Master Plan for Aging
Long-Term Services and Supports Subcommittee
Meeting Transcript

STATE OF CA – DEPT OF AGING: Master Plan for Aging Meeting

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SPEAKERS

Ellen Goodwin

Kim McCoy Wade

Mari Cantwell

Kristina Bas-Hamilton

Sarah Steenhausen

Brandi Wolf

Maya Altman

Lydia Missaelides

Craig Cornett

Marty Omoto

Jeff Thom

Ana Acton

Donna Benton

Nina Weiler-Harwell

Karen Keesler

Patty Berg

Peter Hansel

Denise Likar

Ellen Schmeding

Claire Ramsey

Dr. Jose Arevalo

Irene Walela

Victoria Jump

Kathy Kelly

Jedd Hampton

Anastasia Dodson

PRESENTATION

Moderator — Ladies and gentlemen, thank you for standing by. Welcome to the Master Plan for Aging Meeting. At this time, all participants are in a listen-only mode. Later we will conduct a question and answer session. Instructions will be given at that time. [Operator instructions].

Now, I'd like to turn the call over to Ellen Goodwin. Please go ahead.

Ellen — Okay, thank you very much, operator. Welcome to our LTSS Subcommittee meeting. I'm just going to go over a few quick meeting logistics before we hand it over to Kim. The meeting materials are all posted online if you need additional copies or someone else does.

Today, people can call in. We'll have a public comment section at the end of the meeting. We also have now two online Survey Monkey vehicles so that people

can give us more input, and for today, if you have to go to the restroom, if you go out in the hall, there's a big Christmas tree. It's just to the left, kind of in the back of the Christmas tree.

Be sure to take, there are some—there are little teddy bears and things, and they're attached to cards. That will get you back in through the door. You don't need it for the bathroom, but it will get you through the doors to get back in here once we've closed that door.

So, I think that's it.

Kim Welcome. We have a very full day for this, our Master Plan for Aging Stakeholder Subcommittee on Long-Term Services and Supports. As you know, we are doing—what's the right word? A sprint through the universe of LTSS in November and December and January to be sure that we have covered it all, at least opened the conversation in time for the report coming from stakeholders to the administration in March per the executive order.

I do want to commend all of you. We've just posted, as of yesterday, the progress report kind of summarizing where we are after a few months of work. We hope you received it in email or it's on our web page, but just to kind of again remind us where we are in this complex and exciting world.

Let me talk about what we're going to do today, and then I'm going to get out of the way so we can start doing it. We are going to, per the agenda slide, review the emerging LTSS recommendations. We are going to, today's topic is Home and Community-Based Services but not IHSS. IHSS will be the 17th. Is that right? Off the top of my head. That's next.

So, we're going to break the HCBS conversation into three pieces starting with we're so happy that our colleagues from the Department of Healthcare Services are here to talk about Medicaid-funded HCBS, and particularly in the context of everyone's favorite acronym, CalAIM, California Advancing and Innovating Medi-Cal, other state HCBS from my colleagues, the California Department of Aging, and of course, private pay.

Then, we want to go back to the goals and objectives, the framework that's driving our work. Of course, have public comment, and then finish every meeting as we do by trying to summarize the recommendations that have come out so that members of the group can do the work to develop those further.

Again, a reminder where we are. We are at our third deep-dive topic focus. Next will be IHSS, and then we'll take a break for the holiday. We will come back and do a workforce family caregivers and technology conversation, a group living conversations, financing and integration, and then we will take a minute in

January to sum it up and plan that report, write it in February, submit it in March.

Of course, going through the Stakeholder Advisory Committee process as well, and then we will be able to return to the other deliverables in April, May, and June to inform the overall state master plan.

With that, summarizing the recommendations from the previous meeting, who do we have teed up to do this?

[Speaker off mic].

Kim Jose, on the line, please mute your own phone. Okay, so change of sequencing, sorry. We are not going to start with reviewing last recommendations. We are going to do that at the end. Sarah Steenhausen, you're up at the end of the agenda to do that. So, let's go ahead and dive right in.

Again, I am going to briefly, briefly, briefly set the table. We want to always start with person-centered and data-driven, and the person we have here, thank you very much to Age On Rage On, leading age campaign is Francis, and I don't want to read out loud to everyone, but I do want to lift up. Here is a 96-

year-old Californian living at home benefiting from a senior center were she can volunteer and give back and says, “I have no doubt it helps keep me healthy.”

Also has taxi vouchers to travel to the senior center among other and has exercise opportunities and nutrition and healthy meals opportunities. So, lots of home and community-based services being provided in a couple different ways to Francis. Thank you, Age On Rage On.

Next slide, again, just making clear the enormous need for LTSS, both the number of people, the growth in the number of people, the growth in longevity, the growth in chronic conditions, and all of that adding up to enormous human need for these support services to remain living in homes of choice and helping families to continue to thrive.

A couple of key data points we wanted to do to just set the table, and then we will dive in. Next slide. Again, reminding all of us while today we’re going to focus a lot on the public paid programs, we wanted to really look at those three colors, if you can.

See, I’m going to call it purple, Medicaid is, of course, a big chunk of change, and that’s why we’re starting with our friends. Medicare, as you know, also is

increasing paying for LTSS, and then of course, the out-of-pocket piece. So, we want to try to touch on all of that today.

Then, the next slide, this is everyone's favorite slide. We couldn't have this conversation without this slide. I hope Patty Berg is on the phone, LTSS member, and author of this report.

This is the famous or infamous periodic table of California's Long-Term Services and Supports. We even brought it to the room, blew it up. It's a few years out of date, but it highlights that there are many LTSS, and they are in many different departments. I am thrilled to be running the yellow, the Department of Aging, which has lots of letters, but you can also see that the Department of Healthcare Services in the blue, Public Health in the green, even DMV has long-term supports and services.

So, part of this is to show the fragmenting issue that is not new to anyone here that we know services and supports are fragmented which presents challenges for program administration and more importantly, program delivery, and most importantly program access and care coordination. So, we have this posted in our office, and if you don't, I encourage you to.

W Is there a glossary?

Kim It's so funny. There is a glossary. There is a key. This is from the report. It's called "A Shattered System," and we can certainly send that around. We also did a little exercise this summer to update it with the big six departments on here because some of those programs no longer exist and some are new. There's a few news ones, but yes, there is a glossary.

I should just pause. Anyone want to comment who was around, who worked on this report, "A Shattered System?" Patty, give her a chance to weigh in from afar. Lydia.

Lydia I will just make one observation. It's Lydia with the Alliance Leadership. Several programs [speaker off mic]. Maybe that's what that asterisk is, I'm not sure.

Kim Yes, the double—yes. The asterisk means no longer receive general fund support.

Lydia Okay, thank you.

Kim It's very small print, yes. Senior Brown Bag on there, for example.

Lydia [Speaker off mic].

Kim So, asterisk means not currently funded. Then, I just met with a group who let me know about, for example, the Holocaust funding that CDSS administers for elders who survived the Holocaust, and I think that's new, so that's not here. It's out of date, but I think the overall picture of many, and of course, it doesn't have the number of dollars, the number of people, but it shows the variety and the fragmentation.

Okay, so with just those kind of key points about the need, about the funding, and about the fragmentation, we—anything else, Carrie, to kick us off?

Carrie [Speaker off mic].

Kim Alright. Pardon me.

[Speaker off mic].

Kim Yes, so just hand it over. Let's get to it.

[Speaker off mic].

Kim — Let's do it. Ahead of time. We are going to move into Medical and CalAIM, and we're so happy that Mari Cantwell is here. We're just really honored and privileged to have this partnership and expertise, so without further ado—should we do introductions? We probably should anyway as a matter of good meeting housekeeping, and also particularly for our guests.

I am Kim McCoy Wade from the Department of Aging.

Mari — Mari Cantwell [speaker off mic].

[Speakers off mic].

Kristina — Kristina Bas-Hamilton with UDW.

Sarah — Sarah Steenhausen, the SCAN Foundation.

Brandi — Brandi Wolf with SEIU.

Maya	Maya Altman, Health Plan of San Mateo.
Lydia	Lydia Missaelides, Alliance for Leadership and Education.
Craig	Craig Cornett from the California Association of Health Facilities.
Marty	Marty Omoto, family member, California Disability Senior Community Action Network, CDCAN.
Jeff	Jeff Thom, California Council of the Blind.
Ana	Ana Acton, FREED and the ADRC of Nevada County.
Kim	Stakeholder members on the phone, unmuted, can they identify themselves?
Donna	Good afternoon. Donna Benton, California Association of Caregiver Resource Centers, and USC.

Nina Good afternoon. Nina Weiler-Harwell AARP California. I apologize for the background noise. I also have trouble hearing some of the folks around the table like Lydia, FYI.

Kim Yes, we're realizing the microphone has to be passed, so we will do that going forward. Thank you for letting us know.

Okay. Now, without further ago, let's go to part one, Medi-Cal-funded programs, and kick off with Mari Cantwell from DHCS.

Mari Thank you so much, and thanks for having me. It's getting close to being one of my last public meetings since I am leaving at the end of January, so I'm happy I could do this before I go, particularly the CalAIM piece because it is something I've worked on with the team, particularly Jacey Cooper, who I know you all know very well, and Sarah Brooks and others.

We were very excited to release that proposal and excited to continue to work on that and know there are people in this room or on the phone who are participating in those workgroups and really looking forward to makings sure we're considering all of that input as we work to go through this workgroup process, and then obviously finalize the proposals next year after budget and legislative and all of that kind of stuff.

Certainly, there are linkages, and our department really working closely with the Department of Aging to make sure how what we're talking about in the Medi-Cal and CalAIM world really align with and make sure we're not sort of overlapping or doing anything that is not consistent with what the Master Plan for Aging is looking to do. Obviously, CalAIM is a much larger thing, but certainly there are aspects of it that impact long-term services and supports.

So, we knew, all of you guys probably know more about our home and community-based programs than I do, so we aren't going to do a high-level summary of all the programs, but just as a reminder, obviously we do have our very specific waivers that operate under Evelyn Schaeffer's division, the Home and Community-Based Alternatives and the Assisted Living waiver, those are continuing for now, and I'll share with you sort of my longer-term vision.

Obviously, my vision doesn't really matter, but it's a vision of I think the team in general about those things. I know you're going to hear from our partners about MSSP and PACE, etc., so obviously I don't need to go into those.

So, I really wanted to focus on sort of the historical Coordinated Care Initiative and Cal MediConnect really being a multiyear effort that we entered into to really look at how we integrate with managed care, sort of the full scope of

services to the degree possible. Obviously, IHSS still remains separate, and I know you all are having that separate conversation.

Really, the goal of that and really as we then get into the CalAIM is really about how we make sure there are, as was demonstrated by the periodic table, and this is true throughout Medi-Cal's programs as well, a lot of fragmentation. So, you have people accessing multiple delivery systems, and so we really looked at the Cal MediConnect and Coordinated Care Initiative as an initial step towards really looking at if you do more integration, you provide the health plans both the capability and the requirement to really get into these areas so we can see some improvement.

Certainly we have seen successes with Cal MediConnect and the Coordinate Care Initiative. Obviously, I think not as much as we would have liked to, so we have reassessed where we are at with that, and really as you'll see in the CalAIM proposal, really trying to transition from that to a statewide view of how we want to deal with Medi-Cal as a whole, and in particular, these particular services and populations that I know are of particular interest to you all.

So, if you're not familiar with the CalAIM proposal, it really does have three primary goals looking at how you deal with member risk and really also address those social determinants of health and really talk about someone's health, and not just healthcare. So, how we really handle all those linkages and find a way

to better integrate them and have someone really have a better way to navigate those systems and not have to rely on themselves or five different care managers or whatever it is that is happening today.

That really moves into this idea that we want to make Medi-Cal more consistent and seamless, so a big part of our Medi-Cal program obviously is our managed care program today. We do have six different models, and so we have different populations and different services depending on which county you live in, and that's confusing for us who operate the program. So, you know, obviously it's confusing for our beneficiaries who are needing to navigate that who may be moving from one county to another and then discover that certain services or things are from a different delivery system and really having to relearn that.

So, you'll see a big push for standardization across our Medi-Cal Managed Care program statewide in order to sort of get away from some of that complexity. The program is still complex. It will always be, but having those initial steps to it.

Then, the final thing really being focused on outcomes and changing the delivery system to better serve the beneficiaries and to really look at payment reform as a way to drive change, not just at the plan level but plan to provider within our behavioral health system and all of that.

So, those are sort of the overarching CalAIM goals. I will say, I don't know that all of you have heard my spiel on where this all came from, really work we've been doing all the time, but over the last two years, really a fundamental relook at the Medi-Cal program. Some folks participated in our Care Coordination Stakeholder process last year. I think we just finished it about a year ago last year where really I asked the question. If we just were creating the Medi-Cal program today, what would it look like?

I think we all agree it would not look like the way that it is, the way that it's structured. The way that it's financed is very complicated. It's had those layers happen for very good reasons. I made some of those things happen, so I totally get that, but we wanted to try to just take that step back where we could all say what we would ideally want. Is there a way we can, over a course of many years, get to more of what we think the ideal structure should be?

So, I always talk about it as a 5, 10, 15-year vision, so some of that is already in the CalAIM proposal. I think we have things going out through 7 years which is a lot of long-term planning for us and unusual, but there's

more than that, too, that what we're trying to get to, and I would say the overarching thing that I was looking for and hoping for is that eventually people could just get the services that they need and not have to quality for different programs, different waivers.

Again, some of you have heard me say this, but you have purple stripes to get in this program, and then you have yellow polka dots to get in this one, and so really I think the long-term vision of really looking at even our home and community-based waivers and how we make that better or easier to have those services happen. Again, once they're in Medi-Cal, should they have to then also qualify to be in another program, or if those are their needs, how do we just serve them?

So, that's sort of the long-term vision. Again, no specific changes planned in the CalAIM timeframe right now to those waivers other than the ongoing work that Evelyn and her team are doing to improve those and obviously, some of the thought expansion and things that we're doing under those programs.

So, as I mentioned, really we're transitioning on the managed care side way from the Coordinated Care Initiative and Cal MediConnect to really looking at is there a way to do managed long-term services and supports long term within managed care.

The initial steps of that are certainly significant for the populations affected, but there's not real changes to the services themselves. What we are doing is carving in institutional long-term care into managed care. It already exists probably as a managed care benefit in more than 50% of the state when you

think about the Coordinated Care Initiative and the COs, so it's not like we're at 0 and we're going to 100. We're probably 50, 60, and going to 100.

With that also looking at the once the Cal MediConnect program, the existing contract expires, then looking at just on the Medi-Cal side of the population, so not affecting the Medicare side just to be clear because I think there has been some confusion about that.

On the Medi-Cal side, having all dual-eligibles be mandatorily enrolled. Again on the Medi-Cal side, and again this is very consistent with what's already happening in the COs and the Coordinated Care Initiative counties. We are not specifically having requirements on enrollment on the Medicare side.

What we will be looking to do is required our health plans to have these SNPs [ph] that are offered to our dual-eligible beneficiaries so that if that makes the most sense, and hopefully with the Cal MediConnect transition, those folks would continue to see the benefits of that, that if someone was in that D-SNP rate, they would then have that ability to have that coordination between their Medi-Cal said and the Medicare side.

That is a few years out still post the transition of Cal MediConnect, and so something that we're continuing to work with, with our plans, and I think

hearing feedback, particularly from those who have never operated Medicare plans that maybe that timeline needs to be longer and just really thinking about that, but we are super focused on the Cal MediConnect and Coordinated Care Initiative counties on having it be a stat up and running when that transition occurs.

I think a lot of the—they might not sound as direct like home and community-based services or fit the normal rubric of that, but two additional components of CalAIM that I think are really critical to this population, the proposal to have a new statewide enhanced care management benefit.

This really is community-based, face-to-face, sort of really getting into this idea that this population, really the top 1% of 2% of population in terms of cost and need, really needs much more in terms of someone being there helping them understand the services that they need, how to access those services, and really be that single care coordinator instead of having one in the health plan and one with their home and community-based services and one with behavioral health or maybe two because they maybe have mental health and substance use, and really trying to have the plan have this obligation to work with community providers.

They could be community-based organizations, the public health nurses. There's lots of people out there. There are home health providers. We have

our whole-person care pilots where a lot of these enhanced care management ideas came from.

So, really looking for that really intensive enhanced care management that we would be providing as a statewide basis, and currently through the workgroups, really identifying who are the mandatory populations that the plans would have to offer this to, and what would be some optional populations as well that might benefit from that. Of course, ongoing evaluation of if there are different populations that we need to be assessing and adding as the years go on.

The second big piece, and we all hate the name, but there's not a better name, is in lieu of services. So, it actually makes a lot of sense once you understand it, but hearing it first, I'm sure sometimes people are like I don't know what that means.

So, the concept with in lieu of services really came from a variety of things. A lot with our whole-person care pilots, and then also just looking at what some of our health plans have been doing, sort of outside of the rate setting and stuff that we do with them which really is offering these services that are not really healthcare services. They're really about the wrap-around or helping someone's overall health improve.

So, we wanted to continue that success of whole-person care for certainly those things that we have been seeing and try to continue to encourage the building of the infrastructure of these types of services so that after this next five-year period, if there are things where we say okay, there's enough infrastructure, it makes sense to do this, it is actually long-term bending the cost curve resulting in better health for the population, add those potentially as actual benefits at the end of this five-year period.

Those types of services we're talking about, a lot of housing navigation and supportive services, recuperative care, respite care, a key focus, and we're really hoping a lot of plans will choose to do this really relates to the transitions out of institutions, whether nursing facilities, it could be residential, mental health facilities, or others so that people can get back into the community and have the services and supports that they need to stay in their community.

I think all of us share the goal that we want people to stay in their home or in their community organization way more than we want them to be in an institution. We want institutions to be for people who actually need that level of care and not just because they don't have a home to go to, or we aren't being able to provide those services in their home or community.

We do have an in lieu of services proposal that would add onto IHSS to add additional personal care services if that is something that makes sense. Still

thinking through how that might work. Certainly not replacing IHSS or taking anything away from that, but if there's additional services that people might benefit from that we could fit through that, I think we're interested in that as well as medically-tailored meals is another element of our in lieu of services proposal, which again, gets at your health is so much impacted by what you eat, and for people particularly—I mean, for all of us, but for people particularly with certain diseases, it's even more important.

So, how do we do all of these types of things that keep people out of the hospital, keep them out of the emergency room? So, the in lieu of services packages would be things that are voluntary on the part of the plan and on the part of the beneficiary.

