and the Office of Rate Review (ORR) to develop a plan for shared services.
3. Ric Nelson said that his concern is that providers will take this proposal as an opportunity to reduce or eliminate 1:1 services so they can earn more. He added that it may also incentivize participants to meet specific conditions, such as having roommates enrolled in the same service, for the participant to be served.
    i. Denise Shelton said that this change may allow providers, many of whom do not have adequate direct service providers (DSPs), to serve more individuals with their workforce rather than making a push to earn more.

   ii. Amanda Faulkner said that providers support reducing barriers to receiving shared services when it benefits the individuals. However, she said that the service would need to be structured so that it is not solely used as a cost saving strategy.
   iii. Amanda added that providers would likely be supportive of this change if the service is clearly defined. She gave the examples of SDS needing to define "live close to" and ensuring that participants are choosing to share services.
4. Rebecca Marinelli said that it could be even more difficult to get necessary 1:1 services approved because she believed there has been an increase in cost containment efforts from SDS.
5. Kim Champney said that there should be flexibility in the group settings to accommodate tasks for which 1:3 is sufficient and other tasks which require 1:1 under the same service period.
6. Kelda Barstad said that supported living will be offered under Behavioral Health's 1115 waiver for both children and adults. She said that if this service was added to CFC the other "unknown" is the participants who would be served under the 1115 rather than CFC.
7. Deb Etheridge said that SDS, HCS, and ORR will continue to meet and coordinate on topics including regulations packages, rates, MMIS, and certification. SDS will also be looking to involve an external stakeholder group.
8. Denise Shelton asked that the conditions of participation (COPs) be updated to describe the roles and responsibilities of care coordinators and providers for shared services.
   i. Amanda Faulkner said that providers would appreciate this update as well. She suggested having care coordinators develop goals and agency providers documenting the methodology.
      a. Ric Nelson said that he does not want the agency to develop the goals because the agency does not know the client as well as the care coordinator. He said that his preference is to have the care coordinator complete the goals and then the provider can look them over, ask questions, and implement.
   ii. Deb Etheridge said that the COPs are under the umbrella of the regulatory package, so if regulations need to be updated then SDS may be able to update the COPs as well.
9. Deb Etheridge said that SDS will evaluate whether this service will be appropriate for electronic visit verification (EVV). She explained that EVV will be required for PCS, home health, and other similar services that are provided in home.

V. Next Steps, Other ICC Topics, and Questions

1. Denise Shelton asked for more information about EVV.
    i. Deb said that EVV is required through 21st Century Cures Act. The verification may occur via an app on a smartphone or another method for verifying staff are in the participant's home to provide services.
    ii. Caroline Hogan said that there are six elements that must be captured for each EVV check-in: service performed, name of the individual receiving the service, date of service, location, individual providing the service, and the time the service begins and ends.
    iii. Deb said that the State received an extension for implementing EVV to January 1, 2021 because the State did not have a capitol budget this year.
    iv. Deb said that the State opted for an open system model where providers can use their own method to get the information to an aggregate site.
        a. Deb added that there will also be a State system for providers who cannot afford or do not want to develop their own methodology.
    v. Deb said that SDS has two dedicated staff working on EVV who will develop communication plan and work with the public communication office.
    vi. Ric Nelson asked whether a participant receiving multiple services would require the single staff providing all the services to clock in and out between each type of service. He said that this seems to be very burdensome for staff and takes time away from individual receiving services.
        a. Deb Etheridge said that PCA would roll out first and then SDS will see how the process should be updated moving forward.
    vii. Deb Etheridge said that other states have seen improved delivery for services because there was increased accountability for DSPs through EVV.
    viii. Amanda Faulkner asked whether DSPs need NPI numbers for EVV.
        a. Caroline Hogan said that she does not believe so but SDS will need to talk to HCS to confirm this.
2. Ric Nelson said that many people need to travel for work or work from home and travel intermittently. He said that people who receive supported employment are not allowed to travel for work. He said that if people with disabilities are to take on better jobs and move up in companies, this needs to change. Ric acknowledged that it takes time to change regulations, however there are people being denied jobs because they have to stay in their home community for employment.
    i. Deb Etheridge said that this is on SDS' radar and it will be added to the agenda for the next ICC meeting so there can be a discussion about what can and cannot be changed.

VI. Medical Care Advisory Committee (MCAC) Transition

1. Deb Etheridge explained that during the past ICC meetings there has been discussion about the ICC joining MCAC as a subcommittee. She said that Renee Gayhart is the lead for MCAC and is providing information on the structure and vision for the ICC under MCAC.
2. Renee Gayhart provided an overview of the MCAC.
    i. She explained that it is statutorily required and the primary purpose is for members to provide feedback to the commissioner on improving the Medicaid program.
    ii. A primary goal of the MCAC is to have association representation across the entire service spectrum to address budget cuts and identify priorities.
    iii. She said that the board reviews and signs off on the monitoring plan, which is required for any state plan amendments.
    iv. Renee said that MCAC meets quarterly and one of these meetings occurs in-person.
        a. Renee added that all MCAC meetings were in-person to capture public comment from around the state, however travel dollars are no longer available.
        b. Renee said that the in-person meeting is usually held prior to legislative session to review updates from each represented association.
    v. Renee said that the MCAC has up to twelve voting members, but also has subcommittees that may include additional individuals.
        a. Subcommittee members may hold up to three three-year terms.
        b. Voting members represent pharmacy, medical home equipment, behavioral health, nurses, licensed physicians, hospital administrators, dentists, private non-recipients, and non-profits.
    vi. Renee said that the MCAC is trying to create more subcommittees to focus on specific topics. She said that most recent subcommittee focused on evaluating which dental services were provided most often and which may be over utilized.
    vii. Renee said that the next MCAC meeting will be on December 12 and 13 in Juneau. Public notice for this meeting has already been sent out.
3. Deb said that SDS' vision is to have a champion from MCAC's voting members as part of the ICC subcommittee.
4. Ric Nelson said that it sounds like the MCAC is comprised of doctors and providers that deal primarily with medical issues. He said that they may not understand the social services aspect and he is concerned that having the ICC join MCAC may distract from the intent of the ICC. He would like to work with the board to ensure that the ICC is dealing with social services for MCAC.
    i. Deb said that representing social services if one of the reasons SDS would like to make the connection between MCAC and the ICC. She said that the sub-group would be able to have the voice directly to the commissioner without filtering through SDS.

VII. Public Comment

1. Dean Paul said that there are currently tremendous challenges finding DSPs. He said that he does not want to see changes that would make it more difficult to find and enroll DSPs.
   ii. He said he has had tremendous challenges finding DSPs for his aging parents and does not want to be forced to place them in a nursing facility solely because of a lack of DSPs.
   iii. Deb Etheridge said that these comments would be important for the MCAC to hear so they can be communicated across associations and up to the commissioner.