Part of all of that is we are looking at, and again, all of this would be subject to budget and all of those types of things, as those of you have been in any of our workgroups have heard me say, but looking at how we incentivize our health plans to offer these voluntary services.

That really is looking at incentive dollars to help fund infrastructure or other things that need to occur as well as we're actually doing—we'll be changing the way we set our health plan rates by actually allowing the cost of these services to flow into the rates so that there's not a disincentive to provide them and

then have inpatient services go down, and then their rates go down, but we're not accounting for the cost of those other services.

So, those are some big changes we're doing to try and get the services up and running and then how we continue to pay for them and incentivize that behavior including looking at potentially some shared savings options with our health plans that, again, would continue to allow that ongoing investment at the plan level to provide these services.

I know—I think I've talked for about as long as I was allowed to, so really exciting things going on. We definitely want to be hearing from stakeholders. I know we have our stakeholder workgroups. I also know we had 150 to 200 applicants for each workgroup, so I know lots of people didn't get selected for them. They're still open to the public, so definitely invite your participation there.

We do have on our website other meetings where these topics might be being discussed in public. Like this meeting was on that matrix, so encourage you to look at that. Then, also to be providing us any comments in writing. We welcome that on an ongoing basis as we go through the workgroups and as we work to finalize. So, there's going to be lots more opportunity to talk about these ideas and flesh them out and figure out where we missed the mark, or are there changes or other things we need to be thinking about.

So, just definitely encourage your ongoing participation, and really thank you, guys. I know everyone in this room is really committed to this population and the services that Medi-Cal provides. You have a lot of good insight that I know we would benefit from, so definitely look forward to—at least the team looks forward to continuing to get your input as we move forward through this process.

Kim

Great. Thank you for, again, a whirlwind of a very deep and wide and complex conversation. We are doing great on time, so we'd like to open it up for committee member question conversation, and usual, if you would like to talk, it helps us if you do exactly what Karen Keesler is doing putting her name up. Look at Karen, and if you are on the phone, we'll ask the operator for assistance.

So, Karen, question for Mari.

Karen

First, I want to say, Mari, when I heard that you were leaving the department, I thought there's very few people that really create a vacuum and have shoes that are left behind that almost are impossible to fill, so I've had a lot of doubt about whether it's really possible for all of this to be accomplished without you. You've been tremendous in this state.

[Speaker off mic].

Karen That was my goal. [Overlapping voices] to reconsider your career choice.

My question is dealing with the enhanced—whatever they're called. There's that appendix D and the enhanced care options, or whatever the acronym du jour is.

So, I'm wondering on some of those things like personal care assistance, transitional assistance, there's a number of siloed programs that address some of those objectives, and in particular for IHSS, it looks to me like it's kind of a carve-out and not something that would be part of a mandatory managed care, but that managed care organizations could, as they have been able to do in Cal MediConnect, initially be able to purchase services above what a county social worker is assessing as necessary. Do I have that basically correct?

Mari Yes. So, the idea would be above and beyond what IHSS provides. This is in the in lieu of package structure which I said is voluntary for plans as we don't have the statewide infrastructure or funding to necessarily have it as a benefit now.

The one difference is that we did not pay the Cal MediConnect if they did choose to do those services, and then what we are proposing to do now is that

we would count the cost of those. It provides that additional incentive, and then as I said, the shared savings and incentive payments. Change the calculus about whether a plan might choose to do that. Does that make sense?

Donna Hi. This is Donna.

Kim Donna, go ahead.

Donna Oh, okay. Thanks. I was just wondering, just to be clear. The plan would be reimbursed if they chose to do the in lieu of services.

Mari The easiest way to say this is to just say correct. It's a little more complicated from a rate setting perspective, but yes, the idea is that there would be funding for these services that is different from how the rate setting and things work today.

Donna Okay. There will be a cap on how much that funding is statewide, I would imagine.

Mari So, there will be—I'm trying to—we're getting into some complicated rate setting.

Donna Sorry.

Mari No, that's okay. So, there will be dollar amounts for like the incentive payments that I talked about that would be the initial funding for some of those. Other than the limitations that exist in terms of—or, what will exist, whatever we land on in t he final package of these are the potentially eligible populations, etc., there won't be a specific dollar amount cap.

The issue from a plan perspective and what we have to assess from a state to the federal government perspective is are these services ultimately costing less than the inpatients stay at the ER or the SNPs that would otherwise happen because that's what we have to demonstrate.

So, the long term is actually not costing money because it's just replacing other costs that we have, but that's why we want to do some of the incentive arrangements and stuff at the beginning in order to incentivize that initial over-the-hump development of these types of services so that then they can be ongoing.

Donna Perfect. Thank you so much.

Kim Maya.

Maya Thank you, Mari. You know that I've always been really interested in lieu of services so I was very excited to see the package was much broader than I expected. So, that's a lot of great thinking in there. Of course, we always are.

So, one thing I was going to ask you if you've thought about other things in that—what do you call it—periodic table? One thing that comes to mind is adult daycare, not adult day healthcare, but adult daycare, which is an important program for people with cognitive issues, and it'd be a really important component of trying to keep someone out of an institution.

I mean, you know, programs like that that could be other LTSS things that also are really important to sort of build an infrastructure for around the state, and that extra funding would really help those kind of programs develop, so I just want you to think—

Mari Yes, and that's helpful. That is certainly why we put this stuff out for a proposal. I think the one thing I would say is I think we do feel like the number of in lieu of packages we have we probably don't want more than that number just because of then limiting the ability to be consistent and have good measurement about what's working, but we're certainly open to hearing about oh, we actually think

this package of services or adding to this bundle this type of thing, that's absolutely what we want to hear.

So, happy to have those comments come in and helping us think about how they would fit in the rubric of what we're looking at.

Sarah I have a serious issue with the technology—okay there we go. Thank you so much for being here. It's always great to have the opportunity to ask you as many questions as we can. So, I have a lot, but I'll start with one. It's around the managed LTSS expansion because I hear what you're saying which is that in the state right now, about 50% of the counties have some form of managed LTSS. It's not the same as the managed LTSS in the CCI counties because right now that includes the MSSP, but my question is, has there been a consideration given to trying to evaluate how the current LTSS system has worked before committing to expansion?

So, that's the first question because beyond that question is a comment that with Cal MediConnect, we were able to learn so much about what worked, what wasn't working, where there were areas need for improvement based on the work that Carrie Graham [ph] led for the evaluation, and unfortunately we weren't able to have a similar evaluation like that for an MLTSS. Knowing that there probably are nine times the amount of people enrolled inn MLTSS than there are in the Cal MediConnect program, it seems pretty significant.

So, just as examples, we don't know how people are accessing care coordination. We don't know how plans are necessarily referring to CBAS or MSSP for the Medi-Cal only population. We don't know how it's working with the transition to the nursing home.

So, that's just one kind of point, and I can imagine that the state's probably thinking it costs money to do evaluations, but I just wanted to flag that.

Then, second to that is I remember with CCI when it was being implemented, it took some counties a lot longer to get up and running. Thinking about LA and how complicated that was, a lot of the delegation issues, and it ended up being that the plans didn't get up and running until they were ready, so perhaps a consideration can be for the MLTSS side is those counties can be phased in when they're ready and they show the demonstrated network because I think my understanding right now is it's phased in all at once. Is that right for 2021?

Mari So, yes. Long-term care is carved in in 2021, and then the dual-eligible population shift happens in 2023. Certainly, we would never do a transition without assuming a certain readiness, so the plan folks know we make sure they have the networks.

I think the challenge with the concept of phasing any of this stuff is that the consistency statewide and some of the rate changes and other things we're looking to do actually rely upon it not being different county-to-county, and I think that's some of the challenge.

Again, I think we view this as a pretty small step towards true MLTSS. It's really the carve-in of a benefit. Then, the idea is over the course of this five years to evaluate, again, these in lieu of services and other things that can make true MLTSS more of a reality, and looking at then how that interacts with some of our waivers and those things. Obviously, the other change is the carve-out of MSSP. It was only for real carved in in one county. It was financially carved in but not operationally carved in.

So, appreciate that and certainly continue to talk with us about sort of concerns or things that people have, I think, but bottom line for sure we would never go forward with something if a plan was not actually able to do it. That's our requirement to assure that to the federal government and to assure that to the beneficiaries who will be in there.

Nina Good afternoon. This is Nina, AARP again. Can you hear me?

Kim Yes, can you hang on one second? Let me make sure Sarah and Mari that question on evaluation—

Nina Oh, apologies.

Mari I mean, I don't know that I've specifically heard that question before, so I can certainly take that back and see what we have been doing, and maybe it's being able to share out stuff that maybe we haven't shared out, so let me take that back.

Kim Nina, hang on one second because Marty and Jeff in the room, and then we'll go to Nina. Is there anyone else on the phone who wants to be on the queue? Okay, that will do, and then I think we have to move on. Maya and Karen, you both have your cards up, but you're good? Okay, so we'll do Marty, Jeff, and Nina, and then we'll move on. Marty.

Marty Thank you. Marty Omoto, and I actually share Karen's and everyone's feelings about you, Mari. We'll miss you at the budget hearings.

Mari I will not miss being there. One thing I will definitely not miss.

Marty

A couple of things, and first of all, I really appreciate your presentation and even initially when this was first unveiled back in October. You're right about the in lieu title was kind of scary at first, but once you explain it, it's really potentially a great thing long with the enhanced care benefit. I mean, those potentially have a lot of good things that could really help our community assuming everything happens in the right way.

So, a question towards that is just, maybe you said this earlier and I wasn't paying attention, so sorry about that. When will these details start emerging in a public way? Like, obviously some of this might show up in the budget process, but will something emerge and they may revise and then beyond because it would nice if something starts happening.

Then, the other is I think, Karen, you were mentioning or somebody was mentioning the issue of additional type services within the in lieu of like homecare that might be on top of IHSS or other types of homecare services. I know this is still early in the process, and I'll be participating in terms of some of these subcommittees, but will there safeguards put into making sure that there's not a de-incentive?

I don't even know if there's such a word but to cannibalize the services that are currently provided in homecare whether it's regional center type services or IHSS so you don't have people then reducing hours because there's these

additional hours being placed? It's hard to watch over that, but that has been a problem or at least a concern among advocates.

Lastly, the incentivizing this is really, really good, and I just want to emphasize to the rest of the subcommittee that that's something we should look at that if that is making a difference that it changes behavior so that it produces an outcome, that is something we should be looking at as how we proceed forward on other things because we all talked about how you draw down more funding, but it has to be done in the right way.

Mari

The last one was more of a statement so I'm going to take the incentive funding is a good thing was a statement. So, in terms of the details, yes. We're obviously doing the workgroup process now to try to get input and flesh out some more of this information. I can never speak for what the governor may or may not include in his budget, especially one that is way after I'm gone, but I definitely think we assume through the budget process and through a legislative process that would happen next year that some of this would be more finalized.

We have specific timelines in terms of what we've committed to CMS in terms of proposals. Obviously, unlike prior waivers, like 1115 waiver stuff, this is not all one type of waiver, so it does have different timeframes, but we would be assuming that there would need to be both budgetary and legislative action to

be taken sort of in this coming year in order to have January 2021 even work. So, I would look through that process.

We are looking to sort of release a revised version of the package of things sort of in the June period, but that would be some of it would be post the budgetary stuff, so it's going to be a little bit iterative, I think, in terms of process and result.

On your second question, this has been an issue we're trying to think about, and we tried to frame some of the language we did put in. We were very specifically focused on not changing what someone's entitled to under IHSS and make sure that they're getting that before getting something else.

This is definitely an area we would appreciate input on in terms of how we really me sure because we were trying to think about, too, what about while someone's waiting to get assessed for IHSS, but we also don't want to delay that assessment or have there be some thing were someone never actually gets on IHSS because the plan is doing something—not because the plan is doing anything wrong, but maybe just the process gets mixed up. So, definitely would look forward to having comments specifically on that.

Our intention here is to be totally additive and to not take away from what's happening.

Marty [Speaker off mic].

Mari Yes, and that's where I think I probably don't have as much knowledge on that. So, I think helping us think that through about what things we need to know as a state, what the plans need to know before they offer this service to someone making sure they're doing the appropriate referrals to the other services that someone would first maybe be entitled do.

Marty [Speaker off mic].

Mari Great. We would really appreciate that.

Marty Thank you.

Jeff So, a comment and a question. This is Jeff Thom. First comment sort of follows along from part of what Marty said. Having been involved in a lot of discussions about advising health plans in terms of providing additional services, one of the real issues has always been the dearth of data on the cost effectiveness of

providing these services, so I hope that whatever is done in this area that the evaluations will really get at that cost effective issue because I think it can produce excellent data if it's done right.

The question is, is there going to be an openness to a broad array of services both in home and facility-based services that can be incentivized by health plans?

Mari Thank you. So, absolutely on the data side, that is 100% our intention. We think that's necessary in order for us to be successfully argue to everybody at the end of five years that some of these things should become statewide benefits because, in fact, the cost effectiveness is even better than what's happening today. So, that is absolutely part of the plan.

So, certainly appreciate that and certainly look for you all to help us figure that out and support that effort and getting them that information out and really showing how these services truly are not just better for the individual, but in the end better from a cost perspective and the stability of the program.

Now, I forgot your actual question because I loved your comment.

W [Speaker off mic].

Mari Yes, okay, sorry. So, we do not specifically right now have proposals on what the incentive dollars would be for. So, definitely interested in hearing that. I think we do want to make sure we're helping support the infrastructure for these additional services that we're trying to add, but how that would look and what would be the best way to do that definitely share those ideas with us.

Obviously, then, we won't know until through the budget process how much money might be available for incentive payments, and then there will be a need to prioritize what we do end up choosing to do, but absolutely we want to look at a range of things we can incentivize, and then based on the dollars that we have, make decisions after that.

Kim Let's go to the phone again. Nina. Actually, while we're trying to hear Nina, Patty Berg, can you—

Nina Hi, sorry. It took me a while to get to my mute button.

Kim Okay.

Nina This is Nina. I hope my question isn't too elementary. I see that there's a plan to roll in institutional care into the managed care plans. So, really quick question, that would be statewide?

Mari Correct. That would be statewide.

Nina Okay, so then my follow-on question is we know that older Californians or persons with disabilities want to stay in their homes and communities, but sometimes institutional care is necessary. What would happen in the counties that don't have a managed care plan and/or only have one, or have a limited number of institutions or none? What is the thinking around that?

Mari I'm not sure I'm totally understanding the question. We do, from the Medi-Cal side have plans in every county. Obviously, in some counties there's only one because we have a county-organized health system or else—San Benito. I think, again, the requirement on the plan would be essentially we would be looking that they make sure they have an adequate network of long-term care facilities.

One of the measures of that is are they contracting with those who currently provide these services through fee-for-service, and if they're not, why not, in order to make sure there's enough capacity. So, I think really looking at how we make that transition from we're paying for it through fee-for-service, the

availability of facilities, etc. that exist there, and then how to transition that into managed care.

As I mentioned, I think to Sarah's question, in the end we would not do a transition if there wasn't the demonstration of readiness and adequate network, and we have very particular ways that we measure that. We would be doing that before making this change.

Nina You understood my question, so thank you.

Kim We do want to move on, but I want to make sure—Patty Berg has been trying to get a word in edgewise. Patty, are you unmuted both from the operator and from your own phone?

Patty I'm not unmuted from the operator.

Kim Yes, you are. We hear you. Success.

Patty Oh, great because I don't even have a mute sign on my phone. I'm talking to you from my landline. No, I don't have a comment. I've been on the phone

since 1:00, and it's just been frustrating because I've been able to say, "Yes, I'm here." Okay. No, no question.

Kim So, glad we're connected. Ana, do you want have the last word? Ana Action is going to get the last word.

Patty Okay, thank you.

Kim Whoops, I pulled the presenter. What happened? Sorry. One more question from Ana.

Ana Thank you so much. I have a question about the in lieu of services. I'm curious what the thinking and planning is around leveraging existing organizations and services providing that. A good example is CCT, California Community Transition, and many of us have been implementing that program and are winding it down. We also have aging and disability resource connections that have a core service of a transition. We have independent living centers who have a core service of transition.

So, what's the thinking? I guess my concern is that managed care takes these kind of things in house rather than working collaboratively with organizations.

Mari

Sure, and we have the same questions that are coming from our whole-person care pilots who are also now doing some similar type things. What we are trying to say and emphasize is our goal and intention is that those types of organizations that are doing this type of work today be who the plans look to to work that.

So, we will be requiring the plans to tell us what their plan is, who they're planning to contract with as part of the approval process and really looking for not creating whole new or doing things that maybe don't make sense from a plan perspective. Again, for a lot of this, we do think it's really community-based. It's not really something that can be done by a centralized plan organization. So, that will be part of our review process of approving a plan to do these types of services.

Kim

Excellent. Well, that's a pretty good segue. Thank you. First of all, let's take a second and really thank Mari both for today and for so much more. Thank you, and so much of the DHCS team is here as well, and we know we're in good hands. So, Anastasia and Evelyn, I at least want to acknowledge you all as well.

We do want to feature three, particularly Medicaid-funded programs that are so critical in this space, and we're going to start without further ado with Peter Hansel from CalPACE. Go.

Peter Thank you. Let me add my voice to the others saying we'll miss you, Mari. I'm not going to make you cry, so we're doing with that, but thanks for the opportunity to do a little overview on PACE.

PACE is on the continuum of home and community-based service options that is in play. I think one of the key distinguishing things about PACE is it's actually more of a managed care plan itself. It's a fully-integrated plan capitated. It is a manage care alternative, if you will.

We do anticipate that PACE will play a role alongside with the CalAIM implementation. I think the concern is just that it doesn't get lost in the shuffle, but in many ways when we look at CalAIM, it looks to us like it's trying to make all of Medi-Cal look like PACE, so in that sense, who can argue with that?

Anyway, let me go through an update on PACE. I think most of you know PACE is a fully-integrated care program for adults 55 and older who qualify for nursing home level of care. It was established as a demonstration in the early 1980s in the Chinatown neighborhood in San Francisco.

It's evolved since through replication and a whole variety of efforts to embellish it and study it and whatnot, so it is a full-fledged benefit now under Medicaid and Medicare. So, it is kind of moving into the real world.

It provides the full range of services that are covered by Medicare and Medi-Cal. It does that under, as I said, under a capitated arrangement. It has all the flexibilities that are in CalAIM, so all of the elements that are in that proposal in lieu of services, enhanced care management. Flexibility to use the dollars in different ways are inherently part of the PACE model, so I think we're evidence that it can work if it's done right. So, that's encouraging.

One thing about PACE is it uses a very robust care planning process. The interdisciplinary team aspect of PACE involves up to 11 different disciplines, so it's quite robust who are assessing and helping develop care plans. These are generally on-staff folks at PACE centers, so they're essentially able to meet and confer and develop plans of care and update them in real time, which I think is in inherent benefit of PACE, so people do not fall through the cracks in PACE. They're pretty carefully kept track of, and the care plans are adapted very much as care needs change.

Another important thing about PACE is it's a model for managing care, but the setting can be anywhere. So, the person can be cared for in their home, in the PACE center. They can be in assisted living. They can be in nursing homes. So,

there's continuity across the care settings which is another, I think, really strong feature of the model. So, the fragmentation that I think CalAIM is trying to get around is sort of inherently dealt with in the PACE model.

Who do we serve? It's a pretty old population, about three-fourths dual-eligible, upper 70s for average age. I think on top of that when we collect data to look at who we're serving, it tends to be a very impaired population. So, it's people with multiple, overlapping chronic conditions, high levels of impairment, so they are I would say not just eligible for nursing homecare, but they're kind of at heightened risk of nursing home placement.

People tend to come to PACE when they really need it and when there aren't other options that can really do what PACE does, so I think it has a place that's driven by what it does but also timing. Timing is really important for people to get to it at the right time when they reach that level.

In terms of enrollment, it is coming to scale in California thanks to a lot of things the department has done. I have to give Mari credit for helping implement a wide variety of things that are helping it really expand. We estimate out of about 181,000 potential PACE eligibles in this state, about 10,000 are enrolled right now. That's just if you look at who has care needs that might be in that range in their age and income and so forth.

We're in 14 counties, and that's a significant increase, but of course, that leaves 44 more. There are 7 counties in the works in PACE applications, so we're really encouraged. We think the natural footprint of PACE is getting built out. Really exciting to see it come to the Central Valley, in particular. It's starting to take off in Stanislaus and Fresno and Tulare and Kings and Madera and Kern and so forth which are areas that desperately need those kind of services.

A couple other quick points, and then I'll talk about our issues and a couple recommendations, but one of the inherent strengths of PACE also is that it's an adaptable model. It can be offered and built on top of a variety of organizations that have a presence in the community. So, we have sponsoring organizations that are senior housing providers, community health centers.

We have one health plan. CalOptima itself is offering PACE. There's nothing really special. It fits in a lot of settings and with a lot of impetus from the local level which is great.

It's also being adapted to serve different types of populations, so it's being used in San Diego in support of housing arrangements to serve formerly homeless older adults with a high degree of success. It's operating as a wrap-around at least in one county for regional center clients.

There are new flexibilities coming into PACE to allow them to use community-based providers more readily, community-based physicians and other providers which are adding to the flexibility of the model.

PACE is a proven model of care. Our recommendations have some of the sites that we use that people can look at. We collect a lot of data, but we know the model does a very good job of reducing utilization of hospitalization. It's very good at delaying onset of extended nursing home stays. In fact, that's one of the key benefits of PACE.

It tends to yield very high rates of satisfaction among enrollees, and we have one measure is very few people disenroll from PACE. They basically enroll, and for many of them, it's sort of an end-of-life care program, and it transitions from prevention to palliative to hospice and all the way through the settings.

Finally, we think it's cost effective, at least our numbers. I can't read that—one minute, okay. So, issues are a lot of people need the care model. The regulatory environment is becoming more supportive.

The challenges are lack of awareness. PACE is a voluntary enrolment model, so it relies on referrals, and it relies on efforts of people to point people to PACE, so we're very interested in making sure it fits into the rubric in the master plan

for information referral. People are trained and aware of what it is and who can benefit from it.

There are some geographic barriers that will not work in all counties, particularly rural counties will be a challenge probably, but the model is adapting further, and we think there could be some breakthroughs in that area.

There are issues that have to do with how it starts in certain counties that the managed care model, the county-organized health systems. There's a few extra steps involved that make it a little more difficult.

Our recommendations basically would be that we would like to see the state provide access to PACE for any and all older adults and seniors with complex needs who need it and can benefit from it. We have some detailed recommendations that we have along those lines. I'll stop there.

Patty This is Patty Berg. I would like to chime in on this one.

Kim Patty, can you hold? We're going to try to get through PACE, CBAS, and MSSP, if I could do that, and then we will start with Patty. She's in line.

Patty Oh, okay. Thanks, dear. Appreciate it.

Kim With that, Lydia, take it away.

Lydia Thank you. Lydia Missaelides with Alliance for Leadership and Education, formerly executive director for the California Association for Adult Day Services for 30-some years.

I just was reflecting that with Craig here that it felt when I started my career in home and community-based services what we called them back in the mid to late-80s, we were kind of at the middle of an evolution of budgeting and thinking and excitement about preparing for the aging demographics of our state.

For a number of reasons, that was a political moment as well as I think an awareness moment, and it feels to me like we're kind of back in that moment again where there's some awareness as well as political will to get things done. So, that's exciting and why I'm excited to be on this subcommittee.

Adult day services started in California in the 1970s, 1980s, and adult day healthcare which is still a thing, everybody, it is still a licensing category in the

State of California, adult care healthcare started, as PACE did, as a pilot project, an 1115 waiver back in the day.

Today, my slide is actually incorrect. There are now about 260 licensed adult day healthcare/CBAS centers, and they serve about 36,000 people which is almost where we were in 2011 when the program was eliminated. So, we've definitely been growing that population reflecting the need.

It is interesting that 185 roughly a month are still fee-for-service. To access CBAS, you do have to be part of—beneficiaries have to be part of Medi-Cal Managed Care whether or not it's a CCI county or not. So, that's something unique about the program.

Similar to what Peter described in PACE, about 75% to 80% of the individuals served are dual-eligibles. We have people served to our regional center clients, private case about 2,000 people on average, so there are people paying out of pocket for that.

There are still 31 counties without a program, and 17 of those 31 counties have five or fewer programs. Some only have one. So, we definitely lost a lot of capacity over the last decade with the recession and so on.

I also wanted to mention that we also represent [indiscernible], and I'm supportive in Maya's comment about in lieu of services that could include adult day programs for licensed by the Department of Social Services. They're often overlooked because they are not government-funded per se. They do sometimes receive money from AAAs, but they're primarily private [indiscernible] and specialize in serving people with Alzheimer's disease and related dementias.

We think that they should be included as an lieu of service, so I'll be submitting some comments on that and some data to support that. I want to thank Maya for bringing that up today.

So, that's kind of an overall description. Most of the people served are older adults, although we are seeing younger folks. We are seeing an increase in the number of aging people with intellectual and developmental disabilities entering our care as they need additional health services that are not being provided in other means.

Adult day services is a place, and as a place where people gather and get to go home at night and sleep in their own bed, I think there are a lot of opportunities to really maximize the use of that place.

One thing that we've been talking to some health plans about, for example, is testing out the ability to bring mobile dental services to the center so that people can have their oral health needs met. They're often neglected. It's difficult to access those services.

We are also seeing an increasing interest among academic researchers in our field, so we're beginning to see published articles. A couple that I've been involved in with New York University, for example, on our community-based health home projects that are describing positive health outcomes particularly related to social determinants.

Okay, I thought it was pretty close. Thank you.

We have been testing a health home model in the community and are very interested in expanding the scope of services that adult day healthcare can provide to the homeless population, for example, and that's being tested right now.

We're very interested in value-based reimbursement. We've talked to health plans about this, but it's been very difficult for them to figure out a way to do that for us because of the low volume.

There's still similar challenges to what Peter described in terms of lack of public awareness. We have lost a lot of capacity, as I mentioned, areas of the state with no access to services.

Rates are an issue, particularly with increases in minimum wage, AB5, which is requiring more tiers for contractors such as physical therapists can now become employees, and a lot of regulatory barriers to care, and a long startup time for centers. We have a very inefficient system of enrolling people into CBAS because of regulatory requirements and systems that just haven't meshed well yet.

So, those are some of the opportunities and challenges today. Oh, I wanted to just mention one more quick thing. One of the things that emerged from this recent research is the importance of nutrition because nutrition risk, as determined by the determine tool, has been found to be an indicator for all sorts of other health risks as well as social risk. So, we think there might be some opportunities to partner with CalFresh in a way that hasn't been done before and to pilot some fresh thinking there.

Kim Denise, take it away for MSSP.

Denise

Hi, everyone. My name is Denise Likar. I am the site director at Independence at Home, MSSP in Los Angeles County housed by SCAN Health Plan, and I'm also a part of the MSSP Site Association board. Thank you for having me and inviting me today.

Multipurpose Senior Services Program, so a quick run through of the program. This program is also a waiver. It's a 1915(c) waiver that deals with very complex health and social care management needs. We basically see every social determinant of health in this program and address it.

Unlike both PACE and CBAS which are center-based, we're home-based services, and so our population is all 65 and over, Medi-Cal, no share of cost, and all nursing home-certifiable. So, they're frail, they're very poor, and trying to make ends meet, especially here in California as high a cost of living as here.

Our delivery model is an intensive model. It's an RN and social worker combination that we go into the home, and we do a full biopsychosocial assessment, so we are looking at their medical conditions. We're also doing a home safety evaluation. We're also looking at how well their needs are being met, caregiving, the full gamut. We look at everything. When you go into the home, you see some things very, very differently than you see in a doctor's office or maybe telephonically when you talk to a senior.

Our follow-ups are intensive care planning. We are in the home at least quarterly, more often as needed based on the client's actual needs. We are care coordination for most of who we work with. A very high number of our participants are actually monolingual non-English we're finding, and that's a demographic that's changing, or they're just struggling to make ends meet and stay in the community and don't know where to start and don't know where to go. So, we're navigating that for them and putting that picture together.

The uniqueness of the waiver is a lot of the Medicaid rules are waived for us so we can purchase non-traditional medical things like if they don't have a place to sleep, we can purchase them a bed. If they don't have a place to store food, we can get them a refrigerator, but we can also help them with emergency caregiving, respite care for the caregiver in order to keep that network together and keep that person in place so bad things don't happen whether it's go to the hospital, institutionalization, and that they don't fall through the cracks.

We also do a lot of heavy lifting to help them navigate IHSS because that can be very daunting if you're frail, especially if you don't speak English, and those types of things.

In the CalAIM proposal what comes to mind is a lot of the enhanced care management pieces and the in lieu pieces, we kind of check a lot of those boxes. We've been doing this for over 40 years, and my site is actually an original site

from 1977, so we have a lot of institutional knowledge at what we do down in Southern California.

We currently have 9,283 slots. It's called statewide, but we are not statewide. There are several counties that MSSP is not present. We had over 12,000 slots before the economy issues in '07 and '08, and those have never been restored to us, but we continue to be strong and mighty there. So, that's our service delivery and our structure.

Opportunities and challenges for MSSP, so I think opportunities is program expansion is a definite opportunity for MSSP. We have stood ready to get our slots back from the cuts from the—we stood in line with everybody trying to get back what we want, but we stand ready to be able to increase our slots, make this program actually statewide.

I know there's barriers. We've talked about a lot of the barrier that there's not even health plans in some areas of the state, so we'd have to be real strategic together on how we get providers into those areas.

There's also an opportunity to think of our model as more than just the Medicaid and a waiver program. We have a tried and true formula that's keeping people at home and keeping them out of a nursing home.

I don't know that we have statewide numbers—I'll glance at Kim—but, I know for my site, we track and we calculate, and we keep people in the community on average three and a half years at my site. So, that's three and a half years of not being in a nursing home, and that's something I track, a metric we track in our own area.

Also, increased awareness of the program. Sometimes they call us this quiet, little gem that nobody knows about, and there's not billboards that say, "Hey, here's all your HCBS, and here's all your community services." I love that the master plan is helping to address some of that in order to be able to raise that awareness, and especially the benefits of specialty in-home care management and service coordination. Not everybody needs us, but there are some that do, and we can make a difference with that population.

Leveraging our 40 years of our in-home experience and the outcomes that we've had in terms of keeping people at home successfully, also leveraging our CCI learnings. So, Sarah, your comment and, Mari, you alluded to this that CCI some things didn't happen as planned. Some things were successful; some things didn't happen as planned.

We've very much suffered in MSSP from the fact that 95% of our population opted out of Cal MediConnect, so that 95% was MLTSS only, so there was not

care coordination for them from the plans, and so we were still 100% care coordinating them and helping them navigate the systems, and I think there's some learning to dig into those that were not Cal MediConnect to see what we can leverage into CalAIM if that's possible because we want to get it right this next time.

Challenges, although these are challenges, I think they can all be tackled. Waiver limitations and regulatory burden, we know that if the state wants to increase, the feds are pretty good. We've read everywhere and we've seen that if the state says that they want to put in more money which is 50% of it, the feds would match that, so I throw that out as a brainstorm on the parking lot.

Regulatory burdens, I believe those can all be worked through as well because it's all modernizing some of the ways we do things. We could probably—and if we could get some technology statewide, I'll throw that on the parking lot, too- would be probably a great tackler. They gave me the mic.

One last thing is a traditional healthcare system tends to have that limited view of care management. California, we're trying to change that, but that telephonic, one or two calls here or there because it's not as intensive is kind of that tradition for healthcare, and it's not the in-home, it's not the varying levels and tiered approach, so I think we really need to continue the work to understand that one size doesn't fit all. We need to meet people where they're

at on that continuum of aging, and a program like MSSP does really help those in the system that are really struggling with multiple barriers and challenges. I'll stop there.

Kim Let's thank all of the centers for condensing a lot of information to a very few minutes. We do have time for committee discussion here. Patty, can you start us off, please?

Patty Yes, I will. I really appreciate the presentations from all three of you. I am a Humboldt County person, and I'm fortunate to say I have all three programs in Humboldt County. We were one of the first Multipurpose Senior Service Programs. We were one of the first adult day healthcare programs, and we were the first rural PACE program.

I have to say that all three of those programs, in my estimation, to be part of a basic core througho9ut the State of California, and I'm going to be making a recommendation that says that because what PACE does and what MSSP does is it provides, in my opinion, one of the key services which is case management, but I have to say probably one of the best primary care physicians in Humboldt County is the medical director of our local PACE program. She says, after having been in medicine for many years, "This is the first time I really feel like I'm doing what I was trained to do and how much I love to come to work every day."

It's just really incredible. I mean, our PACE program is just going great guns, and I have to say also in terms of adult day healthcare, Lydia, nobody knows this better than you, when the for-profits came into the action versus just nonprofits, that almost made adult day healthcare go away in the legislative arena of which I was there at that time, and really had to do some selling because there was so much cherry picking that was occurring.

Our PACE program, our adult day healthcare program, our MSSP program are all run through a multipurpose senior center with very well-trained staff. I have to say all three programs I think are just incredible and have done so much and continue to do some much for the elders in this community. I can't say enough about those programs, and I think they should all be at the basic core.

Okay, that's my comment.

[Overlapping voices].

Kim This is Kim. Wait, I just want to lift up Patty's point about the core in all communities and how, again, the Master Plan for Aging is very much intended to be both a state plan but also this local blueprint, and that notion of what a common core in all communities would look like is very much in the mix and on our minds, so thank you for lifting that up again.

Patty You bet.

Kim I have Claire and Ana and Sarah in the queue in the room, and it sounds like someone on the phone is trying to get in as well.

Ellen S. This is Ellen Schmeding.

Kim Great. Ellen, I'm going to go ahead and put you first since you haven't spoken yet. Then, we'll go to the room. Ellen.

Ellen S. Okay, great. Well, thank you so much. I'm sorry I can't join you. I am listening in and very interested, and I too, in addition to Patty want to provide my support for both PACE and MSSP. Adult day I'm not as familiar with not having operated an adult day.

What I want to say about PACE is that it has been a long-term dream of ours to have integrated care, and years ago, we were asked in San Diego to address some of the challenges with IHSS. We learned about AB-1040 and began a 20-year journey towards long-term care integration that got us to the point of being one of the pilots with Cal MediConnect.

Unfortunately, that integration effort didn't really pan out fully, but what we still have is PACE, and now I work with St. Paul's and have been so impressed by what PACE is able to do. We have three different locations. As Peter mentioned, we're doing a lot of work on homeless housing, brining homeless seniors in and providing that wrap-around support for PACE.

Our dream now is to also find a way to expand PACE to the middle income on a sliding scale or a purchase basis because so many seniors are frail, they don't have the ability to manage their own care, they need the support, and we're very, very interested in seeing that happen and figuring out a way to get it paid for with some contribution level.

Then, with MSSP, I worked with our area agency for many years, and MSSP was our gold standard case management program. We always advocated for more slots. Again, it's an IDT approach with the nurse and social worker, and for me, these programs are fundamental to assisting people with staying in their homes or staying as well as they can for as long as they can. Thank you for the opportunity to comment.

Patty Good comments, Ellen.

Kim Thank you, Claire. Sorry, Cathy, over here.

Claire Thanks to everyone. This is Claire Ramsey from Justice in Aging. Thank you to everyone for the presentations and the work you're doing. I sort of have a two-part question.

Part one is sort of like what are the things that we're already doing like CBAS, MSSP, PACE that really all we need to do is more of that? Like, I think one of the things that's great about this conversation for the master plan is how we innovate, how we mix things up, and not keep the status quo, but I do wonder how much of it is like oh, we're doing really good things, we're just doing them at this much of a size—I'm making a small finger—and, how much do we do much more?

So, I think part of that, to me, is like really investing in what already works and finding ways to expand. So, I just really want to put that out there. As part of that, it sounds like each of these models in their own way is figuring out how to be cost effective for the particularly high-need population they're serving, and one of the hard things that we've discussed is the way California budgets is very line item-based. We're not going to count savings here unless you literally are saving us money. You would be in a nursing home, but you moved out, so we saved money on that.

Prevention tends not to be counted that way, but obviously there's ways to count it. So, how much can the models that we're using for these integrated models to look at savings be applied to really get us somewhere on a statewide level? Does that question make sense?

Kim Savings.

W [Speaker off mic].

Mari That's a hard question for me to answer. I think it's something that, yes, it's challenging. I would say we at the department have been successful when we are able to show that sort of savings. So, when I think about some of the expansions of some of our HCBS, part of the way that we explain that as really a cost savings versus a cost increase even though you're paying for something different, was really using our historical data and showing, and we had very specific models.

So, I think the same could be done with all of the programs that have been mentioned here given that there's such good history. I think it's always harder when it's a proposal when you don't have data. I think that's where we've struggled more as a state to show—to assume savings when it's not known from a historical perspective, but I do think when you have well-established

programs, whether it's any of these that we've talked about or even any of the others that people have mentioned, I think that's really where it is a very data-based conversation. So, I think that's where it's critical to have that type of information.

Patty May I make a comment? This is Patty, again.

Kim Hang on one second. Claire, finish that.

Claire I was just going to say, knowing that then, it seems like it could be a recommendation of our committee then to say if we have the numbers, what kind of expansion could we do in these programs and look at savings to pay for them because we can see already the numbers? Thanks.

Kim I'll try to have the three people make the comments and then move us just to keep us on time, but it's tough. I had Ana, Sarah, and Maya, and now Lydia has just come up.

Patty You still have Patty.

Kim And Patty.

Jose Dr. Arevalo would also like to comment.

Kim Wonderful. Okay, let's see, can we do five people in five minutes? Let's try. Ana.

Ana A couple things. I serve five counties. We do not have any of the programs just presented except for one exception which is Yuba County with our wonderful MSSP program. So, this idea of a recommendation to build again off of existing infrastructures and programs that we can expand I think is brilliant in what we need to do.

A couple things that I'd like to add. One is there's some eligibility challenges around some of the programs. Again, like you have to have the dots or the stripes, you know, so I think that's something to look at with some of these programs

One example I will give is those with traumatic brain injury. We have a TBI program, one of seven in the state, and what I'm finding is that they're not eligible for a DD waiver or this waiver based on age, and it really doesn't make sense because it's not based on the functional needs of the individual.

So, I think that's something to look at, and it also has occurred to me that some individuals with the cognitive disabilities, specifically I'm thinking of, that could benefit from multiple waivers. So, right now, we kind of have to pick one, like what the best fit is, but that doesn't always make sense for the individual.

I wanted to kind of raise that issue as well, and just leave you with right before coming here I got a call from a woman whose mother is 95. Her dad passed away in September. She was calling us to really to donate the van of her mother and father, and she goes, "Well, honestly, the reason I'm doing it is to spend down into Medi-Cal."

Patty Yes. We drive them into poverty.

Ana Yes, to receive nursing home services. So, I think the idea also of expanding these programs to eligibility of various income levels is really a critical piece.

Sarah Thank you so much, and to build off what has been said by Claire and others, this notion of building access, I think it needs to be considered in the context of the future of Medi-Cal because most of these programs we've talked about are on Medi-Cal-based programs. So, what does that mean in what we hope would be an integrated service delivery system?

So, we can expand access, which I absolutely agree with that we should be doing, but what role will the managed care plans have in ensuring—because they're going to be the hub of a lot of the service delivery—ensuring that people actually know how to access these services, where they are, and what they mean, and what a truly person-centered service delivery system should look like.

So, that's one point, but then it also got me thinking about your comment about the multiple waivers, and you can only choose one home and community-based service waiver. I remember several years ago, John Shen from DHCS had the idea of combining the waivers, and then you could just choose from the menu of services within that waiver. I love that idea. I don't know where it went, but if done well, it could really maybe potentially ease the complications of the system.

Then, my third quick point is about the DD system. They have a very, very high cap on the number of slots. They don't even reach their cap and it's because of Lanterman, and there's an entitlement o home and community-based services. The Department of Finance doesn't have an issue with the fact that we have a huge cap on that program, but they have all these other little waiver programs where they're concerned with growing the slots because of cost.

So, I just want to point out that discrepancy. If we had an entitlement to home and community-based services, it would change things a lot.

Mari

Just to address your middle comment, I'm not going to address anything else. This is Mari from DHCS. So, yes, I think that's sort of the idea I was getting at when I mentioned my long-term vision of you don't want to lose the excellent programs that we have, but how do we change the way that they're delivered or change the way that they're accessed so it's not, again my purple stripes, yellow polka dots, and that whole concept goes into the same thing.

I think still the concept of combing the waivers is still in our minds, but I think that's what we want to continue to work on over the next few years and really think about how we, to the question of some of the stuff we are trying to do in CalAIM, how do we make sure we're not then taking away or not utilizing all of the expertise that is built in the various waivers that we have.

If then we go towards a more seamless, just again, if someone needs these services, they can get them without having to meet super special criteria. I think that's where we want to go. It's then just thinking about how we do that without losing—I mean, sort of everyone loves the different waivers that we have now, but how do we move away from that to something that's more singular without also then breaking maybe what works best.

So, that's why we think it really needs to be a very thoughtful process and one I think the department would really like to engage in over the next several years as we think about sort of what the next big change is. I think this is the biggest area where we want to see more of that improvement so that we are addressing people's needs.

Kim Okay, trying to wrap up quickly. Let me hear from Dr. Arevalo who we haven't heard from yet on the phone.

Jose Thank you very much. This is Jose Alberto Arevalo. I'm a family doc, and I'm at Sutter in the IPA and also the chair of LatinX Physicians of California. I want to thank the presenters. These have been excellent presentations.

Essentially, I have a question. I think I know the answer, but I wanted to follow up with the question. Have there been any experiments? These are all Medi-Cal focused type programs, Medi-Cal and Medicare, but have there been any considerations of experiments outside for other payers like commercial payers?

Again, as part of an integrated health system, these challenges—and, the data is pretty impressive here on improving care and reducing costs, and it's clearly now becoming an appetite, as I had mentioned before in a previous comment, with some of the healthy systems, and particularly the integrated health

systems to look at these kinds of things and this kind of innovation, and as everybody has mentioned here, there's a lack of understanding and awareness outside of the Medi-Cal and some of the Medicare populations or programs.

So, my question is have there been any kind of experiments or any kinds of opportunities with non-Medi-Cal, non-fee-for-service Medicare to look at using these very high-quality type programs an affording because, again at the end of the day, we're here to create a master plan of aging for all Californians, so this would be critical to try to consider in the non-Medi-Cal, Medicare arena.

Kim Do you want to try to answer—you said you might have the answer yourself. Do Mari or other folks in the room want to give an answer to the private pay?

Mari I don't actually have a good answer.

Jose I mean, I think I have that no, these have not been—I think you absolutely hit it on the head that although, for example, within our county and within our program, we have a very powerful PACE program, but it doesn't really go beyond the Medi-Medi population, and so now as we consider larger populations in health programs, and many of the large integrated health systems have moved in that direction, then even learning from within ourselves,

these have been well hidden is a real critical opportunities, as I mentioned again, because we need to create a master plan for all Californians.

Peter I have a minute, a second. As you know, PACE has been replicated in the veterans' health system, so that's one place, so it's connected to the veterans' medical centers and offered offline, not as PACE, but as something else. That's just a partial answer.

We have focused a lot on the Medicare-only population, which I think is a subset of what you're getting at with your question because Medicare is not needs adjusted so a lot of people are eligible, but how do they access programs like this? They actually can access PACE by paying a share of cost, but it's pretty hefty.

So, we're working at the federal level to see if we can tier that because this is driven by Medicare policy, and create a tiered buy-in, I think as Ellen mentioned earlier. Just one possible thought.

Jose So, again, when you mention Medicare, it's Medicare fee-for-service, so as you know, just like Medi-Cal and Medicaid are moving in a managed care environment, there's significant—right now, it's called ACOs in Medicare, and by the way, we do have an MSSP type of acronym as well for Medicare shared

savings program, so there is an ACO type program in Medicare fee-for-service, but there's growing Medicare managed care programs where this would absolutely be—and, that's what I'm referring to, targeting that and targeting those particular health plans and integrated health systems that partner to address the cost.

As you mentioned, Peter, there's good evidence that PACE has really significant positive outcomes in terms of hospitalizations and ER use and things like that that do hit these managed care programs because the risk is directed not just from the health plans but the integrated health systems, so there's a lot of appetite for this now and growing.

So, it's a great opportunity to talk about the other—besides Medi-Medi, to talk about the other populations that we are supposed to be addressing as well. Thank you.

Kim — Thank you. I actually am going to be the bad cop here and transition us to the next topic cutting off Maya, Patty, and Lydia. I can't believe that I have that terrible—Sarah is going to be facilitating a recommendation conversation later in the meeting, so we will remember that and come back.

We are going to transition from Medi-Cal to non-Medi-Cal. Thank you to our DHCS colleagues. This is not the last of our aging in Medicaid. It's the first of our aging in Medicaid conversations. Thank you.

I do want to encourage you to take breaks as you need and thank our foundation partners for funding, once again, coffee and water and snacks. So, thank you very much.

I have to step out for about an hour, and I'll be back, but as always, we are a team. So, Team CDA is going to help us in kicking off the other state home and community-based services. Our program deputy, Irene Walela, is going to somehow do the rest of the periodic table, so good luck to you. No. Irene, here you go.

Irene Thank you so much, Kim. So, I am Irene Walela, from California Department of Aging, and I will not be covering the entire rest of the periodic table, just a full disclaimer.

What we did was we took a look at the periodic table that you all are familiar with or saw today, and we called out five of the departments to do a high-level overview of services for older adults and people with disabilities, so I am going to do my level best to present a high-level quick summary of those five

departments' programs. I want to thank the departments who sent slides and talking points for their support on this, and I'm going to start with the Department of Aging, so that's—oh, I'm sorry. I'm not pressing the button. Will you, Ellen? I'm unfortunately not able to do two things at once.

Alright, so on the first slides that we have for Older Americans Act, and I would also preface this by saying that I am only covering part of the services that California Department of Aging offers. These are the services through the Older Americans Act only. We have the bucket of supportive services which consists of about 31 different types of services. The top 3 are on the slide meaning the top 3 most often delivered services: information and assistance, legal assistance, and transportation.

We have the Nutrition Services Program which provides both congregate or group meals and home-delivered meals. We have the Disease Prevention and Health Promotion Program which provides evidence-based programming such as fall prevention, chronic disease, and self-management.

We have the Family Caregiver Support program. This provides assistance to caregivers of older adults as well as older relatives who are caregivers for children or an individual of any age with a disability.

We also have a program funded from the Department of Labor that's on this list. It is mentioned in the Older Americans Act, but funding from Labor. This is the Senior Community Service Employment Program which is a paid training program that prepares older adults for employment in community service type occupations, and similar to the MSSP, although not a waiver program, we are utilizing some of the slots that are authorized for us due to a lack of enough funding to use all of the slots that are authorized at the federal level.

Then, we also have the Elder Abuse Prevention Program and the Long-Term Care Ombudsman program.

As I mentioned, these consist of about 38 service categories, but these are not all the services that we are engaged with. We are also engaged with MSSP, the CBAS program, the HICAP Program which provides health insurance counseling for Medicare recipients, as well as a number of small grant programs.

So, even within the Department of Aging, we have the opportunity to work together that we can make sure that each of these programs knows about all of the other programs.

Under challenges and opportunities, we have noticed that there may be many Californians who are not aware of all the programs that are available through

the Department of Aging. We are serving, I think it's about 1.2 million older Californians out of the over 8 million that could potentially benefit from those services.

The data for these programs is kept individually and reported up depending on the funding source, but it is not leveraged across programs or statewide. We have an opportunity there to explore data collection and data sharing and start developing data that tells us about the outcomes of these programs rather than the service units which is what our federal partners ask us to report.

Back to the point about a lot of Californians do not have awareness or understanding of what programs are available through the AAA system, the Area Agencies on Aging, there's an opportunity there to do an integrated outreach or information assistance type of program that would share this kind of information, possibly information about all the other programs that are being discussed today across the public instead of separated outreach efforts.

Last opportunity/challenges that the programs for the Older Americans Act are under resourced compared to the number of individuals who could benefit from the programs as well as the diversity of the individuals who could benefit from these programs. There's an opportunity here to perhaps reimagine or innovate the way that services are delivered in California as a part of the master plan.

I should also say that there are people from other departments here, as I talk a little bit about Department of Developmental Services, who can answer more of the questions than I can. So, California Department of Developmental Services provides the services to individuals who have the developmental disabilities so that they can lead independent lives, and they live in their community of choice across their lifespan.

They work through a network of the regional centers, the 21 regional centers, state facilities, other government organizations, stakeholder groups, as well as individuals and families. Those services include case management and other needed services across an individual's lifetime.

We wanted to note that the individuals served by the regional centers are also living longer due to, of course, medical advances, and quality of life opportunities. I understand that there's been an increase to about 9% of the current population of 350,000 Californians with developmental disabilities who are now over the age of 52, and ten years ago that was only about 8%, so we have that population entering into services for older adults, and we heard that mentioned with the CBAS presentation.

The Department of Developmental Services has a number of priorities going on that support older adults as well as all people with developmental disabilities.

Those were called out to us as the Developmental Services Task Force, which is to provide advice about a strong community service system.

There are representatives from families, advocates, those with lived experience, regional centers, providers, labor, and the legislature who work together to provide guidance to the entire developmental services system.

There's the Community Resource Development Fund Program which has a plan that's developed so the regional centers can enhance their capacity and reduce reliance on restrictive living environments. The general purpose of this fund is to support the department's statutory responsibility to ensure that individuals with intellectual or developmental disabilities can live in the least restrictive setting for their needs.

Then, there's the home and community-based services rules, some of which we did talk about earlier with the representatives from the Department of Healthcare Services, but this focus is on the new rule that the newer rule that says that individuals are to receive services in the most integrated settings of their choosing and also have full access to benefits of community living.

The last program I wanted to mention is the Self-Determination program, which is a waiver application. That will allow participants to have more control over

selecting services and supports within their individual budget. It was first approved just in 2018, and so for the first three years, the enrollment is limited to 2,500 individuals, and after three years, the plan, as I understand it, is that this program will be available as an option to any eligible consumer of regional center services.

Then, we have the Department of Public Health which called out three particular programs, and again, all of these programs are about long-term services and supports for older adults and people with disabilities. They lifted up the Alzheimer's disease and Related Dementias Program which has the goal of relieving burden and cost associated with these conditions through various research, training, and education, quality care, support services.

The California Colon Cancer Control Program or C4P which offers screening services for the hard-to-reach, low-income, possibly uninsured or underinsured men and women ages 50 to 75, so focusing on categories of older adults.

Then the AIDS Medi-Cal Waiver Program, another program that does provide home and community-based services for individuals who may otherwise require institutional services and assist them with home management and supportive services.

The Department of Public Health also does licensing and certification programs which are all a part of this landscape. They are responsible for home health aid certification, community-based adult services licensing, which are then Medi-Cal certified by the Department of Aging, and nursing home licensing and certification.

So, an example I'll give of that is that we get lots of inquiries at the Department of Aging, and just a few days ago, I got an inquiry from someone who wanted to know how they become a community-based adult services center. So, because they called us, we knew that they should talk to Public Health, but again, pointing out to the problem of the public, not knowing where the services live or how they are to get a hold of them.

I'm moving on to the Department of Rehabilitation. Am I going fast enough for everyone? I'm way over time. Okay. The Department of Rehabilitation has a number of programs that are specific to community living as well as their large Vocational and Rehabilitation Employment Program.

I'm going to call out the ones on the slide here which are the Independent Living Program, which are the community-based not-for-profit organizations that exist in 28 centers across the state. I think it's 65 locations that provide services to individuals with disabilities of any age across California.

The assistive technology programs which are funded by federal dollars. These services are available to any individual who needs a piece of equipment or product that is used to increase or maintain their functional capabilities. Those services may be found through the independent living centers or through school districts, colleges, regional centers.

So, this is, again, a place where there is a program and availability of supports that are available through a number of different outlets. The Department of Rehabilitation has the responsibility for the federal program that's administered.

Then, the Traumatic Brain Injury Program, which was mentioned a little bit ago, which is a specific a state-funded program, just 7 sites serving individuals with traumatic brain injury for the purpose of community reintegration and community living.

The Older Individuals who are Blind Program which provides services specifically to individuals with visual impairment who are older than age 55 so they can live independently. There's also the Mobility Evaluation Program which is to evaluate an individual's needs for an ability to use adaptive technology to drive a vehicle.

The Blind Employment Program is a part of the specialized services in the Department of Rehabilitation, and that is training and employment for individuals who are legally blind to manage food or vending programs on public and private properties. There are about 90 of those business owners right now, and approximately 250 sites across the state.

Lastly, I just wanted to mention the Limited Examination and Appointment Program which is the alternate examination process for individuals with disabilities to enter into state services.

So, there's plenty of challenges and opportunities for the DOR both internally and across all of these systems. All of these programs engage different networks even within the Department of Rehabilitation. The challenge is to maximize collaboration and resources among the networks rather than each network operating entirely on their own as well as communication so that the individuals who need services get all the services they need.

Same kind of challenge with assistive technology which is open to individuals who are older adults as well as people with disabilities so that all them could have access even if they are not specifically already connected to say an independent living network. That's definitely a challenge and an opportunity.

The Traumatic Brain Injury Program, given its size of only 7 providers and serving only 20 counties, is also an opportunity, particularly because the disproportionate number of older adults who have a traumatic brain injury due to falls. This is the highest causation of traumatic brain injury is falls amongst older adults, but it is sometimes misdiagnosed or co-diagnosed, and so there is a challenge and an opportunity here to really look into research and resourcing this particular area.

I'm going to switch over to California Department of Social Services. Again, a number of services that are available. The Adult Protective Services Program that specifically assists seniors and adults with disabilities who may be victims of abuse, neglect, or exploitation. The SSI/SSP Program providing a monthly cash benefit for individuals over 65 or who are blind or otherwise disabled to have funds for basic living.

Cash Assistance Program for Immigrants, which is a state-funded program for immigrants who may meet the same criteria for SSI/SSP, but due to immigration status cannot receive that. There's the Californian Veterans Cash Benefit Program.

Then, the Deaf Access Program and the Assistance Dog Special Allowance. Those programs have clear constituencies, but I will say that the Assistance Dog, I'm not sure, that might be a question for CDSS if this says it's for guide, signal,

or service dogs, so that would include individuals with different conditions that require the use of a service animal.

The challenges and opportunities that CDSS particularly highlighted would be to increase language access for individuals who are deaf and workforce opportunities so that they could have the language access they need to join the workforce, getting more appropriate interpreters to communicate with deaf children or immigrants who have deafness, and also better language access crossing over to the accessibility for Adult Protective Services, so an internal opportunity and challenge there.

Adult Protective Services has some areas to look at. Education about what it means to be a mandated reporter, connecting Adult Protective Services with community resources, the incidence of homelessness amongst APS clients, and also case management and training for all the APS social workers statewide.

That is my fast-paced, high-level summary from those five departments. I know that we have Marty Omoto and Victoria Jump here to provide more perspective on these programs. Was Shireen able to join us? No, okay.

W [Speaker off mic].

Irene Victoria is right here. Come on up, here, Victoria. Sit by me. She's right there. Then, I can hand her this mic, and Cathy, if you would just hand Marty that mic.

W [Speaker off mic].

Marty Marty Omoto, CDCAN and a family member. Thank you, Irene. That's not easy to do, go through five departments and survive through the walk.

Just really quickly because I know we're pressed for time. My older sister who passed away in 2003, and I was working with her all her life as things changed with her developmental disability. She was a Medi-Medi, Medi-Cal and Medicare, so we went through all the crises that a lot of families go through.

I just want to make sure that people understand if they don't that regional centers support my sister and others in one part of their life, and it's really important to realize that service coordinators, who there are a lot of good people who do tremendous jobs as service coordinators, but they are responsible for coordinated services that are funded by the regional centers.

So, when my sister accessed healthcare through Medi-Cal, the regional center didn't know that she was there, and there's a lot of other services that a person has and needs like everyone else that's important for us to recognize that.

That's one of the things I just want to drive home in terms of the points we need to raise here is we talk about the differences between the different silos. We need to talk about what's in common of the people in those silos because then we can focus on what is really needed so whatever solutions we come up with maybe will be broader-based and look at the whole person.

So, for instance, on homecare, that is a big issue not only for people who access IHSS, a big issue within people within the DE system. There is a homecare service called Supported Living, and many of those people also access IHSS, but it's different. Why is it different? There's also other needs that are similar or common, and we need to look at that.

For instance, most of the people who receive services under the regional center system live in their own homes. Most of the people require transportation or have needs of transportation that are not necessarily met by the regional center unless they're in a program. Most people have problems in terms of food security which everybody else has.

A lot of people have issues regarding their families. They have family members who may be there to help support them, but as you get older, as people get older, their family members are no longer there. Their circle of support is no longer there, and they're on their own. So, that's another issue that is common

that we all face. There's the issues of diversity, cultural diversity that is across all the silos.

Lastly, because again, running out of time and there's a lot of things we need to look at, the issues of workforce is common in all the silos and how you pay a person for the things that they do that is respectful of what they do and yet is also recognizing the reality of limited state resources. That's a problem that we're going to talk about in IHSS, but just want to make sure that when we have that conversation about IHSS we are mindful that the issues of workforce cross all the other silos.

If we're going to really make a difference in what we do, we need to understand that there are many issues that are in common that we all share. So, maybe we need to target one area, but I hope we don't target one silo because the whole thing of this executive order which I really appreciate the governor focusing on that it needs to be person-centered.

So, if we're going to target anything, it needs to be targeted on the person regardless of the silos. Again, thank you for you journey through the five departments. Maybe you can leave your résumé as you go along. So, thank you.

Oh, and by the way, I just want to also emphasize that, again, underscoring that people access other services within the regional center system, access Medi-Cal, as Lydia pointed out, many access CBAS, and actually they're even served by independent livings centers as well, so it's just important to remember the service coordinators in the regional centers is not a self-contained system. We just need to make sure that we understand that, and it's underfunded.

Irene Thank you very much, Marty. That really summed it up really so well. Thank you so much.

Victoria Thank you for the invitation. I'm Victoria Jump with the Ventura County Area Agency on Aging on behalf of the California Association of Area Agencies on Aging. Thank you for the invitation. I've enjoyed listening to the discussion.

Full disclosure, I have an MSSP site so I fully believe that we're looking at the PACE program. We love our adult daycare centers and adult CBAS centers as well. We're also an Aging and Disability resource center as well. So, I totally get this and love what you're discussing.

For the Area Agencies on Aging, we're really—we were purposely built, federally mandated to provide services to older adults. The system does work. The

problem is that it's so poorly funded, and disproportionately, you see the effect with the rural counties.

We've had the budgetary cuts, the recession. We lost a lot of great programs that did tremendous things for people and filled in the gaps. Our Linkages Case Management Program which was a gap while people could be on that program while they were waiting to go onto MSSP waiting to qualify age-wise.

The whole respite program and helping family caregivers. Our Alzheimer's Daycare Resource Centers, which back in the day we didn't have a lot of discussion about Alzheimer's, but now it's everywhere, and it's here, and we don't really have those resources. The centers that are still operating those programs, years later they haven't really been able to scale up. They're pretty much the same size they were back in 2007, 2008.

So, when we look at where the opportunities in the master plan are, it would be really looking at these programs that are on your periodic chart that are not funded, and before you come up with new programs, really look at what those programs did. Where they successful? Did they meet a need back then? Do they need to be retooled and change somewhat? But, look at funding those programs as well and some of our other programs.

You know, you mentioned the Title III B programs, the information and assistance, transportation, and legal services. We have the ability as Area Agencies on Aging to be extremely flexible in what we can offer, and we're pretty agile in that because of the way that we're structured, and we're different in all counties, so we can role out programs pretty quick.

We do see, as AAAs, in our relationship with the independent living centers, a huge opportunity for the state with the Aging and Disability Resource Connection Program. We've seen your documents about your information and assistance and what you're looking for. The perceived lack of access to the resources because people don't know about it.

So, we would like to see that continue, and I think the plan is to role those out county and statewide, and those are needed as well.

Finally, we have programs that are funded under the Older Americans Act, but the state was never in the position to actually put the required match. So, for our Family Caregiver Support Program, you have Area Agencies on Aging and their contracted partners that are having to come up with a 25% match, and that's difficult for some providers who could provide the service, but they can't ever apply to be a AAA provider because they don't have the money to come up with the 25% match.

The same thing with the Senior Employment Program. I know that we don't really talk about senior employment that much, but it's so needed, and if you look at all the studies and economic insecurity and people having to go back to work, you have this program that's a gem, but it's so little slots, and it doesn't really help that many people. If I had my wish list, I would add think about senior employment in your master plan and how you can address that as well.

W Thank you so much for your comments, Victoria. I think, unless there's a burning question, maybe we will go directly into Kathy Kelly's discussion of navigating the private pay market because we are going to really have an opportunity with Sarah a little bit later to talk about recommendations that are coming out of this group. So, if there are recommendations or ideas, we can talk about that in the last part of our meeting.

So, Kathy, are you on the phone?

Kathy Yes. Can you hear me?

W Yes, we can.

Kathy Okay. I have some slides that I'm going to ask Carrie or whoever to advance.

W We're having a little bit of an AV problem here, but why don't you go ahead and introduce yourself, and then—

Kathy Sure. I'm Kathy Kelly. I'm executive director of Family Caregiver Alliance in San Francisco, and we have spent our time at FCA as really developing and being one of the Caregiver Resource Centers in the state. I don't know if you know much about the Caregiver Resource Centers. We work with families who are caring for somebody with cognitive and they can have physical impairments occurring after the age of 18. We don't work with behavioral health or developmental disability issues.

In about 60% to 70% of our population, the care recipient population has some form of dementia, stroke, Parkinson's, all the different kinds, head injury, all the different kinds of cognitive impairments that can occur after the age of 18.

This was a piece of legislation that was specifically targeting the middle income even though there's not really income restrictions on accessing services, but it is targeting middle income because it was recognized back in 1980 that middle income folks were not being targeted.

I'm going to talk about paying for long-term care services for it says Medicare seniors, but really I would term it as a proxy for talking about middle income or at least not eligible for Medi-Cal services in the state. This is a really murky data area. I tried to pull the best data possible. It's mostly data that's done by secondary data analysis like the [indiscernible] study. I'll talk about that.

Small panel studies, surveys, [indiscernible] interviews, projections of cost based on the predictive analysis of certain kinds of trajectory of diseases or certain kinds of disease and what are the costs about that. We just don't have a longitudinal data set that really defines this area precisely, but suffice to say there's an awful lot of money that's being spent and an awful lot of time that's being spent by families that is uncompensated in this area.

Can you advance the slides now?

W Yes, we can. So, we're on the background slide.

Kathy Okay, good. Just as a bit of context setting, we know how many persons over 65, 6 million, 14%, and 20% of the older adult population, roughly speaking, would be eligible for Medi-Cal. Almost all the policy discussions, we saw that today and it had been mentioned earlier by different people, most of the policy

discussions focus on older adults who are eligible to receive services under Medi-Cal or be Medi-Medis on the HCBS world.

We don't really talk about the other 80%, that's the 80% of the population that's not receiving services. So, this is way of saying it's sort of the 20/80 rule; 80% of the conversation is about 20% of the population. So, I really appreciate the time to talk a little bit about the other 80% of families and how they're getting along and how the persons that need assistance are getting along in the state.

Can you advance the slide? So, this is on long-term care costs. Who will need it, and how long? There's a series of slides on this. We know that over half or more than half of those turning 65 now will need some sort of long-term care services. Women will need it more than men because women live longer. Anywhere from two to three years on average is the typical scenario, however, 14% of people will need long-term care for longer than five years, so there's a significant number, and that number will increase.

We're currently spending $225 billion on long-term care expenditures, and 73% of all individuals turning 65 between now and 2019, this is from the Healthcare Almanac information, spends between $25,000 and $250,000 on long-term care. If, in fact, you are dealing with dementia, that cost rises to about

$340,000 to care for somebody with dementia over the course of their disability.

Next slide. Some of the [indiscernible] data recently, this has just been published. We know that one-third of Medicare beneficiaries, and this is a secondary descriptive analysis of that data, use assistive devices, and report difficulty with one ADL. That's typically something that doesn't cause a great deal of functional impairment, depending upon what it is, of course.

One-third of beneficiaries have two or more ADLs currently, and one-third of beneficiaries with cognitive or functional impairment have incomes of less than $24,000, so this is on the cusp of maybe or maybe not being eligible for some of the Medi-Cal waiver programs and services. They may be just over the line and may or not be able to afford the share of cost on some of those services as well.

So, 25% spend 20% or more of their income on out-of-pocket expenses and premiums. We have about almost 4% with high long-term care support needs. Their annual spending is almost $9,200 a year. I'm just rounding these numbers. One in ten older adults with high long-term care needs receive financial gifts usually from family members that does not include the time in which family members actually provide assistance to somebody who needs assistance or with functional impairments. Next slide.

When we look at the cost probably one of the better benchmarks is the Genworth Study, and this is just some of the cost for long-term care. It's not all of the cost that we talk about and we think about in terms of the spectrum of long-term services and supports.

Were you to hire a home health aid on the more or less full-time working basis, 40 hours a week, in the State of California it would cost you $64,000, but if you happen to be in the Bay Area, it would cost you $75,000. I looked at Los Angeles. They're pretty much in the ballgame of all of California. The Bay Area just has the extra glory of having the most expensive care possible.

Daycare looks like the best deal around because it's a little over $20,000 for five days a week year round, not much difference in the Bay Area cost. Assisted living turns out to be equal. Nursing home care, if you were to pay for it privately would be $105,000 generally across the state and $135,000 in the San Francisco Bay Area.

Now, this leaves out all the rest of the services that we're talking about in many of the kinds of programs that these middle income individuals may or may not qualify for: private case management services, financial management services, transportation to healthcare, and other places that somebody might want to go to.

It also leaves out the cost of what we call the gray market in the private pay retaining and paying someone privately as a household employee, or not sometimes. So, we don't really have a very good idea about what's being spent in this gray market. You just can't get your hands around it.

It may be implied by some of the annual costs that I'm talking about, but we really don't know. We don't have a qualification for what those gray market costs should be, but we do know, and it's only with our work with families that if they are going to hire somebody for any significant amount of time, they generally do try to hire in the gray market just because it's a bit less expensive.

Should we move to the next slide? In terms of how do middle-income seniors really afford long-term care, it really actually is being provided by families. Up to 80%, 70% to 80%, depending upon which study you're looking at, of LTSS services is really being provided family members, and while sometimes family members are looked at, family caregivers are looked at as they just take mom to the doctor, they pick up medications, in the new Home Alone Study, which is not on the slide that looked at the prevalence of medical tasks and how many medical tasks families are providing as well as having high assistance with ADLs and IADLs and multiple medical tasks, there's over 50% of families are caring for this particular population, which by most definitions might mean that they're dealing with a complex care individual.

So, they're doing very complex tasks in the home usually with little or no training, so that's one of the pieces that families do. They do all of those ADLs and substitute and surrogate decision making particularly with somebody with a cognitive impairment, but they're also providing a great deal of personal care skills and medical tasks in the home.

So, what do they contribute overall? It's $470 billion in caregiving costs. It's $4.7 billion in the State of California. That's based on $41 million. We have 4.7 million potential family caregivers in the state. What are they paying out-of-pocket for cost of care? It's 80%, just about 80% are spending on average $7,000 a year for out-of-pocket costs, and the family members are using personal savings. They're reducing their retirement savings contributions, or they're dipping into current retirement funds.

Next slide, please. So, what are some of the takeaways from this? One is that 80% of the majority of older adults, 80% are not covered by any insurance or public program to help pay for LTSS. Market penetration of even long-term care policies that might pay for that is less than 10%. It's not clear how many of those are 65 at this particular time.

Most rely on family and friends to pitch in and help with additional services. We know as age increase, assistance with ADLs and IADLs increases along with the need for LTSS. Our failure to plan for the higher percentage of older adults that

are in this particular grouping, this middle-income grouping means that more individuals will defer either care, medications, basic necessities, all of those social determinants.

Families will continue to struggle to provide and pay for care risking their own financial and physical health, which is my very professional state-of-art term for saying this is sort of a Whack-a-Mole game that we're playing in terms of provision of services and cost.

What may not be a cost to the formal system, it may not be a payment from the formal system does mean that it's free of cost for the family because on our observations of looking at our own data, and this is from almost 200,000 families that have contacted us from anywhere in the Bay Area and also nationally, the number-one or number-two question that we get from families upon call as why they're calling us, depending upon the month is how I pay for care or get paid for care. That's the number-one question.

So, adult children call us after they've run through their savings or retirement savings or when they dropped out of the workforce and are looking to retire, now have no savings or retirement, and they're a quarter short of Social Security. That's a typical call.

We have failed in a lot of ways to provide for these folks that are most at risk, which is in the lower-middle-income bracket, but we're also failing to have some services and supports or mechanism for payment for middle-income people in general.

Last slide, possible sort of policy areas to look at. I'm just going to make mention that I have not seen the VA talked. It was referenced a little bit earlier. They're a huge component of research, particularly into this area. They've done most of the workforce training. They go through the VA system. Their services are significant.

They recently had a program that was expanded. They're called it the Caregiver Support Program. It was originally for post-9/11 vets. Now, it's been expanded to all eras. They pay a stipend based on one ADL to the family or friend or whoever the veteran identifies of prevailing wage. They wrap round the person who's providing this care.

Health insurance, therapy service, vacation time, travel to health specialty appointments, and case management services, so it's a rich package of services. It's not income-indexed. So, the VA is also a place to look for where a lot of these programs are being replicated in quite a different way.

On the other policy solutions, we haven't had much experience with Medicare Advantage plans as we have with Advantage Care plans and Medi-Medi like [indiscernible], the plan in Kentucky. There's some health insurance plans in Washington State and Hawaii for possible replication. I know there's a group that's working on that. For the baby boomers, it's probably too late given the fact that these are long-tail programs with vestments, and you have to be employed.

There's [indiscernible] experience of service payments across the state that target middle-income. There is the Support at Home Program—I know that Shireen is not onboard right now—in San Francisco County. It has a small case study of middle-income individuals and underwriting their care. We serve a lot of middle-income folks, obviously through the Caregiver Resource Center, and I talked about the VA program.

I did not talk to Peter before this call, but expanding the PACE model was sliding fee scale for middle-income adults does look promising as well as the CBAS program. Nice to know that there are some private pay, but it's a pretty heavy lift for most folks.

For the caregiver support component on the PACE model, there was a recent study looking at the retrospective analysis of satisfaction and reduction of stress that showed some very promising directions in terms of the impact on the

family by having a family member involved in PACE that they were able to continue employment, and they had a lot less stress because they weren't managing the total care package for that individual. So, that looks particularly promising from a family caregiver perspective.

I'll stop there. Thank you.

W Thank you so much, Kathy, for that presentation. I think it really flows nicely into our next conversation about [audio drops] discuss recommendations [audio drops]. Kathy, it'd be great if you could stay on the phone to answer any questions or be part of that conversation.

Kathy Okay.

W Now, I'm going to hand it over to Sarah Steenhausen who is going to get us into the meat of this conversation where we discuss at least four recommendations that have come through this committee already: the PACE expansion, Lydia has a recommendation on adult day services, the LTSS benefit, and the information and assistance recommendation. We have Jedd in the room who's going to talk a little bit about—

Sarah I'll turn it over to Jedd, and who's presenting the I&A recommendation? Do we know?

W I think it might be Ana.

Sarah Ana. Okay. So, just before we get into the specific recommendations, what I think would be really great is to kind of marry some of the recommendations that have already evolved out of this committee with some of the themes we heard today so that we can maybe develop some new recommendations coming from today's discussion.

So, just to kind of step back and think about what we've heard, from the person's perspective, we know that people don't live in silos, and they don't think of themselves as separate funding streams. So, the goal is to figure out how we can get to a place where people can move seamlessly through the system and get services that meet their needs rather than the other way around which is trying to plug them into the services that are available.

With that said, we know that the future of our service delivery system is likely a managed care infrastructure with the goal of developing a more coordinated, integrated service delivery system. I think everybody recognizes that that's a

tremendous goal but that we have a long ways to go before we get there, and there are many challenges but opportunities at the same time.

So, knowing that that for people on Medi-Cal, managed care is going to be the place where they receive the bulk of their services, and the state it sounds like is envisioning that with time, more and more services will continue to be added, kind of trying to move to that segment of the thinking of the whole-person care.

So, some of the themes that we heard today was recognizing how we can ensure that that system is part of an integrated service delivery system that connects people with the range of services that we just heard about that are outside of that system, so that's one, and that really focuses on care coordination.

The second theme I heard a lot of was access across the board. This system is so underfunded that there is tremendous lack of access across the state, and that is particularly heightened for people in rural areas. It's heightened for people who might not speak English and might not have access to services in their language, but even if we were to expand access and grow all of these programs, we're still going to have significant problems with fragmentation.

So, then that leads to the issue of how we reduce regulatory barriers. How can we ensure that whether or not you're on Medi-Cal it's easy to access some of these services? How can we help, say for example, make MSSP or PACE or CBAS more private pay potential? How can we ensure that more people can access adult day care who are on Medi-Cal and might not currently be able to afford it?

Then, also, even if we were to grow access, and we were to reduce regulatory barriers, and we were to have a more coordinated system of care, then our fourth big, significant challenge is that people don't have a way to pay for long-term services and supports.

Patty Sarah, this is Patty. I'm sorry to interrupt, but my phone is going to lose power, and I'm going to have to call in on my AT&T phone, but I don't know that I'll be able to get back in in terms of my voice, and I do have something to say about the funding thing.

Sarah Okay, well, hopefully, Patty, with your new connection we will be able to hear you, and if not—

Patty You'll hear from me.

Sarah Okay, sounds good. Thank you.

Patty Okay.

Sarah You can text Carrie, too.

Patty Yes, I will text Carrie. Good.

Sarah Thanks, bye. Okay, so even if we address the issues of the infrastructure and expanding access, of reducing barriers, of better coordinating the system of care, then we have a huge roadblock of how people pay for services. If you're on Medi-Cal, that addresses part of the problem, but not all of it because Medi-Cal doesn't cover everything. So, that's where the issue of the LTSS benefit comes in that Jedd's going to talk about.

Then, fifth, kind of overarching all of this, people don't know how the heck to access any of these things, so even if we have a beautiful system that's perfectly funded and structured, they don't know where to start or how to get in, and that's where the I&A recommendation falls in.

So, I think that we're missing a few recommendations that stem from today's conversation, and maybe we can talk more about those, but I want to first turn

to Jedd who will summarize the LTSS benefit recommendation that you all have worked on, and then, Ana, you're going to do the I&A reco, right? Okay.

Then we're going to touch on these other issues, and I want to make sure we hear from Maya and the others who didn't get to finish their thoughts earlier today.

[Speaker off mic].

Sarah Yes, absolutely. Yes, I agree. So, Jedd, let me bring this over to you.

Jedd Thank you, everybody. Glad to be back before you again today. Jedd Hampton, I'm the director of public policy for Leading Age California. We represent over 600 not-for-profit providers of senior affordable hosing, care and services for older adults throughout the state. Our membership includes residential care facilities for the elderly, skilled nursing facilities, home health agencies, PACE. We have a variety of providers within our membership that serve older adults across the continuum.

I am here today as a member of the California Aging and Disability Alliance which is a coalition of over 20 organizations that providers, consumers, advocates, disability partners, and labor that have been working on this issue

for probably two to three years, maybe longer for some of us, looking at ways that we can help finance long-term care.

Now, I know we had a significant discussion about this at the last LTSS subcommittee meeting, so I will probably keep my comments relatively brief and summarize the proposal before you that was developed and sponsored by the California Aging and Disability Alliance, and that recommendation is quite clear and quite simple, and that is to create a social insurance, long-term services and support benefit in California.

The first step that we think is the most critical piece, and it's a piece that CADA has worked on all throughout last year and into this year is securing funding to develop and procure an actuarial study and feasibility study for a social insurance benefit here in California. We were very fortunate for our partners as well as the administration for considering our request, and that actuarial analysis and the money was appropriated to that in this last budget. So, we are very excited that that was put into place and is moving forward.

We do think that that is the first and most critical step because what we really need to do is really understand if there's going to be a social insurance benefit here in California, who is eligible, what benefits will be offered, and what might it cost?

So, now that we have that piece underway, I really wanted to talk about from our perspective, and by our I mean California Aging and Disability Alliance, what a potential social insurance LTSS benefit should really consider—what we should consider in California when it comes to a long-term care LTSS benefit.

I think the most important piece that we should be considering is that the benefit is consumer-directed, and that means that the benefit should be flexible and enable the beneficiary to determine the best use of funds on their individual needs and preferences, so whether that benefit is received in a home and community-based setting, or if it's received in an institutional setting, the individual, the beneficiary should have that consumer-directed approach to utilize that benefit in the way that they see best meets their care needs.

We've also looked at eligibility and believe that an LTSS benefit or social insurance model here in California should consider eligibility based on both the individual's needs and the family's needs for caregiver support and should include a need for the family support in the assessment of the beneficiary.

We are also looking at feasibility and [indiscernible] with fiscal considerations in mind, obviously be mindful of what is politically feasible to the public at large and the policymakers, and also looking at timeline. We do believe that the vestment should be implemented within a five-year timeframe.

We do believe that the actuarial study should also capture—really go wide and deep in terms of considerations for a benefit. That includes looking at target populations including people with childhood-acquired disabilities with a potential buy-in option for specified populations if that individual can pay in.

Obviously, we believe that the actuarial study and feasibility study will tell us a lot in terms of eligibility, financial constraints, and will very potentially shape the political motivation to want to determine that as we move forward, but we do believe hat it should be wide and deep in terms of its considerations.

We also believe that the benefit should consider a wide variety of funding sources and look at any and all options that would help pay for this type of program. We also think that within that we should look at how it's going to save the state general fund money. We know from the work that's been done at the national level, from the work that's been done in Washington and other states that there is a significant component to saving potential savings in Medicaid, and we think that that should be explored in depth in the actuarial study as well.

So, quite simply, I think you're all probably relatively familiar with what this recommendation is. We've discussed it at length, but quite simply, we believe that California should strongly consider creating a social insurance benefit here in California.

M Here, here.

Sarah We'll have time to kind of discuss all of these together after we here from the other recommenders.

Ana Great. Well, thank you so much. We have a team that is bringing forward to you the recommendation for information and assistance. So, just to frame it a little bit that access to good information is the most critical point to start with in getting people connected to local resources that they will benefit from, and is an essential part of the coordinated entry type of a system for long-term services and support.

So, I'm not going to go over the whole recommendation, but I'm going to bring to light a few of—kind of an overview of what we're recommending. This recommendation includes a consumer-friendly branded and standardized web-based and digitalized statewide consumer I&A system that feeds into local programs and systems.

That statewide program, we developed statewide program standards for local community assistance programs we're calling them here to ensure consistency across the sate on the local level. We want to develop a statewide web-based

platform that connects the consumer with local consumer-assisted programs with a standardized assessment and protocol to enable access to a list of available local services and supports as well as a designated 800-number that will connect to the local level services 24/7.

With this, we have outlined some program standards including person-centered approaches to services that we built off of warm hand-offs and follow-up as part of information and assistance and that there's collaboration on the local level with existing community-based organizations that are already providing I&A services.

I also wanted to call out that the best practice at the local level would be the ability to not only provide information and assistance, but perform direct intakes for key programs such as Older Americans Act, IHSS, and Medi-Cal waiver programs. So, this I&A statewide and then local program could do that initial intake as well as risk assessment for various programs that the person might be eligible for.

I wanted to mention that a few things we feel are missing from this recommendation are specific actions for different agencies, state, local, government, or local agencies and really looking at how to break down these recommendations into legislation, regulation, or policy changes. So, in other words, how are we going to implement these recommendations?

I also want to make note that there was a lot of discussion I heard on this committee because this recommendation includes the statewide branding, an 800-number, and website, but I think a lot of us are really focused and prioritize, I would say, supporting the local assistance programs, the local I&A providers because as much as a statewide program will help with branding, and at least it will be a number for people to get connected to local resources, what we know is the best support is done on the local level with people in that community that understand the local culture, understand the local resources available in that specific community.

So, we want to highlight that as something that we've had a lot of discussion about, but I think for myself, I think we could do both, have a statewide branding and guidelines for these programs really focusing on that local support that's going to be boots on the ground support for those individuals and handholding to get them to all the resources and services they're eligible for and want to connect with.

W Thank you.

Patty Are you taking questions?

Sarah Actually, Patty, we will be taking questions and comments as soon as we run through the other—

Patty Oh, sorry. See, I can't see.

Sarah No, that's fine. Peter and Lydia both presented briefly their recommendations. I wanted to see if they wanted to add onto those or summarize them again from what you had already mentioned earlier because I think we have system-level recommendations and then there's going to be, I'm sure, program-specific recommendations as well.

Peter Well, I think our overall recommendation is that the state would provide access to PACE for all who could benefit from it where it's feasible to offer it. Some sub-recommendations would be to make sure PACE is connected to the information and referral system as one of the options and that people are trained in it and understand it. We actually have a fairly low recognition from HICAP, for example. I'm not sure why, but the surveys show that very few HICAP counselors are fully aware of PACE.

We would want to see PACE included in programs that the state assess need for. I'm not sure if we've touched on that as a recommendation, but we would like to see the state actually do some mapping to look at areas that are underserved

for home and community-based programs of various kinds, and we would hope that PACE would be part of that.

To connect to Jedd's presentation, we are hopeful that PACE would be among the things that people could use a long-term care benefit for, and I think that's assumed in the proposal, but it's just something we would want to highlight. Then, we have some CalAIM recommendations that maybe overlap that have to do with making sure PACE is offered in CalAIM as an enrollment choice, that people are aware of it when they make those decisions, that there's consistent and up-to-date information in CalAIM about PACE. We've had mixed results with Medi-Cal Managed Care enrollment materials and how well they represent PACE. We want to take the opportunity to upgrade that if we can.

Then, a sub-point for us is just it's important that given the timing issues with PACE that people be able to enroll and disenroll in CalAIM plans and at PACE in both directions, actually. So, we would have some concerns if there wasn't an exception from people to be able to enroll outside of an annual enrolment period. Thank you.

Sarah Lydia, I'll bring this over to you.

Lydia

I'll be quick. The recommendation I submitted is one of several. They're still coming, but the one that I submitted for today was more around the idea that Sarah mentioned which is regulatory efficiency.

To go back to the future, consolidating licensing and certification in the Department of Aging where now it is divided. We have three departments, if you don't count the Department of Education and the VA and others who oversee programs. It makes for a very confusing understanding of the programs, and it creates a lot of delays in start-up of new sites and a lot of confusion in understanding regulatory requirements for the providers. So, for both providers and consumers, I think it would have a lot to do.

I'm going to be submitting another recommendation about activating a statute that's still on the books around start-up and grants for citing new programs in underserved areas, and one as Peter mentioned relating to CalAIM that we'll talk about in lieu of services and our thoughts about including adult day programs, who can be accessed.

I just want to make one point. As we talk about infrastructure and rebuilding capacity that was long during the great recession, to the extent that we do build up some of these government-funded programs like MSSP, IHSS, and so on, as my friend, Denise mentioned, and CBAS, it is improving access for the private team market if we think creatively about that.

So, I think that's something we should always keep in mind. It's easy to kind of fall back in our patterns of talking about what we know and love and understand, but looking at the boarder group that Kathleen Kelly talked about, the 80%. I think that's an important thing for us to keep in mind.

Sarah Yes, a very, very important point, and along the linens of consolidating, licensing and certification, that does bring another kind of overarching issue that has been discussed in other realms which is the concept of consolidating leadership at the state level. I know there's different perspectives on this, but having one state entity that is responsible for the range of services that are provided to older adults and people with disabilities as a way to coordinate and have strong leadership on all of these issues. So, that's something to overlay.

Right now, I'd love to turn it to who has questions or comments about what we've heard thus far as well as some of the emerging themes that I highlighted at the beginning.

Patty Can I give my input on I&A? Are you still taking input on that information and assistance?

Sarah We are taking comments on anything, and then I'm noting who else wants to talk here. We have Karen and Maya and Craig.

Ellen S. This is Ellen. I'd like to come in, too, at some point.

Sarah Great, and Ellen, okay. You're doing the queue?

Patty I'm sorry, I can't—just tell me, Sarah, when I can.

Sarah Patty, we're ready for you.

Patty On the I&A just because that was the last one you were taking input on, I have some real concerns about a statewide number. If there's anybody that's supposed to be really trained in what is available in the community, professional, degreed people that can really handhold. It has to be at the state level because it's not at the local level.

I mean, I don't know. One of the things you need to find out, one of things that we would need to look at is how much money is going into every I&A service through an Area Agency on Aging in California. Some are only putting $30,000 into the service because there's never been enough money. It's never been the

highlight service, so you have volunteers running these services at the local level who may not know what's going on, who are not trained to do kind of the case thing that you want people to be able to do at the local level, but we don't have that information.

So, somebody has to be—when you're talking about okay, how are we going—what are we missing locally? What you're missing is who is available at the local level to implement it. Uh-oh, I have no power anymore. Can you hear me?

Sarah You always have power, girl.

Patty No, it keeps going bzz, bzz on my phone. Did you hear me?

Sarah We heard you, Patty.

Patty Okay. I mean, I'm serious. I'm serious. We never put more than $35,000 into our I&A service. I mean, that was back in the 90s, but it was never—but, that's a whole other story in terms of CDA funding. It's not CDA. It's Older Americans Act funding, but that's a whole other issue to talk about, and it's whether or not all these services are still needed. Do we need to wipe the slate clean and say okay, what's needed, and how do we get there?

I don't know. I mean, it's just that I can't believe everything that we have out there, and it's all tailored to driving people in poverty in order that they can qualify for nursing home services. We drive people into poverty in this state, and it just makes me sick. It's true.

Sarah Hopefully, some of what you're raising will be addressed in the master plan, and we heard your feedback about needing to ensure that at the state level, any kind of number has the appropriate staffing behind it.

Patty No. We have to look at that. I mean, you can't just talk about an I&A system without having the appropriate system at the local level. We've been doing this since 1975, and we're still talking about people don't know how to contact and get into services. They don't do it by calling the Area Agency on Agency.

Sarah It's a very important consideration, and I think one that will need to be given a lot of attention about how people access services at both the state and local level.

Patty One of the things I want to say before my phone goes out, and I don't know how to deal with this because—anyway, is the thing about funding. Going back, what Oregon did years ago, before there was such a thing as a PACE program,

before we had adult day healthcare, before we had some of our magnificent programs, they went in—of course, it's a much smaller state—but, they went in, and the Area Agencies on Aging took the lead role in this, and they interviewed everybody in every skilled nursing facility in the state of Oregon in order to transition out people who didn't belong there. They took the cost savings of that and reinvested it in other services, and that's something that we could do as well.

Sarah That was supposed to happen with Money Follows the Person.

Patty Well, it didn't, did it?

Sarah That's a great point and something to, I think, think about fiscally. I'm going to turn it to Karen because we have a number of people who want to speak, and thank you for your comments, Patty.

Patty Yes, I'm through. I'm going to have hang up because I'm going to lose my power.

Sarah Thank you.

Patty Bye.

Karen First I want to steal a line from Maya who said that the folks who got these recommendations are the overachievers in our group. I think that's really true. I'm thinking through recommendations, but haven't gotten pen to paper.

I'm wondering exactly what the process is to do some changes that I would see in the documents, and specifically on the information and assistance. You, know, I would want to see additional state agencies. For example, IHSS is the elephant in the room, but the Department of Social Services isn't listed.

You have Area Agencies on Aging under community-based organizations, but for many, depending on their community, they're considered a local government agency. It doesn't include public authorities. It doesn't include behavioral health. There are a number of things that need to be done, I think just in terms of even the local government piece to make sure that you have tighter collaboration at the local level amongst local government agencies including public authorities.

So, my question here is how to go about making recommendations to change and then finalize. I want to, before you answer the question, also react to the word that Ana had said on intake. There's a big difference between providing

information and assistance about programs and actually doing intake that often is viewed as a word that is part of an eligibility and application process.

So, I want to be clear on some of these words that intake, to me, is not information and assistance. It's a completely separate and distinct function, and in many cases, it will have to belong to the counties for Medi-Cal, for IHSS, etc., and shouldn't be farmed out to other entities.

I want to return back to the question of rather than getting into the specific words on each of these, maybe if we could just take a bit of time and understand what the process is going to be to finalize these recommendations.

Sarah My understanding is that this is iterative. It's not like any of this is set in stone, and I think you raised a really important point and considerations about language. Kim, is that true that this is not the last time to—yes, it's just the beginning.

Kim [Speaker off mic]. I kind of like it. In the calendar perspective, we are trying to get as far as we can on substance, and I do think flagging issues of words is really, really important, but on each topic each week, and then in late January, there's kind of a sum-up meeting schedule. Let's go back and review all those things.

I'm trying to do the calendar by heart, which is not my strength. Maybe like the second or third slide, Ellen. Actually, like slide 2 had the calendar, just from a process perspective. Next one. Nope, one more. Sorry.

Okay. It says January 27th, report content and process, and that is let's summarize what we want to say, what you all want to say as stakeholders, how you want to say it at that meeting. Then, our intent is Carrie will start writing and assembling and putting together as much as is asked to do by the subcommittee.

Then, the vision is that there will be ideally a conference call to look at a draft so that everybody can look at the draft and say, yes this is ready to go to the Stakeholder Advisory Committee meeting March 2nd. Again, I'm doing this by memory, so please stay with me here. So, late January, you have the meeting in person to get your marching orders to get the content right to process right. Carrie writes.

You look at the draft late February, say ready to go to SAC. The March 2nd stakeholder meeting talks about the report. The full stakeholder committee meeting may say that they want some changes, and then you all would quickly convene in early March on the phone probably again to finalize so that you can submit to the administration by the end of March.

I think that suggests that there's at least that January 27th meeting, the February call, the March 2nd SAC, and the March call to return to it, but I do think it's important to get as far as you can on content. Then, I should also say I assume there is a lot of work happening outside, calls and emails to continue to do work.

Karen — On the specific papers, each of them that was emailed to us on the author shows the person who created the template which is you, so we could send all of our comments to you, or we could find another way to identify that if we have amendments, who it is that we would suggest those wording changes.

Patty — What we need, Kim, is we need a listing of everybody's email address and their cell phone numbers so we can contact them.

Sarah — That's a great idea, Patty. I think also, to respond to Karen's question, there have been like three, four people that have been working on each of these recommendations. I would offer that I'm happy to circle back with you and Ana and the others who've worked on this, and we can go through and just have a quick half-hour call because I agree. Some of this has to happen outside of this structure.

Does that work, Kim, for us to just kind of—

Kim Yes, although I take the friendly amendment that we need the visibility of who is working on the recommendation who's not there and then the complete contact list. On the author, it says the person who made the template, so it only says Carrie probably, or it says—

W It says you.

Kim It says me, oh. Yes.

Sarah Susan and Ana and Karen.

Kim We can figure out how to appropriately tag who the people are who are taking those iterative coordinated comments all the way along, and then also there's been a request for the complete committee list membership email, and since we have cell phones everybody knows how to find each others.

Sarah Maya, you have waited patiently.

Maya

Thanks. I wanted to—surprise, surprise—follow up on Sarah's integration comment and reemphasize that the system is 70% to 80% of the—80% of people on Medi-Cal are managed care, and they're getting the bulk of their services. It is now a fact, so we have to work within that system.

I love the programs, all the programs that we're talking about today. If I could wave a magic wand that all managed care plans contract with these programs, I would do that.

I'm just going to use MSSP as an example. I think MSSP was part of Cal MediConnect and CCI. In San Mateo, we did successfully integrate the program. Our vision was that you don't have to be eligible for certain tings to be in the program, so for example, we did away with the age limit. You didn't have to be over 65. You needed the services, you got those services. We looked at the set of services that people need.

We don't have a wait list right now, but I think the vision is that there are no wait lists that people, if they need those services, they get them. I think because CalAIM talks about this enhanced care management and, Denise, you said it. Enhanced care management is what MSSP does.

So, let's think about it. What's going to happen with the health plans? You still want them to contract with you for the people that are above the cap. If you have a wait list, how are people going to get services? Well, the health plan should be able to do it through enhanced care management, enhanced care management contracting with you.

So, we want to really work to get these programs and plans more coordinated and more together. I think that's the more likely outcome than, frankly, adding more slots because there's never going to be enough money to add enough slots and enough sites, so how do we use the existing structures to get more services to more people?

Patty Well, I think some of the services are no longer need that we're funding. I mean, we can relook at the slate.

Sarah Hold on. We have somebody in the room that's going to respond.

Denis Maya, thank you. Denise Likar, Independence at Home, MSSP. The first thing is San Mateo was a wonderful example of where it worked, and as you know, the Site Association was always supportive of the transition. You guys were ready to go.

What happened in San Mateo didn't happen in the other six CCI counties, and by the way, when we recommended after five years to carve us out at this point was because we weren't making the progress in those counties, but we didn't recommend for San Mateo. We knew that you guys were working and were a great model.

When I made the comment that one size doesn't fit all, every county is not the same in this state, and you're absolutely right. That end goal—because we all saw it. We worked really hard in the six counties for five years trying to get to that type of teamwork with the health plans and that type of—and, what you guys did in your county and were able to embrace, and you guys started years before because I remember Chris coming to the MSA meetings and talk about the universal assessment you guys were already launching in your county ten years before. Lydia, yes—ten years before CCI every hit the front page.

I think the work you did for that ten years, you guys in your county did, set you guys up for—plus your design in terms of you didn't have a ton of managed care plans to have to work with and all kinds of things—set you guys up for amazing results. That was our hope that we could replicate that, and we didn't. That's why MSSP we didn't want it to go away in the counties where it was going to transition into managed care, and the waiver wasn't going to exist.

You're absolutely right that we have to get to a better place. Sarah's comment that we have to get to a better place where we're using the money more thoughtfully in the system, but it's going to take a while. So, adding slots now for the needs now to a program that is proven, I mean, we have counties in the state that don't have managed care or MSSP, so they have a long way to go.

When we do our recommendations, because that's our next step as an association to turn in our recommendations, my personal kind of—the way I frame it right now is I think there's a three-pathway for MSSP that builds out over time, but salvages a model that we all know, and you just said also that works.

One is we need some slots, and we need to expand the program to places that it doesn't exist because people need things now. They can't wait for us to get it right, but there can be where MSSP, like CBAS, is mandated into the system versus being sucked up by the system. We can work side-by-side like CBAS has proven so the model integrity stays intact and that that moves forward.

I think there is a third possible path, although this one's a real stretch because of the population we serve, but if there's a way that there could be a fee-for-service sliding fee scale of some sort somewhere in there for the family members that live out of state that want mom to stay where she's at, mom doesn't have a lot of support, we see a lot more of that.

Children have moved away. They've left California because they can't afford to live here, and they could pay for services like MSSP. I think there's a longer path, but the waiver for now is what we have, and we know there's a need. If we are mandated as part of the managed care continuum as we build out this next phase, managed care can pay us directly. Then, there's a possibility of that third swim lane. That one is fuzzier to me, but we have to think of all the possibilities for a model that's proven and worked.

W [Speaker off mic].

Craig I don't want to prolong this too long, but I just want to say I think I fully agree with a lot of what I've heard today, and it was very good. As we think about the silos, and there are so many silos right now, the sector that I represent, I think we have always supported and continue to support having people in the most appropriate setting possible, whatever is the most appropriate setting.

What I would encourage us to think about though, since I represent more of an institutional setting, and Jedd does, too, is how we use those settings to enhance what you would do in the settings like PACE or MSSP. Can we use the settings where we work as more like tune-up centers, very short-term, extremely short-term tune-up centers where people might be able to be maintained at home, be maintained in a program, but just for a very short

period of time? Come into a SNP because it's a very urgent problem they have, but extremely short.

That way, I think over the longer term, you can maintain people in those other settings better longer and not wait until they then need a much longer-term care in the SNP setting. So, I think we just need to think about that broadening out. As we reduce the silos, just broadening out the use of the services we have.

Sarah Thank you very much, Craig. I heard a couple of themes, too, emerging from this subset of managed care transition of recognizing that we're going to start planning on how to build these relationships across managed care and the community-based organizations, particularly, like MSSP, etc., but then how do you address the immediate need, the crisis that people aren't getting what they need.

Also recognizing that this is a continuum of care, and skilled nursing facilities, many people still need skilled nursing facilities, so we need to ensure that there is appropriate access to those for those who need them, and particularly people who can't stay at home, maybe cognitive impairment or what have you.

Who was next? Was it Marty?

[Overlapping voices].

Marty Thank you. Marty Omoto, CDCAN, and I echo what Craig said about supporting all that was said. I've been aways a strong supporter of the three programs that have been mentioned here specifically, CBAS but also especially when CBAS was under attack, but also PACE and MSSP.

You're also right that it's not well known, and that lack of visibility actually contributes to the fact that there's not the kind of support that is needed in terms of solutions.

So, this is a process question for Kim because I know that—no, actually as we're getting these recommendations coming through the subcommittee from the members, and there are recommendations coming in from the general public, people who are not necessarily on the subcommittee, and I think that's—it's not a hard, fast deadline, but I think there was a target of next week, next Friday.

How do those get folded in, and who's the lucky person who gets to read all those things? Carrie? Then, how do we map that out in terms of—because some of those will be similar to what is being proposed here, and some of them may actually help expand some of those ideas.

Then, the other thing is as we're looking forward towards moving these recommendations or shaping them to the full committee, what are the—or maybe that's something we still need to talk about. I mean, there's a thing about dream big and the sky and all that, and don't think about funding, but a lot of us have been through the budget process, and I think about the funding issue, and what's possible. So, how much of that plays into it? As we sort of identify these recommendations, what should be short-term goals?

As you said, there are people who need it now. My family was in that position where we couldn't wait for certain help that we didn't get. Then, the longer-term goals, and also there might be targets of populations within the older Californians that maybe we need to target or a certain region, so I don't know.

Is that, in terms of the recommendations because otherwise if we just recommend all these things that are across the board or whatever not taking into account the realities or perceived realities of funding and what public policy and all that stuff, then we're going to be like every other group in the past that we've sat on where we make great recommendation, and they kind of just sit there?

Kim So, two parts to your question. On the recommendations that are coming in, on the template next Friday, you're absolutely right. Carrie Graham, our policy

consultant, will be bringing those to the appropriate meeting, and listen, we know we're halfway through the meeting.

So, it's tricky. We're parallel tracking a lot of things. So, if some come in next week on MSSP, the small group who's working on refining the recommendation will get them.

There's also the public comments. That's part of why we moved it to Survey Monkey so we can have some summary data of that. We'll be sharing that as well sort of at the highest level. The public comments tend to be shorter, more personal stories, more urgent needs, so we want to share those as well.

We are committed to taking those, and as soon as we get them, kind of weaving them in. That was part of the reason why we put this December 13th time line which feels earlier to people, but it's also late for this product.

The second question though, I'm going to answer your question in terms of the first deliverable from this group is a stakeholder report. So, the questions you're asking are really for your peers, and on the one hand, we're trying—we were suggesting we kind of hold that conversation until the 27th because we have to get all this content out on the table, but it is absolutely right.

Do you want your report to be long-term, medium-term, short-term, fiscal, not fiscal, prioritized, not—you know, regional? All those things I think are questions for you all, and it's not too early to start thinking about that. How would you outline it, frame it? That's all welcome.

The second part of the question we have more time for which is the master plan. Again, we'll want recommendations from all of you about how to do that, and ultimately the administration will decide how to issue it, but it is a ten-year plan with benchmarks, so that's the high-level direction we have.

Patty

I just wanted—this is still Patty—I just want to enter this one thing. For the last 45 years that I've been involved in this business, the focus has always been, whether it's federal dollars or state dollars, is on low income people. We've been talking all day about services that serve the low income. The master plan is supposed to also deal with the 80% of people or the 60% or whatever it is that's middle class that's not involved in this service base, and we have to talk about that.

We've been so focused on one population, some just based on age, but not just functional ability. I'm one that says screw the age. It's not age, it's functional ability that should be focused on, but that could be focused on the middle class or low-income people. We haven't been talking about that at all.

Kim I'm going to push back a little on that since we've had three topics so far. The first one was info and assistance that was for all incomes. The second was—

Patty It was totally failed at for 45 years, totally failed.

Kim Well, we're going to try again.

Patty Totally failed.

Kim The second topic was public benefit, which is really about folks in the middle class, the missing middle. Today, we tried to cover the spectrum, and I think we tried to open the door that many of these programs to expand and thrive need to tap into private payers. I think that's a new frontier.

Patty I totally agree with that. I'm just saying—well, anyway.

Kim We have to keep raising it. You're absolutely right. I will also say the executive order does talk specifically about IHSS and the need to figure out some of these—

Patty Because it's a big elephant in the room, Kim. I mean, that's what the state spends the money on. You also don't have a legislature that gives a s*** about older people, you don't, and you don't have a federal government that gives a darn about older people. We've never put the kind of money in that needs to be put in, ever. It just is what it is, and we're funding programs that don't need to be funded anymore. They're not priority programs.

Kim Alright, Patty, for good meeting protocol, I'm going to let other voices in the room speak, and particularly, we're getting very close to the need and desire to hear from public comments. Is there anyone—

Nina This is Nina, AARP. I'd like to speak on [indiscernible].

Sarah You'll get in line. We have Claire and then Lydia, and who was after Lydia? Oh, Ellen. Claire, Lydia, Ellen, and Ana, and Nina. Okay, Claire.

Claire Thank you. This is Claire from Justice in Aging. I have a couple comments, but I will make them quick because I know there's a big line. On the process piece, Marty, thank you for bringing that up because I'm worried that like unless we start having 24-hour meetings, we're like going to snowball into some sort of unworkable—yes, mess. Thank you.

Obviously, I know Carrie is going to do a ton of this work, but [background noise]. Could there be a small group of people who are charged with working on this? I know nobody has any more time, so I don't know who those people are going to be, but somebody [background noise]. I just think we cannot do this—

Kim Wide open to spending more group time talking about that. We're wide open to a small group working on that. We're wide open.

Claire Okay, so maybe that's not the right thing, but I just think we can't do both. We can't have three hours of presentations and then 45 minutes of recommendations [background noise]. So, we have to figure something out.

The other piece I really want to lay out here is why I'm worried about the long-term [background noise].

W Could somebody mute their line? There's a lot of background noise.

Claire Thanks. I'm worried because I really appreciate all the things Mari said when she was here. I know DHCS has done a ton of work on CalAIM, but this is a very good example of how that's—I mean, I love the master plan. It's real, but it's

not right. CalAIM is like this is what we're doing, and they don't have a plan for LTSS.

People are worried. People are pushing back on that. People are asking for a stakeholder group or something comprehensive on that. That thing will happen. What we say might not, so where is—maybe there's a recommendation from this committee directly to CalAIM, directly to DHCS.

It's like you need—I loved what Mari said about we want a plan that's our next frontier. Well, okay, we have to make that happen because no way we're fixing any of this if it's just a fragmented thing, and DHCS just keeps rolling along.

So, I don't know. It's like to turn this into something real, it has to be part of that integrated into that.

Sarah Okay, Lydia.

Lydia Lydia Missaelides. I also had a process question, but it's been discussed now, and I appreciate what you said, Claire, because it does feel like it's a real disjointed process right now, and God bless Carrie and any of you who are going to try to pull this all together.

I have some other ideas I'd like to submit by Friday, but they're not going to have a chance to be discussed by my peers. Like one of them has to do with oral health, dental. We have startup grants and so on, and then Craig and I were just talking about another idea. Maybe he's interested in working with me on it, I don't know. It's his idea, but I like it.

So, I'm just looking for some guidance on—

Kim

We are, too. So, if you would like a process meeting, we can have one. If you'd like full-day meetings, we can have them. If you'd like more meetings—that's what we're trying to figure is how we set tables for the big issues and open them up for airing public comment, and then recognizing there's a ton of work to do.

So, we have that kind of placeholder meeting the 27th for other issues, but we welcome a steering, an executive, people who can start writing and outlining. We'd love it. We agree with you. This is a very aggressive timeline for a very comprehensive product, and CalAIM, we see it, too.

Lydia

I'd like to second Claire's recommendation about putting forth a recommendation ASAP from this group to ask CalAIM to convene some folks

who can really drill into the LTSS part of their plan. There are a lot of people in this room who have concerns about what they've read so far, and if the future continues to be managed care, we have a lot to think about.

Sarah They are releasing a paper soon, DHCS, on the LTSS side of things and the Medicare, Medicaid integration side. So, that would be a great opportunity for whoever wants to from this group to convene and talk about it and break it part or something like that.

Kim Yes, and I want to acknowledge Anastasia in DHCS who's in the room. I don't want to put her on the spot, but I'll give her a second to think about if she wants to be on the spot.

For those of you who were at the last full stakeholder committee meeting, that request was made by the full stakeholder committee, two-secretary galley. I don't believe that a full—no, but I don't believe that a full response has been provided yet. Is that fair? Yes, that's fair.

I'm just updating you on that that request was made and that I don't believe it's been responded to, but unless, Anastasia, do you want to be put on the spot, or do you want to—

Anastasia To that point, the paper is coming. There will be further discussion in January, so I'm not sure, I guess, what the specific thing that folks may want as far as a separate workgroup. So, being more specific, and I'll just say Mari was here, so we're trying to bridge the two efforts together and would welcome further feedback and specifically how you think we ought to bridge.

Kim I think that's where Fig [ph] and I left the conversation was let's hear from Mari today. Let's see where the conversation goes, and then what specifically is the right next step given the urgency, the importance, the workgroup madness all around. What forum with what people with what time with what scope? We're going to try to figure it out, but we'd love if even more if somebody had a clear proposal. We're open.

Anastasia So, there will be more meetings with the specific workgroups for CalAIM coming up around enhanced care management and in lieu of services, so those meetings are already set, and they have meeting materials that will be posted soon. There's a public comment period for those meetings. You can weigh in there, you can weigh in through email. I'm happy to hear more specific—

Kim It sounds like maybe watching that we need to go to public comments, if there are—I'm going to put Claire on the spot and Lydia. If there's a couple people who want to circle up about what process we need to do here to make this process work better and also what a specific ask to DHCS is, we're happy to hop

on the call with you, not hop on the call with you, carry that forward, change from being so content heavy to a little more process, but could you two kind of take that as you'll think and make a recommendation?

Good, Karen. Great. Thank you, Karen. You'd like to figure it out. I'm siting here think the one meeting we have scheduled is on IHSS, and it's a ridiculously packed agenda because there's so much there.

W [Speaker off mic].

Kim Right. So, that's a question. Do we not want to have the IHSS conversation that day and do something else, but on the other hand, March is March, and so love to hear recommendations on that. We're all struggling with this.

Sarah Ellen has been waiting on the line.

Kim Should we let Ellen, and then we'll switch to public comment? Is there anybody else that—does that work? No, Ana's card is up. How about Ana, Ellen—

Patty I think Nina had a comment, too.

Nina You know what, I can hold my comment. It's okay.

Sarah Okay, Ellen.

Ellen S. Hi. This is Ellen Schmeding. I'll make it really quick. I just want to thank all the presenters and the very rich content today. I do think we processed quite a few issues that deal with the middle income which includes the I&A recommendation which I see on a multi-tiered level. There's some basic standards for all regions, and then a best practice is a more integrated system which we've had for years in San Diego.

The other thing I just want to say is Victoria Jump talked about the Older Californians Act. That is also not means tested and for all older adults to access.

Patty That's right. They just have to be 60 years of age and over. Period.

Ellen S. I strongly agree with looking at that as one way to fund tested services that serve populations. Thanks so much.

Patty Me, too. I agree, Ellen.

Ana

Briefly, this is Ana. Ellen and Susan and I worked on the I&A draft. I really would highly recommendation you guys just send us directly any recommendations so we can just incorporate those and provide an additional draft for you to provide input. We really presented it as something for you to chew on and spit up. This is just the start of the process that we can get that feedback.

So, maybe you guys can send out that group of each group that's working on the recommendations. We'll take your feedback. We will incorporate it and give it back.

I think that there's some kind of overarching recommendations that I keep hearing from this group that it would be really great to get those down that would also feed into CalAIM. So, I keep hearing about functional needs versus age or disability or what have you. I keep hearing about expanding existing resources.

Let's be real. Not every AAA, not every ILC is perfect, but we have an infrastructure that we can build on, and we are doing some really innovative stuff. Like the I&A program, for example, when we are—the ADRC is part of that concept, both independent living centers and AAAs, no means testing. We're covering everyone regardless of disability and age and income.

So, we can leverage those, and it's not perfect in every area, but I guarantee you there are programs locally that we can highlight and bring forth that we can expand on to really ensure that it's not business as usual. We are enhancing, we are improving to really meet that local need.

So, I'm thinking that we take some of those overarching, and why not provide that as a recommendation for CalAIM as well? Don't just take in-house all your in lieu services. Here are these collaborative community partners who are doing it. Here's MSSP who could be made a statewide program to build on for the master plan and for CalAIM.

Patty Same with PACE.

[Speakers off mic].

Kim So, in that same spirit of really wanting to hear from the public, I'm going to—oh, boy, can we show very quickly the goals and objectives very quickly. This is also incredibly iterative. The goals, the objectives, the recommendations, and the metrics are all going to continue to work together.

So, similarly, we've been just saying to people send us your feedback on the objective. It's going to be refined as the recommendations shake out. It's going

to be refined as the research committee gets going on the metrics. Next week, the research committee is meeting on LTSS, but this is the current version, and literally it changes all the time as we get your feedback.

I think in the interest of today's meeting time, I'm not going to take comment on that right now, but people want to change that. Again, recommendations will start to flow, metrics will start to flow for the master plan. You do not have to use this for the stakeholder report on LTSS at all, but this is how we're trying to think about and organize the work, so that, too, can come to Carrie and me at any time.

Again, if somebody really wants to volunteer to own this and work on this, we're happy to take volunteers for that as well.

Okay, let's have robust 20 minutes at a minimum, if not the full 30. Where are we are on our agenda, 30 please of public comment. Are we ready? Wonderful. Thank you.

Any phone instructions?

W The operator needs to tell the people on the line—

Kim Operator, can you tell people on the line what to do for public comment? I'm trusting you know.

Moderator [Operator instructions]. We do have a question. It will come from the line of Marty Lynch. Please go ahead. Marty, your line is open.

Kim Marty, we can't hear you yet.

Marty L. Oh, thank you. There we go. Got you. Thanks, Kim. I don't know if I count as a member of the public. I'm not on this workgroup, so I'll take the opportunity.

I think the point that was raised earlier, and I'm sorry I couldn't tell who was raising it, about CalAIM being a real process while our own process is aspirational was a really good point. It just doubles down, to me, the importance of clarifying the input process around the different older adult related activities in CalAIM, which I think at a minimum are long-term services and supports, managed long-term services and supports. The D-SNP proposal, and to some extent, the in lieu of and enhanced care management.

I believe that either the workgroup and the overall stakeholder group, maybe using Kim as a voice, should recommend that DHCS does set up a specific workgroup, and I'm going to just say for the sake of argument that half of that workgroup be appointed by DHCS and half of it be appointed by the MPA process via Kim on CalAIM-related issues to older adults so that we're in sync and that we have a formal process, not just an occasional presentation, which is great. I love Mari, that was good, but not just an occasional presentation, but a formal way to have input, give feedback, and expected outcomes from that workgroup process. Thank you very much for listening.

Kim — Operator, I'm going to hold. I understand there's six people in the queue. Let's do a couple in the room who have been waiting patiently, and then we'll go back to the phone. Yes.

Laurinda — This is Laurinda Reynolds. I'm with American River College. I'm going to focus on workforce issues. I see the entry-level workforce paraprofessionals as the practical bridge between the silos, and there are quite a few training issues and educational issues that intersect across quite a few positions that could solve a lot of informational and service support issues.

Just to paraphrase what's been said today already, there's training requirements, and we need to make sure those training requirements are adequate. We need to make sure there's consistency of oversight wherever

possible. We need to make sure the training requirements are enforceable because they are not now. We also need to establish equitable pay.

You do have representation on the task force from universities, but universities do not train these positions. They train professionals, not paraprofessionals. Community colleges are not represented at this table. I'm a resource for that, and it's unique because I'm in Sacramento, and none of the community colleges across the state have some of these programs that you need, and they have not identified the trainings that are needed.

I'm going to run through a quick list of what I see as solutions so that somebody can finally get in touch with me. We don't have a case manager assistant program. To become a case manager, to be educated in that requires jumping through quite a few hoops that don't work for people inn the field of aging, and it's a national standard set by an organization.

We have no emergency preparedness training program right now, and it's a huge issues across all types of facilities and settings. The service coordinator training is nationally based from a professional organization. There's no standard. That is not being enforced. It's a 36-hour program, and they're not getting it.

There's no housekeeping training for hazardous waste and infection control. We don't have an information and referral assistance training program to help employers get people right on the job. Social services designees, the training goes through the RCFE program through California Department of Social Services, but it's not a real clear training program for outside of that.

Activity paraprofessionals are regulated by Division V and Division VI. They have different standards, different policing, and no policing for some, no enforcement. Caregivers do not have a training for working in home. There's some through RCFE, but there's no requirement. CNAs and HHAs are covered. Registered homecare aids only have to have five hours of training. Then, there's the CEU providing and all of that.

So, there's a lot that can be done to prepare people to be in the workforce to handle this information more adequately, and I just hope that somebody taps me to help with that because I'm probably one of the only people in the state who is working with the Department of Social Services and the Department of Public Health to get my courses approved for multiple positions on this list.

So, thank you for—

Patty Do we have your name and your contact information?

Kim Honestly, the most helpful thing to us to do is to submit the recommendation—

Laurinda Except I don't have the time—

[Overlapping voices].

Kim I feel your pain. I feel your pain.

Laurinda This is the end of the semester. I'm applying right now—

Kim Okay, well the workforce meeting is January 6th. Those of you who are planning the workforce meeting just heard Laurinda, and we welcome your contact again. Yes, that's great.

Other folks in the room who want to comment? Okay, let's go to the phone. Oh, sorry. I didn't—what am I missing?

[Speakers off mic].

Kim Yes, please. Wait for the mic, and then we'll go.

M [Indiscernible] County Welfare Directors Association. I happen to sit on the enhanced care management and [indiscernible] services workgroup on CalAIM. There are five workgroups. They have incredibly aggressive timelines, and their last meetings are all in February. So, if you want to make that connection, I would really encourage you.

One of the easiest recommendations is have DHCS or get ahold of the meeting schedule dates for each of the workgroups.

Kim I don't mean to speak for you, but Justice in Aging has submitted this request in writing to DHCS as recently as two weeks ago, yes? Yes.

On the phone, yes, operator. No, one more in the room. Okay. Knowing that there—I don't think we said this this meeting, but we usually aim for two minutes plus or minutes, so give us your comments, and then we'll go to the six on the phone.

Connie My name is Connie Arnold. I want to mention that On C-SPAN, November 14, 2019, there was an elder care program. Ways and Means Committee held a

hearing on the difficulties in caring for aging Americans including the lack of reasonably priced long-term care for senior citizens and their caregivers.

There was a really good speaker. Her name was Joanne Lynn. She was an MD, and I think it's absolutely critical that everybody sitting on this committee watch that three-hour video and hear the different speakers. You can select the individual speakers and listen to what they say, but as a doctor who became disabled, she said as her premiums doubled for long-term care insurance, she dropped her insurance.

There were other important issues that she brought up, but what I hear a lot today is a pie in the sky and pre-endorsement of CalAIM. There are many people in the disability and senior community who are absolutely opposed to mandatory enrollment into a managed care system and are going to fight it with everything that we have.

We have people interested in medical exemption requests. It should not take a lawyer to get that, and I think you need to hear from the stakeholders on those issues. Somebody else brought up about the workforce.

What we currently have is useless public authorities, poor referrals of untrained, unfit people that are being sent into seniors' and people's with disabilities

homes who are unqualified to even provide services, who are unstable, have mental health issues, are homeless, are drug addicts, are alcoholics, and who don't stay on the job.

So, while you want to plan for new programs to benefit the middle class, you need to address the workforce issues, and you need to get rid of the public authorities, go back to where we had the independent living centers, or come up with something different because those are not working, and there is no backup emergency services 24/7 except maybe in two places I've heard, one being Berkeley, and even that it costs people out of pocket who can least afford it.

When people can't find workers, they certainly can't get the care, and most of us are not interested in giving up our IHSS to be part of PACE, MSSP, and that other one, adult daycare.

Now, if you need to be managed because you have dementia or you have Alzheimer's, or you need a team of people to be able to live independently, and it should not be oh, I can just live there for two years, and then I'm going to be placed in an institution. The goal is person-centered care, self-directed care, keeping people out of institutions, meeting the individual's needs.

If each one of you raise your hand and said okay, anyone over 55, do you want to be treated like you're from a medical model, or do you want to come from a social model, and deal with what your functional limitations. Each person is different, and there is no cookie cutter training program either because it has to be what the individual with the disability themselves needs, and each disability, even if there are two quads, that doesn't mean those needs of those two individuals are the same. Thank you.

Kim Operator, can you just remind me how many people are in the queue at this point, just for a time check? Five?

Moderator At this point there are five.

Kim Okay, great. Let's go through the five, and again, if everyone can aim for two minutes more or less, we appreciate it.

Moderator The question comes from the line of Paula Herman. Please go ahead.

Paula Hi. I'm going to talk really fast. Thank you for opening this meeting up to the telephone comments. I've been listening, and I have ideas pop in my mind as people are talking. I wish I could have replied to be on this committee.

Unfortunately, I take care of my daughter 24/7.

I'm a parent provider. I'm the chairman of the board for the Spina Bifida Association of Greater LA. I'm a disability rights advocate trained by Marilyn Holly [indiscernible] with Marilyn's assistance in 1979 to be the first paid parent in the State of California, and my daughter was the first child on a homemaker's [indiscernible]. So, I have a history.

When I hear the pompoms about managed care, which I've been fighting since 2011, I would like you to consider having a medical exemption request in there so that medically fragile people are not yanked from their doctors and their security and their comfort zone and put a blindfold on and pick somebody out of a booklet and pray to God their network works and has the specialists that you need.

I'm in LA County, and I'm telling you they don't work right. I have been fighting successfully since 2011 to keep my daughter on FSS Medi-Cal. I submit medical exemptions. The doctor fills them out, faxes them in, and I've gone so far as to almost to the steps of the judge and have it withdrawn and another six-month extension.

I do not want my daughter in a guinea pig thing managed care. Now, my daughter has spina bifida. They don't have spina bifida clinics for adults. My

daughter has very tiny, L-shaped feet. She wears custom-made shoes. Medi-Cal pays for one pair a year. That may not be significant to a lot of people to have shoes on their feet, but to me it's very important. She has no feeling below her knee.

My daughter needs to have shoes on her feet, and Medi-Cal will pay for one pair a year. Case managed care plans will only pay if she has diabetes. She's not diabetic. She's spina bifida. So, that's needs to be fixed.

Also, there's a lot of complaints about LA Care which is in LA that they don't want to pay for medical durable goods. They don't want to pay for wheelchairs, so you have to fight with them. My daughter has a shunt in her head. She has about 48 hours before she goes blind if that shunt malfunctions. I don't have time to wait around for a primary for two or three months and then have them refer to a specialist in their network that might not know about a shunt because she'll be dead.

So, I am afraid of your managed care plans. So, you carry on, but I think that you should have a medical exemption. That's my recommendation on that. It's the most important thing in the world to me.

The other things is I want you all to know that I've been doing this since 1976, her provider. She's 24-hour care, and I have never been allowed federally to contribute to my own retirement. When I've ask what I do, well you just take care of her until one of you dies.

So, then you will have me sucking off the state, you will have me spending down every penny I've saved so that I can go on your poor-formed program, too. I don't want to. I'd like a little dignity here. I take care of my daughter. I wanted to contribute to my own Social Security. They don't even let us pay taxes. I mean, it's just a joke.

So, you need to look at these things for seniors. If they get a relative in to take care of them, that relative is not contributing to their own Social Security. If you're a parent or related, it's something about a family member being paid, you can't do it. You can't contribute.

So, that's the thing that needs to be fixed, and the union was going to work on that, I don't know, five years ago. They never went anywhere with it.

So, I'd like to echo a lot of things that Connie Arnold says because she's disabled, and she lives independently, or tries, and goes through a rotation of all

these providers. I hear her complain when I talk to her on the phone about a provider doesn't show up, calls five minutes before she's going to get there.

You know, I think that you need to look at universities, community colleges, and get nursing students into be providers and give them credits. That's what I think would work. Then you're not going to get drug addicts and drunks and homeless people and who know who touching your most private parts. I wouldn't want that for my daughter. I'll take care of her until I croak. I'm not going to have it.

So, these things need to be looked at for seniors. If you're going to rip them out of a comfort zone and take them away from their doctors who they are comfortable with and they trust and rely on and toss them into a pickup plan, that's not okay.

Kim Paula, I want to thank you so much for sharing about your daughter.

Paula Well, you need to know this. It's important because it is for seniors, and it's going to affect them horribly. You can't just toss everybody into a one-size-fits-all because they don't all fit all. My daughter's shoes don't fit anybody but her.

Kim — We have just gotten notice that at 5:00, we need to be out of the room. I'm not wrapping up—

Paula — I thank you for listening to me, and I'm rather passionate about this because it's my daughter.

Kim — I'm grateful for your sharing that experience and the importance of it. I want to make sure other people on the phone have a chance to give that voice. Operator, can you open the next line, please?

Moderator — Next we'll go to the line of George Kutnerian. Please go ahead.

George — Hi, there. Can everyone hear me?

Kim — Yes.

George — Thank you. My name is George Kutnerian. I am with 6Beds which is an association that represents small residential care facilities including to serve the elderly and adults with developmental disabilities as well as mental illness.

I was on the call this morning for the Managed Care Advisory group, and they dealt with the specific component of CalAIM, that being the standardization of benefits and required mandatory enrollment. There was discussion about MSSP where unlike Cal MediConnect where it was carved in that MSSP would be carved out. My understanding from that conversation also was that the other 1915(c) waivers such as HIV/AIDS assisted living waiver, Home and Community-Based Alternatives Waiver that those would also not be carved in.

So, I'm wondering if that's consistent with what everyone is understanding here in terms of on the committee and how that interacts with a required managed care enrollment requirement. So, if people are on an assisted living waiver, would they not be required to be in managed care?

Kim — Denise Likar from MSSP is going to give you an answer.

Denise — Hi. You're correct on that those waivers are carved out. Some of those waivers have been carved out during CCI, but it still was required that if you lived in a CCI county, your Medi-Cal had to go into managed care, and you had choice with your Medi-Care.

George — Okay. So, under the CalAIM, if you're—so, my understanding is that in a CCI county, if you were going to enroll in the waiver, you could opt out of a CCI plan.

So, in that same model you would kind of apply under CalAIM that's currently contemplated?

Anastasia This is Anastasia Dodson from DHCS, and thanks for that great question. As Sarah Steenhausen said, there will be a paper coming out in December, and we can pass that along to people to specify in the paper, but the good thing, and I think it's better in writing just to clarify.

Kim Thank you for the CalAIM partnership and backup. Who's next on the phone?

Moderator Next we'll go to the line of Kathy Nasif. Please go ahead.

Kathy N. Hi. This is Kathy. I'm a 71-year-old senior disabled lady in San Diego, and I want to state my opposition to the proposed CalAIM Managed Care program. I am disabled with stage 5 kidney failure and heart failure and lupus and several other illnesses. I see mostly all specialists. I never go to primary care. It takes too long waiting around. I have serious issues that come up where I have to get in on a dime or to the emergency room.

I can't waste time in a managed care program. I do not think they give you good care. All of them down here are just community clinic doctors that take that kind of Medi-Cal managed care. The good doctors in the system I'm in do not

take it, and I need to be in a good medical system. I'm trying to preserve my life as long as I can.

If you do try to put that through, I'll be one of those people opposing it with all I have. I'm writing the governor about it now. It's not fair for people who are on Medicare that I worked all my life for Medicare, and now that I need to use it, you're going to force me into a Medi-Cal system. I do have both now. I chose not to go into MediConnect in the managed care that's there right now because I don't like Medi-Cal doctors here.

So, I'm highly opposed to that, and I don't think it's legal to make just because you're on low-income or on two programs that you're forced to take a Medi-Cal HMO plan when you should have the same rights as any other senior that paid into the system all your life.

My second thing that I'd like to talk about is the poor public authority list we have down here for caregivers. I am a wheelchair-bound lady. I have been looking for a caregiver for three years to help me on Friday, Saturday, and Sunday. I can't find anybody. The few that I've tried out have been thieves, alcoholics, people that don't show up, and there's very few people that are on the list that even respond to a phone call.

There's people down here that I've heard of that are like 90 years old that cannot get a caregiver. If you talk to the IHSS down there, they'll tell you how difficult it is to get anybody here to help you, and this program is for people that need help to say safely in their homes.

The Homestead Act guarantees that, and instead I have third-degree burns on my leg because I was trying to boil an egg on my own when I have cooking help from IHSS but no one to cook. I also cut up my feet trying to move around in my kitchen. I have a bleeding disorder with pools of blood. I had to call the paramedics out, and I've done this three times in the last two months.

I feel like I'm living dangerously, but I want to live in my home. I do not want to be put into a nursing home, and I deserve to live in my home with the help I need.

There's other issues. These people are mostly foreigners on the list. They don't cook your kind of food. They don't speak your language.

Kim Kathy, thank you. I'm going to pause you right there. I need to make a quick announcement and I know we have two more people on the phone. Let me do a rapid-fire summary of the recommendations, and then we will go to the two on the phone as we are about to be walked out of the room.

Next steps. The people who are working on the recommendations that have already been begun will continue to do that. We will circulate those names so you know exactly who was working on them. We will also do a whole committee list with names and emails and cell phones.

We also have a new ad hoc committee to say let's take a look at our process and timeline and see if we can use our time better. Thank you so much for that. That group is already scheduling their time to talk tomorrow or Monday to help us think how we work together.

There's also a group here that's going to try to reach out to DHCS and suggest new ways for the CalAIM Master Plan to be coordinated, and on our side, we will continue to do that and follow up with DHCS leadership. Thank you to Anastasia for staying and coordinating throughout.

We will also share the resources that were mentioned. Connie mentioned the Ways and Means Committee, the DHCS paper coming. We will do that. Those are the next steps we captured. If we missed anything, let us know.

Let's go to the last two people on the phone, operator.

Moderator Next will be Katy Weber. Please go ahead.

Katy Hi, I'm Katy Weber, [indiscernible] Solutions. I'll talk really fast, which I can do.

Kim Thanks, Katy.

Katy I just wanted to quickly comment on Denise's comment on technology and Claire's and other comments on vesting. We're already working to expand on that.

One thought with the CalAIM process is to propose looking at blended funding models to help the statewide community-oriented medical home model. One of the models like that is the Vermont Blueprint model to fund and scale the program. That's coordinated with the Department of Aging and other departments with the state Medicaid director accessing different fundings including the HFF [ph] fund, 1115 wavier, the IAPD process, the Innovation Model funding.

Basically, because I know you talked a lot around today about existing programs and how we can scale those because a lot of the challenges with community-based providers is they don't have access to funding for technology to scale.

So, that's my quick comment. Thank you.

Kim Thank you. Operator, one more comment, I believe?

Moderator Yes, last one will come from Gary Passmore. Please go ahead.

Kim Perfect. Gary, sum it all up for us.

Gary I'm glad I could end this call. I'm not going to burden you with all my comments and questions at this point, but I will say this has been a very informative meeting, and I really appreciate all the work that went into it. So, have a good holiday.

Kim Bravo. Have a good holiday. More to come. Thank you so much.

Moderator Ladies and gentlemen, we'll conclude our conference for today. Thank you for your participation and for using AT&T TeleConference. You may now disconnect.